ACCEPTABILITY OF NEONATAL CIRCUMCISION AMONG MOTHERS: A CASE STUDY OF HATCLIFF AND RUTSANANA CLINIC

BY

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ABSTRACT

The acceptability of neonatal circumcision among mothers at Rutsanana and Hatcliffe clinics in Harare

Background Male Circumcision is regarded as part of an integrated response to HIV prevention. Zimbabwe has not started implementing neonatal male circumcision. The purpose of this study was to identify factors that may facilitate or hinder the acceptance of neonatal circumcision

Methods: A cross-sectional survey was carried out on 258 pregnant and mothers of newly born babies at Harare City Health department clinics, Rutsanana and Hatcliffe clinics. Data was collected using face to face interviews and group discussions. Data was analyzed using Stat version 12. Univariate, bivariate and multivariate analysis and the chi square test were used to determine the independent association between each variable.

Results: There was a significant association between acceptance of neonatal circumcision and knowledge levels. Those with adequate knowledge levels were more likely to accept neonatal male circumcision (OR=2.04, 95% CI; 1.10-3.80), and this was statistical significant, p=0.025. Women with circumcised partners were more likely to have circumcised sons, OR=5.27, 95% CI (2.02 – 13.71) and this was statistically significant, p=0.001

Conclusions All participants thought that the male circumcision for infants and young boys was the best above the age of one with 25% agreeing that they favored the policy of within the first 8 weeks after delivery. The respondents were aware of the benefits of neonatal male circumcision as an HIV prevention strategy though they deferred the decision to circumcise their new born to a later stage.

Key Words circumcision, neonatal Harare City HIV and AIDS
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   b) The Director, City of Harare, City Health Department
   c) Authorities at Rutsanana Clinic
   d) Authorities at Hatcliffe clinic

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussions</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>MC</td>
<td>Male Circumcision</td>
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<tr>
<td>NGO</td>
<td>Non- Governmental Organizations</td>
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<tr>
<td>NMC</td>
<td>Neonatal Male Circumcision</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint programme on HIV/AIDS</td>
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<td>UTI</td>
<td>Urinary Tract Infection</td>
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<td>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

HIV has infected more than 33 million people worldwide. Since it was first recognized in the early 1980s (UNAIDS, 2010), no cure and vaccine have been found. Zimbabwe has joined the growing list of countries in Southern Africa that is encouraging, and sometimes paying for adult men to get circumcised. The male circumcision programs have been adopted in the wake of studies that suggest that male circumcision in conjunction with other interventions can reduce the HIV infection risk by about 60 percent when a man has sex with an HIV positive woman (Gray et al, 2007; Bailey et al, 2007).

Zimbabwe is experiencing a severe, generalized heterosexually driven HIV epidemic. Several HIV prevention strategies have been adopted as part of the Zimbabwe National Strategic Plan 2006-2010. The focus is on promoting safer sexual behavior as outlined in the National Behavioral Change Strategy 2006-2010 and on a package of health sector interventions such as PMTCT, testing and counseling, blood safety and others as outlined in Zimbabwe’s Health Sector HIV Prevention Strategy. According to the National HIV and AIDS Estimates (2013), HIV prevalence has declined significantly over the past decade from 29.3 % (1998) to 15.6 % (2007) and 15% (2013). A combination of mortality and behavior change could have contributed to the decline. Behavior change aspects of note are 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. Therefore additional changes and new strategies are required to further reduce HIV incidence and this is where male circumcision (MC) comes in.
1.2 Background
Male circumcision has been practiced for cultural, religious, medical and other reasons since time immemorial. The intervention is also among the most common surgical procedures performed globally. One in three males worldwide is circumcised, with almost universal coverage in some settings (UNAIDS, 2010). There is currently increased interest in male circumcision services, since three randomized controlled trials have confirmed that the procedure reduces HIV infection acquisition risk in males by up to 60%. Randomized controlled trials that were carried out in Kenya, South Africa (Orange Farm) and Uganda have shown that adult circumcision reduces HIV infection acquisition risk by 60% among men. The other 40% risk reduction is attributed to HIV prevention measures such as being faithful to one partner, abstinence as well as correct and consistent condom use (Bailey, Moses, Parker, Agot, Maclean, Kriega & Williams, 2008).

Zimbabwe and several other countries with high HIV prevalence are now expanding access to safe male circumcision (Gray, Kigozi, Serwadda, Makumbi, Watya & Nalugonda, 2007). The immediate primary target group is adults aged 15 to 29 years it was previously 18 to 29 years. (MOHCC, 2009) A long term HIV prevention strategy is likely going to include the provision of neonatal and child circumcision. Information on the acceptability levels of neonatal circumcision is therefore essential to guide further expansion of male circumcision for long term HIV prevention.

The importance of male circumcision undertaken for traditional reasons, cultural identity and religious values should not be underestimated. In some cultures male circumcision is an integral part of the transition to manhood and is associated with masculinity, self-identity and spirituality (Mavundla, Netswera & Bottoman, 2009). There are also perceived health benefits such as penile hygiene or reduced risk of infection, especially against sexually transmitted infections. In other settings, male circumcision is commonly carried out neonatally, with the primary reason being perceived penile hygiene or to fit the social norm in many regions such as Europe and North America (WHO, 2010).
According to UNAIDS (2010), male circumcision is less common in the Southern African countries where prevalence rates of 21% have been reported for Zambia, 17% for Malawi and Namibia, 35% for South Africa and 10% for Zimbabwe. Neonatal circumcision is practiced in most countries in the Middle East, North-West African countries including Senegal, Ghana, Nigeria, Mauritius, Egypt, Tunisia and Algeria (UNAIDS, 2010). All of these countries have a high number of Islamic followers which practices circumcision as part of the religious requirements. It has been reported that the low prevalence of HIV among Islamics is due to the cultural circumcision tradition.

In Zimbabwe, Neonatal circumcision is indicated in the national Male circumcision Policy (MOHCC, 2009). Interviews done with some mothers of newly born babies by a service agent in Bulawayo revealed that the HIV fight ought to be confined to the adults as they do not want their babies cut up. Their reservation were based on a number of factors such as the practice not being part of their culture, need for consent from their fathers, possibility of severe and irreversible adverse events including pain for the child (Newsday 11March 2010).

1.3 Problem Statement

Neonatal male circumcision is still a new concept in Zimbabwe though other countries like Zambia and Botswana are already underway in implementing neonatal circumcision. In Zimbabwe the first male circumcision campaign was launched in 2009. Implementation started in 2010. The focus of this campaign has been on adult male circumcision response. However there has been very little reference to neonatal circumcision. From anecdotal information (personal communication) from a local surgeon in Harare there is a low uptake of neonatal circumcision among Zimbabweans. The demand for neonatal circumcision is still limited to specific groups such as Muslims not in the general population.
1.4 Justification of the Study

The benefits of male circumcision among adults have already been demonstrated. Whilst male circumcision has been accepted and its adoption continues to be popular, there is still low uptake of neonatal male circumcision in Zimbabwe.

The City Health clinics are already providing male circumcision to young boys during the school holidays and this platform can be used to launch the neonatal circumcision initiative but there is no data to support neonatal circumcision, hence the importance of the findings from this study. The findings from this study will provide evidence for planning neonatal circumcision which will take into account the concerns of parents especially mothers.

Information on the acceptability levels of neonatal circumcision is therefore needed not only to guide further expansion of male circumcision but also for long-term HIV prevention. A better understanding of the knowledge, attitudes and beliefs of the Zimbabwe’s diverse communities will be required before interventions which include expanded access to safe neonatal male circumcision services should be considered.

Programme Managers in HIV prevention, health workers, public health practitioners and other people working and supporting HIV prevention initiatives will find this information useful for programme planning purpose and as baseline data for formulating indicators for evaluation.
CHAPTER 2

LITERATURE REVIEW

2.1 Prevalence of Male Circumcision

In Zimbabwe, circumcision is traditionally practiced in only a few small populations such as the Tonga, Shangaans and Zulus but these are small groups of minorities scattered in Zimbabwe. It is reportedly rare among the dominant Shona ethnic groups (Daniel, Halperin, Katherine, Fritz, Willi & McFarland, 2008). In the regions of East and Southern Africa where heterosexually spread HIV epidemics are especially severe, large populations of men are uncircumcised, pointing to a possible prevention intervention opportunity. Currently, pilot programs introducing safe affordable circumcision as part of male reproductive health services are underway in most countries such as Zimbabwe, Botswana, Tanzania, Swaziland and South Africa (W.H.O 2a Global H.I.V Prevention, 2009)

According to the Zimbabwean Ministry of Health and Child Care, 200 000 adult male circumcision has been carried out to date against the National target of 1.2 million (MoH&CC, 2009). The number of neonates circumcised is not recorded because circumcision for infants is not offered in the national programme. Neonatal circumcision has not been widely advertised as the National programme has not yet publicly declared that the service is available for neonates. However, reports from Bulawayo indicate that mothers are reluctant to let their children be circumcised. The mothers are reported to have said that HIV prevention should be confined to adults and not to have small babies “cut up” (Newsday 11 march 2010) The Ministry of Health has already begun discussions to promote neonatal male circumcision to lower HIV infection rates in the long term. But as in the case with adult male circumcision, uptake of neonatal male circumcision is slow (MoH&CC, 2009).
Cultural activists say that male circumcision is a dying tradition in Zimbabwe, though some communities still perform the procedure to mark the transition into manhood such as the Shangaans in Chiredzi few Zulus and Xosas in Matabeleland. Many mothers do not understand why an infant has to be circumcised and many claim this is not part of the culture (MoH&CC, 2009). In many parts of the world, the effectiveness of future male circumcision interventions will depend in large part on the acceptance and uptake of the procedure among men and parents of male children in traditionally none circumcising groups (Gray, Kigozi, Kong, 2013).

In African tribes, for example the Xhosa, Zulu and Shanghani circumcision is explained as a process of purifying males from the female characteristics. According to African beliefs, humans are born with both feminine and masculine attributes. The femininity is inherent in the male prepuce whereas masculinity exists in the clitoris. The female spirit is thought to prevent the male from the ability of rational thinking. Therefore, a non-circumcised male is considered socially inept (Mbito M. & Malia, J.A, 2008).

2.2 Advantages of Neonatal Male Circumcision
Male infants account for 75% of urinary tract infection (UTI) (Gruskin S, 20007). In a study conducted in 2010 by Mavhu, Hatzhold & Laver, it was revealed that neonatal male circumcision knowledge (procedure, timing benefits) was poor, particularly among women and health workers not involved in male circumcision. Knowledge and acceptability was high among parents from most ethnic groups. The Nyanza Province in Kenya Male Circumcision Task force (2008), stated that despite initial resistance from cultural leaders in the region, male circumcision was widely accepted with more than 110 000 men undergoing the procedure in 2008.

According to Boyle G.J (2007) acceptance for infant male circumcision was likely to be more varied. While the acceptance among parents is reasonable high, it is also very variable depending on where the health facility is situated. Circumcision is considered a sacred ritual in various religions (Afifi-Sahlieh, 2008; Chandhiok and Gangkhedkar, 2009). Other scholars agree with this and go on further to explain that the circumcision of
the male child on the 8th day is to purify him from birth pollution. There are laws in Judaism that admit the hazards of infant male circumcision refer to the bible verse that talks about circumcision and when it had to be done on a baby. Therefore, some Rabbis exempt some Jews from this procedure, on condition that the child has 2 brothers or a maternal male cousin who died during circumcision. However, some Modern Jewish feminists refute that circumcision has a religious significance (Afifi-Sahlihe, 2008; Chandhiok and Gangkhedkar, 2009).

2.3 Opinion on the Appropriateness of Neonatal Male Circumcision

Research and arguments for and against neonatal circumcision tend to look at the issue from both an objective and subjective interpretation. Opponents of neonatal circumcision often characterize the practice as the morally suspect and abusive mutilation of an infant (Bertancourt, J.R Green, R.A & Carrillo, J.E, 2008).

Beoete (2008) states that the proponents of neonatal circumcision believe it is a prophylactic measure, the benefits of which justify any costs and risks. Similarly, Brenda (2009) states that many parents continue to choose circumcision for their new born sons even though statements by professional societies including the American Academy of Pediatrics do not recommend it routinely. Pollack (2007) postulates that circumcision is based on men’s domination of women of which by this procedure, the child is separated from his mother who does not have any authority over him any longer. This harms the child, for at this stage he needs his mother most and she cannot defend him, in spite of the fact that they are attached to one another at this early age. The knife that is pointed to the child is in fact pointed to the heart and soul of the mother. Pollack (2007) further argues that circumcision is not only an injury to the mother but also humiliates her since it implies that ‘Your authority over males is limited; moreover, this child belongs to the male community’. In this manner, the relationship between man and woman is disturbed and similarly the relationship between mother and child. The child’s separation from the mother is a preparation for his separation from her when he is recruited by the army (Pollack 2007)
The data which justifies neonatal circumcision suggests that there is a reduced risk of human immune deficiency virus infection in later life, penile cancer and urinary tract infection (Bailey & Halperin, 2008). Even if medical benefits are considered insignificant, religious and cultural factors cannot be ignored or minimized. Benator and Benator (2007) argue that the alteration of appearance of the penis after circumcision does not necessarily constitute mutilation. Providing detailed information to parents about medical risks and benefits does not appear to alter the rates of circumcision, the choice seemed to be made for non-medical reasons (Mehta, Moses. Agot, Odoyo-June, 2007).

A qualitative study done in Thailand on acceptability of neonatal circumcision concluded that though Thailand was a predominantly non-circumcising culture, neonatal circumcision was found to be acceptable to expectant parents if they were provided with the benefits and risks of the procedure (Ross D. A, Dick B. & Fergusson J. (Eds), (2006). This decision could help to reduce the risks of the next generation of males from HIV, other sexually transmitted diseases and other childhood diseases such as balanitis, urinary tract infections and phimosis (Westcamp N & Bailey R.C, 2007). In a study conducted in 2010 in Zimbabwe, Mavhu et al (2010) revealed that neonatal male circumcision knowledge (in terms of procedure, timing and benefits) was poor, particularly among women and health workers not involved in male circumcision. Knowledge and acceptability was high among parents from most ethnic groups

2.4 Acceptability of Male Circumcision

Studies have shown consistent result on the acceptability of Male circumcision. A review of 13 acceptability studies conducted in the nine Sub-Saharan African countries (Zimbabwe included) that do not traditionally circumcise found that the median proportion of uncircumcised men willing to be circumcised was 65% (West, Camp & Bailey, 2008).
Since the medical male circumcision trial results, several countries in the sub-Saharan Africa have started rolling out the programme at national level. However, a few countries have achieved substantial scale up of the circumcision services. Largade E, et. al. (2008) stated that the meanings and associations people attach to circumcision should be considered when designing programs and also to understand the meaning attached to traditional forms of male circumcision.

A study done in Mutoko in Zimbabwe which is a traditionally non-circumcising country found out that only 10% of men are circumcised (WHO/UNAIDS, 2011). There are small sub-populations of the Shona and the Ndebele people who may circumcise for religious or medical reasons. The Chewa tribal group of Malawi origin and Muslims who are mostly residing in towns, those circumcise for religious or tribal reasons. There are other small tribal groups like the Tonga, Shangani, Venda and the Fengu/Xhosa who circumcise for cultural reasons. (WHO/UNAIDS, 2010).

The results from the Mutoko study revealed that the Mutoko community was not a circumcising community and they had no term for the procedure, the participants expressed negative perceptions of traditional male circumcision, the Mutoko men believed circumcised men were born without the foreskin and were perceived as not complete. The majority of the men were said to be not familiar with male circumcision but upon being informed of its potential benefits by the study they expressed willingness to be circumcised (Khumalo, 2013).

A number of barriers to male circumcision have been noted in the acceptability studies and culture is one of them. Findings from the studies showed that cultural unacceptability is one reason that stops men from being circumcised (Bailey et al, 2008; Kebaabetswe et al, 2010; Lukobo and Bailey, 2008). The reason was that it was not within the participants’ culture to undergo circumcision. This view of culture is disputed by Lagarde E et al, 2008) study that concludes that culture might not be a significant barrier in the promotion of Male Circumcision as decisions are becoming more a matter of individual and family preference than of cultural identity. Hayden 2009 who defines health
behaviour as the total of all activities undertaken by an individual which influence their physical, mental, emotional, psychological and spiritual being concurs that male circumcision is more of an individual decision than community based with that in mind, one is left wondering what the truth is with regards to culture and circumcision.

Fear of pain during and after the procedure is reported as one of the reasons why men might not circumcise as indicated in studies that were conducted in Botswana and Zambia (Kebaabetswe et al, 2010; Lukobo and Bailey, 2008). This is also further compounded by concerns for safety which were universal in most of the studies conducted in the Sub Saharan Africa region (Kebaabetswe et al, 2010; Ngalande et al, 2008). The issues of safety are raised despite the procedure being declared a simple surgical operation which minimises complications (Rain-Taljaard et al, 2003; Ngalande et al, 2006; Lukobo and Bailey, 2008). In neonatal circumcision this fear is more pronounced.

The safety concerns were also raised in a study that was conducted in India on acceptability of male circumcision among mothers with male children. Agot et al (2007) concur with findings from the other African studies. They observe that when women were informed about the risks and benefits of male circumcision. A total of 81% of the 564 women said they would definitely circumcise their children if the procedure was offered in a safe hospital setting and free of charge. All these studies seem to point to the fact that a lot of work is needed to address the safety concerns before any meaningful improvement in uptake of the male circumcision services can be recorded, especially in formally non circumcising communities. Women were especially opposed to circumcision at the traditional initiation schools as they feared that their children could be injured or die during the process (Kimmel, D.C & Moody G.R, 2007).

Other findings from the acceptability studies seem to indicate that some men are willing to be circumcised if the service is to be provided affordably (Bailey et al, 2008; Kebaabetswe et al, 2009; Mattson et al, 2007; Scott, 2008; Lukobo and Bailey, 2007). However, empirical evidence contradicts this view. Despite most of the male
circumcision (MC) services for HIV prevention being offered for free in Zimbabwe, uptake has been generally low. The services are currently being bankrolled by donors and this goes for many other countries in the region.

There are some motivations for men to be circumcised which pertain to beliefs surrounding enhanced sexual pleasure (Scott et al, 2008; Ngalande et al, 2009; Lukobo and Bailey, 2007.). These findings concur with studies that were conducted in the Philippines (Montagu A, 2008). The findings seem to indicate that the circumcision allows men to have prolonged sex before ejaculation and results in greater satisfaction for women. The other reasons to circumcise include prevention of sexually transmitted infections (Rain-Taljaard et al, 2007; Kebaabetswe, 2010; Scott et al, 2005; Ngalande et al, 2006; Lukobo and Bailey, 2007.) Results from these studies are not easy to generalise because most of the samples used were not representative. For example, the study by Harlpem (2008) had a convenience sample of 100 men and 44 women. This was a small sample which is not generalizable to the South African population or other African populations. The results from the individual interviews and focus group discussions on circumcision preference were different and this calls for further study on group dynamics on results. The main limitation from Lukobo et al (2007)’s study is that it was conducted in only four of the 72 districts of Zambia and so may not be generalizable to Zambia as a whole.

Sawires S.R et al (2006) states that women would choose their partners to be circumcised because of the benefits, for example hygiene, protection from sexually transmitted infections, reduced pain during sex and sexual satisfaction. El-Houty, C. Khaul, (2007) echoes the same sentiments that older men also have the desire to give their female partners sexual pleasure hence the acceptability of male circumcision.

2.5 Male Circumcision and HIV Transmission

Gemmel, T. &Boyle, G.J (2008), suggested that the increased risk of infection in the uncircumcised may be the consequence of the foreskin presenting the penis with a larger surface area. It has been suggested that the moist interlining of the foreskin represents
thinner epidermal barrier than more confined outer surface of the foreskin and the rest of the penis, including the glans. The foreskin tends to trap and transmit micro-organisms, both to the man himself and his sexual partner. The presence of the prepuce is likely to result in greater micro trauma during intercourse, thereby permitting an entry point into the bloodstream for infectious agents.

Penile and vaginal sex has been the main mode of HIV transmission through sexual contact in genital ulcer disease (Muula, A.S, 2007). In southern Africa Male circumcision rates are low but HIV rates are high, male circumcision could reduce the burden of HIV (Fink A.J, 2010). A total of 13 Southern and Eastern countries with high prevalence, low levels of male circumcision and a generalized heterosexual epidemic has been identified by WHO as priority countries for male circumcision scale up (WHO 2010; UNAIDS, 2010)

Auvert et al (2013) conducted one of the first experimental studies to determine the efficacy of male circumcision in protecting men against HIV. The conclusion from the study is that Male Circumcision may provide a degree of protection against acquiring HIV infection. Whilst the study demonstrated that surgery can be used to prevent an infectious disease, it also had limitations. The study was conducted in one area in sub Saharan Africa and therefore, may not be generalizable to other places. Another limitation concerns the timescale of this study. Participants were followed up for a short period of time, and therefore, the study did not explore the long term protective effect of male circumcision.

Silverman (2011) found that male circumcision and HIV/AIDS have been linked since the emergence of the disease and not always positively, and traditional Male circumcision was largely mentioned in connection with the spread of the virus, due to the issue of using the same knife for the initiates. Today Male circumcision is mentioned largely in connection with prevention of the spread of HIV. Epidemiological and biological studies have provided compelling evidence regarding the protective effects of Male circumcision against heterosexual transmission of HIV. The foreskin which is removed is rich in HIV
target cells, Langerhans cells, CD4 T-cells including macrophages, therefore providing protective effect against HIV (El Hout & Khauli 2007).

Over 30 separate clinical trials research studies have shown that circumcised men are significantly less likely to acquire HIV through heterosexual intercourse than those men who are uncircumcised (Schoen 2007). Combined results from the three large randomised clinical trials confirmed that Male circumcision reduced the risk of heterosexual transmission of HIV by 63% (Schoen 2007; El-Hout, Y & Khauli, R.B) 2007; Bonner 2007).

WHO and UNAIDS (2008) recommended that Male circumcision should be included in the HIV prevention package as an additional prevention measure in HIV, in view of the compelling evidence from the three clinical trials. It is estimated that male circumcision could avert about 2 million new HIV infections and 300 000 deaths over the next 10 years (WHO 2010). Male circumcision has also shown to have other medical benefits including prevention of urinary tract infection, sexually transmitted infections, penile cancer and other dermatological infections of the glans penis (El – Hout & Khauli 2007). Bhattacharjee (2008) also concurs with Khauli 2007 that women whose partners have been circumcised are also said to have a reduced risk of developing penile cancer and unlike a vaccine that may need a booster, male circumcision is permanent.

WHO indicates that the rate of male circumcision should be increased from 50-80% and that the service should be extended to infants, early childhood and pre pubertal boys to adult men (Gruskin, 2007).
2.6 Research Question
What are the factors associated with the acceptability of Neonatal Male Circumcision among Mothers at Rutsanana and Hatcliffe clinics?

2.7 Main Objective
To identify factors affecting acceptability of neonatal circumcision based on the constructs of the Structuration Theory

2.8 Specific Objectives
1) To determine the interactions in relation to acceptability of neonatal male circumcision as a potential HIV prevention strategy.

2) To identify the modalities that lead to acceptability of neonatal male circumcision, among mothers of newborn baby boys.

3) To establish the level of knowledge on neonatal circumcision among mothers of new born baby boys

2.9 Theoretical Framework
Giddens’ theory of structuration will be used as the framework guiding this study. This theory was used by another scholar to investigate reasons for a low uptake in the adult male circumcision programme. Though not recorded, the theory managed to bring out the basic assumptions that were being investigated though it was from a sociological point of view. This theory also seemed appropriate for this study.

According to Giddens, society consists of social practices that produce and are reproduced across time and place (Kaspersen, 2007). Through social practices society is created and recreated constantly in a continuous structuration, Giddens continually argues that individuals shape reality through the decisions and actions they take (Kaspersen, 2007). Although social behavior may be guided by roles, norms and shared expectation, individuals perceive reality different according to their interest, motivation and culture or
where they come from. Therefore reality is created through human action (Giddens & Griffiths, 2008). The theory used in this research is a social control theory.

Theories on social control usually focus on societal structural organisation that facilitates harmonious co-existence and systems that ensure equilibrium by enforcing patterns of thinking and behaviour (Griffiths, 2008). Strauss, A & Corbin, J. (2008) describes social structures as the array of costs and benefits or opportunities that are available to the individual. These structures are held to influence behaviour by rewarding what is termed “appropriate behaviour” (Elder-Vass, 2010).

According to Elder-Vass (2010), the implication that structure and agency represent a binary choice that either behaviour is determined by an individual choice or external structural forces is rejected by many contemporary authors. Peter Blav argued for a dialectical social theory of which structure is said to be reproduced and transformed by the individuals in the course of social exchange (King, 2008). Anthony Giddens (2008), further states that this dualism has to be transcended if society wants to comprehend more adequately the complexity of modern society (Kaspersen, 2007).

There are a number of theories that have relevance to our understanding of the phenomenon under investigation. The decision to be circumcised or not to be circumcised may be an individual or societal-based. This therefore means our search for theories with explanatory validity to the issue of acceptability of neonatal male circumcision should cut across many disciplines.

2.9.1 The Basic Assumptions of the Theory of Structuration

The basic assumptions of the structuration theory are as follows;

1. Social life is not the sum of all micro-level activity but social activity cannot be completely explained from a macro perspective
2. The repetition of the acts of individual agents reproduce the structure
3. Social structures are neither inviolable nor permanent
4. The social structures constrain the actions of individual agents

15
5. Structure and action constrain each other in an evolving way

2.9.2 Constructs of the Structuration Theory
According to the structuration theory, a behavioral outcome, such as a mother’s decision to have a male child circumcised is determined by various factors or determinants. Some of these determinants include demographic characteristics, structure, knowledge, interaction and modalities. Giddens states that there are three levels of consciousness in which social practices occur, the discursive consciousness, practical and unconscious motives of cognition, the discursive refers to that which the person can verbalize or express in word on social conditions pertaining to their actions whether true or not.

2.9.3 Studies on the Structuration Theory
For the purpose of illustrating theory of structuration, Lukobo and Bailey (2007)’s study on acceptability of male circumcision for prevention of HIV infection in Zambia will be used. The study was conducted in four districts. Three of these districts contained groups that traditionally did not circumcise males. The findings indicated that nearly all the participants in non-circumcising districts expressed willingness to be circumcised or have their sons circumcised, if the benefits of Male circumcision were clear. The external agent would use information to change the traditional perception towards Male Circumcision. This information is processed by individuals who then decide to undergo circumcision although they traditionally are from non-circumcising communities. This is an illustration of agency.

Bourdieu (2010, Kaspersen 2007) also sees structure and agency as complementary forces. For him, structure influences human behavior and humans are capable of changing the social structures they inhabit. Giddens’ theory of structuration is critical to the understanding of people uptake of new innovations because it presents a human agent who is not as passive or at the mercy of the structures. This is contrary to views by macro-sociological theorists such as structuralists, structural Marxists and functionalists (Beoete, 2008). Kaspersen (2007) concurred and treated social facts as structures that are external to the individual and exercising a constraint upon the individual. The structural
functionalist perspective cannot account for the individual’s agency hence uptake of given services. Giddens’ theory of structuration seems to be the best theory in terms of explanatory validity to the phenomenon under investigation. Figure 1 overleaf illustrates the interrelations between the constructs of the structuration theory.

Structure, according to Giddens (2009) refers to rules and resources organized as properties of social systems. Since the structuration theory is a sociological one, the individual, who in this case is the mother, has an intimate relationship with society. Any social behavioral outcomes are therefore a product of the individuals (referred in the model as human agents) and the society. The structure therefore incorporates sub-concepts such as signification (for example the perceived significance of neonatal male circumcision), domination (the person who dominates in decision making) and legitimation (inferring the person who authenticates decisions as legitimate). In addition, the concept of structure is seen to influence the knowledge the individual possesses. In this study, the knowledge pertains to knowledge of the benefits of male circumcision, knowledge of culture, beliefs and religion regarding male circumcision. The level of knowledge in turn impacts on the decision to have the child circumcised.

Giddens (2009) contends that structure and interaction are a mutually constitutive duality. This means that the three dimensions of structure (signification, domination and legitimation) and those of interaction (communication, power and sanctions) are an integral part of each other and influence each other.

The means by which structures are translated into actions are called modalities, which are interpretive schemes, facilities and norms. These modalities can explain why and how interaction is affected. The dimension of “interpretive schemes” refers to production of meaning (for example a person with a white coat in the hospital has the role of a doctor).

Modality can be seen as the tool that make interaction possible and can be influenced along the way. The result is that social interaction, for example on communities, is influenced by structure and the three modalities interpretive schemes, facilities and
norms. The interpretive scheme translates structure into actions. To sum up, structure influences human behavior and humans are capable of changing social structures they inhabit. Modernity involves the disembarking of relations from local settings and their stretching against time and space (Kelly, Moore 2008). This is largely due to the fact that new methods of communications have replaced face to face relations of pre modern society (Kelly, Moore 2008). Giddens believes that modern institutions are different from all preceding forms of social order in respect of their dualism, the degree of which they undercut traditional habits and customs and their global impact (Karspesen, 2007). Giddens states “that the more tradition loses its hold, the more the individual is forced to negotiate life style choices among diversity of options” (Giddens 1995; 5). Customs and habits are no longer just accepted because of their old authority of tradition. Individuals have to make decisions in the context within which they find themselves in no longer strained by what their fore father did.

In the case of the phenomenon under study, there is already a culture in place. The value systems within this culture shape people’s attitude towards neonatal circumcision. For the social structure to change, individuals within society must be targeted. When general collectivity is reached among members then change occurs in the social structure. What happens is that agents (in this case NGOs and or individuals) try and infuse new value system into a structure. In other words, there is manipulation of the social structure by the agent. This manipulation influences behavior and in this case, can result in increased uptake of neonatal male circumcision services or non-uptake of the services.

2.10 Chapter Summary

Neonatal male circumcision is practiced worldwide. Research and arguments for and against neonatal circumcision tend to look at the issue from both an objective and subjective interpretation. Opponents of neonatal circumcision often characterize the practice as the morally suspect and abusive mutilation of an infant (Betancourt, J.R Green, R.A, &Carrillo, J.E, 2008). However, studies have shown consistent result on the acceptability of Male circumcision.
CHAPTER 3

RESEARCH METHODOLOGY

3.1 Study Design
An analytic Cross-sectional survey of pregnant women and mothers who had babies up to six months at Rutsanana and Hat cliff clinics was conducted. This study design involves collection of data and one point in time no follow up of subject. It was chosen because it provides data for comparison between exposure (information on male circumcision) and outcome (intention to circumcise), it measures association of variables. Exposure and outcome are assessed simultaneously. The advantage of this design is also that it is quick, conducted over a short period of time and inexpensive.

3.2 Research Question
What are the factors associated with the acceptability of Neonatal Medical Male Circumcision among Mothers at Rutsanana Clinic and Hatcliffe clinics?

3.3 Hypothesis
Mothers and pregnant women who have their partners circumcised are more likely to accept neonatal male circumcision than those whose partners are not circumcised.

3.4 Study Population and Setting
The study population was mothers and pregnant women at Rutsanana Clinic and Hatcliffe clinics. The two clinics are under the Harare city Health department, and they are busy clinics located in the high density suburbs. They are both polyclinics offering Maternal Child Health services and the Outpatients care. The two clinics made it possible to recruit an adequate and representative sample of pregnant women and mothers who had babies aged up to six months or less because of the services they offered.
3.5 Sampling Frame
The sampling frame was drawn each day from a register at the maternal child health from the number of new women (pregnant women and mothers) who had come to the clinic. Participants who met the sampling criteria were identified from the daily attendance register. The case files were reviewed for those who matched the eligibility criteria.

3.6 Sample Size Calculation
In the formula below, P is the proportion of women who attend the Antenatal clinic using the Botswana study as it has the same setting as Zimbabwe being situated in the SADC region and it has some similarities with and estimates which are close to the Zimbabwean situation. Their acceptability for neonatal circumcision was \( P = 0.63 \). Using the formula;

\[
n = \frac{Z_{\alpha/2}^2 \times P \times (1 - P)}{\Delta^2}
\]

Where \( Z_{\alpha/2} = 1.96 \)

\( P = 0.63 \)

\( \Delta = 0.0025 \)

\( n = 232 \)

Adjusting for the non-response rate, which was assumed that, 20% of the women chosen were going to refuse to answer? The adjusted sample size = \( 232 / 0.8 \)

A minimum of 240 participants was required for the study. The investigator had intended to recruit 50% of the sample from Rutsanana clinic and another at Hatcliffe clinic.

3.7 Sampling Procedure
Systematic random sampling was used. Every 3rd pregnant woman or mother who was attending the clinic for either antenatal or postnatal review was sampled. The average number of women per day was calculated based on the daily attendance register. This
value was used to define the systematic sampling interval of 3. The following formula was used;

\[
\text{Sampling Interval} = \frac{\text{total population in sampling}}{\text{Sample size}}
\]

3.8 Inclusion Criteria for Interviews
Women who were pregnant and booked at either of the clinics.

Women or mothers who were able to give consent.

Mothers of baby boys up to age six months

3.9 Exclusion Criteria
Mothers who were not able to consent to participate in the study

Women who were ill and are unable to attend the antenatal clinic

3.10 Inclusion Criteria for Focus Group Discussions
Women and men who were in the under - fives clinic not necessarily mothers of babies

Women and men who were able to give consent

3.11 Study Variables
The outcome variable in this study was acceptability of neonatal circumcision (willingness to get the baby circumcised)

The study factors in this study included the theoretical framework constructs shown in figure 1 below:
3.12 Data Collection Instruments

a) A structured questionnaire

b) Documentary review guideline

c) Focus group discussion guide

3.13 Developing the Questionnaire

A structured questionnaire was developed in English using the study variables (constructs) shown in Figure 1 above on the structuration theory adapted from Gideon.
(1984, 2009). The questionnaire included questions on demographic data of the parent, structure, interactions modalities and knowledge of neonatal circumcision.

The focus group discussion guide was developed using the same theoretical framework.

3.14 Pretesting the Instrument

The questionnaire and focus group discussion guide were translated and back translated for linguistic equivalence and conceptual content validity after which these were pretested for user friendliness and understanding of the questions. Corrections were made as indicated.

3.15 Data Collection Process

The investigator reported at each data collection site early on each data collection day before the clinic started. The eligible clients were selected and given numbers of which every 3rd woman was sampled and taken from the waiting area to a private room where the investigator explained the nature of the study to the eligible participants and the informed consent process. All question regarding the study and informed consent were answered to allay anxiety. The investigator asked the eligible participants to sign two identical consent forms. The participant remained with the other copy.

3.16 Focus Group Discussions

Two focus groups were held in this study. The groups were of mixed ages since it was difficult to separate participants. The mixing of age groups did not prevent some people from expressing their views. A wider range of information and reactions were obtained from such groups and this helped in coming up with meaningful programmatic strategies. In most of the cases, it was observed that one person’s viewpoint triggered another person’s thoughts leading to rich, insightful information. Since participants shared a common socio economic and demographic profile (living within the surrounding suburbs), they tended to get comfortable in each other’s company thereby increasing the openness of sharing information.
3.17 Ethical Considerations
Ethical clearance was sought from Joint Ethics Research Committee (JREC/322/13) and the Anonymity of the participants was ensured by using numbers, serial numbers were used for the questionnaire instead of names. Issues of privacy and confidentiality were assured to the respondents. The study ensured respect of persons. Research assistants were trained thoroughly to uphold the best standards during data collection and comply with the policies and procedures required to access the respondents.

Written informed consent was sought and obtained from the respondents. A standard informed consent form was designed. Each participant had the information in the informed consent form read and explained. The participants were informed that their participation was voluntary and they could exit the study without notice. Their exiting from the study would not interfere with their treatment. Upon understanding the information and agreeing to participate, each participant was asked to indicate their willingness to participate by signing on the form.

Face to face interviews were conducted in a private room to ensure confidentiality. All information collected was locked up in a lockable cupboard in the investigators office to ensure confidentiality. Raw data was be kept for two years after completion of the study for reference purposes on analysis then destroyed by shredding if there is no more need to get the raw data back. There was no major risk associated with the study.

3.18 Data Analysis
Data was checked for completeness. The data was cleaned and coded, entered into STATA version 8.1. Data analysis was based on descriptive statistical techniques including frequency distributions. Frequency distributions and cross tabulations (2 x 2) tables were generated and (odds Ratio) OR as well as 95% CI were be calculated to determine the associations between variables.
Univariate analysis was used and the Chi square test determined the independent association between each continuous or categorical study variable. Multiple logistic regression was used whereby a logistic regression model was used to assess whether any variable was significantly associated with willingness to get the baby circumcised. Variables were eliminated as necessary.

Bivariate analysis were also performed to study the association of each independent variables with the main outcome of interest (willingness to circumcise child or circumcised). Contingency tables were constructed for all the comparisons and chi square ($X^2$), and measures of association (Odds ratios) will also be calculated.

A significance level of 0.05 was used as a criterion to retain variables in the model. The strength of the association for remaining variables was assessed. The Odds Ratio and corresponding 95% confidence interval for each remaining variable was reported.

Data was put into tables of frequency distribution and proportions. To test the strength of association, Odds Ratio and 95% confidence Intervals were calculated. The independent association each study factor and acceptability of neonatal circumcision was tested using univariate analysis and the Chi Square test.
CHAPTER 4

RESULTS

4.1 Demographic Characteristics

A total of 258 participants were recruited from two clinics, Rutsanana and Hatcliffe clinics, in Harare. The two facilities are previous Voluntary Male Medical Circumcision sites for adults used by the Ministry of Health and Child care (MOHCC). Table 1 below shows the distribution of participants by clinic.

Table 1: Sites

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of participants n=258</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hatcliffe Clinic</td>
<td>117 (45.4)</td>
</tr>
<tr>
<td>Rutsanana Clinic</td>
<td>141 (54.6)</td>
</tr>
</tbody>
</table>

Table 2 below shows the distribution of participants by their demographic characteristics. The majority of the women selected for the study were married (93.4%).

Table 2: Summary of Socio Demographic Characteristics (N=258)

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>25.8(5.5)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>241 (93.4)</td>
</tr>
<tr>
<td>Not married</td>
<td>76 (6.6)</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>38 (14.7)</td>
</tr>
<tr>
<td>Secondary</td>
<td>200 (77.5)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>20 (7.8)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Formally employed</td>
<td>24 (9.3)</td>
</tr>
<tr>
<td>Informally employed</td>
<td>49 (19.0)</td>
</tr>
<tr>
<td>Not employed</td>
<td>185 (71.7)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>244 (94.6)</td>
</tr>
<tr>
<td>African tradition</td>
<td>10 (3.9)</td>
</tr>
<tr>
<td>Muslim</td>
<td>4 (1.6)</td>
</tr>
</tbody>
</table>
The youngest mother in the group was 16 years old and the oldest was 44 years. The group mean age was 25.8 years (sd = 5.5 years). The majority of participants, 241 (93.4%) were married and 200 (77.5%) attained secondary level of education. A total of 185 (71.7%) were unemployed. In terms of religion, the majority, 244 (94.6%) were Christians.

4.2 Prevalence of Male Circumcision

Table 3 below shows the prevalence of circumcision amongst partners of study participants was 23% and 8% for their sons.

Table 3: Prevalence of Male Circumcision (n=258)

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner circumcised</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>59 (22.9)</td>
</tr>
<tr>
<td>No</td>
<td>199 (77.1)</td>
</tr>
<tr>
<td>Son to be circumcised</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20 (7.8)</td>
</tr>
<tr>
<td>No</td>
<td>194 (75.2)</td>
</tr>
<tr>
<td>N/A</td>
<td>44 (17.0)</td>
</tr>
</tbody>
</table>

A total of 194 (75.2%) participants answered yes to the question on whether their sons were circumcised or not and 44 (17.1%) were either pregnant or did not have sons. Only 20 (7.8%) Prevalence of circumcision among son babies in the study was only 8%.

4.3 Factors Associated With Acceptance of Neonatal Circumcision

The data also allowed for prediction of a parent’s intention to circumcise. A predictive model was created to identify the key predictor of a parent’s intention to circumcise baby and the timing, age of circumcision which was consistent with policy makers or study criterion (circumcision to take place within 8 weeks of the child’s birth). The dependent variable was an ordinal variable timing when the respondent intended to circumcise newborn. “0” is a time within 8 weeks old and “1” when the baby is above 8 weeks old. From the 258 mothers who participated in the study, 65 (25.2%) accepted neonatal circumcision. The median age for circumcision was 24 months (2 years).
Table 4: Partner Circumcision and Son’s Circumcision Status (N=258)

<table>
<thead>
<tr>
<th>Son circumcised</th>
<th>Partner circumcision status</th>
<th>Circumcised</th>
<th>Not circumcised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>43</td>
<td>151</td>
<td></td>
</tr>
<tr>
<td>N/A (no son)</td>
<td>4</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 above shows the distribution of partner and son circumcision status of the women interviewed. Women with circumcised partners were more likely to have circumcised sons, OR=5.27, 95% CI (2.02-13.71) and this was statistically significant, p=0.001

Table 5: Factors Associated with acceptance of Neonatal Circumcision (N=258)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Accept neonatal circumcision</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>62</td>
<td>179</td>
</tr>
<tr>
<td>Not married</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>62</td>
<td>182</td>
</tr>
<tr>
<td>African tradition</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Moslem</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formally employed</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Informally employed</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>Unemployed</td>
<td>51</td>
<td>134</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>6</td>
<td>32</td>
</tr>
<tr>
<td>Secondary</td>
<td>53</td>
<td>147</td>
</tr>
<tr>
<td>Tertiary</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Number of male children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zero</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>One</td>
<td>21</td>
<td>82</td>
</tr>
<tr>
<td>Two +</td>
<td>10</td>
<td>53</td>
</tr>
<tr>
<td>Husband/partner Circumcised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>43</td>
</tr>
<tr>
<td>No</td>
<td>49</td>
<td>150</td>
</tr>
<tr>
<td>Ever had HIV test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>62</td>
<td>172</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Child circumcised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>43</td>
<td>151</td>
</tr>
<tr>
<td>N/A</td>
<td>17</td>
<td>27</td>
</tr>
</tbody>
</table>

Table 5 above shows factors associated with mothers, likelihood to accept neonatal circumcision. All the factors had a p-value of above 0.05 and that means none of them were significantly associated with acceptance of neonatal male circumcision.
Figure 2: Influence of Antenatal / Postnatal Information

Influence of Antenatal / Postnatal Information had on decision to circumcise

Majority of the mothers (70%) were given information on neonatal circumcision. Information on Neonatal Male circumcision that was given at antenatal / postnatal influenced almost 70% of the participants. According to the results displayed on Figure 2 above, 26 (26.7%) strongly agreed and 43 (42.6%) agreed with the statement. Nineteen (18.8%) were neither discouraged nor influenced by the information. Seven (6.9%) disagreed and 5 (5%) strongly disagreed with the statement that their decision was influenced by the information given.
4.3.1 Structural Issues Pertaining to Neonatal Circumcision

Table 6: Structural Issues pertaining to Neonatal Circumcision (N=258)

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of Neonatal Circumcision</td>
<td></td>
</tr>
<tr>
<td>Very Important</td>
<td>188 (72.9)</td>
</tr>
<tr>
<td>Neutral</td>
<td>44 (17.1)</td>
</tr>
<tr>
<td>Not Important</td>
<td>26 (10.1)</td>
</tr>
<tr>
<td>Decision maker on child circumcision</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>183 (70.9)</td>
</tr>
<tr>
<td>Grandparents</td>
<td>8 (3.1)</td>
</tr>
<tr>
<td>Myself</td>
<td>67 (26)</td>
</tr>
<tr>
<td>Who is listened to in the family on child circumcision?</td>
<td></td>
</tr>
<tr>
<td>Me</td>
<td>47 (18.2)</td>
</tr>
<tr>
<td>Father</td>
<td>201 (77.9)</td>
</tr>
<tr>
<td>Grandparents</td>
<td>10 (3.9)</td>
</tr>
</tbody>
</table>

Reference to Table 6 above shows that 188(72.9%) regarded neonatal male circumcision as being very important while 70 (27.1) were neutral or considered it not important. The fathers decision on neonatal Male circumcision was important as stated by the 183(70.9) percent of participant. 67(26%) regarded themselves as the decision makers on Neonatal Male circumcision. On who is listened to on the neonatal Male circumcision the 201(77.9) declared the father and only 10(3.9) nominated the grandparent of the child with 47(18.2) saying that their decision stand.
### 4.3.2 Knowledge on Circumcision

Results on knowledge on male circumcision are displayed on Table 7 below. Majority of the participants were hearing about Neonatal Male circumcision for the first time.

**Table 7: Knowledge on Male Circumcision (N=258)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical neonatal circumcision is the total removal of the foreskin of the baby</td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>66 (25.6)</td>
</tr>
<tr>
<td>Agree</td>
<td>125 (48.5)</td>
</tr>
<tr>
<td>Neutral</td>
<td>39 (15.1)</td>
</tr>
<tr>
<td>Disagree</td>
<td>14 (5.4)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>14 (5.4)</td>
</tr>
<tr>
<td>Medical neonatal circumcision protects the child from urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>65 (25.5)</td>
</tr>
<tr>
<td>Agree</td>
<td>123 (47.7)</td>
</tr>
<tr>
<td>Neutral</td>
<td>36 (14.0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>20 (7.8)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>14 (5.4)</td>
</tr>
<tr>
<td>Medical neonatal circumcision protects the baby from penile cancer</td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>62 (24.0)</td>
</tr>
<tr>
<td>Agree</td>
<td>113 (43.8)</td>
</tr>
<tr>
<td>Neutral</td>
<td>51 (19.8)</td>
</tr>
<tr>
<td>Disagree</td>
<td>18 (7.0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>14 (5.4)</td>
</tr>
<tr>
<td>Medical neonatal circumcision improves penile hygiene in boys</td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>88 (34.1)</td>
</tr>
<tr>
<td>Agree</td>
<td>122 (47.3)</td>
</tr>
<tr>
<td>Neutral</td>
<td>28 (10.9)</td>
</tr>
<tr>
<td>Disagree</td>
<td>12 (4.7)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>8 (3.1)</td>
</tr>
<tr>
<td>Medical male circumcision will protect the baby from HIV by 60% when they become adults and are sexually active</td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>82 (31.8)</td>
</tr>
<tr>
<td>Agree</td>
<td>120 (46.5)</td>
</tr>
<tr>
<td>Neutral</td>
<td>31 (12.0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>13 (5.0)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>12 (4.7)</td>
</tr>
<tr>
<td>Circumcision is more convenient when boys are young</td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>87 (33.7)</td>
</tr>
<tr>
<td>Agree</td>
<td>133 (51.6)</td>
</tr>
<tr>
<td>Neutral</td>
<td>21 (8.1)</td>
</tr>
<tr>
<td>Disagree</td>
<td>9 (3.1)</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>8 (3.1)</td>
</tr>
</tbody>
</table>
Reference to table 7 above indicate that 199 participants agreed/strongly agreed with the statement that neonatal Male circumcision is the Total removal of the foreskin, while 39 did not know and 28 disagreed/strongly disagreed with the above statement.

In terms of protection from urinary tract infection, 188 participants agreed/strongly agreed with the statement that Neonatal male circumcision protected male babies from urinary tract infection though 36 did not know and 34 disagreed/strongly disagreed that it protected the babies from urinary tract infection.

The Majority on the participants managed to answer the (6) knowledge questions correctly with a few answering neutral.

### 4.3.3 Interactions in Relation to Neonatal Male Circumcision

**Table 8: Interactions in Relation to Male Circumcision (N=258)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In your culture, is male circumcision acceptable?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>184 (71.3)</td>
</tr>
<tr>
<td>No</td>
<td>74 (18.7)</td>
</tr>
<tr>
<td>Whose recommendation do you value most on circumcising your son?</td>
<td></td>
</tr>
<tr>
<td>Doctor / Nurse</td>
<td>81 (31.0)</td>
</tr>
<tr>
<td>Friend</td>
<td>3 (1.2)</td>
</tr>
<tr>
<td>Maternal family</td>
<td>15 (5.8)</td>
</tr>
<tr>
<td>Paternal family</td>
<td>102 (39.5)</td>
</tr>
<tr>
<td>Spouse / partner</td>
<td>57 (22.1)</td>
</tr>
</tbody>
</table>

Reference to table 8: 184(71.3) participants stated that Neonatal Male circumcision was acceptable in their culture and 74(18.7%) said it was not acceptable. 102(39.5%) regarded the paternal family’s recommendation on male circumcision with 81(31.0%) regarding the Doctor/Nurse’s recommendation on neonatal male circumcision. Only 57(22.1%) would regard the spouse’s recommendation.
4.3.4 Modalities Influencing Neonatal Circumcision

Table 9 below shows the intention of parents to get their sons to be circumcised. A total of 222 mothers intended to circumcise their children at a public hospital or Spillhaus Clinic. Others planned to circumcise their sons at other private institutions.

Table 9: Modalities (facility for circumcision) influencing Neonatal Circumcision
(N = 258)

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In which facility would you take your child for circumcision?</td>
<td></td>
</tr>
<tr>
<td>Private clinic / private doctor</td>
<td>28 (10.9)</td>
</tr>
<tr>
<td>Public hospital/ Spillhaus</td>
<td>222 (86.0)</td>
</tr>
<tr>
<td>Not applicable (child already circumcised)</td>
<td>8 (3.1)</td>
</tr>
</tbody>
</table>

Is the chosen institution above influenced by economic circumstances?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>200 (77.5)</td>
</tr>
<tr>
<td>No</td>
<td>58 (22.5)</td>
</tr>
</tbody>
</table>

On the modalities influencing Neonatal Male circumcision, the facility that was chosen by the majority of participants was Spillhaus Center which is already offering the adult male circumcision for free and is a public/private clinic that provides Family planning services. Only 28(10.9%) chose the private doctor/clinic and 8 had already circumcised their children hence they responded as not applicable.

4.3.5 Knowledge Levels on Neonatal Circumcision

A catalogue of six questions measuring knowledge levels on a 5-point Likert scale from strongly agree (5), to strongly disagree (1) were considered. These were summed up to give a score out of 100. A score below 80 was considered below adequate knowledge level and a score of 80 and above was considered adequate knowledge level. Using the scores the knowledge levels for the study participants are displayed in table 10 below:
Table 10: Neonatal Circumcision Knowledge Levels (N=258)

<table>
<thead>
<tr>
<th>Knowledge level</th>
<th>Number of participants, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate</td>
<td>160 (62.0)</td>
</tr>
<tr>
<td>Inadequate</td>
<td>98 (38.0)</td>
</tr>
</tbody>
</table>

4.3.6 Relationship between Acceptance of Neonatal Circumcision and Neonatal Circumcision Knowledge Level

Table 11: Relationship between Acceptance of Neonatal Circumcision and Knowledge Level

<table>
<thead>
<tr>
<th>Neonatal circumcision knowledge level</th>
<th>Accept neonatal circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Adequate</td>
<td>48</td>
</tr>
<tr>
<td>Inadequate</td>
<td>17</td>
</tr>
</tbody>
</table>

Table 11 above shows that there was a significant association between acceptance of neonatal circumcision and knowledge level. Those with adequate knowledge levels were more likely to accept neonatal circumcision (OR=2.04, 95% CI; 1.10-3.80), and this was statistically significant, p=0.025

4.4 Qualitative Results

They were three main themes that directed the focus group discussions the Social constructs that is beliefs and culture and also the knowledge on HIV and Neonatal circumcision and Modalities of neonatal male circumcision
Table 12: Distribution of FGD participants by Age Gender and location

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Place where FGD was conducted</th>
<th>No of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 years to 30 years</td>
<td>mixed</td>
<td>Hatcliffe clinic</td>
<td>5 females and 5 males (10)</td>
</tr>
<tr>
<td>30 years and above</td>
<td>mixed</td>
<td>Hatcliffe</td>
<td>6 females 4 males (10)</td>
</tr>
<tr>
<td>19 years to 30 years</td>
<td>mixed</td>
<td>Rutsanana clinic</td>
<td>3 females and 8 males (11)</td>
</tr>
<tr>
<td>30 years and above</td>
<td>mixed</td>
<td>Rutsanana clinic</td>
<td>6 females and 4 males (10)</td>
</tr>
</tbody>
</table>

There were four focus group discussions, two from Rutsanana clinic and two from Hatcliffe clinic. Forty one people took part in the focus group discussions. Information of Neonatal male circumcisions is still not well disseminated despite that there was another study which was done in 2010. Information on adult Male circumcision has been well disseminated in the media and verbal information from the campaigns which have been conducted since 2009.

4.4.1 Knowledge on HIV and Male circumcision

Several participants knew information on HIV, the community still uses the words like Utachiona, Muzvwezve and HIV. Information on preventing transmission of HIV was named correctly they talked of condoms abstinence and some even went on to say rumours say that:

“If one is on ARV the chances of them transmitting HIV are slim”.

On benefits of Male circumcision the answers which were given were:
Shona ‘vamwe vanenge vachiti zwakaipa vachifunga kuti ganda rinochengetedza kuti vasabate tsvina uye vasabate hutachiona’. 24 year old man said (English) Some say it is wrong to circumcise as the fore skin protects the penis from dirt and sexually transmitted diseases).

These were some of the answers on thoughts behind male circumcision. Some were saying it is not in our culture so it’s something that needs a lot of thinking because it is a permanent decision and cannot be reversed once it’s done, a 40 year old man asked if one could have their foreskin back if after circumcision they realized that they want it back, what the authorities would do. This brought laughter but the man was not moved.

Shona, “Mumwe anoti nezera rangu ndochekwa ndovigwa imwe nyama yangu ndiri mupenyu ndinopenga here” those were the sentiment of a 43 year old man from Hatcliffe clinic.

English: One would say that at my age I cannot be cut and have part of my flesh buried when I am still alive. The other young man said that they hear that circumcision protects one from contracting HIV from an HIV infected female but reduces sexual pleasure as the head the penis is constantly rubbing against the underpants and loses sensitivity, hence the foreskin is there to increase sensitivity that brought a lot of debate as the group could neither agree or disagree with the young man. The older men in the group agreed with him and went on to say that one can becomes impotent after the circumcision. A younger man in the group was brave to come up and say he was circumcised and he was very happy and he was now taking longer to ejaculate unlike before.

4.4.2 Social Constructs, Interactions related to male circumcisions
Women discussed male circumcision because they wanted to understand it as during campaigns they do not get much time to ask questions mostly because the nurses and doctors usually deal with men. They highlighted that they are allowed during group discussions and Neonatal Male circumcision has never been discussed and as this is new information they needed to discuss with their partners on how to handle it. They also said men are afraid of the unknown hence one will only go if someone they know testified that they had gone through it themselves and then recommend the procedure. There is still uncertainty on the outcome of Male circumcision.
“Men have never tolerated pain even though they are thought to be brave imagine the bigger part of your body being cut, people do not know how important a penis is ask a man, a man with no penis is not a man what woman will want you when you cannot get it up”

The participants were in agreement that if circumcision is done when is young it is better as one will never know or remember the pain. They also went on to say that a small part of the body that makes a man and that boys when they are young they discuss even the sizes and compare in the toilets when urinating.

The issue of abstinence was also a concern one man stood up and said:

“I have had sex since I don’t remember when and u expect me to stay six weeks without I can’t even stay a week what more six weeks u guys are not serious”

There was a murmur of agreement though one young man whose wife had just delivered said he timed his circumcision with the delivery as that made it easier for the couple while the wife was nursing her episiotomy he was nursing himself, though he highlighted that erections still come because the thought of sex when one is sleeping with a woman is inevitable and contact did not help the situation but the erections subsided as he diverted his thoughts or emptied his bladder. He actually encouraged the group members to join him. The women in the group were not in agreement with men on issues of abstinence as they felt that they too abstain soon after delivery for the same duration:

“We abstain after delivery to six weeks and we do sits’ baths and we do not complain if they go through the same then they will understand labour and why would a man think of sex when he has a wound they will concentrate on getting better as we will be doing during that time”.

The other women agreed that men should not worry about abstinence as it would be once in their lifetime and they do it all the time delivering their babies. The young women were worried about sex after their partners went for Male circumcision and one lady said that a circumcised penis was good to look at as it is clean and one does not have to worry about offensive smells and discharges from other women, she went on to say it is easier to see whether he has a sexually transmitted disease or not.
On the advantages of neonatal male circumcision the one participant from the Muslim community was happy that it was being introduced as it is in their religion and he said for them it was so natural and uncircumcised penis was not good to look at. He went on to say they were finding it difficult to access the service as during the campaigns the children were being turned away as the policy of the Ministry of Health and Child care says 13 years and above. He also said they now had agreement with a local doctor who is only doing from 6 years old which still left the smaller ones with problems.

Shona “‘Mwana anogara akachena uye nhengo yake haizwo kuvare mai vachiyedza kuyivhura kana vogeza mwana’”said a 28 year old mother of two boys.

English: A child will always remain clean the mother does not have to struggle to clean the penis when bathing the child

“Vamwe vanogona kunzwisisa kuti vanenge vagadzirira mwana wavo zwakwakwana nekuti ponde rinongoitwa nengo yakavhurika” 30 year old man.

A young lady also agreed with the other saying that a mother would want to get his son circumcised so that the child is clean all the time and there is no need to open the foreskin to clean it as that traumatizes the baby. The tradition that some women follow of opening the foreskin and expressing milk on the penis will not be necessary for those practicing it as the penile head will be exposed although the reasons for doing it could not be clarified.

Other reasons for circumcising babies were that the child will have no urinary tract infections, although one participant was not in agreement as she said what if the child is not able to have a  erection in future when he is sexually active she will feel responsible. She went on to say it is better if the child is grown up and decides for himself she also felt that it is selfish to bring the HIV fight to innocent children while grown up men continued spreading the disease. Other participant went on to say that Male circumcision is for adults as they know the gains of being circumcised.
Others were concerned with pain as a child many not be able to communicate and mothers were saying that babies cry a lot imagine if he is in pain it will be worse for the mother. However the other mothers, begged to differ as they said a child may not feel pain like an adult and the wound will heal like the umbilical stump, they will be no sex interruption as the baby is not sexual active, no missing of school, the child will not run around showing others his penis and he is small and is with the mother all the time. , Chances of infection are slim as the mother will be the sole provider for the baby. One mother highlighted that when the boys are older they always want to run around increasing chances of bleeding and infection and they are not easy to convince to go for circumcision.

Another participant a lady said when a man is older the skin becomes harder and the penis gets bigger and there is increased blood supply so the adult penis is prone to increased pain than that of a child and chances of bleeding are high as there is increased blood supply and the circumference being cut is bigger than a child’s, so the men will experience severe pain cause of the above reasons. Others feared that the baby’s penis may be castrated as it was small.

One older man said

“Imagine a 40 year old man going back to hospital and seeing nurses trying to explain that he is experiencing pain and exposing his penis to those nurses to inspect lets be serious it’s not easy’’

There was agreement that it is not easy for an adult man to expose his manhood which is not diseased to other people and certainly not to women except if one has a problem and they need help. If it is a baby then it is ok as he will not be embarrassed to open up his fly to show his manhood. The mothers all greed that they needed more information on the procedure. The community will need to be educated on the importance of Neonatal circumcision as this was a new concept that they had just heard. They went on to agree that it is easier said than done as a child was not a mother’s alone:
“Shona “Mai vanogona kutya kuti mwana akazotambudzika pabonde akura hama dzinoti ndimi makachechewudzisa mwana zvisiko kudzinzaravo”

If she goes ahead to get her son circumcised she may get into trouble with in-laws even if not married. As long as it is not in one’s culture issues may arise.

One mother said only the partners (fathers) are able to make the final decision in Male circumcision and they need to discuss that before the mother is delivered when she is still pregnant as discussion after the delivery may delay the decision and takes longer for the child to go through the procedure.

4.4.3 Other Modalities of Neonatal Male Circumcision

The mothers highlighted that if the services were free and done while they were still at the hospital during confinement and there was no added cost to coming for the procedure it was welcome. The mother had issues with coming back after they got discharged from the hospital because some had come as referrals from nearby health centers hence staying with relatives.

Some of the mothers were not worried as they say they are taught on how to care for the umbilical stumps so they were sure that they will be shown how to care for the circumcised penis too. One mother was worried about the baby waste contaminating the site and she went on to say importance on the care of the site was very important. The mothers also went on to say that caring for the baby would be easy as every mother instinctively would want to protect their baby, and if they were given paracetamol that would make it easier as the adults are given pain killers for free. Distance from the clinic would affect them except if mobile clinics are provided, or if the visits are such that it coincides with the scheduled clinic visits as anything outside that would prove costly in term of money and time.

On the service being integrated in the routine childhood activities like vaccination the mothers highlighted that men should be informed as marriages may be in trouble with women being divorced if the men do not believe in it, they added that the women’s
forum, men’s Padhare and other men’s organizations should be sensitized for the programme to succeed, to avoid home deliveries as mothers will be running away from the procedure,

“’The issue of male circumcision is a men’s issue as it touches on their manhood and man are sensitive to it”.

Donnelly Nyoni R088211X
CHAPTER 5

DISCUSSION

5.1 Discussion

The culture of Male circumcision in Zimbabwe is not well understood and Neonatal Male circumcision being a new concept except in the small Muslim communities that are mostly found in the olden suburbs. This service has not been offered in the public institutions and is still to be and the Government is working towards the millennium goals zero discrimination, Zero new infection and Zero AIDS related deaths. This is set to be accomplished through universal access to effective HIV prevention, treatment, care and support (UNAIDS 2010). The Global UNAIDS report continues to say that prevention must include combinations of behavioral, biomedical and structural responses. Male circumcision is one of the tools proposed to expand effective prevention and neonatal Male circumcision is also going a long in preventing new infections (UNAIDS 2010).

The findings indicate that none of the demographic factors were significantly associated with acceptance of neonatal male circumcision. The findings are in line with the sentiments of Gidden’s theory that, all human action is performed within the context of apreexisting social structure which is governed by a set of norms and or laws which are distinct from those of other social structures (Kelly, Moore 2008). However, the structure and rules are not permanent and external, but sustained and modified by human action in what are termed reflexive feedbacks. In other words, social structures make social action possible and at the same time that social action creates those very structures. The balance between agency and structure is reality created through human action, (Kaspersen, 2007).

Campaigns had been running during school holidays in both clinics and country wide hence the participant had information of Circumcision. The perception of the respondent’s partner appeared to be the important determinate in whether the child would
be circumcised or not. Without the consent the likelihood of the child being circumcised would be low.

The finding of the survey showed that participants were willing to get their baby boys circumcised but when they were older with a high percentage advocating for above a year old. These findings were consistent with findings from other studies for example a study of Male circumcision acceptability done in Jamaica, Melonie, Nalcort, & Puline (2013) revealed that the parents were mostly willing to have their sons circumcised if they were above a year old.

The interactions in relation to acceptability of neonatal male circumcision included that the popular dancehall musician was circumcised and the young group wanted to be identified with him and Pinda Musmart featured as the most common word used during the campaign and they agreed that yes the man feels smart though pain is involved. The abstinence from sexual activity was another concept related to male circumcision of which older men in the group were not happy about and that made them advocate for neonatal male circumcision. One men in the group said that it is easier if it was baby as issues of sexuality do not come into discussion and the group agreed with him.

On the same question the older men from the Muslim community said that he was born circumcised which brought laughter from the group and he was adamant about it was then explained to him that if a baby is circumcised as it is in their culture he would think the same way only if parent would explains to him, he highlighted though that he had not seen a child born without the fore skin he also believed it is better than as if it happened to him he does not remember any pain or bleeding as was young.

A question from the guide was posed on the issue of what would make a mother not get his son circumcised; the participant highlighted that if one was a single mother nothing would stop her as the decision lied with her and her parents she might ask for their opinion if they were Muslims they would readily agree. For those who were Christians or did not have it in their culture they would not find it easy as that is a big decision as the child is not for one person, these phenomenon was pressed upon by Griffith 2008, who
stated that theories view individuals as possessing the power to make choices pertaining to their lives autonomously, hence the society influences rather than direct individual action. For the mother who was married the husband and his family played a big role in giving permission for circumcision especially if the husbands’ family did not believe in circumcision that was highlighted as a barrier. The participants went on to say that it would have been easy if it had been discussed before the birth of the child as that would make it easier on timing, but if discussed after the child’s birth the decision could take longer. Another participant also agreed with the above sentiments although then he said if the partner was circumcised in the programme it would make the decision easier for the mother.

From the descriptive results it emerged that 184 participants who were interviewed agreed that male circumcision was acceptable in their culture and they valued the paternal side of the family or father of the child on recommendation for circumcising their sons. The qualitative results also brought out the same results that interactions among men could lead to acceptability of neonatal male circumcision. The participants believed that one had to consult the older men in the family as the consequences of circumcising the child without their consent may be grave leading to split marriages or child being a cast away if the father or family does not believe in it.

The father’s circumcision status was also a positive influence to neonatal male circumcision. In fact, the present study results showed women with circumcised partners were more likely to have circumcised sons, OR=5.27, 95% CI(2.02-13.71) and this was statistically significant, p=0.001.

A study that was done in Kenya expressed similar sentiments. Mbito, M.N & Maniaja (2008), revealed that in Kenya, a father’s circumcision status was associated uptake of Neonatal Male circumcision. Social acceptability of neonatal circumcision among fathers or partners who were circumcised was also found in a study, the results also concurred with results of a study done in Saskatoon Sask region done by Ross D.A, & Dick B
(2006) and Rosenblatt P.C & Fisher (2008) it revealed that the new born circumcision rates continue to be heavily influenced by the circumcision status of the child’s father.

The fear of bleeding from the site, this to a larger extent mirrored findings from surveys from the acceptability of adult male circumcision with an example from the study done in the Nyanza province in Kenya were the strongest predictor of circumcision preference was related to the perception that the procedure was painful (Bailey, R.C, 2008). In reality from a medical perspective, neonatal male circumcision is a safe and simple procedure and does not yield comparable levels of pain or complications associated with adult circumcision. In another study from Zambia a neighbor to Zimbabwe neonatal Male Circumcision has been implemented as a long term prevention strategy for HIV, it was reported that the acceptability of neonatal male circumcision is challenged by a fear of negative outcomes, concerns about pain and issues involving culture identity (Lukobo, M.D & Bailey R.C, 2007). In a study done in Mutoko Zimbabwe and Vulindlela South Africa, the vulindlela participates also highlighted that if they were assured of safety and reduced pain after the procedure they were willing to adopt the medical neonatal and male circumcision (Khumalo- Sakatukwa, 2013)

The issue of HIV testing was discussed. Some participants stating that one could have their HIV test elsewhere to avoid embarrassment of being turned away.

When the groups were asked about the influences from organizations or institutions the response was in line with what Giddens & Griffiths (2008) postulated, ‘the more tradition loses its hold the more individuals are forced to negotiate lifestyle choices among diversity of options” Customs and habits are no longer merely accepted because of the age –old authority of tradition. The group maintained that male circumcision while it was traditional for other it was an individual choice for older men and a community choice for younger people as they needed consent for them to be circumcised. The participants also stated that groups like paDhare/ Enkundleni men’s forum and youth group, traditional leader in the rural communities and church leaders could go a long way in explaining this new concept to parents as well as young man. In Zimbabwe it has been seen the Members
of parliament Spear heading the campaigning for Medical Male circumcision, which shows how much the Government, is involved in making it work.

5.1.1 The Modalities in Relation to Acceptability of Neonatal Male Circumcision

The majority of participants were willing to take their sons for circumcision to facility that offered free service. The present findings concur with those from a study in Mutoko by Khumalo (2013) which revealed that men were likely to take up services if they were free. The issue of cost was also highlighted in the focus group discussion. The majority of the participants favored the clinical setting and this finding is positive for the policy which requires a clinical setting for neonatal male circumcision to be carried out successfully.

The participants of the Muslim community also highlighted that for them they would encourage their women to go for it as that would reduce cost of going to their doctors when the child is older, with the economic conditions their children had missed the 8th day which was stipulated hence they were having problems accessing circumcision for their sons during the campaign as they are told that it is for those above 13years though some of their sons as your as 8 have accessed it due to an understanding but it was difficult for those below that age. He went on to say he hopes that when the program me starts for neonatal male circumcision they will include age groups up to 8 years old.

5.1.2 The Level of Knowledge in Relation to Acceptability of Neonatal Male Circumcision

The study revealed that there was a significance association between acceptance of neonatal male circumcision and knowledge level. Those with adequate knowledge were twice more likely to accept neonatal male circumcision with (OR=2.04, 95% confidence interval) and this was statistically significant at p value = 0.025. Khumalo and Sakatukwa (2013) in their study in Mutoko and Vulindlela they found that the majority of men in Mutoko were not familiar with circumcision and its benefits but after they were informed of its potential benefits by the study interviewers they expressed willingness to accept
Male circumcision. Giddens (2008) refers to agency as the capacity of individuals to act independently and to make their own free choices. The expectations from the traditionally non circumcising communities are such that people would not be circumcised but individuals were willing to be circumcised and circumcise their sons after they were given the potential benefits of the procedure. This was breaking the norm and the theory of structuration allows for this.

On the question of Male Circumcision and HIV both groups where not sure of the link though they had been given information that it reduced chances of contracting HIV the forum was then used to explain the randomized controlled trials and their findings that HIV was reduced by 60% and the use of condoms consistently and correctly increased the percentage of protection.

The issue of stigma in Male circumcisions was highlighted if one is turned away it becomes apparent that everyone would think one is HIV positive since it is said the programe is for those who are negative as it is of no benefit for those who are positive. In the study done by Mavhu & Karin (2010) on neonatal male circumcision the results also revealed that there were very low levels of knowledge or experience in the procedure though the acceptability was high in that study though the definition of age of acceptability was not stated. The statement about age was that the participant generally felt that neonatal male circumcision should be done three to six months after birth which differs from the result of this study where parent were comfortable after a year.
CHAPTER 6

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

All participants thought male circumcision for infants and young boys was the best. A total of 75% preferred circumcision above the age of one year while 25% agreed that they favored the policy of circumcising babies within 8 weeks of delivery. This was because it was thought to be less painful and recovery was faster the younger the individual. In terms of policy that could be challenging as neonatal circumcision is best done within 8 weeks of birth.

Most respondents were aware of the benefits of neonatal and male circumcisions a form of HIV/AIDS prevention strategies, but education aspects should emphasize more on the immediate benefits of a circumcised child in reducing the risk of urinary tract infection, phimosis and paraphimosis as most of the defendants have deferred the decision to circumcise their new born to a later stage. This goes against the objective of the neonatal male circumcision.

Knowledge on neonatal male circumcision should continue to be disseminated to the people especially during campaigns for the adult male circumcision for the parent to appreciate it and mostly targeted to male as they are seen in the fore front of giving the consent for the procedure for their son.

Finally, we failed to reject the study hypothesis. The study findings supported the hypothesis that women with circumcised partners were more likely to have circumcised sons [OR=5.27, 95% CI(2.02-13.71)] and this was statistically significant (p=0.001).

6.1 Recommendations

1. Social mobilization and evaluation is critical to successful neonatal Male circumcision campaigns as well as continual assessment of local knowledge and attitudes towards Neonatal male circumcision as attitude and knowledge revolve over time
2 Correct communication messages on neonatal male circumcision and male circumcision are critical.

3 National communication strategies need to ensure that clear and consistent messages are disseminated and that neonatal male circumcision is promoted within the context of comprehensive HIV prevention strategies. The message should be carefully tailored so that issues such as the stigma that comes with not getting the cut and assumption that one is HIV positive are dealt with.

4 Given the importance of the parent’s consent in deciding whether to circumcise a baby it is very important for the education and promotion process to include both mother and father of child.

6.2 Limitations
The study recruited participants from two study sites and they might not be representative of the whole population.

The instruments used for data collection were developed by the investigator and used for the first time in this study. Although the instruments were developed from literature to increase content validity, there is a possibility of threats to reliability since the instruments did not have psychometric tests.
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APPENDIX A

QUESTIONNAIRE

My name is Donnely Nyoni. I am a student at the University of Zimbabwe. I am studying towards a Masters in Clinical Epidemiology. To fulfill the requirements of my studies, I am carrying out a research on acceptability of neonatal circumcision at the postnatal clinic.

In the questionnaire I’m kindly seeking information on how you perceive neonatal circumcision. The information obtained is going to be used only for this study and will not be published elsewhere. Please answer truthfully.

Please do not write your name on the questionnaire. When you have answered, please hand it to the interviewer.


Section A: Demographic Data Chikamu Chekutanga: Nhoro wondo ye Mubvunzi

In this section I am going to ask questions about yourself. Please answer truthfully. You are also asked not to write your name on this paper.

1. How old are you? ................. Mune makore mangani? .................

2. What is your marital status? Single □ married □ divorced □ widowed □
   Makamira sei panyaya dzewanano? Handisati ndawanikwa □
   Ndakawanikwa □ Takarambana □ Ndakafirwa □

3. What is your level of education? Nil □ primary □ secondary □ tertiary □
   Makadzidza kusvika papi? Handina kuenda kuchikoro □ Puraimari □
   Sekondari □ Kukoreji □

4. What is your employed status? Unemployed □ formally employed □
   informally employed □
   Makamira sei panyaya dzekushanda? Handishandi □ Ndakabairwa chitupa □
   Ndinozvishandira □

5. How many male children do you have? ......................................
   Mune vanakomana vangani? Mumwechete □ Vaviri □ Vatatu □ Vanopfuura
   vatatu □

6. What is your religion? Christian □ Moslem □ African Tradition □ Other
   (specify) □
   Chitendero chenyu ndechipiri? Chi Kristu □ Chi Moziremu □
   Chivanhu □ Chimwewo (Chidome)..........................................

7. Is your husband/boyfriend circumcised? Yes □ no □

Ndinokumbirisa kuti musanyore zita renyu pagwaro rino retsvakurudzo. Kana mapedza
munokumbirwa kuti mupe gwaro iri kune muongorori.
8. Have you had an HIV test in your life?   Yes □   no □

Muupenyu hwenyu mati mamboongororwa ropa kurariswa HIV here?
Hongu □  Kwete □

9. If your answer is “yes” to question 8 above, what was the result of your most recent HIV test?   Positive □   Negative □   Did not collect   □   Not applicable (Never been tested for HIV)

Kana mati Hongu kumubvunzo wepfumbamwe  uri pamusoro apo, ropa renyu rakawanikwa rakadini pamakapedzisira kuongororwa?

Riine hutachiwana hwe HIV □   Risina hutachiwana hwe HIV □   Handina kudzokera kunoudzwa zvakabuda mungororo yeropa rangu □
Handisati ndamboongororwa ropa □

10. Was this baby’s pregnancy booked?   Yes □   no □

Pamuviri pemwana uyu pakange pakanyoreswa here?   Hongu □  Kwete □

11. Where was this baby delivered?   Hospital □   Clinic □   Home □
Other (specify)______

Mwana uyu akasunungukirwa kupi?   Kuchipatara □   Kukiriniki □   Kumba □
Kumwewo (kudome)______

12. Were you given information on male medical neonatal circumcision?  
Yes □   No □   Do not remember □

Makapihwa ruzivo here maererano nekuchecheudzwa kwevanakomana vachangovarwa kunoitwa neveutano?   Hongu □  Kwete □  Handitonderi ndichipihwa □

13. Who gave you the information on neonatal circumcision?  Tick all that apply
i) Nurse (Midwife) □  ii) Nurse aide □  iii) Doctor □  iv) Counselor □  v) faith healer □  vi) Nobody

Ndiani akakupai ruzivo urwu?   Isa mucherechedzo pane vose vakakupa ruzivo urwu.
14. To what extent do you agree with the following statement?

*Information given to you at the antenatal /postnatal clinic influenced your decision on circumcising your son?*

- Strongly agree □
- Agree □
- Neutral □
- Disagree □
- Strongly disagree □

*Munobvumirana zvakadini nechirevo chinotevera?*

*Ruzivo rwamakaphwa kukiriniki rwune chekuita nesarudzo yandakaita iri maererano nekuchecherdzwa kwemwanakomana wenyu*

- Ndinonvumirana nazvo zvakanyanya □
- Ndinobvumirana nazvo □
- Ndiri pakati nepakati □
- Handibvumirane nazvo □
- Handibvumirane nazvo zvachose □

Section B: Structural Issues Pertaining to Neonatal Circumcision

15. How important is the idea of having your child circumcised?

- Not Important □
- Neutral □
- Very Important □

*Zvakakosha zvakadini kwauri kuti mwana wako achecerdzwe?*

-Hazvina kukosha □
-Zvakakosha zviri pakati nepakati □
-Zvakakosha zvikuru □

16. Who in your family has the final say regarding having the child circumcised?

- It is me □
- Its the father □
- It is the grandparents □

*Ndiani wemumhuri menyu anopa mvumo yekuti mwana achecheredzwe?*

- Ndini □
- Ndibaba vacho □
- Ndumbuya/sekuru vacho □

17. In your family, whose decision is listened to when it comes to having the child circumcised?

- Mine □
- The father’s □
- The grandparents’ □

*Ndiani wemumhuri menyu anonyanya kuteerewa kuti mwana achecheredzwe?*

- Ndini □
- Ndibaba vacho □
- Ndumbuya/sekuru vacho □
Section C: Knowledge on Circumcision / Chikamu Chechipiri: Ruzivo Maererano Nekuchecheudzwa

In this section I would like to find out how much information you have on neonatal circumcision. Please answer questions 18 to 25 by indicating the extent to which you agree with each of the following statements. The information obtained is very important. Please answer as honest as possible by ticking an appropriate box for one most applicable response to each statement.

**Muchikamu chino, ndiri kuda kuona kuti mune ruzivo rwakadini maererano nekuchecheudzwa. Ndarutira pindurai mibvunzo yegumi netsere kusvika pamakumi maviri neshanu nekuisa mucherechedzo pakunangana neudzamu hwekubvumiana kwenyu pachirevo chimwe nechimwe. Ruzivo ruchawanikwa muchikamu chino rwakakosha zvikuru. Naizvozvo ndarutira pindurai mibvunzo zvakatendeseka muchiisa mucherechedzo mubhokisi rimwechete rakakodzera pachirevo choga choga.**

18. Medical Neonatal circumcision is the total removal of the foreskin of the baby.

   **Strongly agree □        Agree    □        Neutral □        Disagree   □        Strongly disagree  □**

   *Kuchecheudzwa neveutano kunoreva kubiswa ganda rose rakafukidza kumuromomo kwenhengo yechirume yemwana.*

   **Ndinonvumira nazvo zvakanyanya □   Ndinobvumirana nazvo □      Ndiri pakati nepakati □        Handibvumirane nazvo □        Handibvumirane nazvo zvachose □**

19. Medical Neonatal circumcision protects the child from urinary tract infections

   **Strongly agree □        Agree    □        Neutral □        Disagree   □        Strongly disagree  □**

   *Kuchecheudzwa neveutano kunodzivirira mwana kuutachiwana hwenhengo dzemwana dzinorasa mvura*

   **Ndinonvumira nazvo zvakanyanya □   Ndinobvumirana nazvo □      Ndiri pakati nepakati □        Handibvumirane nazvo □        Handibvumirane nazvo zvachose □**

20. Medical Neonatal circumcision protects the baby from penile cancer

   **Strongly agree □        Agree    □        Neutral □        Disagree   □        Strongly disagree  □**

   *Kuchecheudzwa kwevana vachangozvarwa kunodzivirira mwana kugomarara renhengo yemwana yechirume*
21. Medical Neonatal circumcision improves penile hygiene in boys

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

Kuchecheudzwa kwemwana achangozvarwa kunokwidziridza hutsanana hwenhengo yechirume kuvanakomana

22. Medical male circumcision will protect the baby from HIV by 60% when they become adults and are sexually active.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

Kuchecheudzwa kwemwana kunodzivirira mwana kubva kuutachiwana hwe HIV zvakapetwa makumi matanhatu kubva muzana apo anezenga asvika pazera rekusangana nevasikana pabonde.

23. Circumcision is more convenient when children are young.

Strongly agree □  Agree □  Neutral □  Disagree □  Strongly disagree □

Kuchecheudzwa kuri nani zvikuru kuvana vachiri vadiki.

24. Looking back do you think there is any information that you missed on neonatal circumcision?

Yes □  No □

Muchitarisa mumashure, munofunga kuti pane ruzivo rwamusina kwavana here maererano nekuchecheudzwa kwevana vachangozvarwa?
Hongu □  Kwete □
25. If yes to the above question (question 24), use the space below to indicate the missed information

26. In your culture is circumcision acceptable? Yes □ no □

27. Whose recommendation do you value most on circumcising your son?
Maternal family □ Paternal family □ Spouse/partner □ Friend □
Doctor / Nurse □

28. In which facility would you take your child for circumcision?
Private clinic/doctor □ public Hospital □ Spilhaus (Harare Hospital National program) □
Not Applicable (Child already circumcised) □

29. Is the institution stated in question 28 above influenced by economic circumstances?
Yes □ no □

30. Has your son been circumcised? Yes □ no □
29. If the answer to above question (question 28) is “no”, please give the reasons why your child is not circumcised. ........................................................................................................................................
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Kana mhinduro yenyu iri “kwete” kumubvunzo wemakumi maviri nepfumbamwe uri pamusoro apo,
ndipeiwo zvikonzero zvekuti sei mwana asati achecheudzwa
........................................................................................................................................
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30. At what age will you take your son for circumcision?

   (i) Age .................   □   (ii) Not Applicable (Child already circumcised)   □

Muchaita kuti mwana wenyu achecheudzwe pazera ripi?

   (i) Zera ...................... (ii) Mwana wangu akatochecheudzwa kare □

31. Where do you intend to take your child for circumcision?

   Private clinic / private doctor □   Government Hospital □

   Spilhaus □   N/A My child is already circumcised □

Ndekupi kwamuchada kuenda nemwana wenyu kunochecheudzwa?

Kupuraivheti kiriniki / kwachiremba vepuraivheti □   Kuchipatara cheveruzhinji □
KuSpilhaus (KuchirongwachekuGomo chekuchecheudzwa kwevana vachangozvarwa)
Mwana wangu akatochecheudzwa kare □
Thank you for taking your time to answer the questionnaire

*Maita henyu nekutora nguva yenyu kupindura mibvunzo*
APPENDIX B

FOCUS GROUP DISCUSSION GUIDE HIV Context

1. What are some of the words or phrases that people in this community use when talking about HIV and AIDS?

Ndéapi mamwe mazwi anoshandiswa nevanhu vemunharaunda ino kana vachitaura nezve HIV ne AIDS?

(a) Let’s go around the room and share one or two words or phrases that come to mind.

Ngatitorei zvijana tichipanana mazwi anoshandiswa angangouya mumusoro medu

(If coded words / phrases are used, please probe for the meaning).

2. What are some things people do to protect themselves, or their sexual partner against HIV?

Ndézipi zvinoitwa nevanhu kuzvidzivirira kana kudzivirira vavanoenda navo pabonde kuti vasabate utachiwana hwe HIV?

Male Circumcision Acceptability

3. When you hear people talk about male circumcision in the community, what are some of the things they say?

Kana vanhu vachitaura nnezvekuchecheudzwa kwevanhurume munharaunda ino, ndézipi zvinhu zvavanotaura?

(a) What are some of the ways male circumcision is described?

Ndéapi mamwe matsanangurirwo anoitwa kana pachikurukurwa nezve kuchecheudzwa kwevanhurume?
(b) What are some of the things that you have heard discussed about the relationship between male circumcision and HIV?

_Ndezvipi zvimwe zvamakambonzwa paikurukurwa nezve ukama huri pakati pe kuchecheudzwa kwevanhurume ne HIV?_

4. Imagine that two young Shona men are having a conversation about male circumcision. What are some of the things they might say?

_Chimbofunga kuti pane vanhurume vechiShona vaviri vechidiki vari kuita hurukuro nezve kuchecheudzwa kwevanhurume. Ndezvipi zvimwe zvavangataure muhurukuro iyi?_

(a) What are some of the reasons they are discussing circumcision?

_Ndezvipi zvimwe zvikonzero zvingavaite kuti vatange hurukuro iyi?_

(b) What are some of the things they would say about male circumcision in the context of their Shona culture?

_Ndezvipi zvimwe zvinhu zvakanangana netsika nemagariro avo zvavangapinze muhurukuro yavo?_

(c) What are some of the things that they would say about circumcision and a man’s health?

_Ndezvipi zvinhu zvavangapinze muhurukuro yavo zvakanangana nekuchecheudza uye utanho hwemunhurume?_

(d) What other things might they be discussing about circumcision?

_Ndezvipi zvimwe zvinhu zvavangakurukure nezvazvo maererano nekuchecheudzwa?_

5. Imagine two elders are having a conversation about male circumcision. What are some of the things they might say?

_Chimbofunga kuti pane vanhurume vechikuru vaviri vari kuita hurukuro nezve kuchecheudzwa kwevanhurume. Ndezvipi zvimwe zvavangataure muhurukuro iyi?_
(a) What are some of the ways that their conversation might differ from the conversation between the young Shona men?

*Kana tikaenzanisa hurukuro pakati pevarume vechidiki veChishona nevarume vechikuru ava, ndeupi musiyano ungawanikwe pakati pehurukuro dzavo?*

6. Two mothers are considering getting their sons circumcised. What are some of the reasons that may lead them to get their sons circumcised?

*Ngatitii pane madzimai maviri angangoda kuti vanakomana vavo vachecheudzwe. Ndezvipi zvimwe zvikonzero zvingangoita kuti vana Mai ava vabvume kuti vana vavo vachecheudzwe?*

(a) How would hygiene impact their decision?

*Nyaya dzeutsanana dzingavaite kuti vade kuchecheudzisa vana zvakadini?*

(b) How would sexual pleasure impact their decision?

*Pfungwa dzekuti vana vavo vagozogutsikana pabonde dzinokonzera zvakadini kuti madzimai aya asarudze kuchecheudzisa vana?*

(c) How would protection from HIV impact their decision?

*Ko mifungo yekudzivirira utachiwana hwe HIV ingakonzera zvakadini mukuita sarudzo yekuchecheudzisa vana?*

(d) How would protection from STIs impact their decision?

*Kudzivirira zvirwere zvepabonde kungave chikonzero chakadini kumadzimai aya mukuita sarudzo yekuchecheudzisa vana ava?*

(e) Are there any other reasons?

*Pane zvimwe zvikonzero here zvingaite kuti madzimai aya ade kuchecheudzisa vanakomana vavo.*
7. What are some of the reasons that these mothers might decide not want their sons to get circumcised?

_Ndezvipi zvimwe zvezvikonzero zvingaite kuti vana Mai varambe kuti vanakomana vavo vachecheudzwe?_

(a) How would cost impact their decision?

_Muripo wemari unodiwa pakuchecheudzwa unotadzisa sarudzo yekuchecheudzisa vana zvakadini?_

(b) How would travel to and from the health facility impact their decision?

_Kufambira kuchecheudzisa mwana kuenda kunzvimbo dzekuchecheudzisa nekudzoka zvinotadzisa kuti madzimai aya aite sarudzo yekuchecheudzisa vanakomana vavo?_

(c) How would pain impact their decision?

_Ko kutyira kuti vana vanorwadziwa pakuchecheudzwa kunotadzisa zvakadini kuti vana Mai ava vaite sarudzo yekuchecheudzisa vana?_

(d) How would infection impact their decision?

_Kutyira kuti vana vangabate utachiona pakuchecheudzwa kungatadzise vana Mai ava kuita sarudzo yekuchecheudzisa vana zvakadini?_

(e) How would bleeding impact their decision?

_Kutyira kuti vana vangarasikirwa neropa pakuchecheudzwa kungatadzise vana Mai ava kuita sarudzo yekuchecheudzisa vana zvakadini?_

(f) How would their culture impact their decision?

_Ko tsika nemagariro zvingatadzisa vana Mai ava zvakadini kuti vaite sarudzo yekuchecheudzisa vana?_
(g) How would stigma impact their decision?

*Ko kutya kuti vanwe vanozoti kudini maererano nekuchecheudzisa vana kungatadzisa zvakadini kuti vana mai ava vaite sarudzo yekuchecheudzisa vanakomana vavo?*

(h) Are there any other reasons?

*Pane zvimwezve here zvingatadzise vana mai kuchecheudzisa vanakomana vavo?*

8. If a mother decides to talk with her colleagues about getting her son circumcised, what are some of the things that her colleagues might say?

*Kana mai vakasarudza kukurukura nevamwe vavo maererano nepfungwa dzekuchecheudzisa mwanakomana vavo, munofunga kuti vanwe vavo vanotaura kuti kudini?*

(a) What are some of the things the colleagues might say to convince the mother to get her son circumcised?

*Ndezvipi zvimwe zvezvinhu zvingangotaurwa nevamwe vavo kuvakurudzira kuti vachecheudzise mwanakomana vavo?*

(b) What are some of the things the colleagues might say to convince the mother not to get her son circumcised?

*Ndezvipi zvimwe zvezvinhu zvingangotaurwa nevamwe vavo zvingavaoresa moyo votadza kuti vachecheudzise mwanakomana vavo?*

(c) What are some of the ways that mothers should involve their colleagues in the decisions to get their sons circumcised?

*Ndezzipi dzimwe nzira dzingashandiswe navana mai kuti vabatsirwe nemazano ekuita sarudzo yekuchecheudzisa vanakomana vavo?*
9. The Government of Zimbabwe now recommends male circumcision for HIV prevention. What would be some of the ways to sensitize men and women about the benefits and risks of male circumcision?

*Hurumende ye Zimbabwe yave kukurudzira kuti vanhurume vachecheudzwe kuitira kudzivirira utachiona hwe HIV. Ndedzipi nzira dzingashandiswe kupa mazano kuvanhurume nevanhukadzi maererano nezyakanakira nezyakashatira kuchecheudzwa kwevanhurume?*

(a) What are some of the groups that should be involved in sensitizing men about male circumcision?

*Ndeapi mamwe mapato anofanira kupinzwa muhurukuro dzekudzidzisa vanhurume maererano nezyekuchecheudzwa?*

10. In the end this mother decides to get the child circumcised. What would his neighbours say about her if they found out that her child was circumcised.

*Tomboti mai ava vabvuma kuti mwana wavo achecheudzwe. Vavakadzani vavo vangati kudii kana vakazviziva kuti mwana wamai ava akachecheudzwa?*

(a) What are some of the positive things they might say?

*Ndezvipi zvimwe zvezvinhu zvinovaka zvavangangotaura?*

(b) What are some of the negative things they might say?

*Ndezvipi zvimwe zvezvinhu zvinoputsa zvavangataure?*

11. Summary Question

*Mubvunzo wekupendera*

Are there any other factors pertaining to male circumcision that we missed, but should be discussed?

*Pane here zvimwe zvakanaunganana nekuchecheudzwa kwevanakomana zvatsiya zvatinofanira kukurukura nezvazvo?*
APPENDIX C

INFORMED CONSENT FORM

PROTOCOL TITLE

The acceptability of neonatal circumcision among mothers at Rutsanana and Hatcliffe clinics.

NAME OF RESEARCHER: Donnely Nyoni

PHONE: 0772 308 032

PROJECT DESCRIPTION:

This is a research study being done in partial fulfillment of the Master of Science degree in Clinical Epidemiology. The study will be done at Rutsanana and Hatcliffe clinics. About 240 pregnant women and women with baby boys aged up to 6 months will be interviewed to establish whether circumcision of newly born baby boys is acceptable or not. Small groups of women will be selected for group discussion on the same issue of circumcision of newly born baby boys.

YOUR RIGHTS:

Before you decide whether or not to volunteer for this study, you must understand its purpose, how it may help you, the risks to you and what is expected of you. This process is called informed consent.

I am giving you this informed consent form so you may read about the purpose, risks and benefits of this research study. Routine care is based upon the best known treatment and is provided with the main goal of helping the individual client. The main goal of the study is to gain knowledge that may help future patients. This research is not going to benefit you directly but may benefit others in the future. You have a right to choose to take part or refuse to participate with no harm befalling you. Whatever decision you take will not affect your regular care at this clinic. Your choice to participate is voluntary and you may withdraw anytime you wish to.

PURPOSE OF THE RESEARCH STUDY
You are being asked to participate in a research study of acceptability levels of neonatal male circumcision among mothers. You have been selected to participate in the study because you are either pregnant or you have delivered a live baby.

PROCEDURES INVOLVED IN THE STUDY

If you decide to participate, I will ask you questions that are already prepared and typed and write down your responses. If you do not understand any question, you are free to ask me and I will clarify. The interview will not take more than 20 minutes of your time. May you please answer the questions truthfully.

DISCOMFORTS AND RISKS

There are no major risks involved in the study, you may be emotionally upset with some of the questions if that so happens you may stop answering the questions.

BENEFITS OF THE STUDY

I cannot guarantee or promise any benefits from participating in the study. The information from the study will benefit the providers on future developments concerning neonatal circumcision.

CONFIDENTIALITY

No Names will appear on questionnaires. There will be and identification number, any information obtained will remain confidential and only disclosed to those who are involved in the study.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the clinic. If you do decide to participate, you are free to withdraw consent anytime with no penalty.

OFFER TO ANSWER QUESTIONS

Before you sign this form. Please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.
AUTHORISATION

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS STUDY. YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE, HAVE HAD ALL QUESTIONS ANSWERED, AND HAVE DECIDED TO PARTICIPATE.

------------------------------------------------------------------------------------------------------------------------

NAME (PLEASE PRINT)                  DATE

------------------------------------------------------------------------------------------------------------------------

WITNESS                        DATE

YOU WILL BE GIVEN A COPY OF THIS TO KEEP

If you have any questions concerning this study or consent form beyond those answer by the investigator, including questions about research, your rights as a research participant or research related injuries, or if you feel that you have been treated unfairly and would like to talk to someone other than the member of the research team, please feel free to contact the Medical Research Council of Zimbabwe on telephone 791792 or 791193.
APPENDIX D

GWARO RETENDERANO

MUSORO WENHOROWONDO

Kugamuchirika kwekucheudzwa kwevana vachangozvarwa kunanamai vepamakiriniki e Rutsanana ne Hatcliffe.

ZITA REMUONGORORI: Donnely Nyoni

NHAMBA DZAKE DZENHARE: 0772 308 032

TSANANGUDZO YEONGORORO:

Ino iongororo iri kuitwa kuzadzikisa zvinodiwa mudhigirii re Masters ye Clinical Epidemiology. Ongororo iri kuitwa pa kiriniki dze Rutsanana ne Hatcliffe. Vanhukadzi vakazvitakura nevane vanakomana vane mwedzi yekuzvarwa inosvika mitanhatu vanosvika mazana maviri nemakumi mana vachapinda mubvunzurudzo ye kuziva kuti kucheudzwa kwevana vachangozvarwa kuri kutambirwa here kana kuti kwete. Vamwewo madzimai vachaiswa mune kuitwa vanhukadzi vakazvitakura nevane vanakomana vachangozvarwa.

KODZERO DZENYU:

Musati masarudza kuti munozvipira here kupinda mutsvakurudzo ino, munofanira kunzwisisa donzvo, zvamungabatsirika nazvo, njodzi uye zvinotarisirwa kwamuri. Zvose izvi zvinodaidzwa kuti Tenderano yakatsanangurwa zvire.

CHINANGWA CHETSVAKURUDZO INO

Muri kukumbirwa kuti mupinde mutsvakurudzo ino yekugamuchirika kwekuchecheudzwa kwevanakomana vachangozvarwa kunanamai. Masarudzwa nekuti mune pamuviri / makabva kupona mwanakomana.

ZVITEVEDZWA ZVETSVAKURUDZO INO


ZVINGANGOKUITAI KUTI MUBATIKANE KANA NJODZI


ZVAMUNOGONA KUWANA

Handikwanisi kukuvimbisai kuti mune mibairo yamichawana nekuda kwekuti mapinda mutsvakurudzo ino. Zvichabuda mutsvakurudzo zvichandiswa neveutano kugadzira remangwaana riri maererano nekuchecheudzwa kwevana vachangozvarwa.

KUCHENGETEDZWA KWEZVAKAVANDIKA

Hapana mazita achanyorwa pamagwaro etsvakurudzo. Panenge paine mucherechedzo we nhamba chete. Umbowo hwese hwamuchapa huchachengetedzwa zvakasimba uye huchangoonkwa cheete nevane chekuita neongororo ino.

KUPINDA MUTSVAKURUDZO PASINA KUMBUNYIKIDZWA

Kupinda mutsvakurudzo ino ndekwezvisarudzira pachenyu. Mukasarudza kuti hamudi kupinda mutsvakurudzo ino, sarudzo yenyu haizokanganisa hukama hwenyu nevapakiriniki ino. Kunyangwe masarudza kupinda mutsvakurudzo, makasununguka kubuda mutsvakurudzo ino pasina kutemerwa mhosva.
MIBVUNZO YAMUNGANGODAI MUINAYO

Musati maisa runyoro rwenyu pagwaro rino, ndapota bvunzai chero zvipi zvazvo zviri maererano ntsvakurudzo ino zvingangodaro zvisina kujeka. Munokwanisa kutora nguva yamunoda muchifunga nezvazvo.

MVUMO

MURI KUITA SARUDZO YEKUTI MOPINDA HERE KANA KWETE MUTSVAKURUDZO INO. RUNYORO RWENYU RWUNORATIDZA KUTU MAVERENGA KANA KUVERENGERWA NDOKUNZWISISA ZVIRI MUGWARO RINO UYE MAPINDURWA MIBVUNZO YOSE YAMINGAVE MUINAYO UYE MASARUDZA KUPINDA MUTSVAKURUDZO.

--------------------------------------------
ZITA (NYORAI NEMAVARA MAKURU) ZUVA ,MWEDZI NE GORE

--------------------------------------------
MUFAKAZI ZUVA, MWEDZI NEGORE

MUCHAPIHW A RIMWE GWARO RAKAITA SERINO KUTI MUCHENGETE

Kana muine mibvunzo kunze kweyapindurwa nemuongorori maererano ntsvakurudzo ino, kana gwaro retenderano rino, kusanganisira mibvunzo maererano ne tsvakurudzo, kodzero yenyu semubvunzwi kana tsaona dzamungasangana nadzo kana kuti muchifingira kuti hamuna kubatwa zvakakodzera nekudaro munoda kutaura nemumwe munhu asiri mumwe wevaongorori vetsvakurudzo ino, makasununguka kubata vebato re Medical Research Council ye Zimbabwe panhamba dzenhare dzinoti 791792 kana 791193
## APPENDIX E

### TIME FRAME FOR DATA COLLECTION

<table>
<thead>
<tr>
<th>Task</th>
<th>Data collection time frame from October 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weeks</td>
</tr>
<tr>
<td></td>
<td>Oct 1 2 3 4 Nov 1 2 3 4 Dec 1 2 3 4</td>
</tr>
<tr>
<td>Pretesting Instruments</td>
<td></td>
</tr>
<tr>
<td>Preparing material for data collection</td>
<td></td>
</tr>
<tr>
<td>Collection of Data</td>
<td></td>
</tr>
<tr>
<td>Coding data for Analysis</td>
<td></td>
</tr>
<tr>
<td>Analyzing Data</td>
<td></td>
</tr>
<tr>
<td>Final report preparation</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX F

**BUDGET FOR THE STUDY**

<table>
<thead>
<tr>
<th>Budget item</th>
<th>Cost per item</th>
<th>Number of items</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond paper (reams)</td>
<td>$7</td>
<td>30</td>
<td>$210.00</td>
</tr>
<tr>
<td>Toner cartridge</td>
<td>$90</td>
<td>2</td>
<td>$180.00</td>
</tr>
<tr>
<td>USB</td>
<td>$30</td>
<td>1</td>
<td>$30.00</td>
</tr>
<tr>
<td>Typing costs (per page)</td>
<td>$2</td>
<td>100</td>
<td>$200.00</td>
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<tr>
<td>Staples (per 100)</td>
<td>$2</td>
<td>500</td>
<td>$10.00</td>
</tr>
<tr>
<td>Pens</td>
<td>$0.50</td>
<td>100</td>
<td>$50.00</td>
</tr>
<tr>
<td>Binding</td>
<td>$5</td>
<td>6</td>
<td>$30.00</td>
</tr>
<tr>
<td>Photocopying (per 10 pages)</td>
<td>$1</td>
<td>2400</td>
<td>$240.00</td>
</tr>
<tr>
<td>Travelling costs Transport(car)</td>
<td>$1.30 per liter of petrol</td>
<td>120 liters</td>
<td>$156</td>
</tr>
<tr>
<td>Data collection</td>
<td>$ 100 .00 per day</td>
<td>21 days</td>
<td>$2 100.00</td>
</tr>
<tr>
<td>Data Coding</td>
<td>$ 25 per hour</td>
<td>8 hours</td>
<td>$200.00</td>
</tr>
<tr>
<td>Data Entry</td>
<td>$ 25 per hour</td>
<td>24 hours</td>
<td>$600.00</td>
</tr>
<tr>
<td>Statistical Analysis</td>
<td>$ 100 per hour</td>
<td>8 hours</td>
<td>$800.00</td>
</tr>
<tr>
<td>Flip Chart (reams)</td>
<td>$ 10.00 per ream</td>
<td>4</td>
<td>$40.00</td>
</tr>
<tr>
<td>5 interviewers</td>
<td>$ 50 per day</td>
<td>21 days</td>
<td>$5,250</td>
</tr>
</tbody>
</table>
### The Budget Justification

The following points seek to explain the need for the items included in the budget to finance the implementation plan.

- These are costs that cover office items such as bond paper, staples, photocopying, typing which are thus referred to as stationery expenses. They cover the development of the data collection tools, the protocol and any other material that are needed to complete the research activities. It is essential to have funding for these items since they cover the core aspects of the research work to be undertaken. It is also worth noting that the costs involved are high that an individual researcher cannot afford.

- The data collection exercise will involve intensive traveling by the researcher from the office to research site as indicated in the write-up. This travel shall cause some transport costs to be incurred. The researcher has secured a vehicle for this purpose that needs 120 liters of petrol to completion of the exercise. Hence some funding has to be provided to cover transport costs to the tune of $156.00.

- To ensure data integrity, the researcher with the assistance of data capturers, shall carry out data coding, entry and statistical analysis as this is also important in the study. The activity shall cause some costs to the study hence funding is required to meet this cost.
The study shall not be deemed fully executed until the study findings are availed to the public domain. This results dissemination costs shall be funded as part of study costs hence their inclusion becomes vital at this stage.

The study will run for three to six months including the collection of data and analysis and the researchers’ expenses need to be covered as well as training of the interviewers so as to collect accurate data.
APPENDIX G

Joint Parirenyatwa Hospital
And College of Health Sciences
Research Ethics Committee

Parirenyatwa
Group of Hospitals

5th Floor College of Health Sciences Building
Telephone: +263 4 708140 Email: medresearch@medsch.uz.ac.zw

APPREVAL LETTER

Date: 4th December 2013

JREC Ref: 322/13

Names of Researcher: Donnelly Nyoni
Address: University of Zimbabwe, Department of Community Medicine

Re: Acceptability Of Neonatal Circumcision Among Mothers: A Case Study Of Hatcliff And Rusaraa Clinics (Harare).

Thank you for your application for ethical review of the above mentioned research to the Joint Research Ethics Committee. Please be advised that the Joint Research Ethics Committee has reviewed and approved your application to conduct the above named study.

- APPROVAL NUMBER: JREC/322/13
- APPROVAL DATE: 4th December 2013
- EXPIRATION DATE: 3rd December 2014

This approval is based on the review and approval of the following documents that were submitted to the Joint Ethics Committee:

- a) Completed application form
- b) Full Study Protocol
- c) Informed Consent in English and/or appropriate local language
- d) Data collection tool version:

After this date the study may only continue upon renewal. For purposes of renewal please submit a completed renewal form (obtainable from the JREC office) and the following documents before the expiry date:

- a. A Progress report
- b. A Summary of adverse events.
- c. A DISMB report

MODIFICATIONS:
Prior approval is required before implementing any changes in the protocol including changes in the informed consent.
TERMINATION OF STUDY:

On termination of the study you are required to submit a completed request for termination form and a summary of the research findings/results.

Yours faithfully,

[Signature]

Professor MM Chidzonga
JREC Chairman
APPENDIX H

CITY OF HARARE

Director of Health Services

Donnelly Nyoni R088211X

22 April 2013

Donnelly Nyoni
Clinical Epidemiology Resource and Training Department
University of Zimbabwe
P.O. Box A178
Avondale
HARARE

Dear Madam

RE: PERMISSION TO CARRY OUT A RESEARCH ON ‘ACCEPTABILITY LEVELS OF NEONATAL CIRCUMCISION AMONG MOTHERS’

I refer to your letter dated March 29 2012 concerning the above.

Permission is granted for you to carry out the above research in Hatcliff and Rutsuana Clinics. For further assistance please liaise with the Sisters in Charge of the respective clinics.

Yours faithfully

DIRECTOR OF HEALTH SERVICES

cc. S.I.C - Hatcliff and Rutsuana Clinic