Chapter 1: Introduction

Male circumcision involves the removal of all or part of the foreskin of the male reproductive organ and is one of the oldest and most common surgical procedures worldwide. It is undertaken for religious, cultural, social or medical reasons. Data from a range of observational epidemiological studies, conducted since the mid-1980s indicated that circumcised men have a lower prevalence of HIV infection than uncircumcised men. Three randomized controlled trials conducted in Orange Farm, South Africa; Kisumu, Kenya and Rakai District, Uganda showed that following circumcision, the incidence of HIV infection in men was reduced by more than half. (Auvert and Taljaard 2005)

In March 2007, WHO and UNAIDS convened an expert consultation to review all the evidence for male circumcision for HIV prevention including the data from the randomized controlled trials conducted in Kenya, South Africa and Uganda. Based on the strength of the evidence recommendations were made that male circumcision should be considered an important new intervention for HIV prevention and should be promoted as part of a comprehensive HIV prevention package. The WHO/UNAIDS conclusions and recommendations on male circumcision for HIV prevention specify that countries with a high prevalence of HIV, low prevalence of male circumcision and heterosexual epidemics should consider the scaling up of male circumcision as part of the comprehensive HIV prevention package.

HIV in sub-Saharan Africa is predominantly transmitted by unprotected heterosexual intercourse, and effective prevention strategies include behavioral change programmes to promote abstinence and delayed sexual debut in young people, fidelity within partnerships where
both people know they are seronegative, reduction in the number of partners and correct and consistent condom use. Reduced incidence and prevalence in several African countries, including Zambia and Zimbabwe in southern Africa, show that these prevention messages can work, but the alarming number of new infections every day in the region means that there is a need not only to intensify and expand current prevention programmes, but also to identify new methods to add to the existing ones. Male circumcision is one of the new potential methods. So far, it is the only new prevention method to have shown consistent efficacy through randomized controlled trials. In the Eastern and Southern Africa (ESA) Region, 13 focus countries have been identified by the United Nations Interagency Task Team (IATT) for technical support to scale up their male circumcision programmes. Some of the countries are Botswana, Uganda, South Africa, Zambia, Tanzania and Zimbabwe.

In the past decade, Zimbabwe has suffered greatly from the impact of HIV and AIDS. The Ministry of Health and Child Welfare (MOHCW 2008) estimates that out of the total Zimbabwean population of 12 million people about 1.1 million people are living with HIV and AIDS. Out of these 932 000 of them are adults between 15-49 years. New infections continue to be recorded and in 2009, 48 168 new infections were recorded for adults and the estimated death rate of 1,614 persons in the same period. The continued decrease in the number of AIDS deaths shows the impact of scale up of both prevention and care and treatment efforts in averting deaths. A decline in HIV prevalence has been noted among persons aged between 15 to 49 years from 15.07 percent in 2008 to 14.26 percent in 2009 and the current 13.1% in 2010, according to MOHCW (2008). The MOHCW further noted that despite this decline in the 15-49 years age group, the age group of 15-24 years has recorded an increase in the HIV prevalence rate from
3.2% in 2009 to 3.3% in 2010 which is also within the priority age group for male circumcision of 15-29 years.

While the decline in HIV prevalence among the 15-49 years age group is encouraging, overall more than one in seven Zimbabweans is still infected with HIV according to the HIV estimates of 2009. According to the MOHCW (2008), Zimbabwe will continue to invest in interventions targeting behavior change, improve prevention strategies and improve care and treatment services for those affected by HIV in order to decrease the number of people becoming infected with HIV and dying from the infection.

Zimbabwe has one of the highest HIV prevalence in Sub-Saharan among the 15-49 years age groups. According to the MOHCW (2008) high rates of HIV infection in Zimbabwe are the result of sexual risk behaviors involving multiple concurrent partners, casual sex and transactional sex. These practices combined with the widespread practice of unprotected sex and the presence of STIs produce the ideal climate for HIV transmission in Zimbabwe.

Numerous prevention programmes have been implemented by the government, local and International organization, but the country still continue to encounter new infections daily. As outlined in the Zimbabwe National Strategic Plan 2006-2010, many of these programmes have focused on: increasing condom use, reduction of sexual partners, reduction of casual sex, increased STIs checkups and increased counseling and testing services. Zimbabwe has been fighting a staggering reduction of HIV prevalence and has managed a decline from 29.3% (1998) to 15.6% (2007) and the current 13.1% according to the National HIV and AIDS
Estimates (2008). The decline was attributed to a combination of mortality and behavior change, particularly reduction in partners and high levels of condom use with casual partners. Despite these reductions in risk, heterosexual transmission of HIV remains the main driver of HIV transmissions in Zimbabwe.

WHO/UNAIDS(2007) states that development of new prevention programmes such as male circumcision is vital and the promotion of male circumcision should be recognized as an additional, important strategy for prevention of heterosexually acquired HIV infection in men. And as rightly put in the Zimbabwean Male Circumcision policy document, male circumcision services shall be part of a comprehensive HIV prevention package and be provided in the framework of existing and related health services. The broader package shall include information about the risks and benefits of the procedure, counseling about the need to adopt and maintain safer sex practices, access to HIV testing and counseling, condom promotion and provision, and the management of sexually transmitted infections.

Data from a range of observational epidemiological studies as cited by Auvert and Taljaard (2005) and Bailey (2007) showed that circumcised men have a lower prevalence of HIV infection than uncircumcised men. Bailey (2007) noted some biological evidence on how male circumcision reduces chances of new HIV infections among men. Firstly the author highlights that the area around the foreskin is a warm and moist environment which promotes the replication of bacteria especially if penile hygiene is poor. Another explanation as highlighted by Bailey is that the inner surface of the foreskin is less protected and so especially when having sex, is more susceptible to abrasions or inflammation which can facilitate sexually transmitted infections. Bailey (2007) further explains that the tissue on the inner skin of the foreskin is rich in HIV target cell called Langerhans and other receptor cells. During a sexual contact this inside
surface of the foreskin is directly exposed to vaginal fluid and the possibility of infection from STIs or HIV is very high. Through the removal of the foreskin these possible routes for STIs and HIV infection are removed.

Auvert and Taljaard (2005) further noted some geographical evidence in terms of the prevalence of male circumcision. HIV prevalence is generally lower in populations that traditionally practice male circumcision than in populations where most men are not circumcised. Some regions in sub-Saharan Africa where men are more commonly circumcised have lower HIV prevalence. Countries in the sub-Saharan Africa with low levels of male circumcision have a higher HIV prevalence when compared with countries with high rates of male circumcision - countries in West Africa where male circumcision is common have HIV prevalence levels lower than countries in eastern and southern Africa. HIV prevalence in south and south East Asian countries namely Bangladesh, Indonesia, Pakistan and the Philippines where nearly all men are circumcised remain extremely low.

Male circumcision, as with any surgical procedure may have post-operative complications if carried out by inexperienced personnel. In addition, adverse reactions to the anesthetic used during the circumcision may occur. The safety of male circumcision also depends on the setting were the procedure is carried out. Male circumcision for religious or traditional reasons frequently takes place in a non-clinical setting. Circumcisions undertaken in unhygienic conditions by inexperienced providers, with inadequate instruments or with poor after care can result in serious complications, including death. Male circumcision also raises human rights issues and hence the need for health care providers to provide up-to-date information on the health risks as well as the benefits of male circumcision. In response to these issues the Joint United Nations Programme on HIV/AIDS (UNAIDS) came up with a policy document – a legal
and regulatory self-assessment tool for male circumcision to guide all sub-Saharan countries wishing to implement and scale-up male circumcision services for HIV transmission on legal, regulatory and policy considerations associated with male circumcision of which Zimbabwe is one of the countries. The policy document also affirms male circumcision as one important strategy for prevention of heterosexually acquired HIV infection in men.

As enshrined in this policy framework, the governments of the countries have the duty of formulating and implementing laws and regulations governing the provision of male circumcision services in their respective countries. Governments should ensure adequate resource allocation, training, supervision, quality assurance and monitoring and evaluation and that health care providers appropriately implement such services.

The policy document also mandate governments to ensure safe male circumcision for HIV prevention is available, accessible and culturally acceptable to all individuals who want the services without discrimination. The key recommendations covers key topics on socio-cultural contexts, communications, health systems strengthening, gender implications, ethical/legal/human rights principles to guide service delivery, maximizing public health, safety, HIV testing, the need for additional resources, and unmet and future research needs.

In line with the aforesaid policy guidelines, Zimbabwe also came up with a policy document on male circumcision. In 2007, the National AIDS Council in collaboration with the MOHCW convened a large-scale stakeholder consultation, which recommended considering male circumcision as a public health intervention. Following this meeting the MOHCW initiated a comprehensive situation analysis, which was shared in another stakeholder meeting convened by the MOHCW in 2008. In this meeting it was proposed to develop a policy on male circumcision
and a Steering Committee on male circumcision was constituted. This policy is built on findings from the comprehensive situation analysis carried out in 2004 by the MOHCW and recommendations from stakeholders meetings. In addition, global research evidence and global policy recommendations have been considered. The Zimbabwean national male circumcision policy was launched in November 2009.

According to the MOHCW (2008:6) the goal of the male circumcision policy is to reduce the incidence of HIV infection, other STIs, penile and cervical cancer through provision of safe and voluntary male circumcision services.

The policy document will be implemented under the following guiding principles:

1. Development and expansion of male circumcision services will be based on human rights based approach to ensure that the procedure can be carried out safely, confidentially, under conditions of informed consent and without coercion or discrimination.

2. Male circumcision services shall be delivered in a culturally sensitive manner with respect for traditional cultural and religious values and beliefs to minimize stigma that may be associated with circumcision status.

3. Male circumcision shall not be offered in isolation but as part of a comprehensive HIV prevention as well as sexual and reproductive health package that includes promotion of safer sex practices, treatment for sexually transmitted infections and any measures that may be required to minimize behavioral disinhibition.

4. The service should not interrupt other health services or divert resources from other primary health care services.
5. Further development of male circumcision services should be informed by evidence from monitoring and evaluation and appropriate operations research.

6. HIV and AIDS is an emergency in Zimbabwe. Thus benefits and risks of promoting and scaling up male circumcision services shall be balanced against this reality.

The MOHCW (2008) set the following targets for the implementation of male circumcision in Zimbabwe:

1. All geographic areas shall be targeted for promotion of male circumcision.

2. Male circumcision shall be encouraged and promoted in all age groups.

3. First priority shall be given to men aged 13-49 years with a particular emphasis on men reaching ages with the highest incidence of new HIV infections, i.e. men aged 20-29 years.

4. Second priority shall be given to all infants/neonates.

5. Also to be prioritized are men at particularly high risk of HIV infection such as mine workers, commercial farm workers, prison inmates and others.

6. All initial prioritization will be relaxed over time as services are expanded so that all males of all ages have access to male circumcision.

In April 2009, the pilot phase of male circumcision began in Zimbabwe with 1,818 men being circumcised at four sites namely Bulawayo eye clinic, Harare Spilhaus - Zimbabwe National Family Planning Council Centre, Mutare Provincial Hospital and Karanda Mission hospital in Mount Darwin. The male circumcision programme aims to reach about 80% of Zimbabwe’s young men by 2015. Services have also been extended to the army hospital in Harare as the uniformed forces have been identified as one high risk group.
The Zimbabwean male circumcision policy also has some human rights considerations in accessing the services. The policy upholds the need to ensure non-discrimination in access to services. No person shall be denied male circumcision services on non-medical grounds such as race, religion, ethnic origin, sexual orientation; or belonging to particular population groups such as prisoners, men who have sex with men or male sex workers. The policy document also seeks to protect women in the context of male circumcision. Providers of male circumcision services are mandated to monitor and prevent possible negative outcomes of male circumcision on women. Such negative outcomes include unsafe sex resulting from behavioral disinhibition due to perceived absence of risk following male circumcision. Women should be protected from sexual violence related to male circumcision and increased risk of passing HIV infection to female partners during the healing stage of the operation.

Children’s rights are also enshrined within the policy document. According to the laws of Zimbabwe a child is anyone under the age of 18 years. In the case of male circumcision in children all programming shall be in the best interest of the child. Boys who are able to participate in decisions that affect them shall have the right to be involved and have a say in decisions about their circumcision.

According to the policy document, circumcision of men living with HIV is not recommended in view of the increased risk of passing HIV infection to female partners during the healing stage of the operation (MOHCW, 2008). Men living with HIV should receive adequate explanation and counseling on why male circumcision is not recommended for men living with HIV. Whilst the circumcision of men living with HIV shall be discouraged, HIV testing shall not be a precondition for circumcision. Where medically indicated, male circumcision shall be provided to all men irrespective of their HIV status. All men need to receive clear information and
thorough counseling on the increased risk of transmission of HIV from men living with HIV to women, if sexual relations are resumed before wound healing.

Privacy over personal health matters is a basic human right. In the context of male circumcision, the issue of confidentiality requires a number of specific considerations. Zimbabwean laws require that all medical consultations and treatment be performed under conditions of confidentiality. However, in certain communities that traditionally circumcise as part of the rites of passage to manhood the fact of being circumcised is a source of pride and evidence of belonging and it is expected that families and the boys involved will want the new status of the boy to be known. Male circumcision shall be accorded the same degree of confidentiality as any other medical procedure in accordance with the laws of Zimbabwe in respect of medical ethics. Where male circumcision is performed as part of a rite of passage to manhood disclosure of the circumcision status shall be left to the discretion of the families and the boys concerned.
Statement of the problem

Male circumcision has been approved as a new HIV prevention method after the three randomized trials conducted in South Africa, Kenya and Uganda to ascertain the effectiveness of male circumcision in reducing HIV transmission. It has been found to be efficacious in reducing HIV transmission among heterosexual partners by more than 50% as noted by Auvert (2005).

The WHO/UNAIDS (2007) recommended that male circumcision should be implemented and scaled-up in countries where there are high HIV prevalence, especially in southern Africa and conducted by well trained medical professionals under conditions of informed consent. Male circumcision has however been received with different views especially in non-circumcising communities of southern Africa including Zimbabwe.

According to the MOHCW (2008), few men are coming forward for male circumcision because of varying perspectives, despite the government of Zimbabwe’s target of intending to reach out to 80% of males and new born babies by 2015.

One determinant for men to accept male circumcision is that it ensures a lower risk of urinary tract infection, a reduced risk of sexually transmitted infections including HIV, penile cancer and cervical cancer in the partner. However some men’s barriers to the acceptability of male circumcision are fear of pain, concerns for safety and the cost of the procedure.

Amongst women, male circumcision improves penile hygiene which is widely recognized as being extremely important and is perceived as a major benefit of circumcision by both men and
women. Women feel that it is easier for a circumcised man to maintain cleanliness and this is a major factor in women’s acceptability of male circumcision.

The effect of male circumcision on the sexual enjoyment of the circumcised male’s partner has also been expressed with different views. Some women noted that they hardly achieve an orgasm with a circumcised partner whilst some would prefer circumcised men because of the longer time they take to reach orgasm and also some women prefer circumcised men for hygienic oral sex. It is further noted that women also find it harder to manually stimulate circumcised partners during sex. Circumcision among children has also been a cause of unnecessary pain to children who are circumcised and have a risk of complications due to surgery.

Circumcision has been perceived with different views in terms of its acceptability as an HIV preventive strategy. The above mentioned views needs to be further ascertained through this study by assessing the knowledge, attitudes and beliefs of people in accepting male circumcision as a preventive method in HIV and AIDS, in Mbare and Southerton suburbs of Harare.

**Assumptions**

The results of this situational analysis will help in determining the demand of male circumcision and identify gaps in terms of training needs and service provision of male circumcision. This study will analyse respondents’ key behaviors and attitudes that influence male circumcision among individuals and the communities, cultural and traditional influences on male circumcision, number of male circumcision carried out and at what age, and prevalence of male
circumcision among adolescents and adult males. The responses, if positive, will help the government in planning for appropriate services.

The findings will further inform interventions required to increase rates of male circumcision and will provide a base for the government for assessment on whether it is able to meet the current and future demand for services and come up with strategies to increase demand for services.

**Aim of the study**

To assess the knowledge, attitudes and beliefs of people in accepting male circumcision as a preventive method in HIV and AIDS, in Mbare and Southerton suburbs of Harare, Zimbabwe.

**Objectives**

1. To establish the knowledge, attitudes and beliefs of people in Mbare and Southerton suburbs of Harare on male circumcision as a preventive method in HIV and AIDS.
2. To gain an insight into the acceptability of male circumcision among different social and demographic groups.
3. To analyse the involvement of women and their role in the acceptability of male circumcision.
Definition of Terms

Male circumcision

Various definitions of male circumcision have been put forward by several scholars.

Bailey (2007) defines male circumcision as the removal of a simple fold of skin (the 'foreskin' or 'prepuce') that covers the head (glans) of the un-erect penis

Auvert and Taljaard (2005) and WHO/UNAIDS (2008) concur that male circumcision is the removal of the foreskin (prepuce), a loose fold of skin that covers the head of the penis.

Auvert and Taljaard (2005) and WHO/UNAIDS (2008)’s definition will be adopted in this study.

Male Initiation

Male initiation is the traditional procedure of removing the foreskin of the penis as a sign to mark the graduation of boys to manhood. Experienced community members perform the operation. Men undergoing initiation spend up to three months in seclusion from the other community members, being taught new manhood roles.
Chapter 2: Literature Review

Origins of male circumcision

Doyle (2005) explains that the word "circumcision" comes from Latin word *circum* (meaning "around") and *cision* (meaning "to cut"). Historically, male circumcision has been associated with religious practice and ethnic identity. Circumcision was practiced among ancient Semitic peoples, including Egyptians and Jews (Johnson, 1993), with the earliest records depicting the practice coming from Egyptian tomb work and wall paintings dating from around 2300 BC. To the ancient Egyptians, circumcision was a sign of fertility and of godly sacrifice. At first, circumcision was a special religious ritual for both men and women of the elite, not performed universally, but increasingly being practiced by other people through the years.

Muslims are the largest religious group to practice male circumcision. As part of their Abrahamic faith, Muslims practice circumcision as a confirmation of their relationship with God; the practice is also known as *tahera*, meaning “purification” as noted by Johnson (1993). There is no specific mention of circumcision in the Qur’an (Tierney, 2006), and it is only obligatory among one of the six Islamic schools of law (the Shafi’ite school). The other schools regard the practice as traditional and strongly encourage it. With the global spread of Islam from the 7th century AD, male circumcision was widely adopted among previously non-circumcising communities. In some regions, male circumcision was already a cultural tradition prior to the arrival of Islam. In other regions, Islam became a major determinant of circumcision. In Islam, one theory behind the Egyptian practice was that men were born bisexual, and in order to mature in a healthy way, they needed to remove the female part of their genitals which was the hood or
prepuce. It was deemed necessary for priests. Among some West African people, circumcision is still seen as the removal of the "feminine" characteristic of the man, changing the boy into a totally masculine being.

In sub-Saharan Africa there is no clear consensus on compatibility of male circumcision with Christian beliefs (Westercamp and Bailey, 2007). Some Christian churches in South Africa oppose the practice, viewing it as a pagan ritual (Rain-Taljaard, 2003), while others, including the Nomiya Church in Kenya, require circumcision for membership. (Mattson, 2005). In Malawi and Zambia there are similar beliefs that Christians should practice circumcision since Jesus was circumcised and the Bible teaches the practice (Lukobo and Bailey 2006). In some West African countries, circumcision prevalence tends to be lower among those of traditional religion than among Christians (Demographic and health surveys: MEASURE 2010). Although religion and ethnicity can be closely correlated, religion can be a strong determinant within an ethnic group.

Circumcision has been practiced for non-religious reasons for many thousands of years in sub-Saharan Africa. Prevalence of circumcision within a country can vary by ethnicity. For example, although an estimated 84% of all Kenyan men are circumcised, the percentage is much lower among the Luo and Turkana ethnic groups in the country (17% and 40%, respectively) (Demographic and health surveys: MEASURE 2010). Luo men and women found no knowledge of any history of male circumcision among the Luo in Kenya. Instead, children traditionally had their six lower front teeth removed at initiation. In the majority of these cultures, circumcision is an integral part of a rite of passage to manhood, although originally it may have been a test of bravery and endurance. Circumcision is also associated with factors such as masculinity, social
cohesion with boys of the same age who become circumcised at the same time, self-identity and spirituality (Niang, 2006).

Today, male circumcision is performed for a range of reasons, mainly social or health related, in addition to religion and ethnicity. The desire to conform is an important motivation for circumcision in places where the majority of boys are circumcised. A survey in Kenya, where circumcision occurs shortly after birth, found that parents, especially fathers, of newborn boys cited social reasons as the main determinant for choosing circumcision (for example, not wanting him to look different). The main correlate of circumcision status was circumcision status of the father, with 90% of circumcised fathers choosing to circumcise their son, compared with 23% of non-circumcised fathers, according to MEASURE (2010).

Socioeconomic factors also influence circumcision prevalence, especially in countries with more recent uptake of the practice. When male circumcision was first practiced in the United Kingdom in the late 19th and early 20th century, it was most prevalent among the upper classes (Mattson, 2005). A study published in 1953 found that 74% of private-hospital patients in New York City were circumcised compared to 57% of non-private patients. A similar association was seen in a recent nationwide survey in Australia, which found that the proportion of men circumcised was significantly associated with higher levels of education and income (Connolly, 2002). In the United States of America, a review of 4.7 million newborn male circumcisions between 1988 and 2000 also found a significant association with private insurance and higher socioeconomic status (Nelson, 2005), which is likely to reflect the low circumcision prevalence among recent immigrants, many of whom, in addition to coming from non-circumcising countries, such as
China and Mexico are more likely to be of lower socioeconomic status. Although circumcision is uncommon in countries like Thailand, it tends to be associated with higher educational and socioeconomic status. In order to make male circumcision more accessible, it was recently added to the procedures covered under a flat rate payment scheme for a medical visit or procedure of any type as noted by Nelson (2005). In contrast, the Demographic and Health Surveys in sub-Saharan African countries show no consistent association with socioeconomic status. For example, in Tanzania, Zimbabwe, Botswana higher rates of circumcision are seen among men with higher levels of education, of higher socioeconomic status and living in urban areas, whereas in Lesotho, circumcision is most common among men with no education, in the lowest wealth quintile and living in rural areas (Demographic and health surveys. MEASURE DHS, 2010). Circumcision prevalence in Ethiopia is universally high (93%) but men are most likely to be circumcised if they are in a higher wealth quintile, have at least secondary education and live in an urban area.

Another driving determinant in the spread of circumcision practices is the perception that it results in improved penile hygiene and lower risk of infections. These were also the main determinants found in recent studies of factors determining acceptability of male circumcision in sub-Saharan African communities that do not traditionally circumcise (Westercamp and Bailey, 2007). A male circumcision service was established at the University Teaching Hospital in Lusaka, Zambia, in August 2004, and of the 895 circumcisions that have been undertaken there, 91% of clients requested the procedure because they considered it protective against sexually transmitted infections, including HIV (Bowa and Lukobo 2006). In Ghana, male circumcision is seen as cleansing the boy after birth (Niang, 2006). Improved hygiene was also cited by 23% of
110 boys circumcised in the Republic of Korea, the principal reason given for circumcision among those who thought it was necessary, was “to improve penile hygiene” and to prevent conditions such as penile cancer, sexually transmitted diseases and HIV. In Nyanza Province of Kenya, 96% of uncircumcised men and 97% of women, irrespective of their preference for male circumcision, stated their opinion that it was easier for circumcised men to maintain cleanliness (Mattson, 2005). Men participating in focus group discussions in Botswana, Kenya, Malawi, the United Republic of Tanzania, Zambia and Zimbabwe also believed that it was easier to keep the circumcised penis clean according to Bailey (2002). Perceived improvement of sexual attraction and performance can also motivate circumcision. In a survey of boys in the Philippines, 11% stated that a determinant of becoming circumcised was that women like to have sexual intercourse with a circumcised man (Schoen, 2005), and 18% of men in the study in the Republic of Korea stated that circumcision could enhance sexual pleasure. In Nyanza Province, Kenya, 55% of uncircumcised men believed that women enjoyed sex more with circumcised men, and this belief was a strong predictor of preference to be circumcised. In Tanzania, younger men associated circumcision with enhanced sexual pleasure for both men and women (Nnko, 2001), and in Westonaria District, South Africa, women preferred circumcised partners (Lagarde, 2003). In southern Nigeria, the enhancement of sexual performance and reproductive ability was also an important reason given for male circumcision (Myers, 1985)

Male circumcision is common in many African countries, and is almost universal in North Africa and most of West Africa. In contrast, it is less common in southern Africa, where self-reported prevalence is around 15% in several countries (Botswana, Namibia, Swaziland, Zambia and Zimbabwe) (Demographic and health surveys. MEASURE, DHS, 2010) although higher in
others (Malawi 21%, South Africa 35%, Lesotho 48%, Mozambique 60%, and Angola and Madagascar more than 80%). Prevalence in Central and East Africa varies from approximately 15% in Burundi and Rwanda to 70% in Tanzania, 84% in Kenya and 93% in Ethiopia. This variation is partly due to some groups who are traditionally non-circumcising.

The history of male circumcision varies: in many countries it is described as a very ancient practice. In some areas, it has been abandoned after centuries of practices. Historians believe in Botswana, southern Zimbabwe and parts of South Africa and Malawi, circumcision was stopped by European missionaries and colonial administrators. In Zululand and Swaziland male circumcision was abandoned during wars in the early 19th century, presumably because of the difficulty of holding the initiation schools during the continual fighting (Halperin, 2005) (UNAIDS, 2007). For similar reasons, many other groups in southern Africa are thought to have abandoned male circumcision at that time, including the Swazi, when King Mswati II banned the practice as it incapacitated men at times of war (Halperin, 2005). Another smaller region where circumcision was not traditionally practiced is Côte d’Ivoire, Ghana, and Burkina Faso.

There is considerable variation in the age at which circumcision takes place, which may have effects on HIV prevalence. Neonatal circumcision is common in West Africa, but is uncommon in East and southern Africa, where median age at circumcision varies from boyhood to the late teens or twenties. In Zambia children are circumcised between 7-10; 8-16 in Kenya, to the late teens or twenties in Tanzania and South Africa. Social class and level of education also has a bearing on whether one should be circumcised or not. For example in Burkina Faso, families of higher socio-economic status and education level, or living in urban areas, are more likely to
circumcise their sons at a young age (UNAIDS, 2007). In South Africa the median age of circumcision for black Africans is 18 years compared to 10 years for Coloureds, 2 years for Whites and 1 year for Indians.

In other countries like Guinea, circumcision ceremonies are carried out by groups of villages every four to six years. But sometimes, villages can wait up to 16 years to organize a circumcision ceremony. In some areas in southern Senegal, the ceremony takes place every 30 years. Changes seem to take place concerning age and location of the procedure. In the larger cities of Senegal, male circumcisions are more and more often practiced only by the family and more frequently performed in medical centers. Huge community circumcision ceremonies tend to disappear. But the traditional system is still strong in the rural areas (Niang, 2006).

Traditional circumcision ceremonies in Zimbabwe are held by small ethnic groups. Such groups are the Tonga of Binga, the Chewa who are mainly concentrated in Harare, the vaVenda and the Shangani of Chiredzi and Mberengwa and Muslims, who constitute approximately 1% of the total population. As noted by Rizvi (1999) the main male initiation ceremony is the murundu among the vaVenda, in which boys aged about ten to twelve are circumcised and, over a period of months, taught manly behavior. Among these tribes which practice circumcision, the boys know what to expect, and are encouraged to show their courage by lying still and not showing pain during circumcision. Among the vaVenda, however, the custom has been to keep the practice secret from the boys before the rite, and to swear them to secrecy afterwards.

Rizvi (1999) further noted that the boys in their ignorance are led to a bloodstained stone for the operation. The supervisors of the ritual make a loud noise, so that the screams of pain and terror
are not heard by the other boys. While the writhing boy is held down, he is circumcised by an elderly experienced man using a spearhead. More significantly, and amazingly, the vaVenda did not practice this ceremony, or even circumcision, until well into the twentieth century. It seems that especially in the early days, it was not even experienced "surgeons" who circumcised the struggling youths as noted by Rizvi (1999).

Zimbabwe is in the inception of practicing clinical male circumcision and men in all the country’s geographic areas are not commonly circumcised. According to the MOHCW (2008) it is not possible to provide male circumcision services to all interested men during the first phases of the roll-out. Currently male circumcision services are provided to men within and immediately before the ages of highest levels of new HIV infections, i.e. men aged 13-49 and second priority is being given to all new born infants.

There is however debate about the role of the foreskin, with possible functions including keeping the glands moist, protecting the developing penis in utero (Schoen, 2005), or enhancing sexual pleasure due to the presence of nerve receptors. Epidemiological studies have shown that circumcised men have a lower risk of several reproductive tract infections than uncircumcised men. Williams (2007) noted several likely biological mechanisms for this. The area under the foreskin is a warm, moist environment that may enable some pathogens to persist and replicate, especially when penile hygiene is poor. There are several mechanisms by which the foreskin may specifically increase risk of HIV acquisition. Firstly, Williams (2007) noted that there is an increased risk of genital ulcer diseases in uncircumcised men which, in turn, increases risk of HIV, as the disrupted mucosal surface of the ulcer increases risk of HIV acquisition. Secondly, the foreskin may increase risk of HIV infection directly as tissue from the inner surface of the
foreskin mucosa contains accessible HIV target cells called Langerhans cells. The density of these HIV target cells in the inner foreskin is similar to that in the glands of the male reproductive organ and outer foreskin, but those in the inner foreskin are closer to the surface than those situated elsewhere in the male reproductive organ. Within the inner foreskin the Langerhans cells are more likely to be found near the surface than other cells, and are likely to be the first to be infected by HIV (Doyle 2005). More direct evidence of the susceptibility of the foreskin to HIV infection comes from Tierney (2006), who found that infectivity of the inner mucosal surface was greater than that of cervical tissue, which is a known primary site of HIV acquisition in women. In an uncircumcised man, the cells in the inner foreskin are directly exposed to vaginal secretions during intercourse, and this superficial location of the HIV target cells presumably increases risk of infection. In contrast, in a circumcised man the penile shaft is covered with a thickly skin which provides some protection from infection as noted by Urassa (1997).

The WHO/UNAIDS came up with guidelines in terms of the methods and procedures of male circumcision in a clinical setting. According to the WHO/UNAIDS (2007) neonatal circumcision should only be undertaken if the baby is a normal full-term delivery with no significant medical problems after birth. There are four techniques for neonatal circumcision: the Dorsal slit method, the Plastibell method, the Mogen clamp method and the Gomco clamp method. The use of clamps reduces pain, minimizes or eliminates bleeding, promotes haemostasis and protects the glands. If anesthesia is to be used there are several options available. Firstly local anesthetic cream (EMLA cream) can be applied to the end of the penis 60–90 minutes prior to the procedure, or local anesthetic can be injected at the base of the penis to block the dorsal penile
nerve and lastly local anesthetic can be injected in a ring around the middle of the penis in what is called a subcutaneous ring block according to WHO/UNAIDS (2007).

With all these devices the same basic procedure is followed. First, the amount of foreskin to be removed is estimated. The foreskin is then opened to reveal the glans underneath and ensure it is normal. The inner lining of the foreskin (preputial epithelium) is then bluntly separated from its attachment to the glans. The device is then placed and remains there until blood flow has stopped. Finally, the foreskin is amputated (WHO/UNAIDS, 2007).

The Plastibell method is widely used around the world and has been shown to be acceptable and practical in developing country situations but incorrect technique can lead to complications and this method is recommended in the context of regular circumcision practice but not for occasional use. The Mogen clamp is used widely in North America and complications are less frequent than with other methods when used in neonates. Comparative studies have shown that it is quicker and causes less pain than the Gomco clamp (Niang, 2006). Unlike the Plastibell, the clamp is reusable and precautions are needed to ensure sterility. The Gomco clamp has different bell sizes and so can be used in infants and older children. Circumcision is simpler in infants and young children and healing is usually complete within a week. Bleeding is rare because the clamp crushes the foreskin edge. The use of local anesthesia for the procedure is recommended for neonates and for older children (Schoen, 2005).

Adult and adolescent circumcision is carried out using one of the three methods: the forceps-guided method, the dorsal slit method or the sleeve method. The procedure is more complex than in children, requiring local or general anesthesia. The nerve supply of the male reproductive
organ consists of the twin dorsal penile nerves and anesthesia blocks the dorsal penile nerves and its branches. The sleeve method produces the tidiest result but requires a higher level of surgical skill than the other method according to Mattson (2005). The forceps-guided method can be performed without an assistant and is suitable for resource-limited settings like Zimbabwe. The dorsal slit method is widely used by general and urological surgeons throughout the world and, whilst requiring more skill than the forceps-guided method, can be done without an assistant. All methods of adult and adolescent circumcision require suturing and dressing. Minor bleeding should stop with a few minutes of pressure with gauze. Once bleeding has ceased, the wound is dressed. Adult circumcisions require 4 to 6 weeks of abstinence from masturbation or intercourse after the operation to allow the wound to heal.

In Zimbabwe the forceps guided method was adopted as a standard method for male circumcision program and in order to ensure high quality service provision there is use of sterilized pre-packed male circumcision kits. The operating procedure takes twenty to twenty five minutes to circumcise one man and in Zimbabwe it is recommended that two operating procedures be conducted per doctor/nurse team per hour.

Male circumcision for religious or traditional reasons frequently takes place in a non-clinical setting, although in some cultures an increasing proportion now takes place in clinics (Doyle 2005 and Bailey 2002). In the Jewish religion, males are circumcised by a specially trained traditional circumciser, in a ceremony called a Bris Milah according to Doyle (2005). The surgical training includes anatomy, surgical technique, minimizing complications, treating
complications and preoperative and postoperative care routines. The technique employed is similar to the Mogen clamp. Methods of non-clinical circumcision among Muslims vary and may be undertaken neonatally, which will generally be a safe procedure. However, if it is performed at older ages there is an increased risk. In Turkey, circumcision is traditionally undertaken by non-medically trained individuals, including barbers and traditional drummers (Ozdemir 1997). The usual technique involves pulling the foreskin in front of the glans, placing some kind of shield to protect the glans, and excising the skin. In Sudan, the traditional circumciser inserts a straw made from savannah grass into the foreskin opening, and pushes the glans down while pulling the foreskin as far forward as possible. A cord is then tied around the foreskin above the glans, and the foreskin excised with a knife immediately in front of the cord. The inner epithelium is then folded back over the glans and the wound is dressed, but not stitched. Among the Xhosa of South Africa, circumcision is carried out using a razor blade or penknife (Doyle 2005), without anesthesia. The wound is covered with eucalyptus leaves (Niang 2006) or maize (Nnko 2001), and left in place for four weeks while the boys are in seclusion. Traditional circumcision can also be more painful than clinical circumcision, as use of anesthetics is rare probably due to the perceptions of circumcision as a marker of bravery and endurance (Doyle, 2005). Among the Australian Aboriginals and Polynesians, the foreskin is reportedly removed using seashells, and boys then squat or stand for several hours over the smoke from a fire covered with eucalyptus leaves to promote homeostasis (Doyle 2005). Eucalyptus is used as it is believed to stop continuous bleeding.

Such traditional practices however expose men to the danger of contracting HIV and AIDS as they tend to use one unsterile gadget for the exercise. Mayatula and Mavhundla (1997) further
noted that the men actually prefer use of one tool for circumcision in order to show that they are of the same tribe and culture.

The degree of foreskin removed also varies in traditional circumcision. A study among the Meru people in central Kenya revealed distinct differences between medical and traditional circumcision. It was noted by Brown and Brown (1987) that traditional male circumcision is highly variable, with some resulting in insufficient skin removal and flaps of foreskin partially covering the glans, and others with excessive skin removed, including non-foreskin tissue from the penile shaft (Bailey 2007). This can lead to problems and having residual foreskin may lead to further surgery to complete the procedure. Adult and adolescent Ethiopian Jews immigrating into Israel undergo “correctional” male circumcision to further remove (small or large) foreskin portions not cut by the traditional circumcisers in their home villages. This, according to Schendel (1968), was required as the Jewish definition of circumcision is the complete removal of the foreskin.

Adverse events however can occur during or after the operating procedure in a clinical setting. The safety of male circumcision depends crucially on the setting, equipment and expertise of the provider. Neonatal circumcision is a simpler procedure than adult circumcision, and has very low rates of adverse events as noted by Connoly (2002). One complication of male circumcision is the narrowing of the urethral opening, which may be a longer-term complication of circumcision. It is thought that because the foreskin no longer protects the meatus, ammonia formed from urine in wet diapers irritates and inflames the exposed urethral opening. This complication can lead to
discomfort with urination, incontinence, bleeding after urination and urinary tract infections according to Drain and Bailey (2006)

Urassa (1997) cite that circumcisions may remove too much or too little skin. If insufficient skin is removed, the child may develop phimosis in later life. Urassa (1997) further state that "when operating on the infantile penis, the surgeon cannot adequately judge the appropriate amount of tissue to remove because the penis will change considerably as the child ages, such that a small difference at the time of surgery may translate into a large difference in the adult circumcised penis.

Other complications include concealed penis as noted by Schoen (2005), urinary fistulas, ulceration of the glans, and impotence can also be experienced. Schoen (2005) further stated “Virtually all of these complications are preventable with only a “modicum of care” and "most such complications occur at the hands of inexperienced operators who are neither urologists nor surgeons.” Another complication of infant circumcision is skin bridge formation, whereby the remaining part of the foreskin fuses to other parts of the penis (often the glans) upon healing. This can result in pain during erections and minor bleeding can occur if the shaft skin is forcibly retracted. Nelson (2005) advises that to prevent adhesions forming after circumcision, parents should be instructed to retract and clean any skin covering the glans. Niang (2006) also stated that hemorrhage and infection are the major causes of deaths after circumcision.

There are several differences between traditional circumcision procedures and the clinical procedures adopted for HIV prevention as noted by Auvert et al, (2005). These include variations in the equipment used and the counseling provided to the men before and after surgery, as well
as the overall context for and meaning of the surgery. In clinical male circumcision it is mainly for HIV prevention and health, compared with a rite of passage to manhood in traditional male circumcision.

Another difference is how much of the foreskin is removed. Some traditional circumcisions involve only a small cut to the foreskin or partial removal. Nelson (2005) noted that while it is not known exactly how much foreskin must be removed in order to reduce the risk of HIV infection in men, complete removal is thought to be necessary. Thus, the practice of partial removal of the foreskin may help explain why some cultures that practice traditional male circumcision still have high rates of HIV prevalence. It is important to understand variations in the amount of foreskin removed by traditional circumcisers so that the benefits of male circumcision for HIV prevention can be maximized.

Despite these differences in procedures, there are many ways that clinical and traditional circumcision services can work together. Traditional and clinical providers can collaborate to improve the safety and acceptability of circumcision, reduce complications, enhance the health education content of civic education and rituals, and improve the sexual and reproductive health of men and women, while preserving the socio-cultural importance of the circumcision process.

Reported demand for male circumcision is increasing in some countries with high rates of HIV. WHO, UNAIDS and JHPIEGO have recently developed a manual to train practitioners in safe medical circumcision (WHO/UNAIDS/JHPIEGO 2007). This manual is targeted at trained health-care providers circumcising adult men, and is accompanied by guidance on training, instrumentation, and regulatory, licensing and ethical issues, including counseling on sexual behavior. Countries in the sub Saharan Africa have been recommended to use this manual given
the high HIV prevalence in their countries and hence the need to scale up their male circumcision programmes.

According to Nelson (2005) demands for safe, affordable male circumcision is already increasing in southern Africa. Considerations should be given for the need to provide increased access to safe, affordable male circumcision services on a large scale, embedded within a comprehensive package of proven HIV prevention measures. The current randomized controlled trials of circumcision also indicate that demand for male circumcision in non-circumcising communities is substantial when the procedure is offered at no cost in a safe setting as noted by Auvert (2005).

One concern around the potential for male circumcision as an HIV prevention measure is that it may not be acceptable in communities that do not traditionally circumcise. Some of the barriers to the acceptability of male circumcision as noted by Auvert (2005) are fear of pain, concerns for safety and the cost of the procedure. Auvert (2005) further noted that in areas where traditional circumcision is uncommon, the preference is for a medical practitioner to be the service provider, as this is perceived to be safer. This fear is based largely on knowledge of traditional circumcisions in which pain is often viewed as an integral part of the rite of passage to manhood. Concerns for safety are common, especially among mothers when asked about infant and early childhood circumcision. Fears about the risk of excessive bleeding or infection have been expressed if the procedure is performed by a traditional circumciser outside the clinical setting (Rain-Taljaard, 2003). Cost is also a significant barrier to male circumcision acceptability as noted in a study in Siaya, Kenya were demand for circumcision rapidly increased when the cost
was reduced from US$ 3.62 to US$ 1.45, and half of all circumcisions carried out during the 25-month study occurred during the two-month period in which lower fees were charged (Bailey, 2002).

The main factors associated with willingness to be circumcised are improved penile hygiene and a reduced risk of sexually transmitted infections including HIV. Penile hygiene is widely recognized as being extremely important and is perceived as a major benefit of circumcision by both men and women. Halperin (2005) noted that it was easier for a circumcised man to maintain cleanliness and this was a major factor in women’s acceptability of male circumcision as, in many parts of Africa, cleaning of the penis following intercourse is viewed as the woman’s role, for example in Zambia, Malawi, Zimbabwe and Uganda (Lukobo and Bailey, 2007). Circumcision protects against infections and allows for easier identification of sores and ulcers, permitting earlier treatment. It is easier for uncircumcised men to acquire STIs compared with circumcised men (Mattson, 2005), and circumcision reduced risk of STIs and HIV.

However a major concern about the increased uptake of male circumcision in areas with high HIV incidence is that circumcision does not provide complete protection against infection. The public health message is that the procedure may reduce, but not eliminate, risk of infection, and safer sex practices must still be followed. However, this message may be difficult to communicate, and there is potential for risk compensation i.e. increases in risky behavior sparked by decreases in perceived risk as noted by Mattson (2005).
Gender is also one aspect in addressing the HIV and AIDS epidemic in sub-Saharan Africa. Scott, Weiss and Viljoen (2005) cite that gender relations bring about a fundamental issue of power and decision making. Women and mothers play important roles in the decision making process concerning male circumcision and in the fabric of preparation and post operation processes. Scott, Weiss and Viljoen (2005) suggested that in South Africa women have an influence on men’s decision to circumcise, often scheduling the appointment for their boyfriends or husbands (Rain-Taljaard et al., 2003). Thirteen percent of circumcised participants in another South African study as noted by Lagarde (2003) reported undergoing circumcision because their partner expressly requested it. Thus women’s views in male circumcision should be considered.

**Theoretical framework**

The complexity of the issues around male circumcision in Africa is often obscured by the question of the frequency of male circumcision and of its association with HIV. There are very few attempts to understand the conceptual aspects and the broader social and cultural dynamics involved. Male circumcision in most of Africa as noted by Tierney (2006) is a holistic concept with multiple and interconnected dimensions—religious, spiritual, social, biomedical, aesthetic and cultural.

Johnson (1993) postulates that theories regarding the persistence of male circumcision in cultures around the world include its use as:

- a rite of passage from boyhood to adulthood
- a mark of defeat or slavery; or initiation into a new group
- a sign of cultural identity
• an attempt to become more appealing to females
• an attempt to suppress or enhance the sexuality of the person
• a demarcation of social status
• a demarcation of one group from outsiders
• a form of hygiene for those not able to bath regularly
• a symbolic castration
• a demonstration of one's ability to endure pain

One theory note that circumcision began as a way of "purifying" individuals and society by reducing sexuality and sexual pleasure. Human sexuality was seen as dirty or impure in some societies; hence cutting off the pleasure-producing parts was the obvious way to "purify" someone according to Johnson (1993). It is now known that the male foreskin, or prepuce, is the principal location of erogenous sensation in the human male. Removal of the prepuce substantially reduces erogenous sensation. Therefore circumcision is revealed as a sacrifice of "sinful" human enjoyment (in this earthly life), for the sake of holiness in the afterlife.

Male circumcision causes lowered sexual arousal of pubescent males, and hypothesize that this was a competitive advantage to tribes practicing circumcision, leading to its spread. Williams (2007) believes that circumcision represents a signal of commitment to a group, and may serve evolutionary purpose by reducing the incidence of extramarital sex.

In other cultures circumcision is associated with preparation for marriage and as a sign of entry into manhood. Australian Aboriginals circumcise a boy when he reaches puberty in a ceremony that is part of “men's business”. In Tonga, boys are circumcised at 7–9 years in hospital without anesthesia, pain being seen as part of transition to manhood. Among the VaVenda of Zimbabwe
boys are initiated between 10-12 years in preparation for manhood. This procedure is done without anesthesia. In the Philippines circumcision, generally carried out at age 12-14 years, is part of a coming-of-age ritual, again without anesthetic. In Madagascar, where all men are circumcised regardless of religion, the reason is that women say that sex with a circumcised man is longer, stronger, better for them and cleaner, so the men are more likely to get sex by being circumcised.

In Japan, circumcision has become a fashion amongst young men. The procedure is promoted by way of articles and advertisements in the vast array of “girlie”, sex magazines read by young males. The message is that it improves hygiene and attractiveness to women.

According to Johnson (1993) the ritual removal of the foreskin in diverse human traditional cultures, ranging from Muslims to Aboriginal Australians could be a sign of civilization in that human society acquired the ability to control, through education and religion, the age at which sexual intercourse could begin.

Male circumcision offers the opportunity to re-engage with religious and ethnic groups in HIV prevention. Because such practices carry major religious, social and cultural meaning for many of these groups, some of whom have not always been comfortable with HIV prevention, male circumcision as an HIV prevention strategy could provide new avenues for dialogue. Many groups with diverse social histories that practice male circumcision for religious and ethnic reasons exist worldwide. In mapping the context of existing practices and strategies for potential interventions, local religious institutions and leaders should be consulted and should occupy central roles in advocating for HIV prevention (Niang, 2006).
Various attitudes can be found in the Christian religion, in which baptism is the pivotal sacrament. Myers (1985) noted that until 1960 the Catholic Church celebrated “Circumcision Day” or “The Feast of the Circumcision” on New Year’s Day (the 8th day after the day that the birth of Jesus of Nazareth is celebrated. The Jews believed that circumcision was ordained by God for Jews, and Myers (1985) further asserts that circumcision is not a requirement for Christians, but is a required tradition among the Muslims to this day. Generally, the practice persists because of cultural tradition. Since the 19th century, medical reasons have been added to the purposes of circumcision. Today, a debate rages about the function and efficacy of the surgery.

One school of thought discovered the germ theory of disease. The germ theory of disease elicited an image of the human body as a conveyance for many dangerous germs, making the public "germ phobic" and suspicious of dirt and bodily secretions. The penis became "dirty" by association with its function, and from this premise circumcision was seen as preventative medicine to be practiced universally (Schendell, 1968). In the view of many practitioners at the time, circumcision was a method of treating and preventing masturbation.

However, ethical questions have been raised over removing healthy, functioning genital tissue from a minor. Ozdemir (1987) postulates that opponents of circumcision state that infant circumcision infringe upon individual autonomy and represent a human rights violation. Schoen (2005) also noted that using circumcision as a way of preventing HIV in high prevalence, low-income countries in sub-Saharan Africa, is controversial, but argue that "it would be unethical to not seriously consider one of the most promising new approaches to HIV-prevention in the 25-year history of the epidemic".
Chapter 3: Methodology

3: Type of research

The research was a qualitative, descriptive research. Pope (2000) noted that with qualitative research, the researcher gets a more realistic feel of the world that cannot be experienced in the numerical data and statistical analysis used in other research methods.

Some qualitative research techniques like interviewer administered questionnaires and focus group discussions were used in this research. The advantages of using these techniques in a qualitative research are that they allow the researcher the flexibility to probe initial participant responses – that is, to ask why or how. The researcher must listen carefully to what participants say, engage with them according to their individual personalities and styles, and use “probes” to encourage them to elaborate on their answers.

The questionnaires were composed of closed and open-ended questions which were designed in a way that sensitive questions appeared as neutral as possible. Open-ended questions have the ability to evoke responses that are meaningful, culturally relevant to the participant and rich and explanatory in nature. With open-ended questions, participants are free to respond in their own words, and these responses tend to be more complex than simply “yes” or “no” (Kirk and Miller, 1986). Participants have the opportunity to respond more elaborately and in greater detail. In turn, researchers have the opportunity to respond immediately to what participants say by tailoring subsequent questions to information the respondent has provided.

An interview was used due to its ability to correct misunderstandings, probe inadequate and vague responses, and to attain the highest quality of response (Lee, 1992). An interview also
allows for the establishment of rapport and motivates the respondents to answer questions (Judy, 1991; Skinner, 1991). This is the most common method used for health related research in developing countries as noted by Goergen (2000).

Focus group discussions were used to allow the researcher to discover knowledge, ideas, concerns, attitudes and approaches of people in their own terms. Focus group discussions often stimulate people to talk and to reveal facts and opinions that may not have been revealed otherwise. It may also allow the group to clarify attitudes or beliefs in words that were probably not easy to articulate.

3:2 Target Population

The study looked at three groups of people as follows: males circumcised at Spilhaus, Harare Hospital who reside in Mbare and Southerton communities. The hospital register had 389 circumcised men from Mbare and Southerton suburbs.

The study also targeted non-circumcised males between 15-49 years in Southerton community. There are approximately 7,300 men between 15-49 years in Southerton suburb.

To get the views of women in male circumcision, women from women’s clubs in Mbare community were also a target group. There are 10 women’s clubs in Mbare registered with the City of Harare Social Services Department, with an average of 15 women in each group giving a target population of 150 women.

The Key Informant who is a medical doctor was drawn from Spilhaus, Harare Hospital.
3:3  Sampling

A total of 20 circumcised men were followed-up from the register at Harare Hospital and consent was sought from the respondents if they would like to participate in the study. The respondents represent just over 5% of the total men circumcised at Spilhaus, Harare Hospital.

Twenty women from the 10 Mbare women’s clubs were selected for the interview. Each club has an average of 15 members making a total of 150. The 20 women were divided into two groups, one group of women had circumcised partners and the other group had non- circuncised partners. Two representatives from each club were to participate as long as they were sexually active. Availability sampling was more convenient to use in selecting the respondents as the club members do not all come at the same time to the clubs and hence whoever was first to come whilst the researcher was at the site could be interviewed. The respondents represent 13% of the target population.

Twenty non-circuncised men from Southerton suburb participated in the study. The respondents were eligible only if they were between the 15-49 age groups. This age group was intentionally chosen as this is the age group that has the highest HIV prevalence in Zimbabwe according to the MOHCW (2008) estimates.

3: 4  Data Collection Techniques

The Researcher explained the purpose of the research and gave the respondents an assurance. The Researcher further explained that the respondents have a right to remain quite or refuse to participate.

Qualitative data was collected from the respondents (20 circumcised men) through the use of questionnaires for men circumcised at a health facility and the key informant (medical
practitioner). Interview guides were administered to non-circumcised men and the two groups of women, women with circumcised partners and women with non-circumcised partners.

Individual one-to-one interviews were conducted with circumcised men and the key informant, for a duration of 45 to 60 minutes. Interviews were carried out in vernacular. Focus group discussions lasted between 60-90 minutes (1hour to 1 hour 30 minutes). Participant’s responses were recorded manually, in writing on a separate sheet. An interview guide was used for the focus group discussion of 20 non-circumcised men.

3:5 Data Analysis

Participant’s responses were coded manually. Categories were generated according to the sequence the questions were asked.

The findings are presented in a descriptive manner, indicating the main forms of response highlighting cases of consensus, or disagreement between respondents, and where possible providing reasons which supported participants’ viewpoints.

3:6 Feasibility

The researcher had sought permission from the respondents before they participated and they agreed to participate. The researcher had also sought permission from Mbare District Social Organizer from the City of Harare, Mbare Social Services Department, who works with the women from the women’s clubs to conduct focus group discussions with them.
3:7  Ethical Considerations

At the beginning of each interview the respondents were informed about the purpose of this research and nature of the interview. Each participant was asked for their consent to participate in the interview.

The researcher explained that measures will be taken to ensure confidentiality of respondents’ information in the analysis and presentation of the findings. Participants were assured that their confidentiality would be protected, and advised of their right to refuse to participate or answer any question, without any repercussions. The respondents were assured of anonymity and the researcher will not present any names in the research.

3:8  Limitations of the study

The population studied was small compared to circumcised males in the country and therefore findings may not be generalized from this small group met. Also the areas studied are urban and thus the study does not capture the views of men and women in the rural communities.
4:1: Demographic Characteristics of Respondents

In total 60 respondents were interviewed: 20 circumcised males, 20 non-circumcised males and 20 women.

Figure 1: Age analysis of respondents

Figure 1 above shows the age groups of the respondents ranged between 15-70 years. The figure further shows that the majority of respondents were between the 30-44 age group in both sexes. The age group with the least number of respondents in both sexes is the 15-29 age group. This confirms Auvert and Talijaard (1995)’s assertion that although the young adults between the age
groups of 15-29 are equally affected by HIV most of them are not committed in HIV prevention programmes until they realize that they are HIV infected.

**Figure 2: Educational Level of Circumcised men**

![Educational Level of Circumcised men](image)

*n=20 circumcised men*

Education was identified by some respondents as playing a role in men’s attitude towards male circumcision. The general impression was that more educated men are more likely to be aware of the benefits of male circumcision for reduced risk of HIV and other infections and as a result are more likely to come for safe male circumcision.

‘The educated ones take it positively and mostly go to hospitals for circumcision’

Figure 2 above indicates the different educational attainment by the respondents. Twelve respondents who represent 60% of the total number of respondents indicated that they have
acquired some higher national diplomas with 2 of the respondents (20%) having gone through the University level. Seven of the circumcised men (35%) indicated that they have gone through secondary education in Zimbabwe, with 2 of them having gone through to all the 6 years of secondary education. One respondent (5%) indicated that he has been to primary school and could not continue further.

From the figure, one can deduce that higher educational levels influence the prevalence of male circumcision. These findings concur with the Demographic and Health Surveys (2006) that in sub-Saharan African countries like Tanzania, and Botswana with higher rates of circumcision, also have men with higher levels of education having at least secondary education, of higher socioeconomic status and living in urban areas.
Figure 3 above shows the different religious beliefs among the respondents who were circumcised. Twelve circumcised men (60%) indicated that they did not belong to any religion. Five of the circumcised men (25%) of the total circumcised men were Christians. Two indicated that they go to Roman Catholic Church, two go to Apostolic Faith Mission and one indicated that he goes to a Pentecostal church. The respondents indicated that religion is a key factor which may contribute to limited demand for male circumcision in Mbare and Southerton suburbs. Certain denominations are likely to be less supportive of circumcision, seeing it as linked to traditional beliefs and rituals which is not relevant to Christian life. These findings concur with the findings done by the Demographic Health Survey (2006) which found out that people, especially the Roman Catholic and the Evangelical denominations of Zimbabwe were less likely to be circumcised compared to those who stated that they had no religion. Some respondents said that: “Most would say male circumcision is against God’s will to cut off part of their body”
4:1:2 Definition of male circumcision

Circumcision in all the groups with exception for men circumcised at a health facility and the Health Provider defined it in light of initiation schools. Respondents highlighted that the first thing that comes to their mind when asked about male circumcision is the initiation school.

Male circumcision performed at health facilities is known by a few people especially those men who were circumcised at a health facility. Those circumcised at a health facility appreciated the benefits and safety of male circumcision. The counseling they receive at the health centers explains the benefits of male circumcision.
4:1:3 Extent of male circumcision in Southerton and Mbare Suburbs

Figure 4: Extent of male circumcision in Mbare and Southerton suburbs.

Figure 4 indicates the proportion of men circumcised in each age group according to the key informant interviewed at Spilhaus, Harare Hospital.

According to the key informant these statistics cover circumcision performed only at Spilhaus, Harare Hospital for 389 residents of Mbare and Southerton suburbs drawn from the main register of circumcised men. One hundred and fifty eight (158) men between the age group of 19-49 years have been circumcised. Among the adolescents aged 15-18 years, 75 men were
circumcised. Eighty one (81) men in the 50 and above age group have also been circumcised. Among the 9 to 14 years, 38 men were circumcised. 29 boys between 2 to 8 years were circumcised and only 8 infants of between 0-1 year old have been circumcised. These numbers of circumcised men confirm the general situation of male circumcision in Southerton and Mbare where the main focus of circumcision is among those men aged 19 to 49 years. This further shows that the practice of male circumcision for young boys just after birth has not yet gained interest among the Mbare and Southerton communities.
4:2:1 KNOWLEDGE ON MALE CIRCUMCISION AND REDUCED RISK OF HIV INFECTION AND STIs

The data presented in Table 1 below is a synthesis of the responses from 20 circumcised men, 20 non-circumcised men and 20 women making a total of 60 respondents.

Table 1: Knowledge on STIs and HIV

<table>
<thead>
<tr>
<th>Easier to contract STIs if</th>
<th>No of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcised</td>
<td>24</td>
</tr>
<tr>
<td>Uncircumcised</td>
<td>36</td>
</tr>
<tr>
<td>No difference</td>
<td>0</td>
</tr>
<tr>
<td>Do not know</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Easier to contract HIV if</th>
<th>No. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcised</td>
<td>26</td>
</tr>
<tr>
<td>Uncircumcised</td>
<td>28</td>
</tr>
<tr>
<td>No difference</td>
<td>0</td>
</tr>
<tr>
<td>Do not know</td>
<td>6</td>
</tr>
</tbody>
</table>

\[ n=60: 20 \text{ circumcised men, 20 non-circumcised men and 20 women} \]
Table 1 above indicates the respondents’ knowledge levels in relation to the association between male circumcision, HIV transmission and STIs.

Thirty six respondents (60%) knew that it is easier to contract an STI if one is non-circumcised. Twenty four (24) respondents, representing (40%) thought that it is easier to contract an STI if you are circumcised. The latter expressed that a circumcised penis is “always dry”, “susceptible to cracking” and that this state provided a portal of entry for bacteria and viruses.

On the knowledge levels of contracting HIV, 28 respondents (47%) expressed that it is easier to contract HIV if you are not circumcised. The respondents acknowledged that it is important for a male to undergo circumcision because the whole process minimizes the risks of infections such as STIs and HIV and AIDS during sex. They explained that if a person is not circumcised the foreskin is likely to keep dirt and as a result diseases would occur. The respondents mentioned that STIs were more severe and more infectious in uncircumcised men, with ulcers healing faster in those who are circumcised. These views confirm Bailey (2006)’s observation. Bailey (2006) noted that circumcised men have a lower prevalence of HIV infection than uncircumcised men. Bailey (2006) pointed out that the area of the penis around the foreskin is a warm and moist environment which promotes the replication of bacteria especially if penile hygiene is poor. Bailey (2006) further highlighted that the inner surface of the foreskin is less protected and so especially when having sex, is more susceptible to abrasions or inflammation which can facilitate easy contraction of sexually transmitted infections. The tissue on the inner skin of the foreskin is rich in HIV target cell called Langerhans and other receptor cells. During a sexual contact this inside surface of the foreskin is directly exposed to vaginal fluid and the possibility of infection
from STIs or HIV is very high. Through the removal of the foreskin through circumcision these possible routes for STIs and HIV infection are removed.

Twenty-six respondents (43%) expressed that it is easier to contract HIV when one is circumcised. These respondents alluded to their earlier expression when they said that it is easier for circumcised men to contract STIs because of the dryness of their penis after circumcision as may result in some cracks during a sexual act and thereby exposing the men to HIV infection through the openings if the STIs are not treated. Their views that it is easier to contract HIV when you are circumcised is in variance with the findings from a study conducted by Auvert and Taljaard (2005) who noted that male circumcision is efficacious in reducing the transmission of HIV by more than 50% in heterosexual contacts. Six respondents (10%) did not know the difference on whether one is more susceptibility to HIV acquisition when they are circumcised or when they are not circumcised.

The most important factor raised by the respondents was lack of knowledge amongst the population on the benefits of male circumcision. Respondents felt that not enough information had been made available to the general public from the health centers and other AIDS service organizations about the benefits of male circumcision. It was perceived by a number of respondents that if information becomes widely known, then there would be a large increase in demand for safe facility-based male circumcision in health centers. The following are some of the sentiments from the respondents:

“Most men do not know the importance of male circumcision”

“Lack of knowledge and inadequate information about the importance of male circumcision”
However the understanding that circumcision can reduce the risk of HIV had been taken too far by some circumcised men. As a result there was the danger of circumcised men claiming that they were now completely free from sexually transmitted infections and could no longer be infected with HIV. This view was expressed by the key informant (the health practitioner) who was concerned about the potential for increases in risk behavior and the ability of the health care system to cope with an increased demand on its services.
4:3 ATTITUDES AND BELIEFS ON MALE CIRCUMCISION

4:3:1 Circumcised men’s views on male circumcision

All the respondents defined male circumcision as an operation that removed the foreskin from the penis. They viewed the operation positively, as a way of minimizing the risks of sexually transmitted infections while it also makes sexual contact smoother and not hurtful to their sexual partners. This group’s understanding of male circumcision included the reduction of risk that is offered through male circumcision as a benefit for undergoing male circumcision.

All the circumcised men interviewed expressed that there are advantages to a man being circumcised. The main benefits were that it helps improve hygiene; it reduces the risk of STIs and reduces the risk of HIV infection. Circumcised men further noted that when having sex, they now take longer to ejaculate than before and can now satisfy their partners in their sexual needs. The responses in Table 1 showing that male circumcision may not be beneficial are responses from some non-circumcised men and women’s views. Otherwise all circumcised men realize that there are benefits for being circumcised.
4:3:2 Beliefs around sexual aspects of circumcision

Table 2: Beliefs around sexual aspects of circumcision

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcised men enjoy sex:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than non-circumcised men</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>More than non-circumcised men</td>
<td>15</td>
<td>75</td>
</tr>
<tr>
<td>The same as non-circumcised men</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Do not know</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

No=20 circumcised men

Table 2 above indicates the beliefs around sexual aspects on male circumcision.

According to the table, 15 respondents (75%) confirmed that circumcised men enjoy sex more than non-circumcised men. These respondents denied that male circumcision reduces sexual pleasure and confirmed that they are actually having more fun than before. This view concurs with findings from a study by Bailey (2005) in Kenya were it was seen that women enjoyed sex more with circumcised men, and this belief was a strong predictor of preference to be circumcised. This group also reported that before undergoing male circumcision, they had fears that they will not be able to function properly, all men feared the pain associated with the operation. Of the 20 circumcised men, 12 of them (60%) feared that they will have problems with penile erection and fail to satisfy their partners. Respondents claimed that their fears have now been allayed and now view male circumcision positively and encourage other men to undergo the operation. Respondents in this group expressed that men are not forthcoming to
undergo this operation mainly due to fear. They also suggested that more community awareness programmes need to be targeted in places were men gather like beer halls and workplaces. They further suggested that awareness could be done through use of the media for information dissemination so that more men come out for the programme.

Five of the circumcised men (25%) however felt that there is no difference in terms of sexual pleasure between circumcised men and non-circumcised men though there are other advantages to male circumcision, like the reduction of STIs infection, contracting HIV and improved penile hygiene.
Table 3: Why men do not go for male circumcision

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of pain</td>
<td>10</td>
<td>60</td>
</tr>
<tr>
<td>Religious and Cultural reasons</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Female staff in the hospital</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Fear of reduced sexual pleasure</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Age</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 3 above indicates the reasons why men do not prefer to go for male circumcision in health facilities. According to the table, 10 respondents (50%) expressed fear of pain that one undergo during the operation. The respondents recognized the importance of male circumcision as an operation that protects people from sexually transmitted infections and also believed that circumcised men are cleaner, but fear the operation that one undergo. This group expressed knowledge on the benefits of male circumcision but expressed their fear to undergo the operation.

Three respondents’ representing 15% felt that male circumcision would diminish sexual pleasure through reduced sensitivity and less sexual arousal. These respondents expressed that they fear the adverse effect of male circumcision which may result in impotence, disfigured penis, insufficient removal of the skin and some urinary tract infections. They however had different
views with regard to circumcised men. Respondents believed that there are women who like circumcised men while others do not mind whether a man is circumcised or not. If such a myth dominates people’s attitudes to male circumcision, there is a risk that it could overshadow efforts to make people aware of the reduced risk of HIV.

Uncircumcised men pointed out that age was one of the primary reasons that prevented uncircumcised men to get circumcised. One respondent (5%) mentioned that they are too old to be circumcised. On the other hand, they believed that male circumcision performed at hospitals is not highly regarded and recognized as a tradition; therefore, that becomes a major hindrance for male circumcision at a health facility.

It is however important to note that for the development of this programme, without a dramatic increase in men’s awareness of the health benefits of circumcision, there could be a poor uptake of services due to men’s indifference to the benefits of male circumcision.

Another objection raised was that they would be exposed to embarrassment and disgrace in health centres having to undress and be operated upon in front of female nurses. This view was expressed by three respondents representing 15%. Again it should be noted that an awareness campaign needs to address this concern in order to reduce potential opposition to male circumcision in future.

Three respondents (15%) pointed to the confusion which exists between traditional initiation and male circumcision carried out in health centres. This confusion could however be problematic in several ways; firstly it could cause men to discard male circumcision as something traditional, of the
past or contrary to their religious beliefs. Secondly there is the danger of men thinking of male circumcision as the rite of passage to manhood, whereas this traditional ritual belongs to the sphere of the traditional initiation schools.

4:3:4 Women’s views of male circumcision

Table 4: Beliefs around sexual aspects of circumcision

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women enjoy sex with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-circumcised partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>no</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Circumcised partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>9</td>
<td>45</td>
</tr>
<tr>
<td>No difference</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

*no = 20 women*

Table 4 above indicates the different beliefs by women around sexual aspects of circumcision. 10 of the women had circumcised partners and ten had non-circumcised men.

Nine respondents representing 90% of the women with circumcised partners highlighted that they now enjoy sex with circumcised men compared to when their partners were not circumcised. According to these women, circumcision makes sex more pleasurable. These women said that now
their sexual needs can be fully satisfied as their partners now take longer to ejaculate than before where they used to ejaculate prematurely before they had reached orgasm. This view concurs with the findings from a research which was conducted by Bailey (2005) who confirmed that women enjoyed sex more with circumcised men, and this belief was a strong predictor of preference to encourage their partners to be circumcised. In southern Nigeria, the enhancement of sexual performance and reproductive ability was also an important reason given for male circumcision (Myers, 1985).

Some of the sentiments expressed by the respondents are as follows:

‘Sex is enjoyable with circumcised men’.

‘Circumcised men can satisfy women’s needs’.

This same group of women expressed that they prefer circumcised men because they perceive circumcised men as clean and free from infection. However according to the Key Informant, there is a danger that some women have come to believe as a result that they cannot be infected at all by STIs and HIV once the man has been circumcised. This can lead to women engaging in unprotected sex more frequently with circumcised men believing that they are safe. This however needs to be addressed through community sensitizations campaigns in order to avoid the danger that this false belief could result in higher risky sexual behaviors.

Only one respondent, representing (10%) of women with circumcised partners reported that since her partner had been circumcised, almost close to a year now, there has not been any difference in regards to his performance when having sex. She further said that he still performs just as he used to do before.
Four respondents representing 40% of women with non-circumcised men expressed that they enjoy sex with non-circumcised men. They pointed out that a non-circumcised man is easy to stimulate than a circumcised man because the erogenous cells will still be intact unlike in a circumcised male. This group of women also noted that circumcised men are dangerous because they think they are safe from HIV infection and so engage in more promiscuous sexual behaviors.

Six respondents representing the majority of 60% of women with non-circumcised partners expressed their dissatisfaction with their partners. They noted that their partners do not satisfy their sexual needs most of the time. They expressed that their partners often ejaculate prematurely before the women have reached orgasm.

Generally, the sentiments of women with non-circumcised partners highlights that sex with a non-circumcised men is not as pleasurable as sex with a circumcised male. All the women highlighted that there is need to encourage all men to be circumcised because of the advantages that include penile hygiene and a reduction in contracting HIV and STIs when a man is circumcised.
**Preferred Practitioners to carry out male circumcision**

**Figure 5: Preferred Practitioner to carry out male circumcision**

<table>
<thead>
<tr>
<th>Practitioner</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>52%</td>
</tr>
<tr>
<td>Nurse</td>
<td>33%</td>
</tr>
<tr>
<td>Traditional Healer</td>
<td>15%</td>
</tr>
</tbody>
</table>

*N=40:20 circumcised men, 20 non-circumcised men*

Figure 5 above shows the different practitioners that respondents would prefer to perform male circumcision. Twenty-one respondents representing 53% prefer that the operation be done by a doctor. Thirteen respondents (32%) preferred that male circumcision should be conducted by a trained nurse and 6 (15%) respondents highlighted that they would prefer to be circumcised by a traditional healer.

Those who preferred to be circumcised by the doctor highlighted that there is need for well trained and experienced practitioners to perform circumcision of which doctors were mentioned as such practitioners. The respondents said that if there are any adverse reactions a doctor will be able to correct them unlike a traditional healer.
Those who preferred to be circumcised by a nurse highlighted the issue of long queues at health centres were circumcision is carried out by medical doctors. The long queues are due to the fact that only doctors perform the operations and they take time to attend to all men who want to undergo circumcision. These respondents pointed out that the anesthesia that they are administered before the operation can weaken before being attended to. These respondents thus strongly feel that nurses should be trained to do male circumcision. The Key Informant also noted that currently only medical doctors are authorized to carry out male circumcision in Zimbabwe. The Key informant however supports the need for increasing the hospital staff that performs the operation through training nurses on male circumcision.

“Change the mindset – male circumcision is a minor operation that can be performed by Nurse Clinicians, theatre nurses, and all nurses if trained.”

However the respondents expressed that if nurses are recruited to perform the operations they will prefer to be circumcised by male not female nurses. These findings also concur with the findings by Auvert (2001), who also noted that many men may feel embarrassed about exposing the private parts of their body and having their foreskin cut by females.

Six respondents who represent 15% who prefer to be circumcised by a traditional healer expressed that being circumcised in a health institution by a doctor or nurse does not make up a full men. These respondents expressed that even when one is circumcised in a clinical setting he still needs to undergo traditional circumcision through attending traditional male initiation schools were men are taught traditional manhood values and bravery. Such traditional practices however expose men to the danger of contracting HIV and AIDS as they tend to use one
unsterile gadget for the exercise. Mayatula and Mavhundla (1997) noted that the men actually prefer use of one tool for circumcision in order to show that they are of the same tribe and culture.
4:3:6 Circumcision of children and infants

Figure 6: Age for circumcising children and infants

Figure 6 above indicates the views of the 60 respondents in view of the preferred ages for circumcising children. Respondents were asked on the appropriate age they would like to have their children circumcised, whether at birth or as children.

Thirty- three (33) respondents representing (55%) interviewed expressed that they would like to have their sons circumcised just after birth between 0-18 months. Nine (15%) respondents would prefer to have their sons circumcised as children between 19 months to 10 years. Eighteen respondents expressed that they would prefer to have their children circumcised when they are adolescents.
The group of respondents that preferred their children to be circumcised whilst still at infant stage expressed that the children will not feel the pain associated with the circumcision process. The other group of respondents expressed that they would prefer their children to be circumcised between 19 months and 10 years. They expressed their fears that circumcising infants might result in adverse situations as the children are still too young, instead they prefer the next age group of between 19 months to 10 years.

The last group of respondents who chose the 7 to 18 years (30%) pointed out that the best age will be between 11 to 18 years because the children will be involved in something they have consented to. Thus these parents will not bring in their children for circumcision until they reach the adolescents stage.

It was explained by the researcher that circumcising babies is technically easier than for older boys or men with a lower risk of complications and healing is usually complete within a week. The respondents were asked whether this new information would influence the decision of parents to have their infants circumcised. The respondents did not change their minds. It was explained that at first it may be difficulty given that this proactive has not been common in Zimbabwe, that some mothers have never seen a baby circumcised before. Traditional circumcisions have occurred during adolescent or adult years, so it may take some time for parents to adjust to a new approach of safe health-based male circumcision.
4:3:7 Decision on male circumcision

Table 5: Whose decision to go for male circumcision

<table>
<thead>
<tr>
<th>Mode of Decision Making</th>
<th>No of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consult parents</td>
<td>9</td>
<td>22.5</td>
</tr>
<tr>
<td>Consult wife/partner</td>
<td>15</td>
<td>37.5</td>
</tr>
<tr>
<td>Own decision</td>
<td>16</td>
<td>40</td>
</tr>
</tbody>
</table>

*Table 5 indicates the main decision maker in male circumcision.*

The study was keen to find out about whose decision it usually is for one to go for male circumcision, especially in regards to women’s roles in male circumcision. According to the table, 16 men representing (40%) will not consult anyone for them to undergo male circumcision. Fifteen men (37.5%) of the respondents indicated that they would consult their wife/partner whilst 9 respondents (22%) of the young men indicated that they will consult their parents if they decide to go for male circumcision. Young men would consult their parents so that if there is any cost involved in the process, their parents will pay.

Bailey (2005) noted that when decisions on male circumcision are made, normally the mothers make decisions when a male child has to be circumcised at a health facility but, fathers make decisions where a male child has to go to the initiation school. The notion by Bailey (2005) is also supported by Rizvi (1999) who said that in Zimbabwe men make decisions on cultural aspects on male circumcision in view of the initiation schools. Women and mothers play
important roles in the decision making process concerning male circumcision and in the fabric of preparation and post operation processes. Scott, Weiss and Viljoen (2005) suggested that in South Africa women have an influence on men’s decision to circumcise, often scheduling the appointment for their boyfriends or husbands (Rain-Taljaard 2003). Thirteen percent of circumcised participants in another South African study as noted by Lagarde (2003) reported undergoing circumcision because their partner expressly requested it. It is worth noting that decisions are based on both the cultural, religious and medical reasons, hence why in most cases women (mothers) are mentioned to be decision makers when male circumcision is done for medical reasons especially during the child ‘s early age and men make decisions for initiation. Thus women’s views in male circumcision should also be considered.
4:3:8  Level of stigma attached to male circumcision

Figure 7: Respondents’ views on stigma and circumcision

<table>
<thead>
<tr>
<th>Level of stigma attached to male circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>55%</td>
</tr>
</tbody>
</table>

n=60: 20 circumcised men, 20 non-circumcised men, 20 women

This presentation below is a synthesis of the views of all the 60 respondents in as far as stigma is attached to male circumcision.

Of the sixty respondents, 33 (55%) felt that there was stigma attached to male circumcision. These respondents felt that stigma was being directed to circumcised men, especially because the practice is not common in Zimbabwe. One circumcised men stated that soon after being circumcised some men wanted to have a look at his circumcised penis and he was called by all sorts of names. Circumcised men can further be stigmatized by those who undergo the traditional initiation ceremonies. One respondent pointed out that those men circumcised in health
institutions are traditionally not regarded as ‘real men’, ‘true men’ or ‘complete males’, which traditionally only results from going through initiation school and being circumcised as part of this process.

Such stigma can potentially reduce the demand for male circumcision. Possible options need to be explored on how this barrier to male circumcision can be resolved. Possibly there is need to explore whether men who choose to have male circumcision at a health facility, could still be allowed to go through initiation schools without being circumcised by traditional leaders. This was found to have occurred as two of the respondents claimed to have undergone both the medical male circumcision and later for traditional initiation.
Figure 8: Scaling up the provision of male circumcision

n=60 respondents: 20 circumcised men, 20 non-circumcised men, 20 women

Figure 8 above indicates the required interventions that can facilitate scaling-up the provision of male circumcision.

Forty-three respondents (71.6%) highlighted the need for a widespread health education campaign in order to improve people’s awareness of the benefits of male circumcision. Without an effective education campaign it will certainly not be possible to increase the demand for male circumcision at health facilities. Health workers were urged not to confront people’s religious and cultural affiliations (to initiation school), as this would only create unnecessary controversy, it is best just to present the male circumcision service and educate the public on its benefits.
“Health Education on the importance of male circumcision should be done during public gatherings”

“Do not confront cultural and religious affiliations, just present the service and educate the public”.

Several forms of health education were suggested including:

- Special television and radio programmes about the benefits of male circumcision
- Door to door visits to provide education and handout information
- Special public gatherings for men and adolescent boys
- Establish a special ‘Male Circumcision Day’ to generate awareness and increase demand
- Health Education on male circumcision carried out in schools, workplaces, churches and at community halls.
- Use of Health videos on male circumcision at health centres to provide education while people are waiting for their appointments with the health personnel.
- Using Peer Education as a means of communicating information on male circumcision with the peer educators chosen from amongst those who have undergone health-based male circumcision.

These respondents also suggested messages which could influence men to get circumcised. Most of the messages proposed were focused on how male circumcision can reduce the risk of HIV and STIs. In some messages however there was the danger of suggesting that the person would be completely safe from HIV after being circumcised.

“Circumcise and protect yourself against sexual infections”
“Male circumcision makes a man free from STIs and HIV”.

The respondents focused on the traditional link between being circumcised and being a real man.

“Strong men circumcise to protect HIV spread to the new generation”.

Focus on improved sexual pleasure was also promoted.

“Change its shape for the better, be circumcised”

“A well sharpened pencil writes better than the unsharpened pencil – Get it sharpened”.

One respondent proposed that the message of circumcision needs to be combined with other forms of HIV prevention, such as consistent and correct condom use.

“Safer sex with condoms, go for highly enjoyable sex and much safer sex with both condoms and male circumcision”

The need to invest in more infrastructure, facilities, and equipment to enable male circumcision to be carried out on a larger scale was also noted. Five respondents representing 8% of the total respondents noted that there is need for a large amount of investment in infrastructure, new facilities and equipment in order for it to be possible to greatly increase the number of male circumcisions conducted. Separate facilities for male circumcision should be set-up especially at hospitals and larger health facilities. The view was that this would give greater privacy for men wanting to come for safe male circumcision.

“Male circumcision facilities should be isolated from other services, like ART corners”

“There should be a special department or unit specializing in male circumcision”.

“
The recruitment of more staff to carry out male circumcision was another factor noted by the respondents. The Key Informant and eight other respondents shared the same view that there is need for more staff to be recruited in order to respond to large increase in number of circumcisions carried out.

Training of staff to be able to carry out male circumcision was also identified as a requirement in scaling up male circumcision. Male circumcision should be part of every health personnel’s training. Four respondents (20%) emphasized that the availability of male circumcision needs to be increased. Male circumcision should become available at most if not all health centres. This can be achieved through trainings and capacitating the health personnel.
Figure 9: Respondents views on HIV testing for Male circumcision

N=60: 20 circumcised men, 20 non-circumcised men, 20 women

The researcher explained to the respondents that male circumcision services will include the offer of voluntary HIV testing and counseling and medical services. The researcher further explained that men who are found to be HIV positive are not encouraged to go for male circumcision because their wounds will take time to heal and there is also fear that they might spread HIV to their partners if they decide to engage in sex before they are fully healed. One’s HIV status according to the Zimbabwean male circumcision policy (2008) should not however be a barrier to male circumcision but people need to make informed decisions.

Respondents expressed concern on this issue and highlighted that offering HIV testing will have an impact, mainly a negative effect of reducing the number of men interested in male circumcision. This will be due to people’s fear of HIV testing and knowing their status.
Thirty- five respondents (59%) disagreed with the idea that HIV testing and counseling would have a negative impact on male circumcision. They felt that HIV testing and counseling is becoming more widespread and people are no longer so fearful of HIV testing. With the availability of anti-retroviral treatment ensuring that there is still a future with a positive status, many are no longer in so much fear of knowing their status.

These respondents (35) even said that offering HIV testing could have a positive effect upon demand for male circumcision because it will be providing a second service which people may also be seeking.

According to 17 respondents representing just over 28%, a lot will depend upon the situation, on how HIV testing is offered- as a voluntary choice or as an opt-out clause where the health personnel assume that people want to be tested unless they categorically refuses and also on how the counseling is being carried out and explained to the patient.

Eight respondents (just over 13%) expressed that they do not know how the issues of providing other health services like HIV testing before circumcision impact on the programme.

The Key Informant highlighted that the health facility offers provider- initiated counseling and testing to men coming for male circumcision so that if there are other health needs identified like HIV, patients are offered comprehensive services early. He noted that HIV testing is not mandatory but those men who want to undergo male circumcision are encouraged to undergo HIV testing also as a way of protecting women from being infected with HIV if the men decides to have sex with an unhealed wound.
5:1 Summary

Respondents were between the age groups of 15 to 70 years, with the majority of the respondents between 30 to 44 years in both sexes.

These numbers of circumcised men at Spilhaus, Harare Hospital confirms the general situation of male circumcision in Southerton and Mbare where the main focus of circumcision is among those men aged 19 to 49 years. This further shows that the practice of male circumcision for young boys just after birth has not yet gained interest among the Mbare and Southerton communities.

The majority of the respondents (60%) knew the relationship between STIs and male circumcision and 47% were knowledgeable on the relationship between male circumcision and HIV.

The majority of the circumcised men stated that they would prefer to be circumcised by a trained medical doctor because they are able to deal with any adverse circumstances if they occur than the other practitioners. They stated that it is beneficial because it reduces the contraction of STIs and HIV. It is also important in that it increases sexual pleasure.
The main objections raised to male circumcision were embarrassment and disgrace of being handled by females at health facilities, fear of pain associated with male circumcision and that circumcision interferes with sexual pleasure due to reduced insensitivity and less arousal. Women generally have positive views of male circumcision as they said it is associated with pleasurable sexual relations and cleanliness. There was the concern that it may lead to increased risk behavior if their partners believe that they are now protected from HIV.

While Bailey (2005) have suggested that women’s views in male circumcision might have a powerful influence on the circumcision decisions of men, the study have shown that women and mothers play important roles in the decision making process concerning male circumcision and in the fabric of preparation and post operation processes. Thus women continue with their roles of carrying the heavy burden of caring for the family.

Respondents felt that people’s religion, culture and educational levels do affect an individual’s attitude to male circumcision. Religion’s role is said to be such that some religious denominations do not allow their followers to undergo male circumcision. Education was said to having an influence on male’s attitude towards male circumcision in that educated men are aware of benefits of male circumcision in relation to reduced risk of HIV and STIs, thus making it easy for them to seek the male circumcision services.

Respondents reported that there is stigma associated with males circumcised at the health facilities as they are not considered as real men because they have not been initiated into manhood culturally.
Factors which may lower the rate of male circumcision include:

1. Lack of knowledge about the benefits of male circumcision
2. Not being aware of the impact of male circumcision on reduced risks of HIV and STI infection
3. Not enough information has been given to the communities about male circumcision
4. Religion plays a role in that certain denominations do not support male circumcision
5. People fear to go for male circumcision due to the pain perceived to be associated with the operation.

In terms of the factors to consider in increasing the provision of male circumcision the respondents advised that they be in the following order of priority:

- Health education
- More staff
- More infrastructure
- Trainings for health staff

Most respondents proposed the use of health education to increase demand for male circumcision. Health education will be in form of television and radio programmes, door to door visits, public gatherings for men and adolescents boys, special ‘male circumcision days’ and health education at schools and workplaces.

Concerning the age at which the respondents would like to have their children circumcised, the majority felt it should be at birth because male circumcision is easier to perform and the healing process is faster and has fewer complications. This shows that if the health authorities stick to the
respondents’ views, there could be a reduced rate of HIV prevalence because at these ages the children will still be at the stage of prevention and not yet sexually active.

In terms of offering HIV testing and counseling, most respondents (59%) disagreed that this will scare away men who want to come for male circumcision. Instead more men will come for the service so that they access comprehensive services.

5.2 Conclusions

• The majority of patients coming for male circumcision are adults while very few infants are brought in by parents for male circumcision. Yet according to the key informant (the health practitioner) circumcising infants was more effective, given that it is a simpler procedure with less risk of complications, accompanied by a quicker healing process. More importantly, at an early age male circumcision can still be effective in reducing the future risk of HIV and STIs. More so, some adults are being scared by the HIV testing that is done before circumcision.

• This study has identified the following issues which need to be tackled in order to achieve greater demand for male circumcision:
  ▪ Lack of awareness about the benefits of male circumcision
  ▪ Widely held myths and misunderstandings which deter men from male circumcision
  ▪ Men’s objections to being treated by female medical staff
  ▪ Lack of staff authorized to perform male circumcision
- Substantial financial investment needed to increase the provision of male circumcision

- The majority of the people expressed the need for an awareness/education campaign as this is crucial in increasing the demand for male circumcision.

- One of the most damaging myth/misconception prevalent among the respondents is that they feel that if one is circumcised they are completely safe from HIV.

- It however needs to be noted that this study was by no means exhaustive. The data suggest that male circumcision might prove a useful HIV intervention in the country and I believe this will stimulate more research questions in the mind of the readers and eventually realize a world free from HIV.

5:3 **Recommendations**

- Awareness & education campaign to increase people’s awareness of the benefit of male circumcision in reducing the risk of HIV.

- Focus education on dispelling the myth that male circumcision can completely protect men against HIV.

- Increase the number of male health professionals involved in providing male circumcision to cater for patients who find it difficult to be treated in such a sensitive area by female staff.
• Cooperating on the information provided and training given to circumcision initiates to maximize good health outcomes for the participants and their current or future partners and family members.

• Ensuring a smooth and rapid transfer to or intervention by, clinical services if a medical complication associated with the circumcision arises.

• Developing models by which clinical and traditional providers can cooperate and share responsibility for the tasks involved in the circumcision process, while respecting the different skills that each contributes.

• Significantly increase the number of male circumcisions performed at hospitals through the additional use of Nurse Clinicians - who in the process could receive in-service training from medical doctors while performing male circumcision.

• Expand the provision of male circumcision through the larger health centres which already have the facilities to perform minor procedures and enough staff to conduct this alongside their main health services.
There is need for greater financial investment into the health care system to ensure that the increased costs associated with the scaling-up of male circumcision can be fully covered.
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bailey R</td>
<td>2002</td>
<td>The acceptability of male circumcision to reduce HIV infections in Nyanza Province, Kenya. Nyanza: AIDS Care</td>
</tr>
<tr>
<td>Bowa &amp; Lukobo,</td>
<td>2006</td>
<td>Improve the quality and accessibility of comprehensive MC and male RH services in Zambia: Lusaka: Lusaka’s University Teaching Hospital Publications (UTH)</td>
</tr>
</tbody>
</table>
Fleming D, Wasserheit J 1999 From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sex Transmission Geneva, UNAIDS.


MOHCW and NAC 2008 Situation analysis of male circumcision in Zimbabwe. Harare: MOHCW.


Nnko S  2001  Dynamics of male circumcision practices in northwest Tanzania. Dare-esalam: The Lancet


Rain-Taljaard RC  2003  Potential for an intervention based on male circumcision in a South African town with high levels of HIV infection. Soweto: AIDS Care.

Rizvi, S  1999  Religious Circumcision: A Muslim View

California: Hourglass

Schendel G,  1968  Medicine in Mexico; from Aztec herbs to betatrons. Austin, University of Texas Press.

Schoen E.  2005  Circumcision. Berkeley, California,


UNAIDS  2003  Male circumcision: Current epidemiological and field evidence; program and policy implications for HIV prevention and reproductive health Geneva: UNAIDS
<table>
<thead>
<tr>
<th>Author/Institution</th>
<th>Year</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNAIDS</td>
<td>2005</td>
<td>United Nations work plan on male circumcision and HIV. Geneva: UNAIDS.</td>
<td></td>
</tr>
<tr>
<td>UNAIDS/CAPRISA</td>
<td>2007</td>
<td>Consultation on social science perspectives on male circumcision for HIV prevention. Geneva: UNAIDS</td>
<td></td>
</tr>
<tr>
<td>UN</td>
<td>2006</td>
<td>Regional Working Group on Male Circumcision: Regional Consultation on Safe Male Circumcision and HIV Prevention: Nairobi, Kenya</td>
<td></td>
</tr>
<tr>
<td>Urassa M</td>
<td>1997</td>
<td>Male circumcision and susceptibility to HIV infection among men in Tanzania: Dare-esalam: AIDS Care</td>
<td></td>
</tr>
<tr>
<td>Wawer M</td>
<td>2008</td>
<td>Trial of male circumcision in HIV positive men, London: Chapman and Hall</td>
<td></td>
</tr>
<tr>
<td>Author(s) / Organization / Institution</td>
<td>Year</td>
<td>Title / Description</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Williams B, &amp; Auvert B.</td>
<td>2006</td>
<td>The potential impact of male circumcision on HIV in sub-Saharan Africa. Cape Town, PLoS Medicine</td>
<td></td>
</tr>
<tr>
<td>Lee, R.</td>
<td>1993</td>
<td>Doing research on sensitive topics. London; Sage</td>
<td></td>
</tr>
<tr>
<td>Central Statistical Office</td>
<td>1995</td>
<td>Zimbabwe Demographic and Health Survey. Harare, Central Statistical Office</td>
<td></td>
</tr>
</tbody>
</table>
Thank you for agreeing to talk to me. My name is Etiya Chigondo. I am a student at the School of Social Work, University of Zimbabwe and I am conducting a study on male circumcision. I am talking to men and women in an effort to find more about male circumcision. The objective of the study is to learn more about the knowledge, attitudes and beliefs with regards to male circumcision.

The interview will last about 30 minutes

There is no right or wrong answers to the questions; I want to learn more about your personal thoughts and attitudes. If you do not understand any questions, please tell me, you can add further questions at any stage.

Your answers will be kept confidential and any information that you are going to give will be used solely for the purposes of this study and your names will not be used in relation to the responses that you are going to give.

Place of interview---------------------------------------------
Number of participants------------------------------------------
Section A: Demographics

1. How old are you? .................................................................

2. Are you a member of a specific tribe: e.g.
   - Shona □
   - Tonga □
   - Venda □
   - Chewa □
   - Xosa □
   - Muslim □
   - Shangani □
   - Other (specify) ...........................................................

3. How many children do you have? ......................................

4. Where were you born? ......................................................
   Type of area: Rural—— Town——— City——— Growth point—— Other——

5. Where are you living now?
   Name of place .....................................................................
   Rural——— Town——— City——— Growth point——— Other——

Section B: Community perception on male circumcision

1. What is the tradition in this area around male circumcision?

2. What cultural significance that are attached to male circumcision in this community?

3. In this community, who takes the decision about whether a male is to be circumcised or not?

4. Is there any health significance in regards to male circumcision perceived by the community?
   Prompt: What are they?

5. What do people generally say about male circumcision in this community?
Section C: Personal Experience

1. What was it like undergoing male circumcision? Do you have memories of it, or not?
2. Did you have any fears before undergoing this operation? What were they?
3. Do you still have any fears after undergoing this operation? What are they?
4. Is there any health significance in regards to male circumcision that you perceive?
   \textit{Prompt: What are they?}
5. What are some of the preconceived benefits of male circumcision that you think you are going to enjoy?
6. What might stop someone from using a health facility?
7. What are the benefits of using a health facility?
8. What are the negatives about using a health facility?
9. How might male circumcision at a health facility be improved?
10. Have you ever heard of the operation going wrong at a health facility?
11. If you have or had a son, would you support his circumcision?
12. If “yes”, when would be the best time for him to be circumcised?
13. As male circumcision only reduces the chance of infection, what other ways of avoiding HIV should you use?

Section D: Perception of significant others

1. What is your partner’s perception on male circumcision?
2. Does she complain of any changes in your sexual life? Are the changes positive or negative?
3. Do you think your partner/wife would encourage other women to have their partners circumcised?
4. What are your friends’ perceptions on male circumcision? Do you think they would consider going for male circumcision as well?
5. Do you have friends who are also circumcised? What do they say about their sexual lives after being circumcised compared to when they were not yet circumcised?
Section E: Increasing demand for male circumcision

1. After undergoing this operation, what would you think the most “perfect” situation would be for conducting male circumcision?

2. If the health programme in this area wanted to increase the number of people seeking male circumcision, what types of messages would people best respond to? How should the messages be given (e.g. by radio, posters, teachers, family e.t.c)

3. If the health programme in this area wanted to increase the availability of male circumcision services what would be good, or bad, ways to do this?

In relation to male circumcision, are there any subjects, topics, or thoughts I have not discussed with you that might be important, or useful, for us to talk about?

THE END
Thank you for agreeing to talk to me. My name is Etiya Chigondo. I am a student at the School of Social Work, UZ and I am conducting a study on male circumcision. I am talking to men and women in an effort to find more about male circumcision. The objective of the study is to learn more about the knowledge, attitudes and beliefs with regards to male circumcision.

The interview will last about 30 minutes

There is no right or wrong answers to the questions; I want to learn more about your personal thoughts and attitudes. If you do not understand any questions, please tell me, you can add further questions at any stage.

Your answers will be kept confidential and any information that you are going to give will be used solely for the purposes of this study and your names will not be used in relation to the responses that you are going to give.

Place of interview----------------------------------------
Section A: Identification

1. Date:

2. Interviewer:

<table>
<thead>
<tr>
<th>Name of interviewee</th>
<th>Designation</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section B:

1. Have you ever performed a male circumcision? Yes…………….. No……………
2. If yes, approximately how many circumcisions have you performed?
3. What were some of the reasons male circumcision was performed?
4. How many circumcisions that you have performed resulted in a complication or adverse event?
   Prompt: What were the main types of complication
   Excessive bleeding
   Infection
   Disfigurement
   Impotence
   Other (specify)………………………………………………..
5. What were the ages of males you circumcised?
   Prompt: What would be the best age for male circumcision
6. How much is charged for a male circumcision?
7. What training have you received to perform male circumcision?
   Prompt: Would you need further training on male circumcision and what would it be?
8. In your opinion, who should be allowed to perform male circumcision?

Section C

1. What is the association between male circumcision and a reduced risk of HIV infection to men?
2. What do you think a non-circumcised man might think about male circumcision?
   Prompt: Would these feelings be the same if they were from different backgrounds such as religion?
3. What do you think women might think about male circumcision?
   Prompt: Would these feelings be the same if they were from different backgrounds such as religion?
4. What percentage of males in each of the following groups in this district do you estimate have been circumcised at any given time?
   - Newborns (up to 1 year old)
   - Pre-puberty (1 year to 8 year old)
   - Puberty(9-14 years old)
• Adolescents (15-17 years old)
• Adult men (over 17 years old)

5. What do you believe are the factors affecting rates of male circumcision in this district?
   *Follow-up: Can you say which factor you think is the most important and which one is least important?*
   *Follow-up: Is there any stigma attached to a man being circumcised or uncircumcised*

6. What ideas do you think people have about the results of male circumcision?
   *Prompt: Do you think men have riskier sex after circumcision, such as more partners or not using a condom, thinking that they were now protected from acquiring HIV and sexually transmitted infections.*

Section D:

1. If you were to increase the provision of health facility-based male circumcision services, what would be the most important factors that you will consider changing from the way you are currently conducting the procedure?
   *Prompt: Are all the staff members trained to do the operation?*
   *Prompt: Do all health facilities have an operating theatre?*

2. If you were to increase the number of people seeking male circumcision, what factors were you to consider?
   *Prompt: What messages do you think would have the most influence on people to encourage male circumcision? What about new-born or children?*

3. Programmes for male circumcision will likely include the offer of an HIV test, with referral to counseling and medical services, if the person is HIV positive. Taking an HIV test will not however, be mandatory and men who are HIV-positive may still receive a circumcision. Do you think this policy of offering HIV testing will affect a programme to increase acceptability of male circumcision?

In relation to male circumcision, are there any subjects, topics, or thoughts I have not discussed with you that might be important, or useful, for us to talk about?

**END**
Focus Group Discussion- Guides for men

Status of Focus Group

Men not circumcised

Thank you for agreeing to talk to me. My name is Etiya Chigondo. I am a student at the School of Social Work, UZ and I am conducting a study on male circumcision. I am talking to men and women in an effort to find more about male circumcision. The objective of the study is to learn more about the knowledge, attitudes and beliefs with regards to male circumcision.

The interview will last about 30 minutes

There is no right or wrong answers to the questions; I want to learn more about your personal thoughts and attitudes. If you do not understand any questions, please tell me, you can add further questions at any stage.

Your answers will be kept confidential and any information that you are going to give will be used solely for the purposes of this study and your names will not be used in relation to the responses that you are going to give.

Place of interview-------------------------------------------------------------
Number of participants-------------------------------------------------------
Median age---------------------------------------------------------------
Section A: Knowledge

Explain the term ‘male circumcision’

1. What is the tradition in this area around male circumcision?

   *Ask for the reasons behind any traditions- why is it done or not done?*

2. In this community who takes the decisions about whether a male is to be circumcised?

   a. *Has that changed in recent times?*

3. Do you know if male circumcision is available at the nearest health facility?

Section B:

1. What is the first thing that comes into people’s minds when they hear the term ‘male circumcision’?

2. Why might some men not be circumcised?

3. Who are the people who are usually circumcising in this community?

4. What are the benefits of male circumcision?

5. What could encourage male circumcision, both adults and infants?

6. At what age would parents prefer their sons to be circumcised?

   *Prompt- at birth or as a child, and the pros and cons of each.*

7. How will people react if they were told that, when a man is circumcised, he has a much reduced risk of being infected with HIV and other sexually transmitted infections?

8. Would you consider being circumcised after the above statement?

   *Prompt- If not, why?*

9. Do you personally fear circumcision?  Yes ☐  No ☐

   *Prompt Support your answer*
Section C

1. If it were possible to describe the perfect situation in which adolescent and adult males could get circumcised, what would that situation be like?

   **Prompt:** Would male circumcision be done traditionally, or in a medical facility, or if male circumcision was part of traditional initiation rites, perhaps the procedure would be in the hospital but everything else would remain the same, or a medical professional would attend a traditional event and carry out the male circumcision?

2. If the health programme in this district wished to increase the number of people seeking male circumcision, what type of messages would people best respond to? How should the messages be given (for example, by radio, posters, teachers, family, and e.t.c)?

3. If the health programme wanted to increase availability of male circumcision services, what would be good, or bad, ways to do this?

4. How much do you think can be charged by the health service provider for the operation?

In relation to male circumcision are there any subjects, topics of thoughts that have not been discussed that might be important, or useful, for us to talk about?

*END*
Focus Group Discussion-Guides for Women

Status of Focus Group

Majority of Women with circumcised partners

Thank you for agreeing to talk to me. My name is Etiya Chigondo. I am a student at the School of Social Work, University of Zimbabwe and I am conducting a study on male circumcision. I am talking to men and women in an effort to find more about male circumcision. The objective of the study is to learn more about the knowledge, attitudes and beliefs with regards to male circumcision. The interview will last about 30 minutes

There is no right or wrong answers to the questions; I want to learn more about your personal thoughts and attitudes. If you do not understand any questions, please tell me, you can add further questions at any stage.

Your answers will be kept confidential and any information that you are going to give will be used solely for the purposes of this study and your names will not be used in relation to the responses that you are going to give.

Place of interview-----------------------------------------------
Number of participants------------------------------------------
Median age-----------------------------------------------------
Section A:

Ensure that it is understood that male circumcision only reduces the risk of infection with HIV, and therefore other methods of prevention must also be used. Take note of the questions asked by the group, as this is an important indication of the level of awareness of certain issues.

1. What is the tradition in this area around male circumcision?
2. What cultural values or significance are attached to male circumcision in this community?
3. How are men normally circumcised in this community?
4. In this community, who takes the decision about whether a male is to be circumcised.
   Prompt: Have there been changes to this pattern in recent times.
5. Do you know where male circumcision services are offered in this community?

Section B:

1. As women, what does male circumcision mean to you?
2. When you become mothers, or as mothers, what will your son’s circumcision mean to you?
3. Whom would you consider marrying a non-circumcised man? Give reasons to your response.
4. What do you think are the benefits of male circumcision? What do you think are the negative or bad things of being circumcised?
5. Do you have any thoughts about sex with a circumcised man compared to sex with an uncircumcised man?

Section C:

Now we are wrapping up our discussion and I want to understand a few issues.

1. If the health programme in this country wanted to increase availability of male circumcision services what would be good, or bad, ways to do this?
2. If the health programme in this country wished to increase the numbers of people seeking male circumcision, what type of messages would people respond to? How should the messages be given (e.g. by radio, posters, teachers, family, e.t.c)?
3. How much do you think would be a fair price for a male circumcision operation?
   • As part of a traditional rite
   • In a health facility

In relation to male circumcision, are there any subjects, topics, or thoughts that have not been discussed that might be important, or useful, for us to talk about?

THE END
Thank you for agreeing to talk to me. My name is Etiya Chigondo. I am a student at the School of Social Work, University of Zimbabwe and I am conducting a study on male circumcision. I am talking to men and women in an effort to find more about male circumcision. The objective of the study is to learn more about the knowledge, attitudes and beliefs with regards to male circumcision. The interview will last about 30 minutes

There is no right or wrong answers to the questions; I want to learn more about your personal thoughts and attitudes. If you do not understand any questions, please tell me, you can add further questions at any stage.

Your answers will be kept confidential and any information that you are going to give will be used solely for the purposes of this study and your names will not be used in relation to the responses that you are going to give.

Place of interview-----------------------------------------------

Number of participants-----------------------------------------------

Median age-----------------------------------------------
Section A:

Ensure that it is understood that male circumcision only reduces the risk of infection with HIV, and therefore other methods of prevention must also be used. Take note of the questions asked by the group, as this is an important indication of the level of awareness of certain issues.

6. What is the tradition in this area around male circumcision?
7. What cultural values or significance are attached to male circumcision in this community?
8. How are men normally circumcised in this community?
9. In this community, who takes the decision about whether a male is to be circumcised.
   Prompt: Have there been changes to this pattern in recent times.
10. Do you know where male circumcision services are offered in this community?

Section B:

6. As women, what does male circumcision mean to you?
7. When you become mothers, or as mothers, what will your son’s circumcision mean to you?
   • Would you consider your son to be circumcised?
8. What do you think are the benefits of male circumcision?
9. What do you think are the negative or bad things of being circumcised?
10. Would you like your partner to be circumcised?
   • Give reasons to your answer
11. How would you react if you were told that, when a man is circumcised, he has a much reduced risk of being infected with HIV and other sexually transmitted infections?
   • Would you consider male circumcision for your partner?
12. Do you have any thoughts about sex with a circumcised man compared to sex with a non-circumcised man?

Section C:

Now we are wrapping up our discussion and I want to understand a few issues.

4. If the health programme in this country wanted to increase availability of male circumcision services what would be good, or bad, ways to do this?
5. If the health programme in this country wished to increase the numbers of people seeking male circumcision, what type of messages would people respond to? How should the messages be given (e.g. by radio, posters, teachers, family, e.t.c)?
6. How much do you think would be a fair price for a male circumcision operation?

In relation to male circumcision, are there any subjects, topics, or thoughts that have not been discussed that might be important, or useful, for us to talk about?

END