

# Making Medical Male Circumcision Work for Women

Women's HIV Prevention Tracking Project (WHiPT)  
December 2010

## South Africa Country Report

An excerpt from the original five-country report with coverage of Kenya, Namibia, South Africa, Swaziland and Uganda



## ABOUT WHIPT

The Women's HIV Prevention Tracking Project (WHIPT) is a collaborative initiative of AVAC and the ATHENA Network launched in 2009 to bring community perspectives, particularly women's voices, to the forefront of the HIV and AIDS response. The specific purpose of WHIPT is to advance and facilitate the monitoring of HIV prevention research, advocacy and implementation by women who are the most affected by the epidemic.

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Photo Credits: Cindra Feuer

Front cover: Women from Sigwe village gather while SWAPOL introduces the WHIPT project and provides an introduction to the status of male circumcision for HIV prevention rollout in Swaziland.

This report is dedicated to

## Lynde Francis

1947–2009

Founder of the first AIDS treatment clinic in Zimbabwe.

Influencer of formative dialogue around women and medical male circumcision.



Thembi Manana, a SWAPOL caregiver and resident of the village of Sigwe, gathering women to be interviewed for their opinions on the implementation of male circumcision for HIV prevention.

# EXECUTIVE SUMMARY

## KEY FINDINGS

- There is general support from women participating in WHIPT for the implementation of medical male circumcision (MMC) as an HIV prevention strategy. However, these women qualified their support with various statements.
- In general, women who participated lack detailed factual knowledge of the benefits and risks of MMC for HIV prevention.
- Many women interviewed believe erroneously that they would be *directly* protected against HIV if their partners were medically circumcised.
- Country studies highlighted a perceived belief among women interviewed that traditional male circumcision (which has not been evaluated for its HIV prevention benefits) might afford the same protection as MMC for HIV prevention.
- Women from some communities participating in WHIPT reported a conflation of female genital mutilation<sup>1</sup> and medical male circumcision, including the perception that both would reduce the risk of HIV infection.
- For women to access and act on information related to MMC and HIV, the information needs to be tailored to women. Also, the socio-cultural context and the realities of women, particularly in traditional male circumcising communities, need to be taken into account.

## 1. BACKGROUND

The Women's HIV Prevention Tracking Project (WHIPT) is a collaborative initiative of AVAC and the ATHENA Network launched in 2009 to bring community perspectives, particularly women's voices, to the forefront of the HIV and AIDS response. The specific purpose of WHIPT is to advance and facilitate the monitoring of HIV prevention research, advocacy and implementation by women who are the most affected by the epidemic.

The pilot phase of WHIPT has focused on strengthening women's knowledge about, engagement with, preparedness for, and monitoring of medical male circumcision (MMC) for HIV prevention in countries where roll-out was underway or imminent. Community-based teams of women in Kenya, Namibia, South Africa, Swaziland and Uganda assessed women's knowledge, perceptions and involvement with MMC as an HIV prevention strategy, with a strong emphasis on women living with HIV. The work was predominantly done in collaboration with networks of HIV-positive women. Additional work is needed and will be undertaken with women who are HIV-

1. The authors acknowledge this diversity in language and the various implications of alternatives like female genital cutting and others. The consensus among teams was to use "female genital cutting" in the report.

negative and/or do not know their status. However, HIV-positive women are at the forefront of health-related advocacy and information in their communities and are critical allies in implementation of any new prevention strategy. In all but one region of focus (Nyanza in Kenya), MMC for HIV prevention had not yet been rolled out; therefore, most of the women documented perceptions and concerns around MMC's pending rollout, not actual or anecdotal experiences of the rollout.

The Women's HIV Prevention Tracking Project emerged from the June 2008 Mombasa Civil Society Dialogue on Male Circumcision for HIV Prevention: Implications for Women, convened by AVAC in advance of the World Health Organization's consultation on the same topic. The Mombasa Civil Society Dialogue was a critical milestone in the effort to create opportunities for women, particularly HIV-positive women, to engage with male circumcision for HIV prevention and related topics of HIV prevention research and advocacy. The Mombasa Dialogue specifically responded to the desire for community stakeholders to understand the findings from the MMC clinical trials and for these same stakeholders to be able to debate and discuss the implications of the research for women.

This report is one component of ongoing civil society work in countries to elevate women's concerns and to ensure that the rollout of MMC as an HIV prevention strategy is beneficial and safe for women. Over the next year, WHIPT teams will execute advocacy plans based on the findings reported here.

## 2. METHODOLOGY

The intent of the WHIPT five-country pilot was to document and analyze women's perspectives and levels of participation in discussions and decisions about MMC for HIV prevention; and to build qualitative research capacity and knowledge of MMC among various stakeholders, particularly women in communities.

Project activities included training in community-led research; research literacy with respect to HIV prevention science including the scientific evidence for MMC as an HIV prevention strategy; literature review; information and data collection through multiple means, including a questionnaire, facilitated focus group discussions, and formal and informal interviews with key stakeholders; and information dissemination on MMC for HIV prevention among community-based women's organizations and networks.

Each country team consisted of one or more point people at the organizations charged with conducting the surveys; the executive director of the organization; staff or volunteer members trained in the survey methodology; and, in all but one case, a consultant providing technical analysis in quantifying and analyzing the findings.

The WHIPT teams developed two tools to ascertain impressions of and knowledge about MMC for HIV prevention from women in communities. (For questionnaires, visit [www.avac.org/WHIPT](http://www.avac.org/WHIPT)). Some country teams then trained women in the respective communities to undertake the research among their peers, or the teams themselves conducted the research.

In total, 494 women completed the questionnaire across the five countries and almost 40 focus groups were convened. In each country, the research was carried out in diverse locales, selected to reflect a diversity of practices, including traditionally circumcising and non-circumcising communities as well as those practicing female genital mutilation.

### 3. KEY CONSIDERATIONS OF WHIPT SCOPE AND STRUCTURE

The goal of the WHIPT project was to expand the community of women engaged with male circumcision for HIV prevention and broader related topics in biomedical prevention. AVAC and ATHENA's capacity building included ongoing dialogue around MMC research and the conduct of biomedical prevention trials. Perceptions and understanding of issues and, therefore, presentation of information to key informants and focus groups may have shifted over time.

This was a pilot project designed to build capacity and understanding of key issues affecting women. It was not designed as a formal qualitative study.

A diverse array of women participated in the research, both as researchers and as participants, thereby creating variability across those who undertook the research and those who were interviewed. This variability (or heterogeneity) likely influenced the findings due to the range of experience in undertaking qualitative and quantitative research as well as the sensitive nature of the topics under discussion such as sex, sexuality and gender-based violence.

The work was grounded in networks of HIV-positive women but did not exclusively involve HIV-positive women. As no one's HIV status was disclosed, it is impossible to control for the responses of HIV-positive and HIV-negative interviewees. However, HIV-negative women may have different views or concerns. Additional dialogue and issue exploration is needed to learn about perceptions and concerns of the findings to HIV-negative women.

The Executive Summary presents aggregated data in order to document overall trends across the five countries. The WHIPT team members feel this provides an accurate picture of crosscutting issues. However, given the previously listed structural considerations, there are limitations to the conclusions that can be drawn from pooled data.

### 4. SUMMARY OF FINDINGS<sup>2</sup>

#### WOMEN'S AWARENESS OF AND INVOLVEMENT IN MMC

Out of all the women interviewed, 79 percent (of 494 women) had heard about MMC. When probed, women had varying levels of knowledge but sought to be involved in the process.

- 40 percent of women talk to their sexual partners about MMC
- 74 percent would want to be involved in the process of their partner's MMC
- 36 percent of women perceive themselves as potentially involved in the decision-making process around MMC

#### RECOMMENDATIONS

- Given the gap between women's interest in engaging with male circumcision for HIV prevention, and their reported lack of involvement, there is an urgent need to ensure that MMC programs and policies actively create opportunities for women to engage with and inform MMC implementation.

2. The percentage figures represent the aggregated total across all five countries, but the total number of interviewees within each country is not consistent across countries. Individual country figures can be found in the country chapters.

## WOMEN'S SUPPORT FOR THE INTRODUCTION OF MMC

Among the women interviewed, there is general support for the implementation of MMC as an HIV prevention strategy in their communities. (A range of specific concerns was also raised and is explored below.)

- 87 percent would support the introduction of MMC
- 85 percent believe that it could be introduced into their communities
- 77 percent believe that men would volunteer to become circumcised

## UNDERSTANDING PROTECTION

A total of 46 percent of the women interviewed believe that MMC is protective for them. Out of these, some believe correctly that they would be indirectly protected over time once a critical mass of men in the population are circumcised; others incorrectly think they'd be directly protected. Others did not specify how they might be protected. There were also reported misconceptions that medically circumcised men are by definition HIV-negative.

- 72 percent understood that MMC is partially protective or not 100 percent protective
- 58 percent understood that condoms should be used even with circumcised men
- 58 percent understood the need to abstain from sex during the wound-healing period post circumcision

## RECOMMENDATIONS

- Advocates, grassroots women's groups, implementers and governments through national plans must provide clear and correct messages to men and women and train the media with factual information, highlighting risks and benefits of MMC for HIV prevention overall and the specific implications for women. Correct messaging should emphasize the lack of a *direct* HIV risk-reduction benefit for women with circumcised partners.
- Advocates, implementers and national plans should emphasize MMC as a complementary HIV prevention method rather than as a stand-alone method.

## IMPLICATIONS FOR SEXUAL DECISION-MAKING AND GENDER-BASED VIOLENCE

Of the respondents, 64 percent believe MMC would change ideas around HIV risk either negatively or for the better. These perceptions range from concerns that men would increase behavior risks to the hope that information and education for men during MMC would decrease men's risk behaviors—increasing condom use and decreasing sexual partners.

The majority of WHIPT participants perceive that MMC might lead to an increase in gender-based violence (GBV) and heightened stigma for women living with HIV. This would be a result of circumcised men's misperceptions that they are not HIV-positive and/or cannot transmit the virus. Thus sex and/or safer sex would be less negotiable than before circumcision, putting women at greater risk for GBV.

- 74 percent of women reported existing gender-based violence in their communities
- 54 percent of respondents say MMC could increase gender-based violence
- 8 percent say they're currently very comfortable asking their sexual partners to use condoms
- 48 percent are not at all comfortable asking their partners to use condoms

## RECOMMENDATIONS

- Implementers, advocates and national plans should ensure that MMC programs are implemented as part of comprehensive HIV prevention programs that also integrate female condom access and empower women to be involved in sexual decision-making.
- Implementers must offer comprehensive MMC packages that will integrate sexual and reproductive health services for men, including condom counseling and gender transformative education.
- Implementers must include gender indicators in MMC rollout monitoring and evaluation efforts.
- Advocates must monitor that resources allocated for MMC rollout are not diverted away from HIV prevention programs and research for women.

### CONFLATION OF MEDICAL MALE CIRCUMCISION AND FEMALE GENITAL MUTILATION (FGM)

Women, particularly those from regions of Kenya and Uganda where female genital mutilation (FGM) is practiced, report a conflation of FGM and MMC, including the assumption that both reduce risk of HIV infection:

- 23 percent surveyed incorrectly think FGM could protect women from HIV
- 25 percent believe that the promotion of MMC might also promote FGM among girls and women

## RECOMMENDATIONS

- Implementers must clearly distinguish MMC from FGM in all program literature and communications in relation to its benefits for HIV prevention.
- Advocates must monitor efforts to clarify the distinction between MMC and FGM.
- All stakeholders must ensure that the rollout of MMC does not lead to an increase in FGM.

### CONFLATION OF MEDICAL MALE CIRCUMCISION AND TRADITIONAL MALE CIRCUMCISION

Many women participating in the research indicated that they have heard about MMC for HIV prevention. However, when discussed further, responses also indicated some level of confusion between MMC and traditional circumcision whose practices can vary and have not been evaluated for HIV prevention benefits.

## RECOMMENDATIONS

- Governments, implementers and advocates must distinguish clearly between traditional and medical male circumcision in all program literature, communications and counselling in regions where traditional male circumcision is practiced.

## 5. DISCUSSION

Looking across all five-country reports, AVAC and ATHENA recognize that MMC is a promising intervention for HIV prevention. There are also essential steps needed to increase women's involvement and understanding of the strategy. These steps are critical to ensuring that the risks and benefits of MMC are understood and that the strategy is adopted as one of, and not a replacement for, the full range of prevention tools.



Women interviewed in communities, including women living with HIV, raise serious concerns about the impact that the partially effective intervention might have on risk compensation (increased numbers of partners for men and decreased use of condoms by men), sexual negotiation, GBV, stigma, FGM, and resource allocation away from comprehensive HIV prevention, particularly from women-controlled and -initiated prevention tools.

The women interviewed by and participating in the WHIPT teams also voice additional concerns around abstinence until wound healing post-surgery. Data suggest that HIV-positive men who are circumcised and resume sex prior to complete wound healing have an increased risk of transmitting HIV to their female partners compared to uncircumcised HIV-positive men.<sup>3</sup> Circumcised partners may or may not know their HIV status because testing is recommended but not required for surgery.

**The myths and misunderstandings identified by the WHIPT teams, such as a perception that MMC is directly protective for women, underscore the urgent need for adequate education campaigns on MMC.** Campaigns should particularly address the impact that this intervention could have on women and emphasize the partial protection from HIV infection MMC provides for men and its non-protection for women. Further, immediate steps must be taken to understand and address the conflation of MMC with FGM as well as the perception that MMC as an HIV prevention strategy could fuel stigma and discrimination against women living with HIV. Additionally, steps need to be taken to distinguish MMC and traditional male circumcision—which may or may not offer the protection afforded to males by MMC.

All five-country chapters express a need for increased access to, and availability of, women-initiated HIV prevention options. The WHIPT findings underscore the importance of monitoring resources devoted to MMC to ensure that they are not diverted from HIV prevention programs and research for women. The teams also stress the need for all HIV prevention programs, including those offering MMC, to provide comprehensive prevention services and interventions that directly address women’s needs and reduce women’s risk of HIV. This includes MMC counseling incorporating men’s sexual health and gender sensitivity training. Such services should be integrated into new MMC programs and also developed in their own right. Finally, the WHIPT team findings underscore the need to increase women’s participation in all aspects of MMC policy and program development so that these policies and programs address women’s concerns in operationalizing the rollout of safe MMC.

## 6. NEXT STEPS FOR WHIPT ADVOCACY

Over the next year, WHIPT teams will execute advocacy plans based on their findings. Actions include:

- Leading national launches of WHIPT’s comprehensive report of findings and key recommendations
- Linking women’s organizations and networks to WHO MMC country delegations
- Working with MMC implementers on women-specific MMC communications materials
- Ensuring implementers include gender indicators in MMC rollout monitoring and evaluation efforts
- Developing a collaborative research literacy curriculum aimed at women in affected communities
- Monitoring resources allocated to MMC
- Further investigating the conflation of MMC and FGM and how an increase in FGM may be mitigated
- Investigating the benefits and disadvantages of infant male circumcision

3. MJ Mawer, et al. Circumcision in HIV-infected men and its effect on HIV transmission to female partners in Rakai, Uganda: a randomised controlled trial, *The Lancet*, July 2009.

# SOUTH AFRICA<sup>1</sup>

JOHANNA KEHLER – AIDS LEGAL NETWORK

## KEY FINDINGS

- There is general support by women for MMC to be introduced into communities. However, this support is contingent upon women having their needs and concerns addressed in the broader HIV prevention agenda.
- Women identify concerns about their inability to negotiate condom use and that MMC will lead to an increase in risk behaviour among men.
- Women identify concerns that MMC will contribute to gender-based violence, including an increase in stigma and blame being directed toward women with regards to HIV infection.
- Women call for increased access to, and availability of, women-controlled HIV prevention strategies in conjunction with MMC rollout, such as the female condom.
- Women from Eastern Cape, where there is a tradition of circumcision, largely responded to the introduction of MMC in their roles as mothers; those from KwaZulu Natal, a largely non-circumcising community, were more focused on the impact of MMC on their sexual health and rights.
- For women to access and act on information related to MMC and HIV, the information needs to be tailored for women. Also, the socio-cultural context and the realities of women, particularly in traditional male circumcising communities, need to be taken into account.

## 1. POLICY FRAMEWORK AND CONSIDERATIONS: THE SOUTH AFRICAN CONTEXT

South Africa has the world's largest population of people living with HIV, and it has been estimated that about a third of men in South Africa are circumcised.<sup>2</sup> The practice of traditional and/or religious circumcision is not fully regulated by the state, hence this estimation is based primarily on the percentage of indigenous communities that are traditionally circumcising, as well as the Muslim and Jewish communities.

A newspaper article dated December 4, 2009<sup>3</sup> reported that South Africa's National AIDS Council (SANAC) had, as early as 2007, raised the possibility of providing medical male circumcision (MMC) services in South Africa but faced a lack of political support. In 2008, civil society engaged with the issue, and SANAC showed more support and a stronger voice regarding the introduction and rollout of MMC services for HIV prevention.

1. This is an excerpt from the South Africa country report. Kehler, J. & Arnott, J. 2010. *Medical Male Circumcision for HIV Prevention: Are women ready?* Cape Town: South Africa. AIDS Legal Network. Available for download at [www.avac.org/WHIPT](http://www.avac.org/WHIPT)

2. [http://www.malecircumcision.org/publications/documents/South\\_Africa\\_MC\\_case\\_study\\_May\\_2008\\_002.pdf](http://www.malecircumcision.org/publications/documents/South_Africa_MC_case_study_May_2008_002.pdf)

3. <http://www.plusnews.org/report.aspx?ReportId=87315>

At the same time, the SANAC Women's Sector raised concerns about the impact on women and questioned how introducing MMC as an HIV prevention strategy would benefit women. Traditional leaders also raised concerns that MMC would conflict with traditional male circumcision practices, which lies at the core of young men's initiation rites for several ethnic groups in South Africa.

An update on the male circumcision policy process in South Africa, dated July 2009,<sup>4</sup> stated that the National Strategic Plan (NSP) for HIV and AIDS would incorporate MMC under prevention strategies towards reducing sexual transmission of HIV. This update on the policy development process included a recognition that any policy on MMC should expressly recognize that this is not a stand-alone intervention but forms part of a comprehensive HIV prevention program and that MMC programs must promote safer sex practices, the correct and consistent use of male and female condoms, and sexual and gender equality and must ensure access to appropriate HIV testing and counselling services. It was also noted that MMC programs needed to be gender sensitive, focusing on women as partners and mothers, and explain advantages of MMC for HIV prevention to women.

As of February 2010, the Department of Health has produced a draft set of Implementation Guidelines, and is conducting a feasibility and costing analysis. The *male circumcision policy for HIV prevention in South Africa* to provide a framework for policy makers and implementers is in the process of finalization.

## 2. METHODOLOGY

### STUDY SAMPLE AND PROCESS

The project was conducted in and around Port Elizabeth, Eastern Cape, and in KwaMakhuta, KwaZulu Natal. While male circumcision as a customary rite to manhood is widely practiced in communities of the Eastern Cape Province, communities in KwaZulu Natal can be described as "non-circumcising", in that male circumcision is not an integral part of customs and traditions practiced in this region.

During the data collection phase, the AIDS Legal Network (ALN) worked in partnership with community-based organizations,<sup>5</sup> primarily positive women's groups and networks, in both provinces. In KwaZulu Natal, the data were collected in partnership with women from the National Association of People Living with HIV and AIDS (NAPWA), and in the Eastern Cape with women from Her Rights Initiative (HRI), the iBhayi Positive Living Centre and Ikhala Trust.

In both provinces, the process of data collection was closely linked to knowledge transfer and capacity building on both MMC as HIV prevention and its impact on women, as well as on research methodology. As such, the ALN facilitated capacity-building sessions with 24 women in KwaMakhuta (December 2009) and 22 women in Port Elizabeth (January 2010). Subsequent to these sessions, a total of 145 questionnaires were administered to women, and four focus group discussions were facilitated in the respective communities.

4. <http://www.slideshare.net/NicoPaul/male-circumcision-research-into-policy-final-s-a-h-a-r-a-dec-09-2009>

5. The ALN has ongoing working relationships with the identified organizations in the provinces.

### 3. RESEARCH FINDINGS

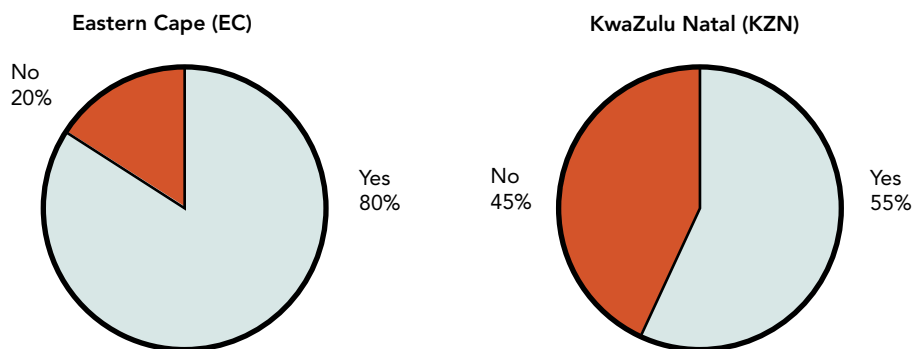
#### SOCIO-DEMOGRAPHIC BACKGROUND OF RESPONDENTS

A total of 145 women participated in the research by responding to the structured questionnaire. Of those women, 69 were from the Eastern Cape (EC) and 76 were from KwaZulu Natal (KZN).

#### KNOWLEDGE ABOUT MEDICAL MALE CIRCUMCISION FOR HIV PREVENTION

Asked whether they had heard about MMC for HIV prevention, 67 percent (97) of the total sample said “yes” and 33 percent (48) said “no”.<sup>6</sup> A markedly higher percentage of women in the EC (55, 80%) indicated that they had heard about MMC for HIV prevention, than in KZN (42, 55%).

Heard about MMC for HIV prevention



Of the total sample, 41 respondents specified that they have heard that MMC reduces the risk of HIV and other STIs, with 57 percent of the KZN and 32 percent of the EC sample making reference to that effect. There was also reference made to the belief that MMC was a “cure” for HIV; one respondent from the EC noted “that it’s safe when it comes to HIV”.<sup>7</sup>

Respondents were further asked how and from whom they had heard about MMC for HIV prevention. In both areas, the radio was by far the significant medium of communication, and both areas had not seen any billboards. In KZN, more than half (13) had heard about MMC through the radio, followed by the community (8).

In the EC, respondents had heard about MMC for HIV prevention equally through the radio (5) as at the hospital/clinic. One respondent from the EC said she saw it on TV, but:

*“I didn’t pay much attention as my husband doesn’t want us to listen when things are on about circumcision.”<sup>8</sup>*

The quote above arguably highlights some of the socio-cultural tensions around male circumcision, and the exclusion of women from gaining access to information. As traditional male circumcision is a “sacred” and “secret” male institution, women who want to access health and HIV information related to male circumcision practices face many barriers, including the control of women’s information-seeking through watching TV. Thus,

6. Only respondents who had heard of MMC for HIV prevention continued with the questionnaire.

7. EC, January 21, 2010, No 32

8. EC, January 21, 2010, No 38

for women to access and act on information related to MMC and HIV, the information needs to be tailored for women and take into account the socio-cultural context and the realities of women in traditional male circumcising communities.

Of all respondents (97) who had heard about MMC for HIV prevention, 17 percent indicated that they were not aware that there is a need for condom use after MMC, and 18 percent were unaware that MMC does not provide 100-percent protection from HIV risk. Given that the main communication messages attached to MMC for HIV prevention are to be linked to the need for condom use and the fact that MMC does not provide 100-percent protection from HIV transmission, these percentages are quite significant and arguably an indication of inadequate and “unclear” messaging and/or information on MMC for HIV prevention.

Moreover, when asked whether they are aware that men need to abstain from sex for six weeks after the “surgery”, 35 percent said “no”. Similarly, given the increased risk of HIV transmission before complete wound healing, this percentage indicates both a lack of adequate factual information about MMC and the need for focused awareness and education campaigns for women.

### **Discussion**

While the data indicate relatively high levels of perceived knowledge about MMC for HIV prevention, they also indicate that a significant number of women at a community level have never heard about it, which is of concern, especially considering that MMC programs are about to be rolled out.

The data also seem to suggest that “hearing” about MMC for HIV prevention does not necessarily translate into having “factual knowledge” about MMC, such as that MMC is only partially protective against HIV risk, the need for condom use after MMC, and the need to abstain from sex during the period of wound healing. Thus, the data arguably confirm the need for education and awareness raising about MMC for HIV prevention prior to the rollout of MMC programs, as well as highlighting the shortcomings of current information and messaging about the benefits of MMC for HIV prevention.

### PERCEPTION OF ADVANTAGES AND DISADVANTAGES OF MMC FOR HIV PREVENTION

To further assess knowledge and perception of MMC for HIV prevention, respondents were asked whether they thought there are advantages and/or disadvantages. Of the 92 respondents<sup>9</sup> who completed the question, the majority (66, 72%) indicated that there were advantages of MMC for HIV prevention, and 26 (28%) did not see any advantage.

#### **Eastern Cape**

In the Eastern Cape sample, most of the 38 respondents who agreed that MMC for HIV prevention has advantages explained this with reference to MMC being safer than traditional male circumcision, recognizing that sterile equipment and trained personnel would make MMC safer.

The second-highest response code for advantages of MMC for HIV prevention was related to the prevention and protection from STIs and HIV infection, since “once the foreskin is cut, there are few chances of STIs.”<sup>10</sup>

At this stage of the questionnaire, common misconceptions also emerged in that some respondents noted the advantages of MMC as reducing HIV completely, as “no foreskin means there is no HIV threat”.<sup>11</sup>

9. The response rate for this question was 92 percent of the total sample.

10. EC, January 21, 2010, No 6

11. EC, January 22, 2010, No 3

The data seem to suggest, especially in the EC sample, that some respondents approached this question as mothers and not necessarily as sexual partners, emphasising the advantage that MMC would limit the number of “boys dying in the bush”. While this stated advantage of MMC does not correlate with MMC for HIV prevention, it arguably highlights that women’s expressed support for MMC may not necessarily be linked to its benefits for HIV prevention, but instead to the desire to increase the “safety” of traditional male circumcision practices.

Of the 28 percent (15) of the respondents who indicated that there were no advantages of MMC, 2 made reference to increased risk behavior in men, and 5 noted that MMC was not 100-percent safe, that it would not cure HIV, and that HIV infection could still occur.

### **KwaZulu Natal**

In the KZN sample, respondents noted advantages that largely centered on the recognition that MMC was a prevention option for males, specifically in relation to HIV (14 responses).

The majority of respondents focused on the advantages of MMC in relation to men, not their male children, and thus answered primarily as partners to men who may or may not benefit from MMC. While some respondents were noting benefits for men, they were at the same time noting that MMC has no benefits for women.

*“It is good for men, not for women, because it is only men who are protected from HIV and STIs. As for me, no I am not protected.”<sup>12</sup>*

In KZN, the majority of the 11 (28%) respondents who noted disadvantages commented on the increased risk behavior in men and that women would suffer, as well as be blamed for, HIV infection.

*“Men are prioritized, and women will be blamed for HIV, as it happened before.”<sup>13</sup>*

### **Discussion**

Although the data suggest high levels of perceived advantages of MMC for HIV prevention, women from the EC sample responded primarily as “mothers” concerned about the safety of their children participating in traditional male circumcision practices, and not as sexual partners to men who may or may not be medically circumcised. Thus, the data arguably emphasize the need for education and awareness raising about the differences between traditional and medical male circumcision practices and benefits.

## **COMMUNITY PREPAREDNESS AND SUPPORT FOR MMC FOR HIV PREVENTION**

Asked whether respondents believed that MMC for HIV prevention could be introduced into their community, the majority (70%, 65) agreed and 28 (30%) disagreed. The response rate showed marked differences between the two samples, in that a much higher percentage of respondents in the EC (80%) thought that MMC for HIV prevention could be introduced to their community, as compared to 55 percent of respondents in the KZN sample.

### **Eastern Cape**

Elaborating as to why respondents thought that MMC for HIV prevention could be introduced into their community, the majority of responses (18) in the EC sample clustered around the need to engage and involve women, as well as community, on issues of education and awareness-raising regarding MMC. Respondents also

12. KZN, December 17, 2009, No 17

13. KZN, December 18, 2009, No 9

noted that MMC was safer than traditional male circumcision practices for their children and that the children would receive the necessary education around HIV.

*“It will also give a chance for our boys to learn about the risk of HIV infection, as they will be educated.”<sup>14</sup>*

Amongst the 11 (20%) respondents in the EC sample who did not believe that MMC could be introduced into their community, explanations as to why focused equally on the risks of men increasing their risk behavior as on its clashing with cultural practices and tradition.

*“They will misunderstand; they will think that you can’t be HIV when you are circumcised.”<sup>15</sup>*

### **KwaZulu Natal**

In KZN, 55 percent (21) of respondents agreed that MMC for HIV prevention could be introduced into their community. Four (4) respondents noted a similar assumption as respondents in EC that introducing MMC as an HIV prevention option would lead to men wanting to be circumcised in order to not have to use condoms.

*“Because men don’t want to be protected and use condoms.”<sup>16</sup>*

Though supporting the introduction of MMC for HIV prevention into their community, there was a strong call for more education and awareness in the community on MMC.

*“We need more information and workshops on MMC.”<sup>17</sup>*

Almost half (45%) of the respondents in the KZN sample did not believe that MMC for HIV prevention could be introduced into their community. Asked to explain, the majority of responses highlighted concerns that MMC would increase male risk-taking behavior and that women would be at greater risk.

### **Discussion**

While the data clearly indicate the support for MMC for HIV prevention to be introduced to communities, the data also highlight the need for more education and awareness in the community on issues relating to advantages and disadvantages of MMC for HIV prevention.

The data also suggest high levels of perceived support amongst men, as well as individual support, for the introduction and rollout of MMC as an HIV prevention strategy.<sup>18</sup> The data, however, also indicate that support for the introduction of MMC for HIV prevention is qualified by the need for women’s greater involvement in MMC for HIV prevention discussions and decisions as well as the noticeable tensions between traditional and medical male circumcision practices.

### **PERCEPTION OF IMPACT**

To measure the perceived impact of introducing MMC for HIV prevention, respondents were asked if they believed that MMC would protect women from HIV transmission, and whether they thought that MMC is changing ideas about HIV risks.

14. EC, January 21, 2010, No 25

15. EC, January 21, 2010, No 36

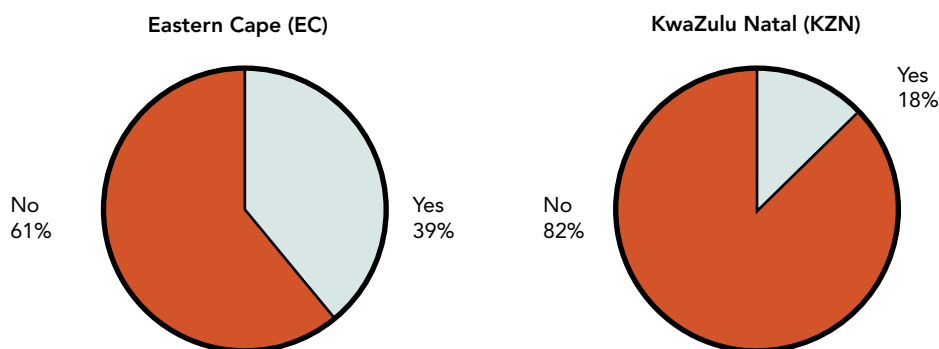
16. KZN, December 18, 2009, No 1

17. KZN, December 17, 2009, No 17

18. More information about this issue can be found in the full report: Kehler, J. & Arnott, J. 2010. *Medical Male Circumcision for HIV Prevention: Are women ready?*. Cape Town: South Africa. AIDS Legal Network.

Of the 85 respondents (88% of sample) who completed this question, the majority (69%, 60) did not believe that MMC would protect women from the risk of HIV; with 82 percent (28) of respondents in KZN and 61 percent (31) in EC.

#### Women are protected from HIV by MMC



Elaborating as to why respondents did not believe that MMC would protect women from the risk of HIV infection, most EC responses related to men being unfaithful, women not knowing how many partners the man has, and men not wanting to use condoms, while KZN respondents made reference to the fact that women are not protected at all, that MMC did not prevent being infected by HIV, and that women were excluded, as MMC would provide protection only to men.

Respondents also mentioned different hopes, as well as concerns, relating to the potential of MMC to change existing ideas and beliefs about HIV risks, ranging from the hope that information and education for men during MMC would decrease men's risk behaviors and increase condom use, to the fear that men always blame women for HIV infections and that this would not change with the introduction of MMC. Reference was also made to the risk that men may perceive MMC as a "license" for unprotected sex.<sup>19</sup>

*"Men will always blame women, as they will think they cannot be infected."*<sup>20</sup>

*"People will think there is a cure, the invisible condom, and will never change behaviour."*<sup>21</sup>

#### Discussion

While the data clearly highlight a general lack of perceived benefits of MMC for women and women's protection, as well as for changing ideas and beliefs about HIV, it also suggests that if **MMC would be linked to other prevention methods, such as condoms, and to additional services, such as education and training, the introduction and rollout of medical male circumcision for HIV prevention could have a protective factor for women.**

#### WOMEN'S INVOLVEMENT

When asked if women are talking with their partners about MMC for HIV prevention, the majority (71%, 65<sup>22</sup>) said 'no' and less than a third of respondents (29%, 26) indicated that women are talking about it with their partners.

19. Although the majority of comments indicate respondents' disbelief in MMC changing ideas about HIV risks, the quantitative data do not necessarily support this, with 54 percent of respondents saying "yes" and 46 percent saying "no".

20. EC, January 27, 2010, No 56

21. KZN, December 23, 2009, No 30

22. The overall response rate for this question was 94 percent.



Responding to “who makes the decision about men getting circumcised for HIV prevention”, the majority of respondents (62%) clearly indicated that it was men who made the decision. While responses in KZN identified “men”, many of the Eastern Cape respondents (30) qualified their answers by making a distinction among man/husband/father, and the boy/man making their own decision to circumcise.

In order to assess women’s actual and desired involvement in the decision-making processes about MMC for HIV prevention, respondents were asked whether women are involved, as well as whether women would want to be involved, in this decision. Of all respondents, 29 percent (26)<sup>23</sup> indicated that women are involved, and 75 percent (70)<sup>24</sup> indicated that women would want to be involved, a marked difference.

Whilst the data suggest a greater current, as well as desired, involvement of women in decisions about male circumcision in the EC sample, women in the Eastern Cape are somewhat involved in traditional male circumcision processes and thus relate differently to questions of women’s involvement in male circumcision. As mentioned above, respondents from the EC sample are more likely to respond in their role as mothers, as compared to engaging with questions of MMC as sexual partners.

Asked to explain why they thought women would want to be involved in the decisions about MMC, more than half (30, 55%) of EC respondents mentioned that this would enable them to advise and help, particularly on issues of HIV. Women also noted that men as fathers focus more on “turning their boys into men”, and do not address the health risks or speak to their children about HIV before circumcision.

Only 4 EC responses (7%) addressed the need for women to be involved in MMC decisions in order to protect themselves from HIV from partners or men who come back from circumcision and want to have unprotected sex.

The need to be involved in the planning, the public education and the after-care; to know more about MMC for HIV prevention; and to partake in decisions regarding the family (5 responses) were highlighted in the KZN sample.

*“Women need to be a part of taking this important decision, education and after care.”<sup>25</sup>*

In both samples (73% EC and 50% KZN), cultural reasons were highlighted for why women do not want to be involved in the decisions about MMC; saying that it was “men’s work” and that “women have nothing to do with circumcision”.

## HIV PREVENTION OPTIONS

Levels of preparedness and support for the introduction and rollout of MMC for HIV prevention is arguably closely linked to existing HIV prevention options and challenges. Asked to identify HIV prevention options available currently, 71 percent (69) of the total sample mentioned condoms, with 43 (78%) responses in the EC sample and 23 (55%) responses in KZN to this effect. Although this high response rate referring to condoms as an HIV prevention option is noteworthy, only 3 respondents (KZN) made specific reference to female condoms—arguably indicating a lack of female condom availability and access.

In the KZN sample, a number of respondents (7, 17%) also stressed the lack of prevention options for women.

23. The overall response rate for this question was 94% (96% EC, 90% KZN) of the total sample.

24. The overall response rate for this question was 96% (100% EC, 90% KZN) of the total sample.

25. KZN, December 23, 2009, No 29

*“For me there is nothing available for now, there is nothing available for women, nothing.”<sup>26</sup>*

In order to assess perception of women’s “ability” to negotiate condom use, respondents were asked to indicate how comfortable they thought women are in negotiating condom use on a five-point scale, ranging from “not at all” (1) to “very much” (5). Of the 92 (95%)<sup>27</sup> respondents who completed the ratings, 37 percent (34) indicated that women are “not at all” comfortable, while 22 percent (20) believed that women are “very much” comfortable. Seventeen percent (16) indicated that women are “somewhat” comfortable. There were also significant differences between the two samples, in that more than twice as many respondents in KZN (54%, 20) thought that women are “not at all” comfortable, as compared to EC respondents (25%, 14).

Respondents indicating that women do not feel comfortable at all to discuss condom use elaborated on their ratings, mainly stressing that men are the ones making sexual decisions.

*“Because women are not making decisions in their relationships.”<sup>28</sup>*

Respondents who thought that women are ‘very much’ comfortable to ask their male partners to use condoms explained their ratings mainly with references to the need for protection and the fact that women are more vulnerable to HIV infection.

*“So that we can be prevented from infections.”<sup>29</sup>*

Assessing condom use further, respondents were asked whether they are currently using condoms with their partners,<sup>30</sup> and what they thought their partners would say if asked to use a condom after being circumcised (open-ended question). More than half of the respondents (56%, 54) were very clear that they could not insist on using a condom, and 24 respondents (25%) said that their partners would or “might” (4, 4%) agree to do so.

Explanations as to why partners would refuse condom use after being circumcised were broadly based on the following themes:

- Men reacting to issues of mistrust and interpreting requests for condom use as suspicions that women or men had been with other partners

*“He won’t allow it, he’ll tell me that he’s circumcised and should I be infected that will mean that I got it from other men.”<sup>31</sup> (21–29 yrs)*

- Men refusing to consider condom use, due to unequal power relations

*“No, since we women let men take control of sex.”<sup>32</sup> (21–29 yrs)*

- Men believing they are fully protected through circumcision

*“He will say what is the use, I am already circumcised.”<sup>33</sup> (21–29 yrs)*

26. KZN, December 23, 2009, No 30

27. The response rate was 100 percent in EC and 88 percent in KZN.

28. KZN, December 18, 2009, No 1

29. EC, January 22, 2010, No 2

30. Based on the fact that 19 percent of respondents declined to answer this question, combined with the challenges of self-reported condom use data, a decision was taken not to analyze these responses.

31. KZN, December 14, 2009, No 69

32. EC, January 22, 2010, No 21

33. KZN, December 16, 2009, No 60

The issue of GBV came through also in this section, with six respondents (KZN) saying that there would be violence/abuse and/or fights if women requested condom use.

*“We will get into a fight, because now they have the wrong information that circumcision prevents HIV.”<sup>34</sup> (50–64 yrs)*

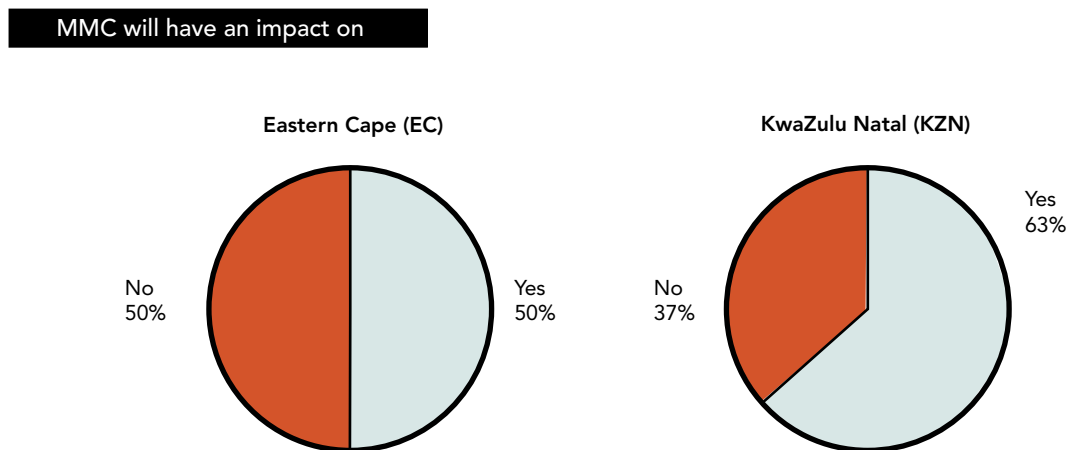
**Discussion**

The data suggest that currently available HIV prevention options, such as female and male condoms, provide limited benefit to women in a societal context of gendered inequalities and power imbalances. The data also confirm that most women are not in the position to negotiate condom use and thus, women are least in control over HIV prevention options. Taking into account that MMC for HIV prevention is not a stand-alone HIV prevention method and that MMC can only be an effective addition to available HIV prevention options, such as condoms, it is crucial to ensure that condom promotion and distribution becomes an integral part of MMC for HIV prevention processes.

**GENDER-BASED VIOLENCE AND MMC FOR HIV PREVENTION**

When asked whether GBV is a “problem” in their community, 63 percent (54) said “yes” and 37 percent (32) said “no”.<sup>35</sup> However, the two samples differ, in that 83 percent (30) of KZN respondents said “yes”, while 48 percent in the EC sample said “yes”.

Respondents were also asked whether and how they thought that MMC for HIV prevention would affect GBV.<sup>36</sup> In total, 55 percent of respondents (44) felt that MMC for HIV prevention would affect GBV in their communities, and 45 percent (36) did not. Corresponding to the higher percentage of respondents who thought GBV is a problem in their community, 63 percent of KZN respondents further believed that MMC would affect GBV.



Responses explaining how MMC for HIV prevention would affect GBV in their community referred to men refusing to use condoms (EC), women being blamed for any infections, and women being forced into unprotected sex (KZN).

34. KZN, December 17, 2009, No 14  
 35. The overall response rate for this question was 87 percent (91% EC and 86% KZN).  
 36. The overall response rate for this question was 82 percent (87% EC and 76% KZN).

### **Discussion**

The data highlight relatively high perceived levels of GBV, which arguably reflects communities' realities of high levels of violence and abuse. However, the data also strongly suggest that the introduction of MMC for HIV prevention may lead to increased GBV, as men may refuse condom use after MMC and women are likely to be blamed for HIV and STIs—arguably indicating the need to address these risks as an integral part of MMC for HIV prevention initiatives and programs.

### **FOCUS GROUP DISCUSSIONS**

Focus group discussions were facilitated in both areas to gain a deeper understanding of participants' knowledge of MMC for HIV prevention, as well as the perceived impact of MMC for HIV prevention on women.

#### **KwaZulu Natal**

In one of the KZN focus group discussions,<sup>37</sup> participants explored how difficult it was to negotiate safer sex with their partners, primarily focusing on risk behaviors in men as well as concerns that MMC would essentially be a risk factor for women and women will be blamed for HIV.

*“It can be introduced, but not as a prevention method, because as a Zulu woman you know how stereotyped Zulu men are? He won't allow us to use a condom when we are having sex, because he will say he is protected because he has removed the foreskin, which means we are both protected.”<sup>38</sup>*

Discussing further the impact on women of introducing MMC for HIV prevention, participants also expressed their concerns about the risks of violence and abuse, as circumcised men may feel “safe” from HIV infection and insist on unprotected sex.

*“It is males who will always claim that they are circumcised and cannot contract HIV. They will force female partners to have sex without a condom. If they refuse they will beat them or dump them, to be on the safe side, you have to agree on submission.”<sup>39</sup>*

#### **Eastern Cape**

The focus group discussions in the Eastern Cape<sup>40</sup> clearly confirmed and re-emphasized the numerous challenges of introducing MMC in communities that practice male circumcision as the rite to manhood, and also identified some of the socio-cultural barriers.

*“I don't want my child to be circumcised medically forgive me, he must use his forefathers' ways. I accept that he must be protected against diseases, but I don't accept medical circumcision.”<sup>41</sup>*

Similar to the questionnaire data, respondents expressed their concerns about the risks associated with traditional male circumcision practices, and shared ideas of how traditional circumcision could be made safer and elements of MMC introduced into traditional practices.

37. KZN Focus Group Discussion in KwaMakhuta on January 13, 2010. Participants were 25–30 years old.

38. KZN Focus Group Discussion, January 13, 2010.

39. KZN Focus Group Discussion, January 13, 2010.

40. Focus group discussions in the Eastern Cape were facilitated on January 27, 2010 in Port Elizabeth and on January 29, 2010 in New Brighton.

41. EC Focus Group Discussion, January 29, 2010.

*“The only thing I think is to improve the way the old or traditional way, they should improve the way of doing it by involving the medical doctors, because this is culture and culture is culture.”<sup>42</sup>*

The challenges about introducing MMC for HIV prevention into a community where traditional male circumcision is practiced were evident when participants spoke about the need to educate men around MMC and emphasized that this should be done without women present in order to place MMC in the male domain to make it more acceptable; or conversely that only women would accept MMC for HIV prevention.

*“People must be given information; although there are few people who would accept medical male circumcision maybe it will only be accepted by women.”<sup>43</sup>*

Though feeling strongly about socio-cultural barriers to introducing MMC for HIV prevention, the need for women to be involved and to overcome these barriers by talking to their sons was also expressed.

*“Women are affected, if something goes wrong men are never around; it is up to a mother to make means to amend the situation.”<sup>44</sup>*

### **Discussion**

The focus of the discussion and the concerns raised during the focus groups in both areas confirm and strengthen the dominant discourse that has emerged in this pilot study on women’s perceptions of MMC for HIV prevention.

In communities where traditional male circumcision is part of culture and tradition, women are primarily concerned about their children and their safety whilst undergoing traditional rites of passage to manhood, which include traditional circumcision practices. Women in these communities are clearly expressing their concerns about the exclusion of women in this ritual, which has historically been a secret male domain, and the fear about their sons being exposed to HIV during the traditional male circumcision process. Recognizing that MMC is safer for their children, women have indicated that they would want to seek a compromise between traditional and medical male circumcision in order to mainly protect their sons from infections and complications. Thus, study participants in the Eastern Cape were primarily responding to the introduction of MMC for HIV prevention in their role as mothers and not partners and/or wives, and sharing limited insight into how MMC for HIV prevention could impact on women as partners.

In contrast, study participants in KwaZulu Natal focused primarily on the impact of MMC for HIV prevention on women as partners. The data show a clear concern for the increased risk behavior of men and the associated risks for women, including the risk of violence and abuse.

## **4. CONCLUSION**

In summary, the data highlight a need to develop strategies that will engage women in all aspects of MMC as an HIV prevention strategy to ensure that women’s needs, concerns and HIV risks and vulnerabilities are ad-

42. EC Focus Group Discussion, January 27, 2010.

43. EC Focus Group Discussion, January 27, 2010.

44. EC Focus Group Discussion, January 29, 2010.

dressed. Moreover, there seems to be a general lack of knowledge, and some level of embedded misconceptions, about MMC for HIV prevention amongst women in the study.

The data further point to concerns about women's inability to negotiate condom use, coupled with an increase in risk behavior in men after MMC, resulting in an increase in GBV, stigma and blame being directed at women with regards to HIV infection. The concern that men were even less likely to use condoms after MMC made the women call for increased access to, and availability of, women-controlled HIV prevention strategies.

Concerns about women's lack of involvement in decisions about male circumcision, as well as its impact, are arguably also reflected in the expressed desires of women to be actively involved in discussions and decision-making processes on MMC for HIV prevention. Although the perceived need and reasons for women's involvement may differ, the data strongly suggest that women's involvement in all aspects of MMC for HIV prevention is essential, so as to adequately respond to women's concerns and needs and to ensure that women's HIV risks and vulnerabilities are addressed with this new HIV prevention strategy.

The data arguably also suggest a link involving women's recognized lack of power to negotiate condom use, expressed concerns about the impact of MMC on risk behavior in men, and perception of an increased risk of GBV following the introduction of MMC for HIV prevention.

Linked to women's perception that men may feel protected from HIV, the data reflect women's fear of being blamed for HIV infection in circumcised men, as well as subjected to increased violence, as a direct result of MMC for HIV prevention.

Taking into account that the rollout of MMC for HIV prevention is imminent, data indicating that a third of all women participating in the study had never heard about this new HIV prevention strategy is of great concern. Furthermore, the data clearly highlighted a lack of adequate knowledge and understanding among women who have heard about MMC for HIV prevention, especially in the context of prescribed abstinence after "surgery".

Whilst not necessarily significant in numbers, the study revealed embedded misconceptions about the efficacy of MMC as an HIV prevention method, which can arguably be linked to the dissemination of unclear and confusing messages about MMC for HIV prevention.

## 5. RECOMMENDATIONS

Recognizing the multiplicity of challenges highlighted in this study, the following recommendations are based on the principled understanding that the active engagement with, and involvement of, all stakeholders are required to ensure that the introduction of MMC as a new HIV prevention strategy has no adverse impact on women and women's risk to HIV transmission and related rights abuses, but instead addresses women's specific risks and vulnerabilities to HIV as an integral part of MMC for HIV prevention policy and program implementation.

In light of a lack of a policy framework, there is a need to engage policy makers so as to ensure

- timely finalization of the national policy framework regulating MMC for HIV prevention; and
- alignment with, and adherence to, existing human rights obligations and principles at a national level in MMC policy development and implementation plans.

Recognizing the expressed need for increased access to, and availability of, women-controlled HIV prevention options, it is crucial to

- monitor that resources allocated for MMC rollout are not diverted from HIV prevention programs for women; and
- advocate increased programming and implementation of HIV prevention programs for women both parallel to, and as an integral part of, MMC for HIV prevention programs.

Acknowledging the need for adequate education and awareness-raising campaigns on MMC for HIV prevention, it is essential to

- ensure the dissemination of accurate and factual information, highlighting advantages and disadvantages of MMC for HIV prevention;
- develop and disseminate information and communication messages emphasizing that MMC provides only partial protection of HIV infection; and
- design specific information and communication messages, as well as education and awareness campaigns, particularly addressing women's realities, risks and potential benefits in the context of MMC for HIV prevention.

Taking into account the challenges and inherent tensions between traditional and medical male circumcision practices, there is a need to

- facilitate broad stakeholder consultations addressing the concerns and fears of MMC "interfering" with cultural and traditional practices of rites to manhood;
- further investigate potential mechanisms of combining the two male circumcision practices; and
- research especially women's actual and desired role and involvement in discussions and decisions about male circumcision within circumcising communities.

Lastly, for MMC to effectively impact HIV prevention, it seems crucial to address the existing challenges of, and barriers to, HIV prevention, such as gendered power imbalances and inequalities, so as to ensure women's access to, control over, and participation in HIV prevention options that truly reduce women's risks and vulnerabilities. Thus, addressing women's risks to HIV prevention, as well as underlying factors both determining and perpetuating women's HIV risks and vulnerabilities, are to become an integral part of MMC for HIV prevention programs.

## SOUTH AFRICA SURVEY RESULTS

	South Africa
Total interviews	145
Have heard about MMC for HIV prevention	67%
Have heard about MMC via billboards and radio	--
There are advantages of MMC for HIV prevention	72%
Are aware that ...	
there is a need for condom use after MMC	83%
MMC does not provide 100% protection from HIV risk	82%
men need to abstain from sex for six weeks after MMC	65%
MMC for HIV prevention can be introduced into community	70%
Men would get circumcised	69%
Would support MMC in community	87%
MMC protects women from HIV	31%
MMC is changing ideas about HIV risk	46%
Women talk about MMC for HIV prevention with their sexual partners	29%
Women are involved in decision-making around men getting circumcised for HIV prevention	29%
Women want to be involved in this decision	75%
Would circumcise own infant boy	--
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	22%
comfortable	6%
fairly comfortable	17%
sometimes comfortable	17%
not at all comfortable	37%
Use condoms with partner(s) now	72%
Gender-based violence is a problem in community	63%
MMC for HIV prevention would impact gender-based violence in community	55%
Female genital mutilation could protect girls from HIV infection	12%
Promoting MMC may promote FGM among girls and women in community	--



**AVAC**

[www.avac.org](http://www.avac.org)

**ATHENA Network**

[www.athenanetwork.org](http://www.athenanetwork.org)

**AIDS Legal Network**

[www.aln.org.za](http://www.aln.org.za)

**Health Rights Action Group**

[www.hag.or.ug](http://www.hag.or.ug)

**Mama's Club**

[clubmamas@yahoo.co.uk](mailto:clubmamas@yahoo.co.uk)

**Namibia Women's Health Network**

[www.nwhn.wordpress.com](http://www.nwhn.wordpress.com)

**Swaziland for Positive Living**

[www.swapol.net](http://www.swapol.net)

**Women Fighting AIDS in Kenya**

[www.wofak.or.ke](http://www.wofak.or.ke)



SWAPOL member interviewing a women in Sigwe.