

To cut or not to cut: Factors influencing the uptake of Voluntary Medical Male Circumcision among older men in Gweru, Zimbabwe.

Mpikелеlo Mpawusi Maseko; Sibangilizwe Maphosa;
Julia Mutambara and Witness Bangiza

Midlands State University
Gweru, Zimbabwe

Corresponding author: mpikemaseko@gmail.com, masekom@msu.ac.zw

Abstract

Despite compelling evidence on the efficacy of Voluntary Medical Male Circumcision as an HIV prevention strategy, Zimbabwe has experienced a low uptake of the procedure. Informed by the culture centred approach to health communication the study examined beliefs of older men (i.e., over the age of 25) on the perceived barriers and facilitators to the uptake of Voluntary Medical Male Circumcision. Using a qualitative descriptive design, researchers collected data from an intensity sample of 36 participants. Data was collected through focus group discussions and in-depth interviews. The researchers isolated themes by identifying recurrent words and phrases into thematic categories. Barriers to Voluntary Medical Male Circumcision related to the pain associated with the procedure, historical cultural practices of shaming circumcised men, partner suspicions and resistance, fear of complications, and the six weeks sex abstinence period. Facilitators included the belief that the procedure reduced the risk of HIV infection, reduced the risk of sexual transmitted infection, and cervical cancer. These findings suggest the need to factor in the role of cultural practices in traditionally non-circumcising groups in Zimbabwe. Further there is a need to co-opt women as female partners of married men play a significant role in the decision whether or not to take up the procedure.

Key Words: HIV/AIDS, Circumcision, older men, married couples barriers, facilitators, prevention

Introduction

Medical male circumcision is one of the oldest surgical operations dating back more than 4000 years. In Zimbabwe the Yao, Lemba, Shangaan, and Tonga constitute a significant percentage of the community of traditional male circumcisers (NAC, 2011; Daimon, 2013). For these communities male circumcision is viewed as a social practice at the heart of traditional belief systems and way of living (Ntombana, 2011). For example, among the Xhosas of South Africa, male circumcision is largely regarded as the most guarded and sacred traditional rite (Gwata, 2009). However Zimbabwe is generally a non-circumcising country as is evidence by the low rates of circumcision among men.

Based on evidence from three randomised clinical trials (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007) that demonstrated the efficacy of Voluntary Medical Male Circumcision (VMMC) in reducing the risk of female-male HIV infection by 51% - 60% among heterosexual men; the World Health Organisation (WHO) and joint United Nations Programme of HIV/AIDS (UNAIDS) recommended VMMC as a strategy for HIV prevention. HIV and AIDS prevention is part of The Sustainable Development Goals (Agenda 2030) under goal number 3 which seeks among other things to end the AIDS epidemic by 2030.

As a result in 2008, 14 priority countries in Sub-Saharan Africa namely Botswana, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe, and Nyanza Province in Kenya with high HIV prevalence rates and low levels of male circumcision began to implement a programme aimed at scaling up VMMC services targeting 80% of men aged 15 - 49 by 2016. Between 2008 and 2012, Zimbabwe had only been able to circumcise 91 335 of the **1 912 595** men aged between 15 - 49 years; which was just 4.8% of the target population (WHO, 2014). As of 2014, only 14% (267 763) of the target had been reached but of these, men aged between 25 - 49 years account for only 61 585 (UNAIDS, 2014; Zimbabwe Ministry of Health 2014). The VMMC has attracted mostly adolescents yet men between 25 -50 years have higher rates of HIV infection. Of the 14 priority countries for VMMC Kenya has performed the most with 49% of the men aged 15 - 49 having been circumcised by the end of 2012 (Macintyre, 2014). Most of the circumcisions in Kenya have been performed among the traditionally circumcising Luo ethnic group. However even in Kenya, only 15% of the newly circumcised men were over the age of 25 (Macintyre, 2014).

The importance of HIV prevention cannot be overemphasised. Voluntary Medical Circumcision is part of the comprehensive strategies for HIV. HIV continues to be a major public health concern. In 2010 HIV/AIDS was ranked as the leading Disability Adjusted Life Years (DALY, measure of overall disease burden expressed as the number of years lost due to ill health, disability or early death) cause for ages 30-44 years (5th globally) in 21 countries in Eastern and Southern Africa, Central Africa, the Caribbean and Thailand (Ortblad, 2013). Since 2000, 38.1 million people have been infected with HIV while 25.3 million people have died of AIDS related illnesses (UNAIDS, 2015). Of the estimated 36.9 million people living with HIV, 25.8 million are in Sub-Saharan Africa which represents 70% of the global total (UNAIDS, 2015). Zimbabwe has 1.4 million (15% of its population) people living with HIV which equates to around 4% of the global total. Zimbabwe has the fifth highest prevalence of HIV in Sub-Saharan Africa (UNAIDS, 2014).

While the number of new infections among adolescents and adults in more than 26 countries decreased by 50% or more between 2001 and 2012 (UNAIDS, 2015),

in Zimbabwe new infection rates dropped by 34% between 2005 and 2013 (Zimbabwe Ministry of Health, 2014). However there were still 69 000 new infections in 2013 and 64 000 AIDS related deaths (UNAIDS, 2014). Recent surveys in several Sub-Saharan countries noted decreases in condom use and/or an increase in number of sexual partners (UNAIDS, 2015). According to Hecht et al (2010), in the absence of serious change in approach AIDS will remain a major pandemic and funding required in resource poor countries could reach to between an estimated US\$397 to US\$722 billion globally between 2009 and 2031. Thus there is still a compelling need for HIV prevention.

Circumcising 1.27 million men in Zimbabwe would avert 212 000 new infections and save the Zimbabwean government US\$2.93 billion by 2025 (Njeuhmeli et al., 2011; Schutte & Forsythe, 2010). In addition, VMMC has been shown to be protective against sexually transmitted diseases and genital cancer in both men and women (Castellsague et al., 2002; Mosconi et al., 2005). A number of studies have been conducted on the barriers and facilitators of VMMC with pain and fear for the procedure, lack of knowledge and perceived efficacy coming out as some of the key factors (Chikutsa & Maharaj, 2015; Hatzold et al., 2014; Mattson et al., 2010 & Rupfudze et al., 2014). However most of the studies did not specifically focus on older men over the age of 25 who have been slow in taking up circumcision. Studies in Tanzania and Zambia by Osaki et al (2015) and Cook et al (2015) respectively noted that among older men the female partner has an important role play in the decision to get circumcised.

As such this study sought to identify the barriers and facilitators to VMMC among men aged 25 and above in Zimbabwe. The specific aims were to ascertain insights among older men on;

- Perceived barriers to voluntary medical male circumcision
- Perceived facilitators of voluntary medical male circumcision

The results are intended to explain why the uptake of VMMC has been slower than anticipated and thus guide new demand creation activities and strategies in the Midlands Province.

The study was informed by the culture centred approach to health communication (Airhihenbuwa, 1995, 2007; Dutta, 2008). This is a model that seeks to better understand health communication within the context of culture. Cultural contexts are placed at the core of meaning-making processes. As such VMMC is not conceptualised from an etic perspective using Euro-American medical conceptualisations. Instead an emic perspective is emphasised with VMMC being viewed not just as a medical procedure but also as a social procedure informed by culture and religion as well as the subsequent conceptualisations of masculinities and femininities. The culture centred approach foregrounds the voices of cultural

members in the co-constructions of health risks and in the articulation of health problems facing communities.

Methodology

In seeking to gain insight on the factors influencing the uptake of VMMC among men over the age of 25, the qualitative descriptive design was utilised (Sandelowski, 2000; 2010). The qualitative descriptive method is a somewhat eclectic approach that 'evolved' from 'traditional' qualitative research approaches. It seeks to produce a straightforward description of participants' perceptions or experiences with minimal inference or re-presenting of phenomena by researchers as is the case in other qualitative methods (such as phenomenology or grounded theory). As Sandelowski (2000, p. 337) states, this method is "especially amenable to obtaining straightforward and largely unadorned answers to questions of special relevance to practitioners and policy makers".

The sample (N=36) comprised men over the age of 25 years and females over the age of 18 (Males, n=22; females, n=14). Table 1 shows the sample for focus group discussions (FGDs) and in-depth interviews (IDIs)

Table 1: sample for FGDs and IDIs

Category	n
In-depth Interviews	
Circumcised Men	3
Uncircumcised Men	3
Female Partners Uncircumcised Men	3
Female Partner Circumcised Men	3
n	12
Focus Group discussions (3)	
Circumcised Men	8
Uncircumcised Men	8
Female Partners of both groups	8
n	24
N	36

The participants were selected from two men and women's forums for HIV prevention using the intensity sampling technique (Patton, 2001). This strategy

for purposive sampling aims at capturing information rich sources that manifest the phenomenon of interest. The logic behind this technique is that information rich cases are likely to illuminate our understanding on the uptake of VMMC. Some of the participants were drawn from males over the age of 25 because this group has been slow in taking up the procedure. Thus circumcised and uncircumcised men as well as female partners of circumcised and uncircumcised men in Gweru participated in the study.

The researchers used in-depth interviews and focus group discussion protocols to gain insight into the participants' perceptions and beliefs on factors that influence the uptake of VMMC among older man. These allowed us to get into the 'life world' of the participants which gives us a deeper understanding of the phenomenon under consideration. Conceptualising experience in this way negates the notion of an objective 'reality' thus we were able to get individual meaning-constructions of their situation (Hammersley 2003).

The participants were drawn from two HIV/AIDS forums for men and women in Gweru that are run by two private voluntary organisations (PVOs). The purpose of the study was explained and informed consent was sought from the participants. Participants were informed that they have a right not to participate in the study and can withdraw anytime without any negative connotations. Permission to use an audio recorder was sought and granted. The identity of the participants was protected through the use of fictitious names (pseudonyms). As indicated in table 1, three separate focus group discussions were conducted with circumcised men, uncircumcised men and female partners of either group. Uncircumcised men are a critical group in the quest to get a better understanding of why the uptake of VMMC is low in this group. Each focus group consisted of 8 participants in line with recommendations of 6-12 participants (Bernard, 1995; and Johnson & Christensen, 2004). Twelve in-depth interviews were conducted with circumcised men, uncircumcised men and female partners of circumcised and uncircumcised men (see table 1)

Narrative responses to interview questions and focus group discussions were transcribed and analysed qualitatively. The transcriptions of the recorded interviews and group discussions spanned approximately 60 pages of translated text. The first step involved immersion analysis. The researchers did a repeat, delayed and 'untargeted' reading of all transcriptions to become familiar with the participants responses and to allow unexpected knowledge to surface. The transcriptions were then subjected to qualitative content analysis, an approach that is oriented towards summarising the informational contents of the data with minimal interference (Sandelowski, 2000). Data driven codes which emanated from recurrent words and phrases (noted during manifest analysis) were assigned to the text. Members of the research team analysed the data independently and

met to iron out coding discrepancies. Codes were identified for similarity and where grouped into emergent thematic categories. These were then debated, refined, revised and merged by the research team.

Results and Discussion

The participants gave a number of factors that influence the uptake of VMMC under the following themes and sub-themes.

Barriers to the Uptake of Voluntary Medical Male Circumcision

The participants identified a number of factors that they felt reduced the probability of voluntary circumcision.

Lack of Knowledge

Almost all participants were aware of male circumcision but some did not have comprehensive knowledge about it. Some had myths and misconceptions about VMMC. The following citations are illustrative

"I personally don't even know the difference between being circumcised and not being circumcised." (Uncircumcised man, age 48)

"I am sceptic about this circumcision issue. I hear it can lead to infertility and tetanus." (Female partner of uncircumcised man, age 45)

"I am afraid we are creating a generation of useless men because if one of your limbs is not functioning properly after the mishaps of circumcision, then you will be disabled." (Female partner of uncircumcised man, age 36)

These findings suggest that some people do not have full information on the efficacy, process and effects of VMMC. There is still a need to utilise all channels of communication to reach out to all segments of the population. More still needs to be done in the area of health promotion

Cultural Representations of Circumcision

Consistent with other research (Chikutsa & Maharaj, 2015; Macintyre et al., 2014) cultural beliefs around circumcision can be a barrier to the uptake of the practice in traditionally non-circumcising groups. Most of the participants were either Shona or Ndebele. These are traditionally non-circumcising ethnic groups. Thus the procedure is viewed by some as an alien practice.

“Look I do not know what the farce is around circumcision. Look at my age. This practice has never been part of our culture. It’s for the Lemba in Mberengwa there. (Uncircumcised man, age 40)

“You guys are just accepting Western ideas at face value. In our culture when a baby is born a part of the umbilical cord that will attached to the belly button falls off after couple of days. When that happens we have rituals to celebrate the ushering in into the genealogy. We bury it in the land of the ancestors. If that is sacred, what about the foreskin of an adult. You are playing with fire. That’s why we having these draughts, mental illness and all. (Uncircumcised man, age 55)

The practice of circumcision may be incongruent with other cultures that are traditionally none circumcising. This suggests the need to engage traditional leaders such as chiefs and traditional healers to demystify the procedure and enhance its acceptability.

Circumcision Related Stigma

In addition to the cultural representations of circumcision, the concomitant stigma that goes with it in traditionally non-circumcising groups may act as a deterrent to the uptake of VMMC.

“My friend’s son was born in USA and was circumcised because the practice is common there. When they came back to Zimbabwe; that boy had serious problems at school. When he was trying to take shower or use the loo the other boys would tease him. They even gave him a derogatory nickname: ‘Nzvonyo’. He was like a freak to the other kids. He ended up becoming a day scholar. I will not allow my son to go through that. As for me and my family, circumcision is out” (Uncircumcised man, age 45)

“The Creator made a foreskin for a purpose and are we going to have a generation of men without foreskins? Most of the doctors who circumcise are not circumcised themselves and where do they put those foreskins?” (Uncircumcised man, age 50)

These findings are consistent with research in Zimbabwe and Tanzania (Chikutsa & Maharaj, 2015; Macintyre, 2014; Rupfutsa et al., 2014). Similarly participants in a study by Moyo et al., (2015) in rural Mhondoro-Ngezi, Zimbabwe expressed fear of stigmatisation as a barrier against the uptake of VMMC. Within traditionally non-circumcising communities the practice of VMMC is associated with dishonour which may act as a barrier.

Pain

Consistent with previous research (Chirau, 2012; Hatzold et al., 2014; Rupfutse et al., 2014 & Westecamp, 2012) pain associated with circumcision can be a barrier to the uptake of VMMC.

“To be honest my experience with VMMC was negative. I am not sure whether they used an aesthetic or not. The wound took longer than usual to heal and the saline solution was hell. I would not advise anybody to risk going through the procedure moreso at this age” (Circumcised man, age 30)

“Being cut on the most private and sensitive part is different from any other part of the body my brother so please let us not experiment like that in any way” (Uncircumcised man, age 25)

“These men of today are very afraid of pain I had discussed the whole thing with my husband and we agreed that he was to be circumcised only for him to quit seconds into the procedure (laughs). I just wish there could be another less painful way to carry out the whole procedure so that our husbands can get circumcised” (Female partner of uncircumcised man, age 36)

The fear of pain associated remains one of the most significant barriers to the uptake of VMMC. It appears that most men are not aware that unlike in traditional circumcision where no anaesthetics are used, with VMMC a local anaesthetic is used. After the procedure over the counter pain killers are also used to ameliorate the pain. Thus in practice the pain associated with the procedure is much lower than is anticipated by uncircumcised males. As such there is need to enlighten them on this fact. Furthermore there is need for alternative non-surgical procedures that are less painful. This is likely to increase the acceptability and uptake of VMMC. Currently the PrePex device is being piloted in Zimbabwe, Zambia and South Africa as a non-surgical alternative.

Pre-Circumcision HIV Testing

The requirement that uncircumcised men undergo an HIV test is acting as a barrier among men that do not know their status. This is more so given that only 54% of the people who are infected with HIV do not know their status (UNAIDS, 2015)

“Some of us would like to be circumcised but I just don’t want to be arm twisted into getting an HIV test. This must be done in good faith.” (Uncircumcised man, age 28)

This suggests the need to further explain why HIV testing is critical before circumcision. There is need for policy clarity on whether HIV testing is mandatory

or it is simply recommended. The ethical implications of mandatory testing can be a barrier to the uptake of VMMC. A Study by the Male Circumcision Consortium (2015) noted that sero-positive and sero-negative did not differ in the time it took to for the wound to heal post circumcision.

Role of the female Partners

Unlike adolescents and other younger man, those over the age of 25 are likely to be married or be in a long term relationship. As such the decision to be circumcised cannot be taken unilaterally.

“We do not use condoms with my husband so I was taken aback when he indicated that he was considering getting circumcised. I felt like he was implicitly suggesting that I am putting him at risk of HIV infection. I cannot accept that. I am not a prostitute.(Female partner uncircumcised man, age 34)

Some female participants were totally against the practice of male circumcision as it increased the likelihood of risk compensation behaviours.

“It should never be used as an HIV prevention strategy because our men get carried away easily. Our husbands are like kids thus circumcision brings a certain level of excitement cause they feel like they have been allowed to engage in risky behaviours because of the so called 60% reduced risk” (Female partner circumcised man, age 31)

“ if the wife is HIV negative what be the purpose of VMMC. Is it not an indirect way of informing the wife that he is having extra marital affairs from which he is afraid of contracting the infection. There is no need for a husband to be circumcised if he and his wife are both HIV free; rather VMMC promotes the men’s habit of having multiple partners” (Female Partner uncircumcised man, age 35)

“For some men circumcision is like an invisible condom. Once they get circumcised they will go about like uninhibited He goats. It’s like a blank cheque. I regret allowing my husband to get circumcised. To make matters he refuses to use a condom” (Female Partner circumcised man, age 30)

The meaning of voluntary circumcision to the female partner is a critical moderating variable. This is consistent with finding by Chikutsa and Maharaj (2015) who noted that the attitudes of female partners for man in long term intimate relationships can be a barrier to VMMC. As such women have an important role to play in the promotion of VMMC. Female partners are also concerned about the possibility of risk compensation. These concerns are genuine given results of the Zimbabwe Health Demographic Survey (ZHDS 2010/2011) which indicated that the HIV prevalence rate among circumcised men is 14% compared to 12% among

the uncircumcised men. Thus demand creation strategies that specifically target the concerns of female partners are critical. Furthermore circumcised men need further health education on the implications of risky sexual behaviour post circumcision.

Marital Status and Age

The rate of VMMC uptake among older men is low (Macintyre, 2014) which suggests that the marital status and age can be a barrier to VMMC. A number of married male participants gave a number of reasons why this could be the case

"We recently celebrated our 10 wedding anniversary. Things are fine with my wife. I cannot just come home and say to her 'Honey look I got circumcised today'. I have to consult her. That's how we operate. (Uncircumcised man, age 40)

"I am 55 and have been married for the past 30 years and have grandchildren. I cannot imagine myself struggling to walk after getting circumcised. (laughs) 'Mungasati mudhara anoda zvinhu uyu'. Even if I was to consider it how would I sell the idea to my wife? I don't need this procedure of yours. It's for teenagers and younger couples perhaps. (Uncircumcised man, age 55).

"Come on! There is no need for me to go through that pain to guard myself from something that I am not in danger of. Where would I get the HIV if I have one wife who I trust and she is not sleeping around? This whole circumcision nonsense is for those men who cannot control their sexual urges and sleep around. It's not appropriate in my context; I am faithful to my uninfected partner" (Uncircumcised man, age 28).

This helps to explain why the uptake of VMMC has been low among older men in the Midlands Province; most of whom belong to traditionally non-circumcising ethnic groups. The general perception that the levels of risk when one is married are low is a barrier among married man. Some erroneously assume that being married inoculates them from the risk of HIV infection. Others feel VMMC is shameful and not age appropriate when one is older. Therefore health promotion initiatives targeting older men may have to be repackaged so that they emphasis other health benefits that come with VMMC for both males and females that are not related to the risk of HIV/STI infection as well as concerns to do with age.

Abstinence Period

WHO (2015) recommends abstinence for at least 42 day post-surgical circumcision to allow the wound to heal completely. For some the period is too long and this can act as barrier when deciding to get circumcised.

“Do you honestly think it is possible for a married man or woman to adhere to the 6 weeks abstinence? It’s a basic need. You guys are just not realistic. The very reason why condoms were invented is because most people including you probably cannot abstain” (uncircumcised man, age 33).

“ Six weeks ‘kuuraya munhu baba’” (Uncircumcised man, age 26)

“I would rather encourage my son to be circumcised not my husband. Six weeks will be difficult for both of us” (Female partner uncircumcised man, age 32)

These findings are consistent with Morris et al., (2012, p. 9) who noted that “that this period of complete abstinence (from both intercourse and masturbation) is often daunting and serves as a disincentive for men to undertake the procedure”. Herman-Rolof (2010) also observed that the post-operative abstinence period was a significant barrier in the uptake of VMMC in Kenya. This is a barrier that may not be resolved for some time given that non-surgical procedures such as PrePex have a longer abstinence and healing period (56 days) (Hatzold, 2014). However circumcision during infancy eliminates this obstacle.

Adverse Events Fear of adverse effects on health, sexual function and activity after circumcision can be a barrier to the uptake of VMMC. Some participants reported adverse effects on sexual function after circumcision.

“Before my man got circumcised, sex was something exciting but when he got circumcised he started having erectile dysfunction. If it was possible to reverse everything I would not again encourage my husband to do such a thing, I am regretting it.” (Female Partner circumcised man, age 28)

Others were of the opinion that it may have an effect on sexual functioning and health.

“The fact that male circumcision involves the removal of that which is or was created as part of a normal man and the removal of that which is natural clearly indicate the dangers that might come after the experience. I would not personally encourage my husband to get circumcised, particularly due to the fact that the process is irreversible and at times the wound of a circumcised penis might take long than expected to heal so I would not want to regret it if it won’t work well for me and my partner. They say if it’s not broken don’t fix it” (Female Partner uncircumcised man, age 30)

“I read from one article that the foreskin is the most sensitive part of the penis so I think a man will be less sensitive upon its removal and that would make him to have a lower libido which will also affect me in a way.” (Female Partner uncircumcised man, age 20)

Male participants also voiced their fears about the outcomes of VMMC. Some were afraid the procedure will incapacitate them in some way.

"I have heard of cases where the organ gets infected and falls off. That will be a disaster at level 12. Besides I am a manual labourer and the sole bread winner. I must bring something on the table daily. I cannot afford 6 weeks at anything less than 100%. The risks and opportunity cost far outweigh the benefits" (Uncircumcised man, age 38)

Thus it appears perceived post-surgical outcomes are barriers to the uptake of VMMC. However it must be noted that in most cases the outcomes are not negative. For example Moss et al., (2012) noted that it takes around 1 million circumcisions to experience adverse effect of penile loss mostly in cases where the procedure is performed by an unqualified practitioner. Further randomised control trials that included over 10 000 participants in Sub-Saharan Africa show that VMMC has no adverse effects on sexual functioning (Kigozi et al., 2008; Krieger et al., 2008; Zulu et al., 2015). This suggests the need to further educate the target population to allay their fears. However the bottom-line is that as with any invasive procedure negative side effects cannot be totally eliminated. They can only be minimised.

Facilitators to the Uptake of VMMC

Facilitators can be defined as those factors that increase the probability and acceptability of VMMC as a procedure. The following subthemes identify factors that emerged as motivators.

HIV/STI Prevention

Most of the circumcised participants indicated that HIV prevention was one of the reasons why they got circumcised. Others also cited the prevention of STIs as one of the motivators for VMMC.

"It is very necessary because it doesn't mean that in being married a person suddenly becomes faithful thus the prevention of STI's and HIV." (Circumcised man, age 32)

"People are dying almost every day due to these sexually transmitted infections especially AIDS thus circumcision is indeed a blessing, people should embrace the whole concept and grasp the 60% with both hands." (Circumcised man, age 25)

This sentiment was also echoed by female participants

"It is a good prevention strategy because it doesn't mean that if people are married they are 100% faithful to each other thus circumcision then it is very useful to prevent HIV and STIs". (Female partner circumcised man, age 34)

These findings resonate with previous research (Chirau, 2012; Morris et al., 2012; Rupfutse et al., 2014 & Westecamp, 2012). In a population based survey of 2350 respondents; Hatzold et al (2014) 93.8% reported they were motivated to undergo VMMC to prevent HIV/STIs. This suggest that health promotion initiatives have been effective in highlighting the efficacy of VMMC in reducing the risk of infection. However it must be noted that the low levels of VMMC uptake in light of such high levels of knowledge suggest there is a need to go beyond basic health education to increase uptake.

Penile Hygiene and Cancer Prevention

Demand creation interventions in Zimbabwe have been using the mantra 'Pinda Musmart'. This implicitly suggests that VMMC is not just about HIV/STI prevention but can also be a way of enhancing penile hygiene. Some participants were circumcised precisely for this reason.

"I am a Christian and I am abstaining. I do not perceive myself to be at risk of sexual transmission. I got circumcised simply because it is hygienic." (Circumcised man, age 26)

Other participants had positive attitudes towards the procedure because it reduces the risk of cancer, especially cervical cancer.

"I personally think that male circumcision also protects us (women) in that it reduces our chances of having cervical cancer" (Female partner circumcised man, age 30)

These findings give meaning to findings from a quantitative study of 2350 respondents aged 15-49 by Hatzold et al (2014) where it was noted that 56% got circumcised for hygiene purposes while 13.1% did so to prevent cervical cancer in their partners. Thus by also emphasising hygiene and cancer prevention, the uptake of VMMC among older who may not perceive themselves to be at low risk of HIV/STI infection can be improved.

Female Partner Influence

Consistent with previous research (Osaki et al., 2015) female partners have a significant role in the uptake of VMMC among older men directly and indirectly through denying sex or providing information.

"My partner comes from traditionally circumcising ethnic group. When I was asking her out the first question she asked me was 'Are you circumcised?'. When I said no she categorically stated that she will not accept my proposal unless I got circumcised because as far as she is concerned all uncircumcised males are boys. She said she 'does not sleep with boys'. So I got circumcised to become a 'real man'." (Circumcised man, age 27).

“A clever woman who is up to date encourages her husband to be circumcised it’s a sign of care and love on the husband’s part to be willing to go through all that pain for the sake of the wife” (Female partner circumcised man, age 33)

“To be honest I was not paying much attention to VMMC until my wife who happens to be a nurse explained the efficacy of the procedure to me. As a result I got circumcised.” (Circumcised man, age 35)

The findings suggest that female partner buy in is very critical among older men who are likely to be married or in long term relationships. Therefore to increase the uptake of VMMC there must be a deliberate effort to target female partners of married and older men. Engaging women in VMMC programmes can substantially increase the uptake of the procedure among older men.

Culture and Religion

While most ethnic groups are traditionally non-circumcising, there are some ethnic groups such as the Yao, Lemba, Shangaan, Xhosa and Tonga for whom male circumcision is a critical rite of passage. According to Shumba (2014), for such ethnic groups circumcision is not a hollow exercise of simply removing the foreskin, but instead it has other dimensions too. These include the religious, social, philosophical, and biomedical significance (Niang & Boiro, 2007).

“I am a Xhosa. Circumcision in our culture is something that is done culturally and it is acceptable. To us medical male circumcision is regarded as something meaningless even though it is associated with less risk as compared to the traditional circumcision that we practice. I think the act of male circumcision has a cultural background and if it is accepted by your culture there is no way you can reject it. However it must be performed traditionally following our rituals. Medically circumcised males are ostracised and treated with contempt and disrespect “ (Circumcised man, age 26)

*“I am from Mberengwa, I am Lemba. For us circumcision is a rite of passage. I do have reservations about VMMC. We prefer traditional male circumcision performed by the **Nyamukanga** (this is a title given to a Lemba surgeon who performs traditional circumcision procedures on the Lemba initiates in a Murundu camp). High social status accorded to traditional male circumcision initiates. In fact, Lemba men who undergo Voluntary Medical Male Circumcision are looked down upon and given a derogatory name ‘**Ruvangu**’.” (Circumcised man, age 35)*

These findings are consistent with results in a study by Shumba (2014). There are some ethnic groups that have positive attitudes towards male circumcision because

it is a part of their culture. However because the procedure has cultural significance and is essential for one's identity and status, VMMC is ultimately shunned. Thus challenge among these groups is packaging the VMMC messages in way that do not appear to denigrate traditional medical male circumcision. There is need to engage traditional and religious leaders in these groups to find common ground and mutual cooperation through unconditional positive regard and an acceptance of cultural diversity.

Conclusions and Recommendations

The participants identified a number of barriers and facilitators to the uptake of Voluntary Medical Male Circumcision. Barriers to Voluntary Medical Male Circumcision related to the pain associated with the procedure, historical cultural practices of shaming circumcised men, partner suspicions and resistance, fear of complications, and the six weeks abstinence period. Facilitators included the belief that the procedure reduced the risk of HIV infection, reduced the risk of STI infection, and cervical cancer. These findings have critical implications for value based praxis in the goal to increase the uptake of VMMC and thus prevent the spread of HIV infection. The findings are especially important to the main actors in the prevention of HIV/AIDS namely the Ministry of Health and Child Care and the National AIDS Council that are currently implementing the Accelerated Strategic and Costed- Operational Plan for VMMC (2014-2018).

VMMC is not just a biomedical procedure. Rather it is a multi-layered and socio-ecological procedure that demands a person-in context approach. There still is need for further health education. While most Zimbabwe have been exposed to VMMC messages through the mass media there still remains a need for further health promotion because a number still have unfounded misconceptions about the procedure especially with regards to pain and adverse events. The use of platforms such as the social media can be effective especially among younger man.

For older man in intimate relationships, it is also clear that the decision whether or not to be circumcised cannot be taken unilaterally. As has been the case with condom use among married couples, circumcision has latent meaning that for some carry mistrust innuendos. Given that VMMC helps to prevent female-male transmission of HIV, taking up the procedure by some male might implicitly suggest that either they do not trust their female partners or they intend to look for other sexual partners (or none of the above). This is a critical red herring. Therefore there is need to emphasise non HIV/STI related benefits among married couples. An expanded role for women in VMMC communication strategies could increase adult male uptake of VMMC services. This implies that a one size fits all approach will fall short of the mark. Rather there is need to identify and segment key audiences in VMMC communication.

Furthermore, to circumvent this obstacle, the Ministry of Health must also consider community acceptability of infant medical circumcision. Infancy can be an ideal time for medical circumcision for a number of reasons. Morris et al (2012) opined that because of the low mobility of infants healing is likely to be faster, cosmetic outcomes are likely to be excellent, and complications minimal. This will help to bypass problems associated adult circumcision such as fears of pain, penile damage, sexual dysfunctions and time off work. In addition because infants are not sexually active the problem with the 6 weeks abstinence becomes a nullity.

Macro-level strategies that conceptualise VMMC within the context of culture are also critical. Local traditional and religious leaders must be co-opted to become VMMC champions. This will help deal with the stigma associated with the procedure in traditionally non circumcising ethnic groups. Furthermore even among the traditionally circumcising groups, circumcision is not a hollow exercise of simply removing the foreskin, but instead it has religious, social, philosophical, and biomedical significance. This implies VMMC communications among such groups have got to be radically altered to get into the life world and thus emic implications of the procedure. Traditional leaders in these must be engaged to find ways of integrating VMMC with traditional male circumcision.

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