A Study To Assess The Acceptance Of Male Circumcision As A Preventive Method In Hiv And Aids, In Mbare And Southerton Suburbs Of Harare, Zimbabwe

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Abstract
This study explored the knowledge levels, beliefs and attitudes on male circumcision in a non-circumcising society within a country with one of the highest levels of heterosexually transmitted infection in sub Sahara. A sample of 20 males circumcised at a health facility, 20 non-circumcised males and 20 females were reached. From the research it emerged that the main factors which increase preference for male circumcision among men were increased sexual pleasure, lower risk of sexually transmitted infections and penile hygiene. The factors which increased preference of male circumcision among women were reduced chances of cervical cancer, increased sexual pleasure and general hygiene. Among both sexes the main barriers to circumcision was fear of pain, deformation of the male reproductive organ and death. The research concluded that generally, the community is not aware of the benefits of male circumcision and hence the need for increased community awareness.

Key words
Male circumcision, intervention, HIV/AIDS, acceptance, Zimbabwe

1. BACKGROUND INFORMATION
1:1 Introduction to the Study
In the past decade Zimbabwe has suffered greatly from the impact of HIV and AIDS. The Ministry of Health and Child Welfare (MOHCW, 2012) estimates that out of the total Zimbabwean population of 12 million people about 1, 1 million people are living with HIV and AIDS. Out of these 831 000 of them are adults between 15-49 years. New infections continue to be recorded and in 2012, 58, 4721 new infections were recorded and the estimated annual death rate of 45, 6211 persons in the same period. A decline in HIV prevalence has however been noted among persons aged between 15-49 years from 14.3 percent in 2009, 13,1 percent in 2010, 14,26 percent in 2012, and a slight increase in the current HIV prevalence of 15 percent.

While the decline among the 15-49 years age group is encouraging, overall more than one in seven Zimbabweans is still infected with HIV according to the HIV estimates of 2011. According to the MOHCW (2012), Zimbabwe will continue to invest in interventions targeting behaviour change, improve prevention strategies and improve care and treatment services for those affected by HIV. Zimbabwe has one of the highest HIV prevalence in Sub- Saharan countries, 15-49 years age group. These high rates of HIV infection are as a result of risk sexual behaviours, multiple concurrent partners, casual sex and transactional sex. These practices combined with the widespread practice of unprotected sex and the presence of sexually transmitted infections (STIs) produce an ideal climate for HIV transmission in Zimbabwe.

Numerous prevention programmes have been implemented by the government, local and international organizations but the country still continue to encounter new infections. These programmes have focused on increased condom use, reduction of sexual partners, reduction of casual sex and increased counselling and testing services. According to the UNAIDS (2007) the development of new programmes such as male circumcision is vital as an additional prevention strategy against HIV. The Joint United Nations Programme on HIV/AIDS came up with a policy document to guide all Sub-Saharan countries wishing to implement and scale up male circumcision services. The policy document also mandate governments to ensure safe male circumcision for HIV prevention is available, accessible and culturally acceptable to all individuals.
In response to the aforesaid policy guidelines, the government of Zimbabwe also came up with a policy document on male circumcision, which among other things states that male circumcision shall be offered in a culturally sensitive manner with respect for traditional, cultural and religious values and beliefs. The Zimbabwean Male Circumcision policy document also states that the priority age group is the 13-49 years group as the 20-29 years age group for men with the highest HIV prevalence is within this group.

Male circumcision, as any surgical procedure may have post operative complications if carried out by inexperienced personnel. The safety of male circumcision depends on the setting were the procedure is carried out. Male circumcision for religious and traditional reasons frequently takes place in a non-clinical setting. Circumcision undertaken in unhygienic conditions by inexperienced providers, with inadequate instruments or with poor after care can result in serious complications, including death. Health care providers should therefore provide up to date information on health risks as well as the benefits of male circumcision so that people accept the programme.

1:2 Understanding Male Circumcision

Male circumcision is the removal of the foreskin, a loose fold of skin that covers the head of the male reproductive organ. Historically, male circumcision has been associated with religious practice and ethnic identity. Circumcision was practised among the ancient Semitic people, including Egyptians and Jews, according to Johnson (1993). Among the ancient Egyptians circumcision was a sign of fertility and godly sacrifice. Today Muslims are the largest religious group to practice circumcision, as part of their Abrahamic faith, to confirm their relationship with God. With the global spread of Islam from the 7th century AD, male circumcision was widely adopted among previously non-circumcising communities. In Islam, one theory behind the Egyptian practice was that men were born bisexual, and in order to mature in a healthy way, they needed to remove the female part of their genitals which was the hood or prepuce.

In Sub-Saharan Africa there is no consensus on compatibility of male circumcision with Christian beliefs as noted by Westercamp and Bailey (2007). Some Christian churches in South Africa oppose the practice, viewing it as a pagan ritual, while others, including the Nomiya church in Kenya, require circumcision for membership. In Malawi and Zambia there are similar beliefs that Christians should practice circumcision since Jesus was circumcised and the Bible teaches the practice. Circumcision has been practised for non-religious reasons in Sub Saharan Africa. Prevalence of circumcision in a country can vary by ethnicity. In most of these countries, circumcision is an integral part of a rite of passage to manhood. Circumcision is also associated with factors such as masculinity, social cohesion with boys of the same age who become circumcised at the same time, self-identity and spirituality as noted by Niang (2006).

Today, male circumcision is performed for a range of reasons, mainly social or health related, in addition to religion and ethnicity. The desire to conform is an important motivation for circumcision in places where the majority of boys are circumcised. This is mainly done in Kenya, where soon after birth a baby boy is circumcised so that he does not look different from others. In other countries like Ethiopia, men are most likely to be circumcised if they are wealthy, have at least secondary education and live in an urban area. In Ghana, male circumcision is seen as cleansing the boy after birth as noted by Niang (2006). Bailey (2007) expressed that men in Botswana, Tanzania, Zambia and Zimbabwe believed that it was easier to keep the reproductive organ clean through circumcision.

1:3 Male Circumcision in Zimbabwe

Zimbabwe is a non-circumcising society but some traditional male circumcision ceremonies are held by small ethnic groups. Such groups are the Tonga of Binga, the Chewa who are mainly concentrated in Harare, the vaVenda and the Shangani of Chiredzi and Mberengwa and Muslims who constitute 1% of the total population. As noted by Rizvi (1999), the main male initiation ceremony is the murundu among the vaVenda, in which boys aged about ten to twelve are circumcised and over a period of months are taught manly behaviour. Among these tribes which practice circumcision, the boys know what to expect, and are encouraged to show their courage by lying still and not showing pain during
circumcision. Among the vaVenda, the custom has been to keep the practice secret from the boys before the rite of passage and to swear them to secrecy afterwards. Rizvi (1999) noted that the boys in their ignorance are led to a bloodstained stone for the operation. The supervisors of the ritual will make a loud noise so that the screams of pain and terror are not heard by the other boys. Circumcision is done by an elderly experienced man using a spearhead.

In accordance with the Joint United Nations Programme on HIV/AIDS requirements, Zimbabwe rolled out its National Male Circumcision Policy in November 2009 with its priority age group of 13-49 years because it encompass men within and immediately before the ages of highest levels of new HIV infections. The methods used in clinical male circumcision for adult and adolescent circumcision are the forceps guided method, the dorsal slit method and the sleeve method. The operation procedure in adults is more complex than in children and therefore requires local or general anaesthesia. In Zimbabwe the forceps guided method was adopted as a standard method for male circumcision. This method can be performed without an assistant and is suitable for resource limited settings like Zimbabwe. The operating procedure takes twenty to twenty-five minutes on one man.

According to the MOHCW (2013) by the end of 2013, about 90,000 males in Zimbabwe have been circumcised, still short of the 2013 target of 115,000 but a remarkable increase from the 40,755 who underwent the procedure in 2012. The government is targeting to circumcise 217,800 people in 2014 and 1.3 million by 2017.

1:4 Aim of the Study
This study sought to assess the knowledge levels and beliefs of people in regards to male circumcision with a focus on Mbare and Southerton areas of Harare. The study also sought to highlight how knowledge and beliefs on male circumcision influence the acceptance rate of male circumcision.

1:5 Statement of the problem
Male circumcision has been approved as a new HIV prevention method after three randomised trials conducted in South Africa, Kenya and Uganda to ascertain the effectiveness of male circumcision in reducing HIV transmission. It has been found to be efficacious in reducing HIV transmission among heterosexual partners by more than 50%. The WHO/UNAIDS (2007) recommended that male circumcision should be implemented and scaled-up in countries where there are high HIV prevalence, especially in southern Africa and conducted by well trained medical professionals under conditions of informed consent. Male circumcision has however been received with different views especially in non-circumcising communities of southern Africa, including Zimbabwe. A few men according to the Ministry of Health and Child Welfare are coming forward for male circumcision due to varying perspectives, despite the government’s target of intending to reach out to 80% of males and new born babies by 2015. Some of the barriers to male circumcision according to men are fear of pain, concerns of safety and the cost of the procedure. Women have varying perspectives concerning issues of sexual enjoyment after circumcision. Male circumcision has been perceived with different views in terms of its acceptability as an HIV preventive strategy. The above mentioned views need to be further ascertained through this study by assessing the knowledge, attitudes and beliefs of people in accepting male circumcision as a preventive method in HIV and AIDS, in Mbare and Southerton suburbs of Harare.

2: STUDY METHODOLOGY
2:1. Research design
Using focus group discussions and key informant interviews, this study sought to establish the factors surrounding the acceptability of male circumcision as a preventive measure in HIV and AIDS. This research employed the qualitative, descriptive approach. Focus group discussion guides were used for the groups of circumcised males, partners to circumcised males and the uncircumcised males. The interview guide was used for the key informant who was the medical doctor at Spilhaus, Harare hospital.

2:2 Sampling
The study had 60 respondents i.e 20 males circumcised in a clinical setting, 20 females with circumcised partners (partners to the first group) and the last group was a group of non-circumcised males from Southerton suburb between 15-49 years. This age group was intentionally chosen as it is the group with the highest HIV prevalence in Zimbabwe. The key informant was a medical doctor at Spilhaus, Harare hospital.

Mbare and Southerton suburbs were purposively selected because people from different ethnic groups’ i.e the Vavenda, VaChewa and other groups of people from other countries like Zambia, Malawi and Mozambique reside in Mbare as noted by Rizvi (1999), and therefore it was easy for the researcher to get a sample of people for the study. Southerton was also selected because of its proximity to the circumcision site, Harare hospital, and also to ensure that other variables like distance to the circumcision site are eliminated.

2:3 Data Recording and analysis
Data was recorded and classified into appropriate major themes and thematic content analysis was used in analysing the data.

3 RESEARCH FINDINGS AND DISCUSSION

3:1 Demographic characteristics of respondents
In total 61 respondents were interviewed: 20 circumcised males, 20 non-circumcised males and 20 women (partners to the circumcised men). One key informant (the medical doctor) was also interviewed. The ages of the respondents ranged from 15-70 years, i.e 15-29 years (7 males and 3 females), 30-44 years (21 males and 11 females) and 45-70 years (12 males and 6 females). The age group with the least number of respondents in both sexes is the 15-29 age groups. This confirms Auvert and Talijard’s (2005) assertion that although the young adults are equally affected by HIV and AIDS, most of them are not committed in HIV prevention programmes until they realize that they are HIV infected.

3:2 Knowledge on male circumcision and reduced risk of HIV infection and STIs
From the forty male respondents, thirty six respondents (60%) knew that it is easier to contract an STI if one is non-circumcised, whilst four (24%) thought that it is easier to contract an STI if you are circumcised. The later expressed that a circumcised male reproductive organ is “always dry, susceptible to cracking” and that this state provided a portal of entry for bacteria and viruses. On knowledge of contracting HIV, 28 respondents (47%) expressed that it is easier to contract HIV if you are not circumcised. The respondents acknowledged that it is important for a male to undergo male circumcision because the process minimizes the risk of infection such as STIs and HIV and AIDS during sex. They explained that if a person is not circumcised the foreskin is likely to keep dirt and diseases will occur. The respondents explained that sexually transmitted infections were more severe and more infectious in uncircumcised men, with ulcers healing faster in those who are circumcised. These views confirm Bailey (2007)’s observation that the area of the penis around the foreskin is a warm and moist environment which promotes the replication of bacteria especially if penile hygiene is poor. Bailey (2007) further noted that the inner surface of the foreskin is less protected and so especially when having sex, is more susceptible to abrasions or inflammation which can facilitate easy contraction of sexually transmitted infections.

Twenty-six respondents (43%) expressed that it is easier to contract HIV when one is circumcised. The respondents alluded to their expression when they said that it is easier for circumcised men to contract STIs because of the dryness of their penis after circumcision as may result in some cracks during a sexual act and thereby exposing the men to HIV infection through the openings if the STIs are not treated. Their views that it is easier to contract HIV when you are circumcised is in variance with the findings from a study conducted by Auvert and Taljaard (2005) who noted that male circumcision is efficacious in reducing the transmission of HIV by more than 50% in heterosexual contacts. Six respondents (10%) did not know the difference on whether one is more susceptible to HIV acquisition when they are circumcised or when they are not circumcised.
The most important factor raised by the respondents was lack of knowledge among the population on the benefits of male circumcision. Respondents felt that not enough information has been made available to the general public from the health centres about the benefits of male circumcision. It was perceived by a number of respondents that if information becomes widely known, then there would be a large increase in demand for safe clinic-based male circumcision in health centres. The following are some of the sentiments from the respondents:

“Isu varume hatitozivi kuti zvinobatsirei kuti tichecheudzwe”, literally meaning that most men do not know the importance of male circumcision.

“Zvinondikachecheudzwa ndozonzi murume pai” literally meaning that if the man is circumcised and the prepuce is removed they will no longer be man enough.

However the understanding that circumcision can reduce the risk of HIV had been taken too far by some circumcised men. As a result there is a danger of circumcised men claiming that they were now completely free from sexually transmitted infections and could no longer be infected with HIV. This view was expressed by the key informant who was concerned about the potential for increases in risk behaviour and the ability of the health care system to cope with an increased demand on its services.

3:3. Attitudes and Beliefs on Male circumcision.

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

All the respondents defined male circumcision as an operation that removed the foreskin from the penis. They viewed the operation positively, as a way of minimizing the risks of sexually transmitted infections while it also makes sexual contact smoother and not hurtful to their partners. All the circumcised men interviewed expressed that there are advantages to a man being circumcised. The main benefits were that it helps improve hygiene; it reduces the risk of STIs and HIV infection. Circumcised men noted an improvement in satisfying their partners sexually.

3:3:2 Beliefs around sexual aspects of circumcision

The circumcised men were also asked if there has been a difference in terms of sexual gratification before and after circumcision. Fifteen respondents (75%) confirmed that circumcised men enjoy sex more than non-circumcised men. These respondents denied that male circumcision reduces sexual pleasure and confirmed that they are actually having more fun than before. This view concurs with findings from a study by Bailey (2002) in Kenya were it was seen that women enjoyed sex more with their circumcised men than before, and this was a strong predictor of preference to be circumcised. This group also reported that before undergoing male circumcision, they had fears that they will not be able to function properly, all men feared the pain associated with the operation which they said one can even die due to the pain. Of the 20 circumcised men, 12 of them (60%) feared that they will have problems with penile erection and that they may be disfigured and fail to satisfy their partners. Respondents claimed that their fears have now been allayed and now view male circumcision positively. Respondents in this group expressed that men are not forthcoming to undergo this operation mainly due to fear. Five of the circumcised men (25%) however expressed that there is no difference before and after circumcision in terms of sexual pleasure, though there are other advantages to male circumcision, like the reduction of STIs and HIV infection and improved penile hygiene.

3:3:3 Non-circumcised men’s views of male circumcision

The researcher sought to understand from this group of men some of the reasons why they do not prefer to undergo male circumcision. From the respondents 10 respondents (50%) expressed fear of pain that one undergo during the operation. These respondents recognised the importance of male circumcision as an operation that protects people from sexually transmitted infections and also believed that circumcised men are cleaner, but fear the operation that one undergoes. Three respondents felt that male circumcision would diminish sexual pleasure through reduced sensitivity and less sexual arousal. These respondents expressed that they fear the adverse effect of male circumcision which may result in impotence, disfigured penis and insufficient removal of the skin. They however had different views with regard to circumcised men. Respondents believed that there are women who like circumcised men while others do not mind whether a man is circumcised or not. Uncircumcised men pointed out that age was one of the primary reasons that prevented uncircumcised
men to be circumcised. One respondent said that he is too old to be circumcised. On the other hand, they believed that male circumcision performed at hospitals is not highly regarded and recognised as a tradition: therefore that becomes a major hindrance for male circumcision at a health facility. Another objection raised was that the men will be exposed to embarrassment and disgrace in health centre having to undress and be operated upon in front of female nurses. This view was expressed by three respondents representing 15%. Three respondents (15%) pointed to the confusion which exists between traditional initiation and male circumcision as something traditional, of the past or contrary to their religious beliefs.

3:3:4 Women’s views of male circumcision
The researcher sought to get the views of women with circumcised partners in regards to the sexual aspects of circumcision. Thirteen respondents out of the twenty women representing 65% highlighted that circumcision makes sex pleasurable than before and there are reduced chances of cervical cancer. These women noted that their sexual needs can now be fully satisfied than before circumcision as the men now take more time before reaching orgasm. This view concurs with the findings from a research conducted by Bailey (2007) who confirmed that women enjoyed sex more with circumcised men, and this reason was a strong predictor of preference to encourage their partners to be circumcised. In southern Nigeria, the enhancement of sexual performance and reproductive ability was also an important reason given for male circumcision as noted by Myers (1985).

The women further commented that circumcised men are clean and free from infection. However according to the key informant, there is a danger that some women have come to believe as a result that they cannot be infected at all by STIs and HIV once the man has been circumcised. This can lead to women engaging in unprotected sex more frequently with circumcised men believing that they are safe. This however needs to be addressed through awareness programmes in order to avoid the danger that this false belief could result in higher risky sexual behaviours.

Seven women representing 35% reported that there has not been any difference in regards to their men’s performance when having sex. Four of these women noted that they enjoyed sex before their men were not yet circumcised. They pointed out that a non-circumcised man is easy to stimulate than a circumcised man. They further said that the removal of the prepuce makes it harder for them to stimulate their men physically, so their men performed better sexually before circumcision. Although these women feel that circumcision have improved their sexual experiences, they however felt that they would not want their newborn males to undergo this operation due to the pain experienced in the procedure which may result even in death and possible deformation of the male reproductive organ. Rather women would prefer men to be circumcised when they are able to consent.

3:3:5 Preferred Practitioners to carry out male circumcision
The researcher sought information on the preferred practitioner to conduct male circumcision from the twenty circumcised males and the 20 non-circumcised males. Twenty-one respondents representing 53% prefer that the operation be done by a doctor. Thirteen respondents (32%) preferred that male circumcision should be conducted by trained nurses and six respondents (15%) preferred to be circumcised by a traditional healer. Those who preferred to be circumcised by the doctor noted that this operation would need highly trained and experienced personnel so that if there are any adverse reactions a doctor will be able to correct them unlike a traditional healer. Those who preferred to be circumcised by the nurse noted the issue of long queues waiting for the doctor as they take time with one patient. These respondents pointed out that the anaesthesia they are administered might even weaken before the operation. These respondents thus feel that the nurse should also be trained to carry out the operation and thereby reduce the queues. However, the respondents expresses that if nurses are trained to do the operation, they will prefer to be operated on by male not female nurses. These findings concur with the findings by Auvert and Talijaard (2005), who also noted that many men may feel embarrassed about exposing their private parts of their bodies and having their foreskin cut by females.

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

3:3:6 Level of stigma attached to male circumcision.
The researcher sought this information from all the sixty respondents, i.e. 20 circumcised men, 20 non-circumcised men and 20 women with circumcised partners.

Of the sixty respondents, 33 (55%) felt that there was stigma attached to male circumcision. These respondents felt that stigma was being directed to circumcised men, especially because the practice is not common in Zimbabwe. One circumcised men stated that soon after being circumcised some men wanted to see his reproductive organ and they called him all sorts of names. One respondent said that those men circumcised in health institutions are not regarded as ‘real men’, ‘true men’ or ‘complete males’, which traditionally only results from going through initiation school.

Such stigma can potentially reduce the demand for male circumcision. Possibly there is need to explore whether men who choose to have male circumcision at a health facility could still be allowed to go through the initiation schools without being circumcised by traditional healers. This was found to have occurred as two of the respondents claimed to have undergone both the medical male circumcision and later for traditional initiation.

4: OPTIONS FOR INCREASING DEMAND FOR MALE CIRCUMCISION
Forty-three respondents (71.6%) highlighted the need for continuous widespread health education in Zimbabwe in order to improve awareness on the benefits of male circumcision especially in the rural areas and farming communities. Without the effective education campaign it will not be possible to increase the demand for male circumcision at health facilities. Health workers were urged not to confront people’s religious and cultural affiliations as this would only create unnecessary controversy. Several forms of health education were suggested including:

- Special television and radio programmes
- Door to door visits to provide education and handout information
- Special public gatherings for men and adolescent boys in schools, workplace, churches
- Establish a special ‘Male Circumcision Day’
- Use of peer education as a means of communicating information on male circumcision
- Use of health video on male circumcision at health centres to provide education

These respondents also suggested messages which could influence men to get circumcised and becoming a real man. One respondent said “strong men circumcise to protect HIV spread to the new generation”. Focus on improved sexual pleasure was also promoted as one man commended “Change its shape for the better, be circumcised. A well sharpened pencil writes better than the unsharpened pencil- get it sharpened”.

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

The recruitment of more staff to carry out male circumcision was another factor noted by the respondents. The key informant also supported the need for more staff to be recruited in order to respond to large increases in the number of circumcisions carried out. Training of more staff to be able to carry out male circumcision was also identified as a requirement for scaling up male circumcision.

Four respondents (20%) emphasised that the availability of more circumcision sites need to be increased to most health centres in Zimbabwe through training and capacitating the health personnel.
5: CONCLUSIONS AND RECOMMENDATIONS

The study has noted that there is still lack of awareness on the benefits of male circumcision among the general populace especially in Mbare and Southerton suburbs of Harare. There are still some myths and misunderstandings which deter men from male circumcision. The study noted that there are still few practitioners trained to conduct male circumcision, which might be a hindrance in increasing the demand for male circumcision as people are discouraged by the long waiting queues. The study also concluded that one of the most damaging myth or misconception prevalent among the respondents is that they feel that if one is circumcised they are completely safe from HIV. The study therefore recommend increased awareness and education campaigns, focussing on dispelling the myth that male circumcision can completely protect men against HIV. The need to expand the provision of male circumcision cannot be overemphasised. This can be done throughout the larger health facilities which already have the facilities to perform minor operations. There is also need to increase the number of health professionals involved in providing male circumcision to cater for more patients. In light of the different cultures and beliefs in Zimbabwe there is need for the clinical and traditional providers to cooperate and develop models which both contribute to, while respecting the different views that each contribute.

LIST OF REFERENCES