Eastern Africa Mapping Report

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African Microbicides Advocacy Group

Global Campaign FOR Microbicides

Eastern Africa Mapping Report

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1. Introduction

In 2007, the African Microbicides Advocacy Group (AMAG) in collaboration with the Southern African AIDS Trust (SAT) conducted a mapping in Malawi and Zambia to determine the landscape, players and needs of microbicides advocates engaged or interested in becoming involved in advocacy efforts. In May/June 2008, Global Campaign for Microbicides (GCM) and AMAG collaborated on a similar mapping exercise in four Eastern African countries: Kenya, Uganda, Tanzania and Rwanda. This exercise will inform on-going work to engage interested NGOs in scaling-up their advocacy for HIV prevention options for women.

This report reflects mapping discussions held with 27 organisations in the four countries by GCM's Deputy Director Anna Forbes and East African Coordinator Pauline Irungu between May 28 and June 30, 2008.

The report is organized by country capturing the responses in each country. The information is further organised by the four major discussion areas which were:

- microbicides awareness and advocacy;
- female condom access and acceptability (in comparison to male condom);
- interest in the vaginal health module that GCM is developing and
- interest in the online Microbicides Essentials course developed by GCM.

Other issues of interest raised by the organisations during the discussions are also captured. At the end of the report, similar findings across the countries been drawn out. Action steps have also been included.

Objectives of the mapping exercise

The overall goal of the mapping exercise was to develop a base from which to build a strong, well-networked constituency among Eastern African NGOs with both the capacity and the desire to advocate for more and better woman-initiated HIV prevention options

The specific objectives were:

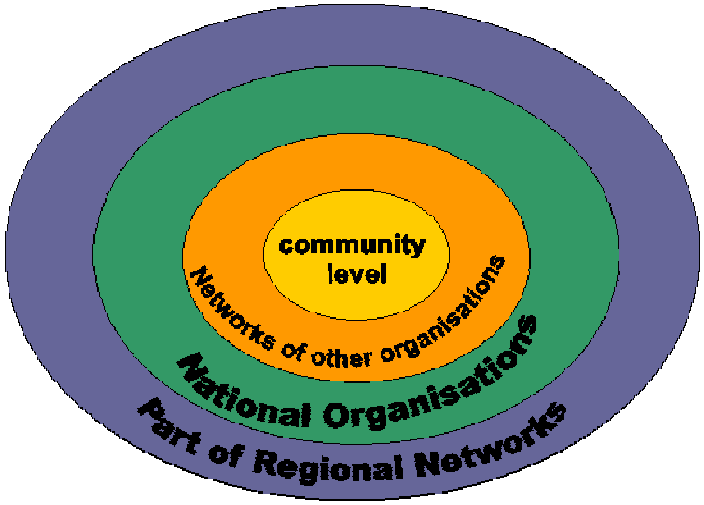
1. To introduce GCM and AMAG to target NGOs, relevant government officials, clinical trial sites and other stake-holders and familiarize them with the functions and missions of both organizations.
2. Assess interest among target NGOs in:
   - Woman-initiated HIV prevention generally as an advocacy issue;
   - Female condom access specifically; and
   - Microbicides advocacy specifically
3. Assess how target organizations see the above issues relating (or not) to the work they are already doing

4. Pinpoint common areas of interest and focus among current and potential partners. Determine where interest might be strengthened through the provision of capacity building services and training.
5. Lay the groundwork for getting input into how GCM and AMAG's trainings, materials, strategies and other resources might be tailored to meet the needs of their constituencies
6. Encourage the organisations to link on an on-going basis with AMAG via its listserv and with GCM via a variety of means including subscription to GC News, use of the website and communication with regional coordinator.

Composition of Organisations visited

The mapping targeted NGOs in Eastern African countries that are working on gender issues, women's health, HIV/AIDS, sexual and reproductive health and rights (SRHR).

The selection aimed to capture a cross section of organisations working at different levels; that is, direct implementation at the community level, networks supporting smaller organisations, national level organisations and even organisations linked to larger regional networks.



These organisations were selected from a list of over 100 organisations that was assembled over a period of 3 months and consisted of current GCM endorsers; AMAG listserve members; and entities recommended by UNFPA, various NGO allies and by community liaison staff working in the Kigali, Mwanza and Mombasa microbicides clinical trials sites.

2. UGANDA

Organisations' Overview

In Uganda, GCM visited 5 organisations namely:

1. Centre for Domestic Violence Prevention (CEDOVIP),
2. Community Health and Information Network (CHAIN),
3. Mama's Club,
4. Society for Women and AIDS in Africa – Uganda Chapter (SWAA Uganda)
5. and Uganda Women's Network (UWONET)

All the organisations visited had a core focus on women but variously they addressed gender based violence (GBV), governance and policy, women's empowerment and support for women and families living with, or affected by, HIV/AIDS. There was a good mix of operational levels; UWONET and SWAA Uganda are larger networks operating at the national level, CHAIN works directly with communities and is affiliated with CHAIN (UK), Mama's Club and CEDOVIP implement programmes at the community level but have had national and international recognition due to their contributions to community transformation. Mama's Club won the UNAIDS' Red Ribbon Award for 2008.

Woman-initiated prevention

In Uganda like other Sub-Saharan African countries, the HIV/AIDS epidemic had taken the face of a woman. Women form the majority of those infected or affected by HIV. The organisations visited cited cultural practices – particularly the disparity in power relations between male and female partners – as a key factor contributing to this disparity. Women frequently do not have control over their sexuality, they reported.

In terms of prevention option, women lack an option that would address their plight and a microbicide was seen as a tool to help change this reality. Dr. Lucy Korukiiko, the Coordinator of SWAA Uganda, highlighted the concern expressed by women that a microbicide could become stigmatised due to cultural beliefs and historical fears about vaginal products. Such fears could be linked to family planning. Another concern expressed was how microbicides could play out in relation to fertility. Would microbicides be contraceptive or would there also be a non-contraceptive option?

Microbicides awareness and advocacy

Among the organisations that were visited, SWAA Uganda had a high level of understanding of microbicides. A current GCM endorser, SWAA Uganda had previously collaborated with GCM and AMAG on awareness raising and had engaged in microbicide advocacy activities at the national and international level. Dr. Lucy Korukiiko said that SWAA Uganda had planned to conduct a media training on microbicides with support from AMAG but this had not yet happened. She noted that

when trials were closed in Uganda, the media reporting was not balanced. She said, **"They report sentiment – they don't report the facts."** SWAA was interested in increasing microbicides awareness among Ugandans.

Mama's Club's Executive Secretary Marion Natukunda was aware of microbicides and had participated in the Microbicides 2008 International Conference in New Delhi, India. However members of the Club had little, if any, awareness. Mama's Club had not engaged in microbicides advocacy because they saw microbicides clinical trials as an academic issue that did not really involve communities.

UWONET had some experience in HIV vaccine trials but not in microbicides trials. UWONET Advocacy Officer Aheebwa Manisurah said that UWONET's participation in a vaccine trial's Gender Advisory Board had shown them that GBV was a concern associated with trial participation. She felt that microbicides trials could face a similar challenge due to the community perceptions and stigma associated with HIV status.

Both CHAIN and CEDOVIP had little knowledge of microbicides. Tina Musuya, CEDOVIP coordinator, said she knew very little about microbicides and she accessed what she knew from the mass media. She had heard that the microbicides trials in Uganda had been stopped.

Even though Uganda had hosted a microbicide trial, the levels of civil society knowledge on microbicides were low. The organisations expressed interest in learning more so that they can be able to engage in advocacy. GCM presented its web-accessible information resources including a low literacy brochure with basic information on microbicides. The organisations were also informed of the CD-ROM based Microbicides Essentials course that GCM was preparing to launch. Most of the organisations expressed interest in the course. They requested to receive copies of the CD-ROM since internet access is costly and sometimes not reliable.

Female Condom Access

The organisations interviewed in Uganda were unanimous on the lack of access to female condoms. They had mixed opinions about acceptability with some citing complaints and concerns about the female condom and others indicating that, despite these problems, there is still substantial unmet demand for them,

They cited the following as the key challenges related to accessibility, acceptability and use of the female condom:

- There is very low supply of female condoms. They are not available through regular channels used for male condom distribution such as government health clinics; NGOs (like TASO); social marketing agencies such as Population Services International; or retail outlets.
- Where available, the cost of female condoms is very high so most women cannot afford it.

- There is lack of comprehensive information and education on usage of the female condom among potential users, both women and men.
- The design of the female condom is also a concern to many potential users. Among the concerns expressed are that the female condom is too big; both the inner ring and the sensation of polyurethane against the skin feel uncomfortable; it is difficult to insert; and it is noisy during sexual intercourse.
- Misconceptions among users have included the fear that the female condom can disappear into the vaginal canal. This was linked to the lack of information regarding the anatomy of the female reproductive organs.
- Women also confided that some men would bypass the female condom, causing women to view it as an unreliable method. This was cited by Tina Musuya of CEDOVIP.
- Policies regarding female condom programming were lacking in Uganda. Regina Kamoga, the Country Director of CHAIN, said that lack of awareness on gender issues among policy makers contributes to this policy oversight.
- Little social marketing and advertising of the female condom has been carried out in Uganda. In comparison, the male condom had been promoted through mass media and other communication channels as an acceptable tool for HIV, STIs and pregnancy prevention.
- Uganda's HIV prevention campaign is geared towards support for abstinence and mutual fidelity. Condom programming generally is declining despite Uganda having been one of the first countries to champion condoms and make remarkable strides in controlling its HIV/AIDS epidemic. This reduction in condom programming is making it even more difficult to access the female condom. CEDOVIP said that, despite the changes at the policy level towards condoms, there is demand for them and female condom could be profiled especially among young people. Tina mentioned a visit by some of CEDOVIP staff to Kasese in 2006 in which the youth demanded condoms despite hearing the abstinence and being faithful (AB) messages.

GCM shared information on the improvements being made to the female condom. FC2 had been designed using new material called nitrile, in place of the polyurethane used in FC1. The "Women's Condom", yet another innovative approach, is being developed by PATH. These improved models are designed to address many of the concerns identified.

All the organisations visited were of the opinion that more could be done to promote use of the female condom. SWAA Uganda felt that there was need to segment the community in order to effectively advocate for the female condom. Mama's Club said that there was need to sensitise and train providers, including the staff and volunteers in NGOs, on female condom promotion. They cited the "mentor mothers", peers trained to work with their other club members, as people who could be successful promoters if trained to educate community members. Demonstrations on use of the female condom should be an integral part of this education.

The NGOs said that community members expressed considerable interest in learning about the female condom. Sandra Kasasiro of CHAIN recalled that, when she held a

session on female condom use at their resource centre, the room was packed to capacity and the participants showed a lot of interest. She added that women felt that men also need to be sensitised about the female condom because its use raises a lot of complex issues, especially in long term relationships and at the family level. Tina at CEDOVIP highlighted the need to address negative attitudes about female condoms at the community level and even in the public health sector, in order to improve its acceptability. She acknowledged that some women and young girls who had used the female condom liked it. The difficulties in access were, however, discouraging them from using it.

When asked about possible interest in participating in piloting the female condom in Uganda, the organisations said that this would be a helpful venture. It would provide an opportunity to introduce the female condom to users and combine supply with education. SWAA Uganda has a male involvement programme through which they could engage men in promotion of female condom use with their partners, in addition to working with the women members of SWAA.

UWONET said that ongoing programmes in their network could generate advocacy for the female condom. Through member organizations working on GBV such as CEDOVIP, for example, they could include female condom education among the other programming underway to help change men's attitudes

An inter-generational dialogue programme which reaches out to young women through mentoring processes provides another opportunity. This programme is a collaboration between UWONET and Makarere University's Department of Women and Gender Studies. In it, young women and men have formed a youth group to discuss gender issues including HIV/AIDS. Dialogues are also held at the district level to engage community leaders such as women councillors, teachers and even religious leaders in becoming change-makers in their own communities. Such leaders could include female condoms among the issues they discuss with their communities.

Mama's Club would particularly work with women living with HIV/AIDS to promote female condom as a tool that could offer protection for negative partners (in case of discordant couples) and protection from HIV re-infection, as well as contraception. As noted above, they propose to train "mentor mothers" educate the club members.

CHAIN saw the VCT services that they offer to the local community as an opportunity to introduce people to the female condom. They could also mainstream female condom information through the sessions held at their resource centre.

CEDOVIP volunteered to participate in a pilot programme by discussing the female condom in the community meetings they hold with both men and women, to help promote it to both sexes. CEDOVIP also cautioned that female condom work would need to be well designed and focused so that its use particularly among married people does not lead to misunderstanding and GBV.

Though the organisations in Uganda raised concerns that the community had expressed about the female condom, they also expressed strong interest in piloting the female condom in a focused programme to increase its acceptability and uptake. Results of the pilot could then be used to advocate scale up.

Vaginal Health Module

GCM shared with all the organisations visited that it is developing a vaginal health training module and asked about their interest in this tool. It also asked if the NGOs were aware of any such tool that existed already. This training module is being developed by the India staff and GCM recognizes that it will have to be adapted for use in different regions to meet the needs of local audiences.

The organisations in Uganda expressed interest in looking at a draft of the vaginal health module once it was available. They felt that some issues relating to vaginal health had been addressed in various training modules, but said that there was nothing comprehensive or specifically focused on vaginal health.

SWAA Uganda was finalising a lifeskills training manual to be distributed to rural women. They were interested in the vaginal health module and said they would possibly adapt some pieces of it to their manual.

Both UWONET and CEDOVIP said that it is still difficult to talk about vaginal health in Uganda. There is little knowledge of the female reproductive anatomy. Awareness of normal vaginal health, STIs, gynecological examinations, etc. is still very low. UWONET mentioned, for example, a recent activity in which women were shown a film on cervical cancer. It was the first time they had heard that such a disease was possible. CEDOVIP said that most people in Uganda linked discussions on vaginal health issues to moral beliefs. CEDOVIP's experience when it participated in a production of the *Vagina Monologues* sponsored by Akina Mama wa Africa in Kampala about two years ago is an example of this. Tina said that, **"The *Vagina Monologues* was castigated publicly and through the press by politicians, the women's movement and religious organisations. There was a big public outcry."**

CHAIN works with children in schools and has also observed very little knowledge on vaginal health. The information available to girls in schools is mainly on bodily hygiene, especially during menstruation, but does not go beyond there. Mama's Club said the module would be useful to the women living with HIV.

The interviewers noted widely varying levels of ease among the staff of different organisations in discussing vaginal health issues. While some were quite comfortable, others were not quite. It could be inferred from these reactions that discussions of vaginal health carry varying cultural sensitivities in Ugandan communities.

A recommendation was made by CEDOVIP that existing local structures should be engaged in providing vaginal health education. This would include the *Sengas* (aunties -

who are the traditional marriage counselors) who normally teach the youngsters about sexuality issues. Teachers and mentor mothers would also be important resources to utilize in vaginal health education.

Vaginal Practices among Ugandan women

Besides exploring interest in the module, the interviewers also sought to find out anecdotally the different vaginal practices that existed in Uganda.

- Vaginal drying and tightening was mentioned by a couple of organisations. UWONET said that this was mainly done by female sex workers but was not common among women who did not engage in transactional sex. Herbs and baking soda were used as the drying agents. CEDOVIP said that products claiming a "return to virginity" – drying and tightening "magic" soaps and herbal products – were being marketed in Uganda. Tabloids such as *Red Pepper* and *Onion* carry advertisements of these products. Taxi drivers also market these products to their clients.

- Enhancing vaginal lubrication with traditional herbs and products such as Vaseline and cooking oil was also mentioned by CHAIN. Cost of conventional lubricants was a concern among the women. CEDOVIP cited a belief among some women that if one were super-lubricated during sexual intercourse, this would offer some protection from HIV.

- Pulling of the labia minora to lengthen them is practiced especially among the Bantu communities in Uganda. This is done by the *Sengas* (aunties) and the girls are told that this will make it easy for them to give birth. They only learn later that this is actually supposed to make them "sexier".

- Another practice among some sections of Ugandan women was "spicing up"; that is, squatting over a small fire in which specific "essences" are burned so that the smoke saturates the vagina. This was said to be practiced among the Banyankole.

- Traditional healers provide women with herbs to "capture" the man and prevent adultery.

- "Essence of crocodile vagina" is sold in an ampoule. It creates a very strong fishy smell when used vaginally. This is supposed to prevent a man from ever leaving the woman.

CHAIN said that the government was developing a policy on traditional healing practices that could be validated as medically useful. This was primarily being done to determine what practices might interact with ARVs constructively. This process could potentially also help document vaginal preparations/practices provided or recommended by traditional healers. It however was not clear which department was developing this policy or when it was likely to move forward.

3. RWANDA

Organisations' Overview

The mapping exercise covered 5 organisations in Rwanda, namely:

1. Rwanda Women's Community Development Network (RWN)
2. Society for Women and AIDS in Africa , Rwanda Chapter (SWAA Rwanda)
3. Icyuzuzo – Association pour la Protection et la Promotion de la Veuve au Rwanda (Association for the Protection and Promotion of the Widow in Rwanda)
4. Femmes Rwandaise dans la lutte contre le SIDA (FRSL) (Rwandese Women in the Fight against AIDS)
5. Réseau Rwandais des Personnes Vivant avec le VIH/SIDA (RRP+) (Rwandese Network of People Living with HIV/AIDS)

These organisations mainly focused on women's issues: gender and women's empowerment, and support for women and families living with, or affected by, HIV/AIDS. The levels of operation among the organisations were varied; with SWAA Rwanda being part of a large pan-African network, RWN and RRP+ being national networks and Icyuzuzo and FRSL being organisations implementing activities directly with communities.

In Rwanda, discussions were also held with the Rwanda National AIDS Commission (Commission Nationale de Lutte Contre le SIDA - CNLS). The interviewers also got an opportunity to visit a clinical trial site, Projet Ubuzima.

An important point to note is that the common working languages in Rwanda are French and Kinyarwanda, hence some interviews entailed translation.

Woman-initiated prevention

The HIV/AIDS epidemic in Rwanda has been particularly influenced by the 1994 genocide. Many women who suffered sexual violence got HIV infections and many organisations in Rwanda are addressing this reality. As in other African countries, huge power disparities exist in sexual relations between women and men. Grace Mukankuranga from SWAA Rwanda said the reality is that, **"as a woman, my private part belongs to my husband and he is the decision-maker in the relationship."** This heightens the vulnerability of women to HIV infection. The lack of a well accepted tool that women can use to protect themselves aggravates the situation.

Microbicides awareness and advocacy

Before conducting meetings with the NGOs in Rwanda, GCM met with two CNLS Officers; Health Advisor, Elisaphan Hakizimana and Research Advisor, Richard Niyonkuru. They said that Projet Ubuzima was the only NGO involved in microbicides research and Mr. Niyonkuru sits on the governing council of the Projet Ubuzima. The

officers seemed sceptical about microbicides but said that it was important to improve communication between the trial site and the stakeholders in Rwanda, particularly at the policy level.

They expressed concerns over the recent closure of trials in other countries and said that it was important for Projet Ubuzima to share with the stakeholders what it considered as success and what was not successful. Another concern they had regarded integration of clinical trials results into the national HIV/AIDS strategic plan.

The CNLS officers said that a session dedicated to microbicides was going to be conducted during the upcoming National AIDS Conference in July. They would invite Projet Ubuzima and international microbicides researchers to discussion issues of concern to Rwanda during this session.

CNLS also said that they were in the process of developing clinical research guidelines and acknowledged that there was a need for capacity building among stakeholders in Rwanda (including the Ethics Committee). The guidelines will ensure that capacity building for Rwanda is a key component of the clinical research process and before approval, inclusion of this in research protocols will have to be demonstrated. In Rwanda, a Research Committee under the authority of the CNLS is responsible for ensuring that research fits into the goals of the country's national HIV/AIDS strategic plan. The IRB address issues of ethical review of research.

Among the organisations we visited in Rwanda, SWAA Rwanda was the only one with a working knowledge of microbicides. Grace Mukankuranga is also a member of Projet Ubuzima's Community Advisory Board (CAB). The rest of the organisations, when asked about their knowledge of microbicides, said that they would like further information as they knew very little about microbicides and clinical trials.

GCM presented the web-accessible information resources that it had developed including a low literacy brochure with basic information on microbicides. Since the Rwandese speak primarily French and Kinyarwanda, GCM highlighted the availability of fact sheets in French. The organisations were also informed of the CD-ROM based Microbicides Essentials course that GCM was preparing to launch. Most of the organisations expressed interest in the course, however language was a key concern because it is currently available only in English.

Female Condom Access

CNLS (National AIDS Commission) Perspective

Rwanda is the only country in Eastern Africa that is working collaboratively with UNFPA to scale up condom access and use through implementation of a multi-sectoral Condom Initiative. They are convening a stakeholders group to plan this initiative and

the interviewers explored their attitudes about including a specific and expanded female condom component in it.

CNLS reported low female condom use in Rwanda and said that people thought the female condom was not user-friendly. It is also largely unknown since there had been almost no social marketing and it is rarely talked about. The CNLS condom policy is part of its four year national HIV/AIDS strategic plan. CNLS said that is does not have enough data regarding the status of the female condom and its potential acceptability. They commissioned Family Health International (FHI) to conduct a study on integration of family planning into HIV/AIDS services such as VCT and treatment programmes. The study would, among other things, find out why there was low uptake of family planning and of the female condom.

As part of the collaboration between the Rwandese government and UNFPA, a condom programming officer from UNFPA, Andrew Ntwali, had been placed at the CNLS to coordinate the new Condom Initiative.

CNLS noted that, in earlier years, the female condom had been introduced in Rwanda by an NGO known as ARBEF but the results were not encouraging and the initiative did not take off. Andrew Ntwali said that the Condom Initiative stakeholders couldn't consider adding female condoms without an evidence base supporting that decision. It would first be necessary to do a needs assessment to determine if the potential acceptability of, and demand for, the female condom warranted including it in the Condom Initiative. By the end of 2008, the CNLS will have conducted a Needs Assessment for condoms in Rwanda which will also be a basis for the strategic plan in which the female condom will be an integral part.

CNLS cited Population Service International (PSI) as the key organization engaging in social marketing of condoms. He also noted that PSI has a small stock of the female condom but this was much too low to meet country distribution goals, if they chose to include female condoms.

CNLS was open to being linked to NGOs that expressed interest in working on female condom promotion. Andrew noted that some NGOs might be able to mobilize funding from donors to support female condom programmes, in which case CNLS could play the coordination role. GCM said that it was willing to advocate with Rwandese Condom Initiative stakeholders for inclusion of female condoms in the Initiative.

NGOs Perspective

Most of the organizations in Rwanda said that the female condom was rarely available and most of them had not even seen it. They cited the following as the challenges facing the female condom:

- The supply for the female condom is so low that potential users, and even service providers, cannot access it. Winnie Muhumuza from Rwanda Women's Community Development Network (RWN) aptly summed up this scenario when

she said (re: the female condom) that, **"I have never even seen one, and I do trainings on them!"**

- Some perceptions that the female condom was not user-friendly and is difficult to insert. Beatrice Kagoyire from RRP+ said that they had gotten some female condoms from Nairobi but the women members of the network did not like them because of difficulties in insertion.
- Information and education on the female condom is not available, especially to people at the grassroots.
- Besides education, the NGOs lacked plastic pelvic models (of the female reproductive organs) for use in demonstrating female condom insertion and fit to community members. If education efforts were to be mounted and scaled up in Rwanda, these models would be necessary since most women do not know enough about their own bodies to visualize how the device works. This gives rise to fears and myths.
- The cost of buying female condoms is prohibitive for most women. Philomène Cyulinyana from FRSL said that, **"I heard that the female condom packet costs Rwandese Francs 3000"** (about US $ 5.70).
- Women are fearful that their male partners may not allow them to use the female condom and it might to lead to conflicts in the relationship.
- Religious beliefs also discouraged people from using the female condom.

Interest in advocacy for the female condom

Most of the organisations in Rwanda expressed interest in advocating for female condom access and promotion. RRP+ had some concerns based on the feedback they had gotten from their members who had used the female condom. They said, however, that they would be willing to be among those writing letters to CNLS to advocate for inclusion of NGOs in a female condom initiative because, from their experience, resistance to female condom use was partially due to lack of adequate information and education. RWN said that they would mention this to the CNLS.

RWN runs support centres for women and children affected by HIV know as the "Polyclinic of Hope". Through these centres, they offered information including education on female condoms but their staff has never seen a female condom. RWN also reaches a wide network of 45 community based organisations that could also bring on board for a female condom initiative.

FRSL said that they were interested in a female condom initiative and would contact UNFPA. FRSL had interacted with women living with HIV from Senegal who were active in the UNFPA supported female condom initiative in Senegal and who shared their experiences. FRSL was therefore interested in joining a female condom initiative in Rwanda. The organisation reaches 2700 women and felt that it could create a huge impact through its support programmes for women living with HIV. FRSL had a few female condoms that it was using for demonstrations at its clinic in Kigali but it did not distribute these due to lack of supply.

SWAA Rwanda has previous experience in promoting use of the female condom. They had heard about the female condom in 2004 at the SWAA International Conference. After the conference, an American volunteer was seconded to their programme (they did not indicate by whom) for three months and she trained the members on the female condom. They described these sessions as very comprehensive – covering correct use, re-use, cleaning guidelines, etc.

Women were very pleased with the female condoms provided and many said their husbands did not object to their use. After the trainer left, the FC supply ran out and they could not obtain more from UNFPA or PSI. SWAA Rwanda said that it would be interested in re-engaging in promoting the female condom. They saw it not only as a preventive tool but also a tool that offers women an opportunity to negotiate. Grace expressed this very clearly saying that a woman could tell her male partner that, **"If you do not put on yours, I will put on mine."**

Icyuzuzo expressed interest in joining advocacy for the female condom but said that they could not be able to assess women's interest in the female condom since most of the women they serve have no awareness of the method.

An issue that all organisations in Rwanda agreed on and emphasized was the need to target and educate men on the use of the female condom, because of the strong patriarchal nature of the Rwandese society. This power disparity in relationships between men and women was best captured by Grace from SWAA Rwanda when commenting on men's attitudes towards their wives' bodies. She said that, **"Once you are married, you are married and it is like a chair to sit in. The man does not ask the chair if he can sit in it. He just sits."**

Vaginal Health Module

GCM informed all the organisations visited that its India staff were developing a vaginal health training module and hoped that organisations in other regions would be interested in adapting the module. GCM's aim was to assess the interest in this tool and to gather information on whether such a tool already existed. The organisations in Rwanda said they were interested in looking the draft of the vaginal health module once it was available to see its suitability to the local situation.

RWN said that they would be interested in the module as it was described by GCM but they wanted to see it first before committing to any activities. They suggested that GCM engage Projet Ubuzima in getting people's input to adapt the module for use in Rwanda because Projet Ubuzima has experience with conducting focus group discussions on sexual health issues.

SWAA Rwanda said that there was a lot of secrecy regarding sex and sexuality in Rwanda. Thus young girls do not learn how to handle issues such as sexuality. They noted, however, that the Ministry of Education has incorporated sex education into the teaching curriculum. Currently, it only covers puberty issues, but not vaginal health and

reproductive health issues. SWAA Rwanda was of the opinion that the module could be added to the on going efforts in Reproductive Health education in primary and secondary education.

SWAA Rwanda currently serves about 6000 clients (female and male) and that the women in their support groups talk very openly with each other about their sex lives, problems with HIV prevention, hygiene, etc. When topics are handled by male facilitators, however, the women tend to shy away. Less literate women, in particular, are not well informed on issues of vaginal health and would benefit from this.

Icyuzuzo said that the module might be useful in their counseling centre and possibly also for the focus group discussions they convene on specific topics. Icyuzuzo recommended that the module have a section that specifically addresses vaginal health issues for HIV positive women. This would make it highly relevant to the women living with HIV that they serve.

FRSL was very interested in the vaginal health module but emphasized the importance of adaptation to the local reality. Though FRSL does not have support groups or women-only venues where the module could be used, they said they could use it for the education sessions that they conduct for their clients at their centre every morning at 8.00 am. The people could then talk with the counsellors privately about the issues raised in the morning sessions if they wished to.

RRP+ said they would be interested in reviewing the vaginal health module, when completed. RRP+ did not want to commit to whether it would be useful or not.

Vaginal Practices among Rwandese women

Vaginal practices among Rwandese women were also explored during the discussions. It was notable that the organisations were less open to discussing these issues than the Ugandans and some probing was required to elicit responses. This could be a reflection of the secrecy in which sexuality and reproductive health issues are held in Rwanda.

The following were raised as some of the practices among Rwandese women:

- Vaginal washing with water for hygiene purposes was common. Beatrice Kagoyire from RRP+ said that women were advised against using soap since it was claimed that **"Soap could make the vagina become like a hole."**

- Use of herbs to attract the men and satisfy them sexually occurs in some part of Rwanda. Marie Michelle Umulisa of Projet Ubuzima in Kigali said that women use some "traditional products" (herbs) to attract men. They also use soap inside the vagina because they think they smell bad. SWAA Rwanda added that some women also use perfumes to "smell good".

- Some women use conventional lubricants to enhance sexual intercourse.

- RWN said that female genital mutilation was a very secretive issue and they were not sure whether this was practiced.

Overall the organisations showed interest in reviewing the vaginal health module, but there were varying reservation to commit to activities before seeing the document. Adaptation of the module was highly emphasized.

4. TANZANIA

Organisations' Overview

In Tanzania, GCM visited 9 organisations in Moshi and Mwanza, namely:

1. Kilimanjaro AIDS Control Association (KACA)
2. Health Communication and Research for Development (HCRD)
3. East African Development Organisation
4. Social Vision Group Organization (SOVIGOTA)
5. KIWAKKUKI
6. White Orange Youth Organisation
7. TAFCOM Tanzania
8. Agency for Co-operation and Research in Development (ACORD)
9. Kivulini Women Rights Organisation

Five out of the nine organisations met with the interviewers as a group in Moshi. In Mwanza, the interviewers met with two organisations. These two regions in Tanzania were selected on the basis of ongoing microbicides related research activities occurring there.

There was a good mix of organisations ranging from small NGOs to larger networks such as ACORD. The organisations work on issues of gender, HIV/AIDS and women's empowerment and addressing GBV.

Besides the organisations, GCM visited MWAMKO Project in Mwanza, a clinical trial site for the Microbicides Development Project (MDP) of the UK. This site is involved in conducting phase III trials of PRO 2000 0.5% gel.

Another unique feature of the mapping activity in Tanzania was that the mapping team did a highly informal survey of pharmacies in Moshi town to assess the female condom's availability and cost.

It is important to note that the common working language for most of the organisations is Kiswahili. One of the two interviewers is fluent in Kiswahili and translated for the other.

Woman-initiated prevention

Tanzania, like the rest of Sub-Saharan countries, harbours an HIV/AIDS epidemic that is feminised. Women are the most frequently infected because, even when they know that their partners are putting them at risk of infection, they do not have access to a tool that can reduce vulnerability. KACA informed the interviewers that protection among married women was particularly difficult due to male dominance.

Microbicides awareness and advocacy

Some of the organisations visited were aware that microbicides research activities were going on in their community but most of them did not have enough information. In Moshi, HCRD and KACA were relatively well informed and had engaged in advocacy and community mobilisation for microbicides studies.

KACA had conducted community mobilization activities in Majengo area of Moshi while HRCD had reached out through the media to disseminate information on the ongoing microbicides research. KACA used drama, song, dances and poetry to educate the community and disseminate information about the trials. They were working closely with HRCD and Kilimanjaro Reproductive Health Clinic – the IPM sponsored microbicides site in Moshi.

HRCD was collaborating with two local FM radio stations (Kili FM and Triple A FM) to disseminate information on reproductive health and HIV prevention clinical trials. From the feedback that HRCD was getting from listeners, it was obvious that there was very little knowledge of prevention research within Tanzania. Indeed, clinical trials are new phenomena in these communities. HRCD is developing a Frequently Asked Questions (FAQ) document from the topics raised by its audience. These include:

- Why are clinical trials important?
- The misconceptions and myths surrounding clinical trials (e.g. participants would get HIV infection from the trials).

HRCD is also a member of the AMAG list serve.

Kivulini in Mwanza were aware of the MDP Mwanza microbicides trials but they had not engaged with the studies. Yassin Ally, Kivulini's Acting Director, expressed the opinion that, for microbicides studies, adherence is not possible if men are not involved. More information and education should be provided to both women and men to create an enabling environment for microbicide use.

GCM presented the web-accessible information resources that it had developed including a low lit brochure with basic information on microbicides to all organisations including the site staff. The organisations were also informed of the CD-ROM based Microbicides Essentials course that GCM was preparing to launch. There was considerable interest in the simplified information materials especially the low literacy brochure but the organisations expressed the need to have some of the materials in Kiswahili. Most of the NGO staff and the site staff expressed interest in the CD-ROM based Microbicides Essentials course. The certification was seen as important to their professional development.

Female Condom Access

Though the female condom had been introduced in Tanzania, it faced similar challenges -- such as low supply – as elsewhere in Eastern Africa. PSI, the main condom social marketing agency was reported to have only a small stock of female condoms. Two

brands of the female condom are distributed in Tanzania, that is, "Care" and "Lady Pepeta" (*This name is nuanced to be erotic and could refer to the gyrating of hips*) .

Some of the challenges that face the female condom include:

- There is very low supply of the female condom. Lokola Ndibalema from ACORD said that they placed large orders to PSI for female condoms but received so few that they were not even able to distribute them to their clients. KACA said that, due to the lack of access, they were hesitant to promote and create demand for the female condom. Kivulini said that large organisations involved in family planning work and sexual and reproductive health such as UMATI do not have the female condom.
- Very few women had seen the female condom and those who had seen it still lacked knowledge on its usage. KACA estimated that only about 4% of the women they served were aware of it while HRCD put this figure at 1%.
- Women said that the female condom was difficult to insert. Winnie Mtoi, a VCT counsellor at KACA said that she discussed the female condom with the women and even helped them to insert it. But they found it difficult to insert and some were shy to ask for the female condom or even to use it.
- The service providers also lack information on the female condom. Exaud Malya the Programme Coordinator at KACA said that, **"we also need capacity building to be able to promote the female condom".**
- The female condom is expensive. Most organisations said that the cost was about 2000 Tanzania shillings per piece. An informal check in the pharmacies in Moshi confirmed this. In comparison a male condom costs about 100 Tanzania Shillings. Pharmacies were not stocking the female condom; possibly due to low demand and/or due to low and erratic access to wholesale supplies.
- There also existed myths regarding the female condom. Some women believed that it could "get lost" in the vagina.
- There were complaints about its noisiness during sex.
- Some clients had reported to ACORD staff that the material used to make the female condom (FC1) was too hard and uncomfortable.
- Many women were surprised by the size of the female condom and preferred convincing the men to use the male condom.
- There was very little social marketing of the female condom.

The Tanzanian NGOs felt that there was need to increase awareness on the female condom and educate both men and women on its usage. It was especially important to reach men since they were the decision makers in relationships. Female condom promotion should also be coupled with increased availability at minimal cost so that more people could be able to use the female condom. Lucas Mkwizu from SOVIGOTA said that, **"it is not possible for people to accept a product that they had never seen and most of the women especially in rural areas had never even heard of it (re: female condom)"**. He added that, **"In rural areas most families have been affected by HIV. People want to avoid death so there is a possibility for change of attitude but there must be education and access going together."**

There were divergent views on who would use the female condom. The Mwanza clinical trial staff said that women who engage in transactional sex are likely to use the female condom; however married women are less likely to use it due to issues of trust in the relationships. KACA on the other hand said that the female condom could be introduced to the married couples as an option for family planning as well as prevention of infections.

ACORD said that it did female condom demonstrations in 2006 at the Mwanza Pavillion. Many people said that they had never seen it and there was a lot of interest expressed. ACORD did not have supplies for distribution although people demanded them.

Although there seemed to be mixed feelings about acceptance of the female condom, most of the organisations in Tanzania were largely interested in advocating for the female condom and emphasized the need for education for both women and men, as well as an assured source of affordable female condoms. GCM informed the NGOs that USAID was supporting access to female condom in Tanzania. There seems to be a need, however, for advocacy to the local USAID Mission to urge them to increase funding and support for the female condom.

Informal survey of female condom accessibility in 5 pharmacies in Moshi

This component of the mapping activity was not carried out in the other countries that were visited. As a result of the feedback from the NGOs in Moshi, the interviewers conducted an informal survey of pharmacies in Moshi town on the afternoon of June 10 to assess the price and availability of the female condom in these retail outlets. They visited 5 pharmacies to see if they could purchase a either a Care or a Lady Pepeta female condoms. The following were the outcomes:

- The first pharmacy that was visited did not have any female condoms in stock but said that the *Lady Pepeta* brand (the one the interviewers were most anxious to see, since they had already seen a display sample of the Care female condom) cost approximately 500 Tanzania shillings for a pack of three when it was available.

- The second pharmacy that was visited did have the Care female condom available at a cost of 2000 Tanzanian shillings for one. It did not have *Lady Pepeta* in stock but said it costs 600 for a packet of three, when available.

- The next two pharmacies that were visited did not have any female condoms (of either brand) in stock and had no knowledge of where female condoms could be accessed. One of the pharmacies said that the interviewers could buy female condoms at the Moshi Kilimani pharmacy (opposite the Mawenzi Provincial Hospital).

- At the Kilimani pharmacy, the attendant said that they did not have female condoms. She did not appear to be knowledgeable about the brands and could not tell where female condoms could be accessed, their estimated cost or the number

of female condoms in a standard pack. She guessed that might be available in a pack of three for 500 Tanzanian shillings.

It is notable that several brands of male condoms were available on the display in each of these pharmacies.

Vaginal Health Module

GCM informed the organisations that its India staff is developing a vaginal health module and that it hoped the organisations would look at the module when it is completed and consider adapting it to the local situation.

Most of the organisations were interested in reviewing the module and willing to make suggestions on adapting it for use in Tanzania. It will have to be tailored to meet the diverse sensitivities and nuances that existed among different communities regarding discussion of vaginal health and sexuality issues. They also said that there was no comprehensive module on vaginal health. The only related materials they have seen address menstruation and STIs but do not approach the topics from a vaginal health perspective.

The organisations highlighted the various venues in which they thought it might be appropriate to present and discuss the vaginal health module. These included:

- Small women's support groups and one-to one meetings with counsellors
- KIWAKKUKI, a national organization focused on women and AIDS that has 6000 members in Kilimanjaro region suggested that they could use it in the health educational portion of their monthly membership meeting.
- Both SOVIGOTA and White Orange Youth Organisation said that they could use the module during their life-skills training sessions for youth (in the young women's groups) where they talk openly without shame about reproductive health and sexuality.
- East African Development Organisation said that they could infuse the material from the vaginal health module into the market-based theatre presentations, since large numbers of women are found in the market compared to men.
- TAFCOM Tanzania holds single-parent support groups (since more women are single parents than men) and they could utilize the module during these sessions.
- Kivulini supports a network of 30 community based organisations in Lake Victoria region providing VCT, HIV care and treatment and PMTCT services. These organisations meet quarterly. The vaginal health module can be used during this forum. Kivulini is also running a mentorship and capacity building programme for the next 3 years for these organisations. It will be providing technical assistance and follow-ups as well as linking these CBOs to funding. This is another avenue through which the vaginal health module could be utilized.

Vaginal health practices among Tanzanian women

There was notable that people in Tanzania were reserved in speaking about vaginal practices. This can be attributed to their cultural background and socialization.

Some of the vaginal practices that the organisations identified were:

- Insertion of herbs, ground fine tobacco powder (snuff), other powder products, medicated soaps and pessaries for cleansing or tightening

- Douching with lemon and lime juice. This is especially done by women who engage in commercial sex to cleanse and tighten the vagina so that the next client does not know that the woman has had sex with someone else.

- Squatting over smoke produced by burning various "essences" to suffuse their genitals with the smoke. This is especially practiced at the coastal region of Tanzania.

- One NGO said that FGM is still practiced by the Chaga and Maasai tribes, even though it is now illegal in Tanzania. Women are sometimes genitally mutilated, without their knowledge or consent, while they are in labour and delivery. This is sometimes organized by the women's extended family (by paying the delivery nurse) without the husband's knowledge.

  Another agency told us that FGM is sometimes performed on baby girls, as another way of accomplishing it secretly to avoid prosecution.

  The "public message" is that FGM is decreasing in Tanzania but some NGOs expressed scepticism about the accuracy of those reports.

Kivulini said that it had not engaged in a discussion on vaginal practices and therefore could not comment on this. ACORD said that it could be involved in carrying out a survey to find out the prevalent vaginal practices in Lake Victoria region where they operated in. This could identify issues of importance to women so that the module would be useful in responding to these issues.

Microbicides Site Visit – MDP Mwanza site – MWAMKO Project

GCM was interested in familiarising itself with the community involvement model that the site was using. This site has a well developed community involvement model that has both a CAB and a stakeholders group.

5. KENYA

Organisations' Overview

In Kenya, GCM visited 8 organisations namely:

1. Kenya AIDS NGOs Consortium (KANCO)
2. Solidarity with Women in Distress - Kenya (SOLWODI)
3. Centre for the Study of Adolescents (CSA)
4. Coexist Kenya
5. Kenya YWCA
6. Reproductive Health and Rights Alliance (RHRA)
7. Health Rights Advocacy Forum (HERAF)
8. Stay Alive for Us All (SAFUA CBO)

The organisations were drawn from various areas of focus including sexual and reproductive health and rights, HIV/AIDS, gender issues, and women's health. One organisation is located in Mombasa while the rest are headquartered in Nairobi but have programmes in different parts of the country.

KANCO, HERAF and RHRA are large networks. Kenya YWCA is a faith-based organisation working particularly with young women. CSA has a focus on young people. SOLWODI works with vulnerable women and children, especially those involved in sex work. SAFUA is a support organisation for women living with HIV/AIDS. Coexist is unique in this group because it is a men's organisation that addresses issues of gender based violence (GBV).

Woman-initiated prevention

In the last five years, Kenya has seen rates of HIV infection go down but women still comprise the majority of those infected. According to KANCO, the age range at which HIV infection is most commonly occurring among women is going up; from 16 – 25 years of age in the past to up to 40 years of age now. This could mean that more women are becoming infected in the context of their long term relationships and it underscores the need for woman-initiated prevention.

Microbicides Awareness and advocacy

Most of the organisations visited during the mapping had heard about microbicides, especially in the context of press coverage when clinical trials had been stopped. While some of had good level of knowledge of microbicides, others had very little information.

KANCO had been engaged in advocacy for woman-initiated prevention, and in raising awareness about microbicides among its consortium members. It is also working collaboratively with ICASO in the *Community Voices* microbicides project.

SAFUA, a support group for women living with HIV in Kibwezi (eastern Kenya) has been involved in sensitising members about microbicides. Its Founder and Coordinator, Jacinta Mulatya, attended the Microbicides 2006 and 2008 conferences and has gained considerable knowledge of microbicides. She has been sharing GCM and AMAG-provided information and updates with the support group members, as well as members of the local district HIV/AIDS network. The key challenge she has been facing is that the women she works with are primarily illiterate or semi-literate, making it necessary to translate the concepts into simplified information using the local language (*Kikamba*) which is not easy. She utilizes the regular group meetings to provide information to the members. She said that, **"When I receive the Global Campaign newsletter, I normally take it with me to the group meeting and give the members updates. I have to translate the information into *Kikamba* and sometimes that is not easy because some of the information is complicated."**

CSA's Rosemary Muganda-Onyando has read a lot on microbicides because the nature of her work in reproductive health requires her to be well informed about various issues relating to women's prevention. She observed, however, that other members of the organization, as well as the young people they serve, are not well informed about microbicides.

SOLWODI was aware that clinical trials were going on in Mombasa but had only heard microbicide mentioned and did not have much information.

All the organisations felt that they needed more information and education on microbicides. They also expressed interest in receiving more information on the CD-ROM based Microbicides Essentials course that GCM has developed. Just as in the other countries, the certification was viewed as important for professional development.

Female Condom Access

The female condom has been introduced in Kenya but the reality of its acceptability and use is no different than that of other Eastern African countries. The organisations identified the following as the challenges facing female condom promotion:

- The supply is very low and erratic and therefore many women had never seen it. SAFUA said that the Comprehensive Care Clinics – set up to offer HIV/AIDS services under government health facilities – do not provide female condoms. SAFUA members got female condoms from ACT Now, a local NGO that gets its supplies from a German NGO. But even ACT Now did not have supplies all the time. SOLWODI said they used to get female condoms from ICRH but these are no longer available.
- The cost of the female condom was cited as being prohibitive by all the organisations. Organisations gave prices ranging from 90 – 150 Kenya Shillings each. An informal check in a supermarket in Nairobi revealed that a pack of 3 costs 430 Kenya shillings. This is very high price compared to 10 Kenya shillings for a pack of 3 male condoms.

- There is little female condom investment by the government and funding agencies despite the fact that they are a part of the Kenya National HIV/AIDS strategic plan. Thus, the public sector and civil society are simply not able to access it.
- Many women have very little information about female condom usage and there is no social marketing for the female condom. Pelvic models (plastic models the female genitalia) are not available for use in female condom demonstrations.
- Misconceptions about the female condom include the belief among some women that the female condom could slip and disappear into the vagina.
- Organisations also said that the design was not user-friendly. Some women say that they can feel the inner ring during intercourse. Also some men by-pass the female condom by pushing the outer ring aside.
- There are complaints about its feel on the skin, as well as noise. Because of these two factors, one woman said that when she used it she felt like she was wearing a polythene bag.
- There are negative attitudes towards the female condom, not just from the community members but also notably among service providers.
- The design, size and packaging were described by the organisations as being a concern for women; some of whom felt the female condom was very big and the packet was difficult to conceal. One organisation reported complaints that it was "messy".
- The issue of the female-condom being women-initiated is not well received. Since women have been socialized that men are the decision makers in relationships, many fear to initiate female condom use in relationships. One organisation said that, **"advocates could have used the wrong scenario to introduce the female condom that is women-controlled thus giving the impression that this was a battle of the sexes especially in African societies"**.
- Promoting the female condom as a tool for HIV prevention may also have impacted negatively on its adoption by people -- especially those who are married and do not perceive themselves as being at risk. Positioning it as a contraceptive could create a different perception among such couples.
- There hasn't been enough social science research in Kenya looking at attitudes and perceptions among communities regarding the female condom.

Most of the organisations felt that more needed to be done to promote the female condom. RHRA expressed reservations; saying that it may be difficult to promote the female condom due to the existing negative attitude and perceptions.

KANCO said that they were working with female sex worker organizations who expressed a high demand for the female condom, although the supply was very low. This was echoed by SOLWODI, an organisation located in Mombasa that works directly with female sex worker in Coast province. These women demanded female condoms from the SOLWODI peer educators when the educators demonstrate and talk about female condom usage... The sex workers told SOLWODI staff that, when inserted early enough, the female condom warms to body temperature and adheres to the vaginal wall. Under these circumstances, they reported that men liked it and said that it felt just like the skin. But if a woman wore it only a few minutes before intercourse, it would be noisy.

CSA said that social marketing was needed to make the female condom attractive, fashionable and "cool". It should especially target younger women; encouraging them to start using it early in their relationships with men so that it can become part of their lifestyle and a method of choice for prevention of infections and pregnancy.

HERAF expressed their willingness to participate in advocacy at the national level to budget for female condoms. They felt this should be targeted to the NACC and the National AIDS and STDs Control Programme (NASCOP). CSA said that NASCOP had a condom working group, an entity to which female condom advocacy could be directed.

Coexist identified a need to reach out to religious leaders since there is resistance to condom use among different religions. Coexist previously engaged in female condom advocacy directed to Muslim leaders in Mombasa and reported some success in changing their attitudes. They used to receive the female condoms from NIFRAT Stockholm. The women they contacted were willing to try the female condom when it was available but Coexist estimates that about 80% of the people they talked to had never seen the female condom.

Kenya YWCA highlighted the need to educate men as the decision makers in sexual relationship to change their attitudes and promote understanding of the female condom. They said that, if men supported it, the likelihood of usage increased.

SAFUA has been educating the members about the female condom. A unique observation by this organisation was Jacinta's statement that, **"There is demand for the female condom; however younger unmarried women (aged about 16 – 24 years) were not keen on the female condom. It is the older married women (above age 35) who use it."** She also said that, while attending a workshop organised by KENERELA+ (Kenya Network of Religious Leaders living with or personally affected by HIV), some male participants said they had used the female condom with their wives and had liked it.

Vaginal health module

GCM informed the organisations about the vaginal health module that is being developed by its India staff; asked if they were aware of any such tool that existed already; and further inquired about their possible interest in adapting such a tool for their local use.

Most of the organisations said they were not aware of any such tool that addressed issues of vaginal health comprehensively. They said that issues like menstrual health had only gotten attention in the last 2 – 3 years. This was due to the civil society campaign to keep girls in school through the provision of sanitary towels to those needing them.

The organisations said they would be interested in reviewing the module but emphasized that, for the module to be used in Kenya, it would have to be adapted to address local needs. An important point raised by Coexist was that. even at country level, the tool might need further adaptations to fit into the differences existing among various Kenyan

communities. Some communities are more open to discussing sexuality issues while others were very reserved about it.

Kenya YWCA highlighted FGM as an important issue to be addressed in the module as it affects women's sexual health. They said that:

- FGM was prevalent among the Somali, Meru, Maasai, Kuria and Kisii communities. Other Bantu communities, also practiced it although the intensity was less.
- Since FGM is illegal under the Children's Act 2001, parents collude with medical personnel to circumcise girls secretly.
- Among the Meru, women who have not under FGM are subjected to it during childbirth. Families collude with the nurses to accomplish this and the women often do not realize what has happened until after child birth

RHRA added that cervical cancer should also be addressed since very few women knew about it. SAFUA raised the issue of including a section on educating women and girls about care for undergarments. Undergarments tend to be viewed as items of shame so many women do not hang them out to dry properly. This can have health consequences if wearing damp undergarments makes women more prone to irritation and infection.

KANCO said that one of the ways they could utilize the module is in training of female sex workers as peer educators. CSA said they could use it for their youth programmes and SOLWODI as part of their peer education activities and during the women's meetings.

Vaginal practices among Kenyan women

The organisations highlighted the following as some of the vaginal practices that they were aware of in Kenya.

- Use of lubricants - KANCO said that NASCOP is developing a standard package of materials offered along with services to female sex workers and lubricants had been proposed for inclusion in that package.

- Female sex worker used medicinal products to stop the flow of menstruation so that it does not curtail them from making money

- Vaginal "drying and tightening" products are imported into the country and marketed through supermarkets and beauty shops. Most of these products are from China and Thailand. They include:
    - "virginity soaps"
    - Pessaries
    - Liquids
    - powders
    - "soluble stones"
    - Douching with lemon juice

Some of these products are also used for cleansing. Women perceive their vaginas as unclean and do this to please the male partners

- Cleansing with salty water and “to make the vagina smooth” (meaning lubricated)

- Due to cost, women (especially in rural areas) often use Vaseline as a lubricant to reduce pain and to make sex more comfortable.

These practices highlight the need for additional vaginal health education to promote the sexual and reproductive health of women in Kenya.

6. Common themes emerging across Eastern Africa

There is little information on microbicides and most people have not heard of them. Clinical trial literacy is also very low so simplified information and skills building for NGOs are needed. GCM and AMAG can engage in capacity building for NGOs, as well as working with local organisations to build the media's knowledge base to help ensure balanced reporting of issues related to microbicides and clinical research. There was considerable interest in the CD-ROM based Microbicides Essentials course that GCM has developed. Most of the organisations said they would prefer to receive a CD-ROM since internet access for these organisations is limited or too costly.

NGOs are interested in engaging in advocacy and promotion of the female condom but expansion of female condom use cannot realistically occur until cost and supply issues are addressed. More investment in the female condom is needed, as is social marketing and education about it for both men and women.

Female condom promotion also needs to also highlight it as a contraceptive method, especially among couples in long term relationships who perceive themselves as low risk of HIV.

There is interest across the countries in the vaginal health module, although organisations in all the countries highlighted the need to adapt the module to local situations and realities.

7. Next Steps by GCM

Provide information on microbicides to the NGOs that they can use with the communities they serve. Translation of some materials into key local language will be essential to increase their accessibility. In Rwanda, materials in Kinyarwanda are needed while in Tanzania, Kiswahili translations are necessary

GCM can collaborate with the NGOs on advocating for increased access to female condoms. In Rwanda, UNFPA is supporting condom programming and may be persuaded to include the female condom as a part of this initiative. USAID is providing female condoms in Tanzania and, through advocacy; it may be possible to get the supply increased and training on condom promotion and education provided to local NGOs. Oxfam Novib is planning a female condom programme in Uganda and GCM may be able to work with them on what form this will take and to encourage their involvement of interested NGOs. There is need to identify which major international organization(s) is supporting similar activities in Kenya and reach out with advocacy effort to increase female condom access, promotion and affordability.

It may also be helpful to reach out to PSI country offices as key social marketers in the region to discuss how promotion of the female condom in the region could be expanded and the supply improved.

GCM also has a clear opportunity to engage NGOs in Eastern Africa in reviewing the vaginal health module and its adaptation to meet local needs.

Finally, GCM appreciates the very candid information sharing by the NGOs and other entities participating in this mapping exercise.

Appendix: List of organisations reached during the mapping

UGANDA

	Organisation	Contact Person	Phone	Email	Physical/ Postal Address
1.	Society for Women and AIDS in Africa (SWAA) Uganda	Dr. Lucy Korukiiko	+256 772 856 556 (Mobile)	lucykorukiiko@hotmail.com	Simbamanyo Building, 2nd Floor, George St., Kampala (c/o Jane Nakuti)
2.	Uganda Women's Network (UWONET)	Aheebwa Manisurah	+256 414 286 539 (Office) +256 712 848 980 (Mobile)	manisurah2000@yahoo.co.uk; manisurah@uwonet.org	Plot 198, Old Kiira Road, Ntinda, Kampala
3.	Mama's Club	Marion Natukunda	+256 772 448 102 (Office) +256-774-290-640 (Mobile)	wwwmarionj@yahoo.com clubmamas@yahoo.co.uk	Plot 49 Kira Road, Kampala
4.	Community Health and Information Network (CHAIN)	Regina Kamoga	+256 414 568 786 (Office) +256 752 693 774 (Mobile)	chainproject@infocom.co.ug	Community House Plot No. 809 Kanyanya, Gayaza road, P.O. Box 16051, Kampala
5.	Centre for Domestic Violence Prevention (CEDOVIP)	Tina Musuya	+256 414 531 249 (Office) +256 712 240 694 (Mobile)	tmusuya@raisingvoices.org	Raising Voices office Plot 16 Tufnell Drive, Kamwokya, Kampala

RWANDA

	Organisation	Contact Person	Phone	Email	Physical/ Postal Address
1.	Commission Nationale de Lutte Contre le SIDA (CNLS)	Elisaphan Hakizimana	+250 08 306 166 (Mobile) +250 570 063 (Office)	helisaphan@yahoo.fr cnls@rwanda1.com	B.P. 3888, Kigali
		Richard Niyonkuru	+250 08 679 879 (Mobile)	Niyo_richard@yahoo.fr	
		Andrew Ntwali		ntwali@unfpa.org	
2.	Rwanda Women Community Development Network	Winnie Muhumuza	+250 583 662 (Office) +250 08 486 149 (Mobile)	rwawnet@rwanda1.com winniea23@yahoo.com	Kicukiro next to WFP/PAM P.O. Box 3157, Kigali
3.	Society for Women and AIDS in Africa (SWAA) Rwanda	Grace Mukankuranga	+250 55 100 782 (Office) +250 08 596 647 (Mobile)	swaar@rwanda1.com	P.O. Box 5196, Kigali
		** Shamsi Kazimbaya	+250 08 301 299 (Mobile)	shamsi_2409@yahoo.fr	
4.	ICYUZUZO	Eugene Twagirimana	+250 504 488 (Office) +250 08 557 293 (Mobile)	icyuzuzo@yahoo.fr twagieugene@yahoo.fr	Nyamirambo, Electrogaz Building, 2nd Floor, Opposite Regional Stadium, B.P. 2576, Kigali
5.	FRSL (Femmes Rwandaise dans la lutte contre le SIDA)	Philomène Cyulinyana	+250 08 558 164 (Mobile)	philoscyu@yahoo.fr	
6.	Réseau Rwandais des Personnes Vivant avec le VIH/SIDA	Beatrice Kagoyire	Mob: +250 08 305 155	beakagoyire@yahoo.fr rrp.rwanda@gmail.com	B.P. 6031 Kigali

Note :
** indicates the person did not participate in discussions but was a primary contact person

TANZANIA

	Organisation	Contact Person	Phone	Email	Physical/ Postal Address
1.	Kilimanjaro AIDS Control Association (KACA)	Exaud Mallya	+255-754-390-402 (Mobile)	exaudmalya@yahoo.co.uk	Bondeni ward, Manyema street, Oysterbay, (Opposite Mbuyuni Market) P.O. Box 8425, Moshi
		Faraji Swai	+255 272 751 645	zopposwai@yahoo.com	
2.	Health Communication and Research for Development	David Ngilangwa	+255 713 282 858 (Mobile) +255 272 750 663 (Office)	dngilangwa@yahoo.com	Majengo Research Clinic Majengo Health Centre (Premises), P.O. Box 7506, Moshi
3.	East African Development Organisation	Silvano Gabriel		juniormambo@yahoo.com	
4.	Social Vision group Organization (SOVIGOTA)	Lucas Mkwizu	+255 754 481 552 (Mobile)	woykili@yahoo.com socialvision@hotmail.com	P.O. Box 343, Same - Kilimanjaro
5.	KIWAKKUKI	** Dafrosa Itemba	+255 272 751 504	Kiwakkuki1@kilionline.com	
		Theresia Sabuni	+255 754 838 745 (Mobile)	Theresia.sabuni@gmail.com	
		Anna Mwalla	+255 753 880 483 (mobile)		
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