Medical Male Circumcision for HIV Prevention: Are Women Ready?

Jayne Arnott ▪ Johanna Kehler

Published by the AIDS Legal Network (ALN)
Suite 6F, Waverley Business Park, Mowbray, 7700 • PO Box 13834, Mowbray 7705, Cape Town, South Africa
Tel: +27 21 447 8435 • Fax: +27 21 447 9946 • E-mail: alncpt@aln.org.za
Website: www.aln.org.za

Table of Contents

Acknowledgements

There are many individuals without whose generous assistance and contributions this study and report could not have been completed. Though it is not possible to mention all of them by name, their help is greatly appreciated.

First, we wish to extent our thanks and gratitude to all the numerous women in the communities who gave their time to be interviewed and share their thoughts. We also wish to thank Silungile Mlambu from NAPWA, Nomfundo Xotyeni from iBhayi Living Centre, Bernie Dolley from Ikhala Trust, and Promise Mthembu from Her Rights Initiative (HRI) for their support in project implementation and data collection in the respective communities of KwaZulu Natal and the Eastern Cape.

We also wish to thank the AIDS Legal Network (ALN) project staff for their efforts and assistance in data capturing and finalising this report.

Finally, we are grateful to AVAC Women's HIV Prevention Tracking (WHiPT) Project and the ATHENA Network for their support throughout the project.

Executive Summary

In 2007, the WHO and UNAIDS recommended that medical male circumcision should be a priority HIV prevention interventions in countries with high HIV prevalence rates and low prevalence of male circumcision. This recommendation was based on the results of three trials in Kenya, Uganda and South Africa that indicated an up to 60% protection from HIV infection in circumcised males. Since then, steps have been taken at a country level to develop policy frameworks, programmes and services to introduce and roll-out medical male circumcision for HIV prevention.

The roll-out of medical male circumcision programmes across South Africa is scheduled for mid April 2010. South Africa's National AIDS Council (SANAC) had, as early as 2007, raised the possibility of providing medical male circumcision services in South Africa, but was faced with a then lack of political support. In 2008, civil society engaged with the issue and SANAC showed more support and a stronger voice regarding the introduction and roll-out of medical male circumcision (MMC) services for HIV prevention.

At the same time, the SANAC Women's Sector raised concerns about the impact of this particular HIV prevention strategy on women, and questioned how introducing medical male circumcision for HIV prevention would benefit women. Traditional leaders also raised concerns that medical male circumcision would conflict with traditional male circumcision practices, which lies at the core of young men's initiation rites for several ethnic groups in South Africa.

Following lengthy consultations with numerous stakeholders, SANAC issued a number of recommendations, including that costs associated with the roll-out of MMC for HIV prevention should not divert funds from female condom distribution and other programmes directly benefiting women; that MMC for HIV prevention should be offered as part of a comprehensive sexual health package, including HIV counselling and testing; and that communities should be informed that medical male circumcision was only partly effective in preventing the risks of HIV infection.

As of February 2010, the Department of Health produced a draft set of Implementation Guidelines, and is conducting feasibility and costing analysis. There is no clarity as yet regarding whether or not South Africa will have MMC for HIV prevention implementation guidelines and/or a policy; or how the costs will be covered.

IMPLICATIONS OF MMC ROLL-OUT FOR WOMEN

In South Africa, women are disproportionately infected and affected by HIV and AIDS. Given the limited access to, and availability of, women-controlled HIV prevention options, the introduction of MMC for HIV prevention can easily be seen as adding to the many risks and vulnerabilities women already face in respect of protecting themselves from HIV infection.

There are presently no known direct benefits of MMC for women. The indirect health benefits of MMC for women in the longer term are reduced risk of exposure to HIV and other sexually transmitted infections, should MMC become widely accepted and utilised. Other potential indirect benefits for women are cited as MMC programmes being an entry point to reaching men, and their partners, with information and services on HIV risk reduction, gender equity, contraception, and shared sexual decision-making.

However, the introduction and roll-out of MMC for HIV prevention also has the potential to impact negatively on women, especially in the context of community and/or individual beliefs that male circumcision is completely protective against HIV, and eliminates the need for other risk reduction strategies. Potential harms that could impact on women are increased risk-taking behaviour in circumcised men, with reductions in rates of condom use, and increases in numbers of sex partners.

Other potential negative impacts of MMC for HIV prevention on women would be further stigmatisation of positive women, by blaming them if a circumcised male is tested positive for HIV, as well as an increase in gender-based violence and abuse, if women insist on condom use after men have been medically circumcised.

THE STUDY

The project intended to document and analyse women's perspectives and levels of participation in discussions and decisions about medical male circumcision for HIV prevention; to document and analyse policy responses in the context of introducing medical male circumcision as an HIV prevention strategy prevention; and to build capacity among various stakeholders, particularly women in communities. In order to achieve this aim, project activities included a literature review, as well as information and data collection through various means, including questionnaire administration, facilitated focus group discussion, and formal and informal discussion with various stakeholders.

FINDINGS

From the outset it is important to note the distinct differences between the two samples; women in circumcising communities (Eastern Cape; EC) and women in non-circumcising communities (KwaZulu Natal; KZN). Within the socio-cultural context of traditional male circumcision practices, women's levels of involvement in, and engagement with, the introduction and roll-out of medical male circumcision for HIV prevention is, as indicated by the data, distinctly different to women in communities in which male circumcision as rite to manhood is not an integral part of culture and tradition.

As such, women in the EC sample largely responded to MMC for HIV prevention in their role as mothers, with little engagement on the impact of MMC on women's sexual health and rights as partners to men who will be, or have been, medically circumcised. To the contrary, in KZN, a non-traditionally circumcising community, women engaged with the concept of MMC for HIV prevention primarily as partners and hence, were more focussed on the impact of medical male circumcision for HIV prevention on their sexual health and rights.

Knowledge levels regarding MMC as an HIV prevention strategy

Whilst the data indicate relatively high levels of perceived knowledge about MMC for HIV prevention, data also indicate that a significant number of women at a community level have never heard about it. This is of concern considering the fact that MMC programmes are about to be rolled-out in South Africa.

The data seem to further suggest that '*hearing*' about MMC for HIV prevention does not necessarily translate into having '*factual knowledge*' about MMC, such as the fact that MMC is only partially protecting against HIV risk, the need for condom use after MMC, and the need

to abstain from sex during the period of wound healing. Thus, the data arguably confirm the need for education and awareness raising about MMC for HIV prevention prior to the roll-out of MMC programmes, as well as highlight the shortcomings of current information and messaging about the benefits of MMC for HIV prevention.

The socio-cultural tensions around male circumcision and the exclusion of women from gaining access to information came through clearly in the data. As traditional male circumcision is a '*sacred*' and '*secret*' male institution, women who want to access health and HIV information related to male circumcision practices face many barriers, including the control of women's information seeking behaviour. Thus, for women to access, and act upon, information related to MMC and HIV, the information must be specifically tailored for women, taking into account the socio-cultural context and the realities of women in both traditional and non-traditional male circumcising communities.

Perceived advantages and disadvantages of MMC

Although the data suggest high levels of perceived advantages of MMC for HIV prevention, it is important to note that women from the EC sample responded to this question primarily as '*mothers*' concerned about the safety of their children participating in traditional male circumcision practices, and not as sexual partners to men who may, or may not, be medically circumcised. Thus, the data arguably emphasises the need for education and awareness raising about the differences between traditional and medical male circumcision practices and benefits.

The KZN sample who noted advantages related to the protective factor for men also noted disadvantages to women at the same time, in that they were not protected. With regards to perceived disadvantages, the data point to women being primarily concerned about increased risk behaviour in men, as well as women being blamed for HIV infection.

Support for MMC

While the data clearly indicate support for MMC for HIV prevention to be introduced to communities, data also highlight the need for more education and awareness in the community on issues relating to advantages and disadvantages of MMC for HIV prevention.

The data further suggest relatively high levels of perceived support amongst men, as well as individual support, for the introduction and roll-out of medical male circumcision as an HIV prevention strategy. It does, however, also indicate that whilst supporting the introduction of MMC for HIV prevention in principle, this support is qualified by the need for women's greater involvement in MMC for HIV prevention discussions and decisions; as well as the noticeable tensions between traditional and medical male circumcision practices.

Perceived impact of MMC on women

While the data clearly highlight a general lack of perceived benefits of MMC for women and women's protection, as well as for changing ideas and beliefs about HIV, it also suggest that if MMC would be linked to other prevention methods, such as condoms, and to additional services, such as education and training, the introduction and roll-out of medical male circumcision for HIV prevention could have a protective factor for women.

The data suggest that currently available HIV prevention options, such as female and male condoms, provide limited benefit to women in a societal context of gendered inequalities and power imbalances. The data also confirm that most women are not in the position to negotiate condom use and are least in control over HIV prevention options. Taking into account that medical male circumcision for HIV prevention is not a stand alone HIV prevention method, and that MMC can only be an effective addition to available HIV prevention options when combined with other preventative methods, such as condoms, it is crucial to ensure that male and female condom promotion and distribution

becomes an integral part of MMC for HIV prevention processes.

The data highlight relatively high perceived levels of gender-based violence, which arguably reflects communities' realities of high levels of violence and abuse. However, the data also strongly suggest that the introduction of MMC for HIV prevention may lead to increasing levels of gender-based violence, as men may refuse condom use after MMC and women are likely to be blamed for HIV and STI's, arguably indicating the need to address these risks as an integral part of MMC for HIV prevention initiatives and programmes.

Lastly the data point to a specific need for women to organise and mobilise around their concerns related to MMC. There was a call for increased access to, and availability and development of women-controlled HIV prevention strategies.

STUDY RECOMMENDATIONS

Based on the research finding, the study recommends that in light of a lack of a policy framework there is a need to engage policy makers to ensure the timely finalisation of a rights-based policy framework regulating MMC for HIV prevention in South Africa.

Recognising the expressed need for increased access to, and availability of, women controlled HIV prevention options, it is recommended to monitor that resources are not diverted from HIV prevention programmes for women, and advocate for increased HIV prevention programming and interventions for women running parallel to as well as forming an integral part of MMC for HIV prevention that addresses the existing challenges of, and barriers to, HIV prevention, such as gendered power imbalances and inequalities.

Furthermore, acknowledging the need for adequate education and awareness raising campaigns on MMC for HIV prevention, it is essential to ensure the dissemination of accurate and factual information around MMC, particularly addressing women's realities, risks and potential benefits, and emphasising the partial protection from HIV infection for men.

Finally, taking into account the challenges and inherent tensions between traditional and medical male circumcision, there is a further need for broad consultations and investigation of potential mechanisms of combining the two male circumcision practices, as well as a need to engage in ongoing research, especially around women's actual and desired role and involvement in discussions and decisions about male circumcision within circumcising communities.

1 Medical Male Circumcision for HIV Prevention:

Introduction and contextual framework

Medical male circumcision (MMC) refers to the complete surgical removal of the foreskin of the penis. Circumcision may be performed for health and hygiene reasons and may also be part of religious or cultural practices. The term MMC applies to circumcision that is performed by a trained health professional, and is differentiated from traditional circumcision, which is performed as part of a religious ritual or cultural rite of passage[1].

BACKGROUND

Three large-scale clinical trials were conducted in Kenya, Uganda, and South Africa during 2005 – 2007 on MMC for HIV prevention.[2] The participants who received circumcision plus the prevention package were estimated to have 50 to 60% fewer infections than those in the control group (who received the prevention package alone).This led researchers to conclude that circumcision provided risk reduction beyond that provided by standard prevention, such as STI treatment, condoms, and counselling.[3]

MMC reduces heterosexual men's risk of HIV transmission from female partners. Benefits to women could be seen in the longer term, if MMC coverage increases to where it reduces the number of positive men. Thus far, there is no conclusive answer why MMC reduces men's risk of HIV infection. Possible explanations include that the foreskin of the penis has many cells of a type that are vulnerable to HIV infection, and circumcision removes these cells, making the penile skin more durable, which might also reduce the risk of HIV infection. Furthermore, medical male circumcision reduces the rate of genital ulcer disease; genital ulcers can increase the risk of HIV infection.[4]

UNAIDS/WHO GUIDELINES

Based on the trial findings, WHO and UNAIDS concluded in 2007 that male circumcision should be a priority HIV prevention service in countries with high HIV prevalence rates and low prevalence of male circumcision. Since then, steps have been taken at a country level to develop policy frameworks, programmes and services to introduce and roll-out medical male circumcision for HIV prevention.[5] The WHO/UNAIDS Guidelines, *Operational Guidelines for Scaling-up Male Circumcision Services for HIV prevention* (2008), looks at issues related to developing leadership and partnerships, conducting situational analysis, advocacy and an enabling policy and regulatory environment. It further speaks to service delivery approaches, as well as operational elements, such as quality assurance, human resource development, commodity security, social change communication and monitoring and evaluation.[6]

Another WHO/UNAIDS report, *New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications* (2007), provides guidance for decision-makers and programme planners, as well as for health service providers, regarding the human rights, legal and ethical obligations and duties when offering or conducting MMC for HIV prevention.[7]

The protection and promotion of human rights focuses on the need for accessible services within a framework of informed consent, and the provision of comprehensive HIV prevention education and counselling that emphasises the partially protective effects of medical male circumcision.

The access to accurate information for all forms a central guiding principle for the roll-out of MMC for HIV prevention. The report also recognises the gender implications in the context of male circumcision. The potential harms of MMC for HIV prevention are outlined as unsafe sex, sexual violence, and the conflation of male circumcision with female genital mutilation.

With relation to implementation, the report recommends for countries to identify priority geographical settings with high incidences of HIV and low levels of male circumcision, and expand services from there. Priority target groups are adolescents and young men, unless the epidemiology of the region identifies other priority age groups.

WHO and UNAIDS have engaged in exploring traditional male circumcision practices with diverse stakeholders and have made some recommendations regarding strategic opportunities to '*modernise*' traditional male circumcision practices, and position medical male circumcision as having the potential to transform initiation schools into sites for HIV and gender education. There was recognition that traditional initiation schools play a significant role in reinforcing gender inequality, and do not provide any significant focus on sexual health and HIV prevention education.[8]

The guideline calls for medical male circumcision services to actively link with other programmes that address gender norms and masculinity, as well as providing other male sexual health services.

IMPACT OF MMC FOR HIV PREVENTION ON WOMEN

In South Africa, women are disproportionately infected and affected by HIV and AIDS. Women also comprise the majority of participants in community organisations and care activities for the sick, and the majority of people living with HIV in the country.[9]

The greatest failure of available HIV prevention interventions programmes is the continuing lack of women-controlled HIV prevention options and women therefore have limited power to independently prevent the transmission of HIV. The male condom is often not a realistic option, given women's position in a dominant patriarchal society, where women have little or no power to negotiate condom use. The issue of condom use becomes even more contentious within the context of marriage, where issues of trust and faithfulness come into play, coupled with male domination in sexual decision-making and lack of recognition of women's sexual rights.

Female condoms are not freely available and/or accessible to women in South Africa, and are not even actively promoted; and the development of a microbicide is still very much in the beginning stage.

Given that prevention that is women controlled is very limited, the introduction of MMC for HIV prevention can easily be seen as adding to the many risks and vulnerabilities women already face in respect of protecting themselves from HIV infection.

There are presently no known direct benefits of medical male circumcision for women. The indirect health benefits of MMC for women in the longer term are reduced risk of exposure to HIV, and other sexually transmitted infections, should MMC become widely accepted and utilised. Other potential indirect benefits for women are cited as MMC programmes being an entry point to reaching men, and their partners, with information and services on HIV risk reduction, gender equity, contraception, and shared sexual decision-making.[10]

However, the introduction and roll-out of MMC for HIV prevention also has the potential to impact negatively

on women, especially in the context of community and/or individual beliefs that male circumcision is completely protective against HIV, and eliminates the need for other risk reduction strategies. Potential harms that could impact on women are increased risk-taking behaviour in circumcised men, with reductions in rates of condom use and increases in numbers of sex partners.[11]

The difficulties that women presently face regarding negotiation of safer sex and condom use with their partners can be increased, when circumcised men believe they are fully protected from HIV. Newly circumcised HIV positive partners may or may not know their status, and may or may not wait until full wound-healing, which will impact on women's risk of acquiring HIV.[12]

Concerns have also been raised by various stakeholders that embarking on a major roll-out of MMC for HIV prevention would divert funds away from existing HIV prevention initiatives and programmes that specifically focus on women's needs, such as prevention of vertical transmission programmes and female condoms, as well as the development of other female controlled interventions, such as microbicides.[13]

Other potential negative impacts of MMC for HIV prevention on women would be further stigmatisation of positive women, by blaming them if a circumcised male is tested positive for HIV, as well as an increase in gender-based violence and abuse if women insist on condom use after men have been medically circumcised.[14]

To ensure accurate information and knowledge, communication messages on MMC for HIV prevention needs to address women's particular HIV risks and vulnerabilities and also be tailored to women as mothers and partners, aiming to clarify the essential differences between traditional and medical circumcision practices. According to Rees (2010), messages should be gender sensitive, focusing on women '*as partners and mother's of sons*' and explaining the advantages and disadvantages of MMC.[15]

POLICY FRAMEWORK AND CONSIDERATIONS:

The South African context

South Africa has the world's largest population of people living with HIV and it has been estimated that about a third of men in South Africa are circumcised.[16] The practice of traditional and/or religious circumcision is not fully regulated by the state; hence this estimation is based primarily on the percentage of indigenous communities that are traditionally circumcising, as well as the Muslim and Jewish communities. A study by the Human Sciences Research Council in 2002[17] made calculations with reference to the major African ethnic groups that practice male circumcision widely (Xhosa, Pedi and Venda), as well as moderately (Sotho, Ndebele and Shangaan), and concluded that 35% of men overall were circumcised.

A newspaper article dated 4th December 2009[18] reported that South Africa's National AIDS Council (SANAC) had, as early as 2007, raised the possibility of providing medical male circumcision services in South Africa, but were faced with a lack of political support. In 2008, civil society engaged with the issue and SANAC showed more support and a stronger voice regarding the introduction and roll-out of medical male circumcision services for HIV prevention.

At the same time, the SANAC Women's Sector raised concerns about the impact on women and questioned how introducing medical male circumcision as an HIV prevention strategy would benefit women. Traditional leaders also raised concerns that medical male circumcision would conflict with traditional male circumcision practices, which lies at the core of young men's initiation rites for several ethnic groups in South Africa.

Following lengthy consultations with numerous stakeholders, SANAC issued a number of recommendations, including that:

1. Costs associated with the roll-out of MMC for HIV prevention should not divert funds from female condom distribution and other programmes directly benefiting women;

2. MMC for HIV prevention should be offered as part of a comprehensive sexual health package, including HIV counselling and testing; and
3. Communities should be informed that male circumcision was only partly effective in preventing HIV infection.

As of February 2010, the Department of Health has produced a draft set of Implementation Guidelines, and is conducting a feasibility and costing analysis. There is no clarity as yet regarding whether or not the country will have MMC for HIV prevention implementation guidelines and/or a policy, or how the costs will be covered.

An update on the male circumcision policy process in South Africa dated July 2009[19] stated that the National Strategic Plan (NSP) for HIV and AIDS would incorporate medical male circumcision under prevention strategies towards reducing sexual transmission of HIV. The proposed plans included convening a multi-disciplinary taskforce that would include traditional leaders and private practitioners to review the WHO/UNAID policy guidelines on MMC for HIV prevention so as to further develop policy and programme recommendations for South Africa.

This update on the policy development process included a recognition that any policy on medical male circumcision should expressly recognise that this is not a stand-alone intervention, but forms part of a comprehensive HIV prevention programme; and that medical male circumcision programmes must promote safer sex practices, the correct and consistent use of male and female condoms, sexual and gender equality, and ensure access to appropriate HIV testing and counselling services.

It was also noted that MMC programmes needed to be gender sensitive, focusing on women as partners and mothers, and explain advantages of MMC for HIV prevention to women. The advantages stated highlighted that MMC would also be protective against HIV for women in the longer term, and that it protects against HPV and cervical cancer, as well as exposure to other STIs. Further emphasis was placed on not diverting funds away from existing HIV programmes focussing on women, such as PMTCT programmes and female condoms, and that MMC should not further stigmatise and blame positive women if a circumcised man becomes infected with HIV.

Moreover, it was stated that programmes will be designed with reference to demonstration programmes, such as the Orange Farm programme, which is already underway. There were concerns about creating demand without services being able to respond to the demand, as well as the need for modelling and costing, with sustainable funding a pre-requisite. It was further noted that research into MMC within the South African context was necessary and should be ongoing, with specific reference to research that engages with the societal context that can analyse, amongst others, the involvement of women and gender roles in decision-making processes around male circumcision, as well as analysing social effects and ways of mitigating adverse effects of MMC.[20]

There are also indications that issues related to traditional male circumcision will be included as part of the broader MC policy, with, amongst others, proposals to standardise the training for traditional practitioners, and consideration of introducing surgical technique during traditional male circumcision in relation to the full removal of the foreskin. Another point made under integrating traditional male circumcision practices was that of expanding messaging to embrace broader sexual health and gender issues.

Recent developments in South Africa, related to government's strategy of MMC for HIV prevention roll-out, points to the intention of the KwaZulu-Natal government to engage in a massive roll-out of medical male circumcision programmes before the end of 2010.[21] Within this context, the KZN provincial government has also decided to support King Zwelinthini's plan to revive male circumcision within Zulu communities. The government further noted that the MMC for HIV

prevention programme would be conducted by health professionals and properly trained people, and that government is looking at performing circumcisions in tents and halls.

Concerns were raised that King Zwelinthini had not consulted traditional leaders before he made the announcement about the revival of the male circumcision custom; which potentially could result not only in community resistance to MMC for HIV prevention programmes, but also in positioning medical male circumcision into the cultural and traditional realm.

The KwaZulu Natal provincial Department of Health has already started with providing medical male circumcisions in state hospitals on a small scale, and has made a funding request of R700 million to the US President's Emergency Plan for AIDS Relief (PEPFAR) towards the roll-out of a province-wide medical male circumcision programme.[22] Thirty five men were circumcised in early March at the Ngwelezane Hospital, outside Empangeni in KwaZulu Natal. The KwaZulu Natal Department of Health noted that it was a successful trial run with a new circumcision tool, the Tara Clamp, that results in no bleeding or need for bandages. This means that men can go home immediately after the procedure. The MEC for Health in KwaZulu Natal estimated that it was possible to perform 100 circumcision procedures a day by July 2010.[23, 24]

2 Background and Methodology

The project intended to document and analyse women's perspectives and levels of participation in discussions and decisions about medical male circumcision for HIV prevention; to document and analyse policy responses in the context of introducing medical male circumcision as an HIV prevention strategy; and to build capacity among various stakeholders, particularly women in communities. In order to achieve this aim, project activities included a literature review, as well as information and data collection through various means, including questionnaire administration, facilitated focus group discussions, and formal and informal discussions with various stakeholders. For this, various research tools were developed, tested and administered.

RESEARCH METHODOLOGY

This pilot study on MMC for HIV prevention and its impact on women forms part of a multi-country study (Namibia, Swaziland, South Africa, Kenya, and Uganda) facilitated and supported by the AVAC Women's HIV Prevention Tracking (WHiPT) Project and the ATHENA Network.

The 19 item (4 page) structured questionnaire included both quantitative and qualitative questions, designed to assess respondents' level of knowledge of, and preparedness for, the introduction and roll-out of MMC as an HIV prevention tool, as well as levels of understanding of the implications for women.

Focus group discussions were held to obtain a deeper understanding of participants' knowledge of medical male circumcision for HIV prevention; perception of acceptability and impact of MMC programmes in their community, as well as of the impact of MMC for HIV prevention on women. Moreover, the focus group discussions gathered information on currently available and used HIV prevention methods, additional HIV prevention needs, and perceived impact of MMC on HIV prevention in the future.

STUDY SAMPLE AND PROCESS

The project was conducted in and around Port Elizabeth, Eastern Cape, and in KwaMakhuta, KwaZulu Natal. While male circumcision as a customary rite to manhood is widely practiced in communities of the Eastern Cape Province, communities in KwaZulu Natal can be described as 'non-circumcising' communities, in that male circumcision is not an integral part of customs and traditions practiced in this region.

During the data collection phase, the AIDS Legal Network (ALN) worked in partnership with community-based organisations[25], primarily positive women's groups and networks, in both provinces. In KwaZulu Natal, the data was collected in partnership with women from the National Association of People Living with HIV and AIDS

(NAPWA), and in the Eastern Cape with women from Her Rights Initiative (HRI), the iBhayi Positive Living Centre, and Ikhala Trust.

In both provinces, the process of data collection was closely linked to knowledge transfer and capacity building on both medical male circumcision as HIV prevention and its impact on women, as well as on research methodology. As such, the ALN facilitated capacity building sessions with 24 women in KwaMakhuta (December 2009) and 22 women in and around Port Elizabeth (January 2010). Subsequent to these sessions, a total of 145 questionnaires were administered to women, and four focus group discussions were facilitated in the respective communities.

The data collection focused on women in the identified areas. Thus, primary research participants were women living in the respective communities. All participants were informed about the purpose of the study and asked whether or not they would like to participate. Study participants were also informed about the anonymity of the collected data.

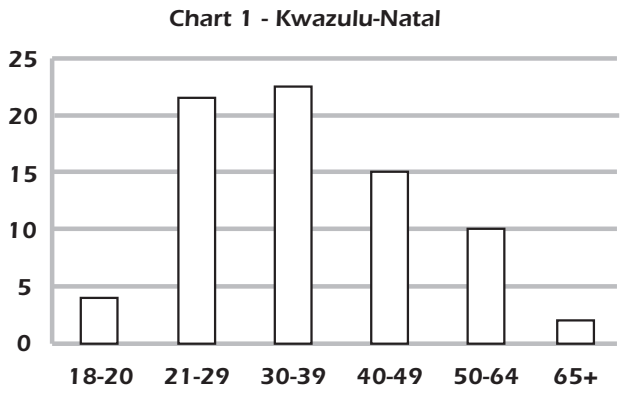
As for the focus group discussions, women participating were informed about the purpose of the discussion and ensured confidentiality, as well as anonymity. Since the focus group discussions were recorded, participants were also asked for their consent to tape the discussions.

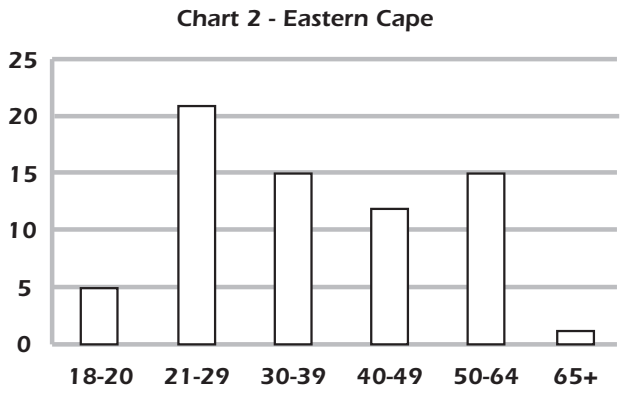
3 Research Findings

SOCIO-DEMOGRAPHIC BACKGROUND OF RESPONDENTS

A total of 145 women participated in the research by responding to the structured questionnaire. Of the 145 women, 69 were from the Eastern Cape (EC) and 76 were from KwaZulu Natal (KZN).

The majority of respondents (81, 56%) were between 21 and 39 years old, with 43 (30%) between the ages of 21 and 29, and 38 (26%) between the ages of 30 and 39. While the EC sample included a higher number of respondents in their 20s (30%) than in their 30s (22%), the number of respondents between 20 and 29 years old and 30 and 39 years old were very similar (22 respondents and 23 respondents, respectively) in the KZN sample. In addition, 19% (28) of all respondents were above 50. Charts 1 and 2 provide details by area and age group.



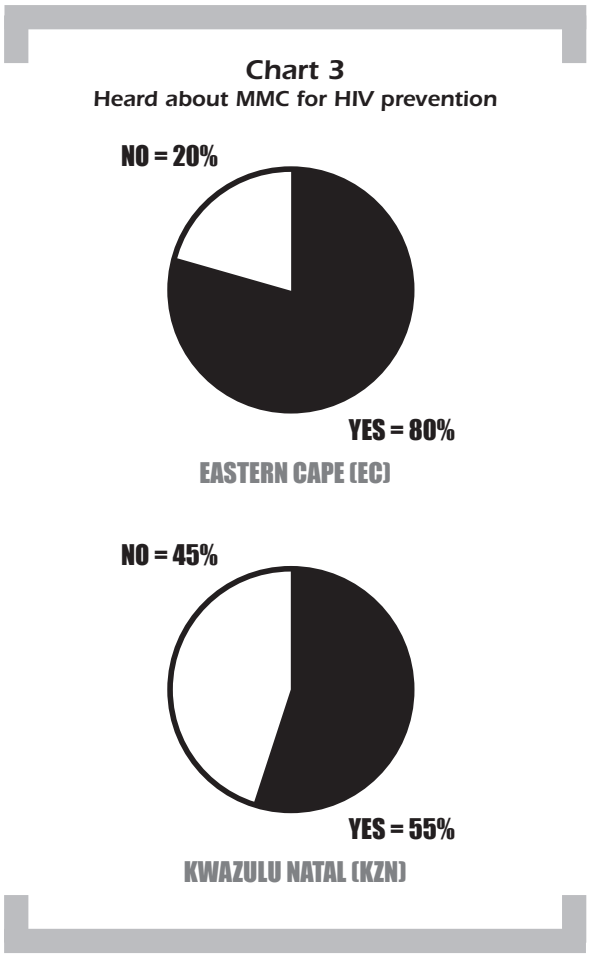


KNOWLEDGE ABOUT MEDICAL MALE CIRCUMCISION FOR HIV PREVENTION

The questionnaire included various questions designed to assess women's knowledge about medical male circumcision for HIV prevention. Respondents were asked whether or not, what, where and from whom they had heard about medical male circumcision (MMC) for HIV prevention; and whether or not they thought there were advantages of MMC for HIV prevention. Questions assessing respondents' general knowledge of MMC for HIV prevention were also included.

Asked whether or not they had heard about medical male circumcision for HIV prevention, 67% (97) of the total sample said 'yes', and 33% (48) indicated that they had never heard of MMC for HIV prevention.[26] A markedly higher percentage of women in the EC (55, 80%) indicated that they

had heard about medical male circumcision for HIV prevention, than in KZN (42, 55%).



Of the total sample, 41 respondents specified that they have heard that MMC reduces the risk of HIV and other STIs, with 57% of the KZN and 32% of the EC sample making reference to that effect. There was also reference made to the belief that MMC was a '*cure*' for HIV; one respondent from the EC noted '*that it's safe when it comes to HIV*'[27].

In the EC, where traditional male circumcision takes place, further 14 responses (26%) related to the intersection between traditional and medical male circumcision. These included references to testing at hospital prior to going for male circumcision, and that people who circumcise must be trained first.

> *…I heard that before a boy goes to the bush he must go to the hospital to test for infections and get anti-biotic to clean the blood system and help recover quickly…*[28]

Respondents from the EC had also heard discussions regarding the advantages and disadvantages of MMC, with one respondent saying that:

> *…others are saying that culture does not agree with that...*[29]

The responses from KZN indicated slightly more awareness that this was protection for men only.

> *…heard that male circumcision is good, because they do not get infected easily, they are protected…*[30]

Respondents were further asked how and from whom they had heard about MMC for HIV prevention. In both areas the radio was by far the significant medium of communication, and both areas had not seen any billboards. In KZN, more than half (13) had heard about MMC through the radio, followed by the community (8). Of those reporting to have heard about MMC on the radio, 6 respondents made specific reference to King Zwelinthini having spoken about introducing MMC for HIV prevention in KZN. The main messages taken away from King Zwelinthini's broadcast were:

1. Maybe HIV can be prevented
2. It prevents HIV
3. Maybe HIV can be cured
4. It will be legalised in KZN

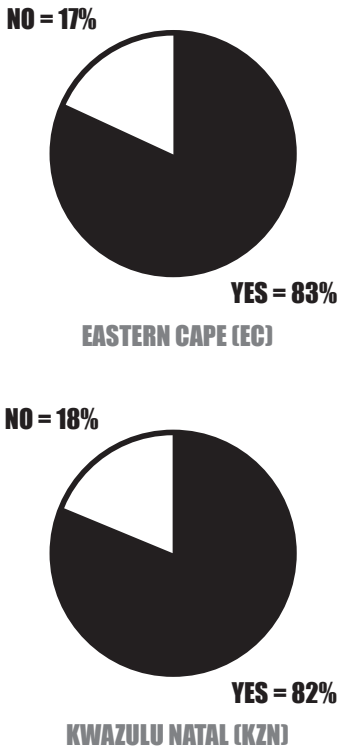
In the EC, respondents had heard about MMC for HIV prevention equally through the radio (5), as they had at the hospital/clinic. There was also reference to organisations, like the Treatment Action Campaign running workshops on MMC (3), as well as hearing about MMC via Love Life(2). The Department of Health (DOH) was more active in promoting MMC in the EC.

One respondent from the EC said she saw it on TV but:

> *…I didn't pay much attention as my husband doesn't want us to listen when things are on about circumcision…*[31]

The quote above arguably highlights some of the socio-cultural tensions around male circumcision, and the exclusion of women from gaining access to information. As traditional male circumcision is a '*sacred*' and '*secret*' male institution, women who want to access health and HIV information related to male circumcision practices face many barriers, including the control of women's information seeking behaviour at the level of watching TV. Thus, for women to access and act on information related to MMC and HIV, the information needs to be specifically tailored for women, and take into account the socio-cultural context and the realities of women in traditional male circumcising communities.

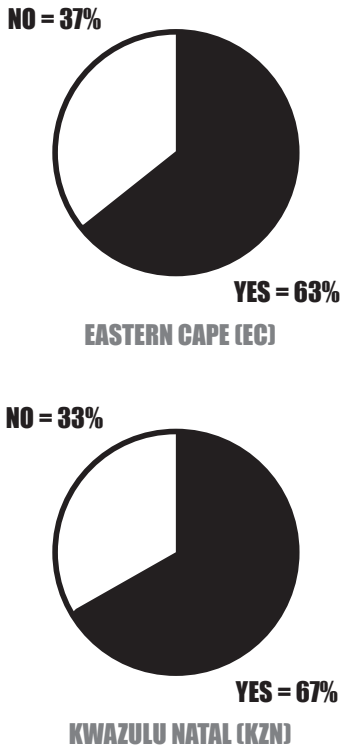
Chart 4
Need for condom use after MMC



Of all respondents (97) who had heard about MMC for HIV prevention, 17% indicated that they were not aware that there is a need for condom use after MMC; and 18% were unaware that MMC does not provide 100% protection from HIV risk. Given that the main communication messages attached to MMC for HIV prevention are to be linked to the need for condom use and the fact that MMC does not provide a 100% protection from HIV transmission, these percentages are quite significant and arguably an indication of inadequate and 'unclear' messaging and/or information on MMC for HIV prevention. Chart 4 provides details on the 2 samples.

Moreover, when asked whether or not respondents are aware that men need to abstain from sex for 6 weeks after the '*surgery*', 35% said 'no' to this question. Similarly, given the increased risk of HIV transmission before complete wound healing, this high percentage is concerning and indicating both a lack of adequate factual information about MMC and the need for focused awareness and education campaigns for women.

Chart 5
Need to abstain from sex for 6 weeks after MMC



Discussion

While the data indicate relative high levels of perceived knowledge about MMC for HIV prevention, it also indicates that a significant number of women at a community level have never heard about it, which is of concern, especially considering the fact that MMC programmes are about to be rolled-out.

The data also seem to suggest that '*hearing*' about MMC for HIV prevention does not necessarily translate into having '*factual knowledge*' about MMC, such as the fact that MMC is only partially protecting against HIV risk, the need for condom use after MMC, and the need to abstain from sex during the period of wound healing. Thus, the data arguably confirm the need for education and awareness raising about MMC for HIV prevention prior to the roll-out of MMC programmes, as well as highlight the shortcomings of current information and messaging about the benefits of MMC for HIV prevention.

PERCEPTION OF ADVANTAGES AND DISADVANTAGES OF MMC FOR HIV PREVENTION

Further assessing knowledge and perception of MMC for HIV prevention, respondents were asked whether they thought there are advantages and/or disadvantages. Of the 92 respondents[32] who completed the question, the majority (66, 72%) indicated that there were advantages of MMC for HIV prevention, and 26 (28%) did not see any advantage.

While the response rate in the two samples were the same, with 72% (28) of the KZN sample and 72% (38) of the EC sample saying that there were advantages, there were marked differences between the samples as to why women thought that there were advantages of MMC.

Eastern Cape

In the Eastern Cape sample, most of the 38 respondents who agreed that MMC for HIV prevention has advantages explained this with reference to MMC being safer than traditional male circumcision, recognising that sterile equipment and trained personnel would make MMC safer.

> *…MMC doesn't use the same 'weapons' like the traditional form of circumcision...*[33]

> *…it is safe as there are trained doctors who follow rules, such as medical check ups and age requirements…*[34]

When discussing the advantages of MMC respondents further explored how traditional male circumcision could be made safer, and linked to/combined with and/or incorporated into medical male circumcision.

> *…in the olden days things were done by old people not with these young men who did these wrong things to the kids…*[35]

> *…some other people bleed too much resulting to be dehydrated so it's where they were sent to the hospital…*[36]

The second highest response code for advantages of MMC for HIV prevention was related to the prevention and protection from STI's and HIV infection.

> *…once the foreskin is cut, there are few chances of STIs...*[37]
> *…when done in hospital, it can prevent HIV risk...*[38]

At this stage of the questionnaire, common misconceptions also emerged in that some respondents noted the advantages of MMC as reducing HIV completely:

> *…no foreskin means there is no HIV threat…*[39]

> *…they are HIV free…*[40]

It is important to note that especially in the EC sample data seems to suggest that some respondents responded to this question as mothers and not necessarily as sexual partners, emphasising the advantage that MMC would limit the number of '*boys dying in the bush*'. While this stated advantage of MMC does not correlate with MMC for HIV prevention, it arguably highlights that women's expressed support for MMC may not necessarily be linked to its benefits for HIV prevention, but instead to the desire to increase the '*safety*' of traditional male

circumcision practices. Thus, participants in the EC suggested combining both practices by performing the actual circumcision at the clinic and then sending the '*boys to the bush*' for the teachings and rituals.[41]

Respondents also felt strongly about the need to have medical checks linked to practices of traditional male circumcision, so as to minimise the risks of infections.

> *…check up at clinic or have side effects and die…*[42]

> *…before the male can go to the bush they need to be tested for infection and HIV…*[43]

Recognising that hospitals are safer and the care is good, respondents supported that medical professionals, such as doctors and nurses, to be involved in circumcision; and, as one respondent noted, '*all the family can visit*'.[44]

Of the 28% (15) of the respondents who indicated that there were no advantages of MMC, 2 made reference to increased risk behaviour in men; and 5 respondents noted that MMC was not 100% safe, would not cure HIV, and that HIV infection could still occur.

> *…partners not wanting to use condoms, as they think they are immune…*[45]

Other disadvantages mentioned included lack of public education about HIV, as well as references to specific disadvantages of traditional male circumcision practices.

KwaZulu Natal

In the KZN sample, respondents noted advantages that largely centred on the recognition that MMC was a prevention option for males, specifically in relation to HIV (14 responses).

> *…yes it's good, because these male circumcisions prevent from STIs…*[46]

The majority of respondents focussed on the advantages of MMC in relation to men, not their male children, and thus, answered primarily as partners to men who may or may not benefit from MMC. While some respondents were noting benefits for men, they were at the same time noting that MMC has no benefits for women.

> *...it is good for men, not for women, because it is only men who are protected from HIV and STIs. As for me, no I am not protected…*[47]

In KZN, the majority of the 11 (28%) respondents who noted disadvantages commented on the increased risk behaviour in men, and also that women would suffer, as well as be blamed for HIV infection.

> *…this will encourage more males to be ignorant about the effects of HIV, and even their partners are on big risk…*[48]

> *…no adherence to condom use…*[49]

> *…women will be oppressed by their sexual partners…*[50]

> *…men are prioritised, and women will be blamed for HIV, as it happened before…*[51]

Discussion

Although the data suggest high levels of perceived advantages of MMC for HIV prevention, it is important to note that women from the EC sample responded to this question primarily as '*mothers*' concerned about the safety of their children participating in traditional male circumcision practices, and not as sexual partners to men who may or may not be medically circumcised. Thus, the data arguably emphasise the need for education and awareness raising about the differences between traditional and medical male circumcision practices and benefits.

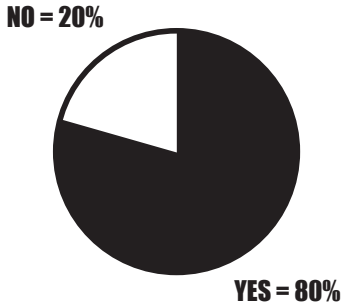
COMMUNITY PREPAREDNESS AND SUPPORT FOR MMC FOR HIV PREVENTION

In order to assess respondents' perception of community preparedness and support for the introduction and roll-out of MMC for HIV prevention, the questionnaire included several questions to measure perceived levels of support amongst community and amongst men. The questionnaire also assessed whether or not and why respondents would support MMC for HIV prevention, as well as respondents'

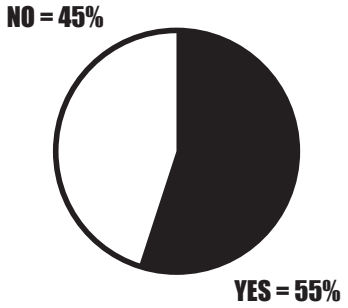
thoughts of what additional services should be provided with the introduction and roll-out of MMC for HIV prevention.

Asked whether or not respondents believed that MMC for HIV prevention could be introduced into their community, the majority (70%, 65) agreed and 28 (30%) disagreed. The response rate showed marked differences between the two samples, in that a much higher percentage of respondents in the EC (80%) thought that MMC for HIV prevention could be introduced to their community, as compared to 55% of respondents in the KZN sample.

Chart 6
MMC could be introduced to community



EASTERN CAPE (EC)



KWAZULU NATAL (KZN)

Eastern Cape

Elaborating as to why respondents thought that MMC for HIV prevention could be introduced into their community, the majority of responses (18) in the EC sample clustered around the need to engage and involve women, as well as community, on issues of education and awareness raising regarding MMC. Respondents also felt strongly that education and awareness raising needed to take place before MMC for HIV prevention would become more acceptable at a community level.

> *…if it could, there is a need for a lot of education…*[52]

Respondents also noted that MMC was safer than traditional male circumcision practices for their children, and that they also would receive the necessary education around HIV.

> *…it will also give a chance for our boys to learn about the risk of HIV infection, as they will be educated…*[53]

Amongst the 11 (20%) respondents in the EC sample who did not believe that MMC could be introduced into their community, explanations as to why focused equally on the risks of men increasing their risk behaviour, as well as a clash with cultural practices and tradition.

> *…they will misunderstand; they will think that you can't be HIV when you are circumcised…*[54]

> *…men are stubborn, even if they will know they will not go to test...*[55]

> *…in our community male circumcision is a respected cultural practice…*[56]

One respondent further noted the testing of men before they go for traditional circumcision as a rationale for not needing to introduce medical male circumcision to the community.

> *…because now, men go for medical check ups before going to the bush…*[57]

KwaZulu Natal

In KZN, 55% (21) of respondents agreed that MMC for HIV prevention could be introduced into their community. Four (4) respondents noted a similar assumption as respondents in EC that introducing MMC as an HIV prevention option would lead to men wanting to be

circumcised in order to not have to use condoms.

…because men don't want to be protected and use condoms…[58]

Recognising men's reluctance to use condoms, it is also possible that women support the introduction of MMC for HIV prevention into their community, as they are aware of MMC providing some degree of protection from HIV.

Reference was also made by 3 respondents noting that MMC should be introduced, as it would reduce the risk of STIs.

…because it is part of HIV prevention…[59]

Though supporting the introduction of MMC for HIV prevention into their community, there was a strong call for more education and awareness in the community on MMC.

…we need more information and workshops on MMC…[60]

Almost half (45%) of the respondents in the KZN sample did not believe that MMC for HIV prevention could be introduced into their community. Asked to explain, the majority of responses highlighted concerns that MMC would increase male risk taking behaviour and that women would be at greater risk.

…women will suffer most as male partners will do whatever they want to do on sex…[61]

…I totally disagree; this prevention is only going to kill more females and will also kill them from HIV…[62]

…men will think that they'll not infect others or get HIV if they are circumcised…[63]

Respondents also indicated that MMC had nothing to do with HIV prevention and that it would only confuse the community. One respondent was of the opinion that men would not be interested in MMC, and another noted that it was Xhosa culture, not part of Zulu tradition.

…because this is a Xhosa culture, not Zulus…[64]

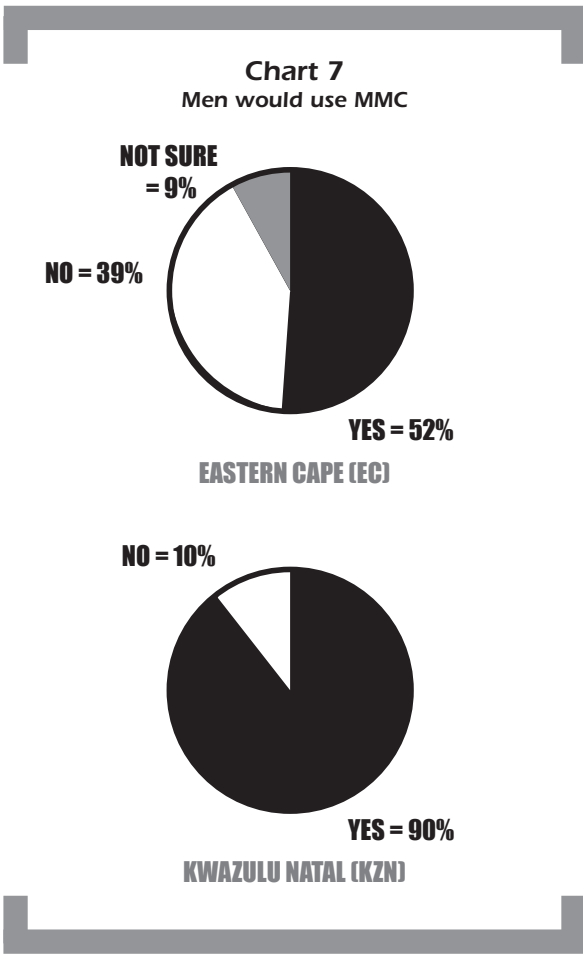
Support for MMC

Respondents who thought that MMC for HIV prevention could be introduced into their community were followed up with questions as to whether or not and why they believed that men would use MMC, and whether or not and why respondents themselves would support the introduction and roll-out of MMC for HIV prevention.

Of the 65 respondents who agreed that MMC for HIV prevention could be introduced to their community, 42 (65%) respondents also thought that men would use MMC and 19 (29%) did not believe so. Four of the respondents (6%) were unsure. Chart 6 details the significant difference in the response rates between the two samples.

Further asked to explain why, more than half of the EC sample thought that men would use MMC to prevent HIV. However, most of the responses were largely qualified, in that they said men would be circumcised if they were to receive information, or if they were not conservative.

…if they have enough knowledge and information about it…[65]



…some will and those conservative will not, the high rate of death through HIV/AIDS is a threat…[66]

…yes I can say yes, others would take it seriously after the advice which is good, but on the other side there are those who will not take it...[67]

The majority of responses in KZN centred on men getting circumcised because they believe in what government is promoting; though emphasising the need for education and information.

…once they have been well informed they will agree to have their foreskin removed…[68]

…men of today believe in it because it is suggested by the government…[69]

The next significant group of KZN responses (6) related to risk behaviours and the fact that men would get circumcised, so they did not have to use condoms.

…they believe in their king, and it will be much easier than a condom…[70]

Respondents (EC) also believed that men would engage in MMC based on the perception that circumcision would prevent HIV infection, which would further translate to men not having to visit clinics, as being circumcised was perceived as staying sexually healthy Reference was also made to HIV testing and MMC as a means for men to get to know their HIV status.

…they are not in a risk they can use it because they are shy of going to clinics…[71]

…so that the male can know his status…[72]

Nineteen (29%) respondents did not believe that men would use MMC, with a significant higher percentage in the EC sample (43%, 17 respondents), than in the KZN sample (10%, 2 respondents). Most of the respondents who thought men would not engage in MMC cited cultural issues as the main barrier to the uptake of medical male circumcision. Responses were also pointing to the issue that women have traditionally no role and/or no place in male circumcision practices; and that MMC, if done in hospitals, would potentially expose boys/men to female staff. Respondents also expressed a strong sentiment that traditional male circumcision is '*sacred*' and in the male domain, it is about rites of passage and not about a medical intervention, and thus, MMC can easily be perceived to be threatening the core of this cultural practice.

…MMC is against our culture and tradition…[73]

…because it's their secret in the bush...[74]

…because they fear discrimination and they won't be recognised as men…[75]

…because of their cultural beliefs that women should not know anything about circumcision…[76]

Assessing support at an individual level, 55 (85%) of respondents indicated that they would support the introduction and roll-out of MMC. A further 8 (12%) respondents indicated that they would not support MMC and 2 (3%) of respondents were unsure.

When asked '*would you support MMC*', a vast majority of EC respondents (86%, 38) said yes, with the majority of responses explaining their support with references to MMC reducing STIs and HIV if linked to adequate education, and impacting on women's involvement in male circumcision processes. Moreover, 24% of respondents supporting MMC indicated that they would do so because '*boys are dying when circumcised traditionally*'.

…yes, we need to educate women about circumcision; unprotected sex leads to HIV whether you are circumcised or not…[77]

…because boys in our community die, when they are circumcised traditionally…[78, 79]

…yes, I would support it because it would help us women to decide on whether we want our children to be circumcised…[80]

…to visit my child in hospital…[81]

There was also an indication that women would support MMC as it potentially would link men to health services and treatment:

…if it turns out that the male is positive it would help him get treatment and assistance…[82]

Amongst the 81% (17) of KZN respondents who would support MMC, reasons cited were mainly related to the reduction of STIs and HIV. Respondents also noted the need for more information so as to make an informed decision whether or not to support MMC.

…must be done in hospitals so that they are safe…[83]

…it will be useful because medical male circumcision will assist a lot…[84]

…by attending workshops…[85]

Respondents (9%, 4) indicating that they would not support MMC in the EC sample felt strongly that it was against their culture and that women had no role to play in male circumcision, while KZN respondents (19%, 4) expressed concern that MMC might increase men's risk behaviour and the impact on women.

…because of our culture…[86]

…if you did something that wasn't done before, meaning that was not done by our ancestors, you will no longer be a man…[87]

…I can't support it as I do not know anything about it…[88]

…because I don't believe in it and don't believe that it will make the HIV rate go down…[89]

Respondents were further asked to identify what additional services they thought should be provided for with MMC for HIV prevention programmes.

Responses (19) to this open-ended question clearly identified the need for more public education and awareness raising on the issue of MMC for HIV prevention (11 EC, KZN 8). In the EC sample three respondents made specific reference to educating boys and young men, while in KZN reference was made to the need for specific awareness raising among women on MMC for HIV prevention, as well as more education to men.

…teach boys at school about circumcision…[90]

…more open talks with together mothers and fathers, and more teachings to young males about the advantages and disadvantages of medical male circumcision…[91]

…more workshops are needed for us as women to make everybody aware of this scenario…[92]

…it will help for women to know the dangers that they face regarding male circumcision…[93]

…men should be taught enough to understand that circumcisions do not prevent AIDS. You can get HIV even after you done circumcision…[94]

…they (men) should be supported and be convinced that it is a useful way to stop the spread of HIV…[95]

The need for condom promotion and access was highlighted by several respondents (11) across both samples. Specific reference was made to the need for condom education for men going for circumcision (KZN), education and promotion of condom use (EC), as well as women enforcing condom use (KZN).

…condom because I believed that, it doesn't protect HIV only but lot of STIs and pregnancy…[96]

…it would be better that if men are going for circumcision they are educated about using condoms…[97]

…add the male condom and women must be strict on using condoms during sex…[98]

EC responses (9) mainly focused on the need to improve on the safety of traditional male circumcision practices, which included transferring medical equipment and personnel to '*the bush*', ensuring sterile equipment, and being able to call on health services if complications arose.

…boys must not be cut with the same knife…[99]

…medical doctors to provide equipment for use in the bush…[100]

…Ngcibi's (traditional surgeons) need to be taught fully, have less numbers of initiates and sterilise their equipment…[101]

Services that would support the involvement of women in awareness raising and decision making on issues regarding male circumcision were raised in the EC sample (4). However, these responses seemed to be related more specifically to the circumcision of their sons.

…what I want is that the man must involve the woman so that the woman can help when there is a need…[102]

…female guidance and mother's care…[103]

In respect of MMC itself, two respondents in the EC explored the need for dedicated wards at hospitals with one noting that the hospital needed a separate section for '*Initiation School*'; arguably highlighting both the tensions between traditional and medical male circumcision and the attempts to integrate the two in a manner that is culturally acceptable. In the KZN sample, four respondents identified the need to introduce MMC into hospitals, the need for well-trained doctors, and the need for '*proper*' counselling to men prior to circumcision.

…each hospital must have a section for circumcision school…[104]

…it should be introduced to hospitals so that it can be done accurately and doctors can be trained…[105]

…they must start by having proper counselling before this male circumcision…[106]

Lastly, one respondent from the EC noted the need for men to be encouraged to access health services.

…men must engage with the health service and not hide their problems away…[107]

Discussion

While the data clearly indicate the support for MMC for HIV prevention to be introduced to communities, data also highlight the need for more education and awareness in the community on issues relating to advantages and disadvantages of MMC for HIV prevention.

The data also suggest relatively high levels of perceived support amongst men, as well as individual support, for the introduction and roll-out of medical male circumcision as an HIV prevention strategy. It does, however, also indicate that whilst supporting the introduction of MMC for HIV prevention in principle, this support is qualified by the need for women's greater involvement in MMC for HIV prevention discussions and decisions; as well as the noticeable tensions between traditional and medical male circumcision practices.

PERCEPTION OF IMPACT

Measuring the perceived impact of introducing MMC for HIV prevention, respondents were asked if they believed that MMC would protect women from HIV transmission, as well as whether or not respondents thought that MMC is changing ideas about HIV risks.

Of the 85 respondents (88% of sample) who completed this question, the majority (69%, 60) did not believe that MMC would protect women from the risk of HIV; with 82% (28) of respondents in KZN and 61% (31) in EC.

In the EC sample, the proportion of respondents believing that MMC would provide protection to women is twice as high as in the KZN sample (39% as compared to 18%).

Asked to explain, references were made to MMC being '*safer*' as traditional male circumcision practices, since '*instruments are sterilised*', thus lowering the risk of HIV infection; and the fact that men would already know their HIV status, inferring that testing for HIV prior to male circumcision would be a protective factor for women.

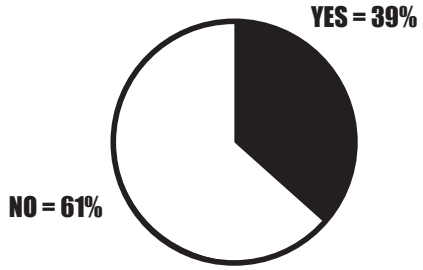
In addition, a number of responses referred to women being protected, if condoms were used, if men were to receive safer sex education during the circumcision process, and if partners remained faithful – arguably indicating

that respondents did not perceive MMC in and of itself as a protective factor for women.

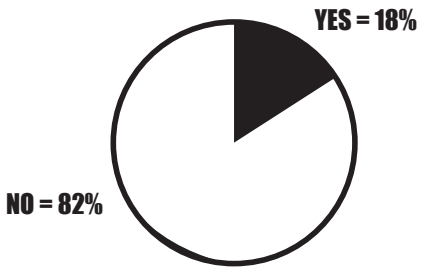
> *…yes, because they have been taught on how to have safe sex…*[108]

> *…if condoms are used…*[109]

Chart 8
Women are protected from HIV by MMC



EASTERN CAPE (EC)



KWAZULU NATAL (KZN)

Elaborating as to why respondents did not believe that MMC would protect women from the risk of HIV infection, most EC responses related to men being unfaithful, women not knowing how many partners he has, and men not wanting to use condoms, while KZN respondents made reference to the fact that women are not protected at all, that MMC did not prevent being infected with HIV, and that women were excluded, as MMC would only provide protection to men. Respondents also highlighted the fact that HIV can occur in circumcised males.

> *…you don't know how many girlfriends he has...*[110]

> *…no, because they will want sex without a condom...*[111]

> *…women are in great danger, even death, but nobody cares for women...*[112]

> *…no, women have nothing to do with male circumcision, as they are not part of it from the beginning...*[113]

> *…it will only help men not us women...*[114]

> *…no, when a man is circumcised he can infect a woman...*[115]

Respondents also mentioned different hopes, as well as concerns, relating to the potential of MMC to change existing ideas and beliefs about HIV risks, ranging from the hope that information and education to men during MMC would decrease men's risk behaviours and increase condom use, to the fear that men always blame women for HIV infections and that this would not change with the introduction of MMC. Reference was also made to the risk that men may perceive MMC as a '*license*' for unprotected sex.[116]

> *…because they will be aware, as they will be educated before the process…*[117]

> *…it's helping people to know more about circumcision and HIV…*[118]

> *…men will always blame women, as they will think they cannot be infected…*[119]

> *…men will have a prevention in their private parts and will demand unprotected sex…*[120]

> *…hides the dangers of having unprotected sex…*[121]

> *…people will think there is a cure, the invisible condom, and will never change behaviour…*[122]

> *…men think women are the ones who bring HIV, and that won't change…*[123]

Discussion

While the data clearly highlight a general lack of perceived benefits of MMC for women and women's protection, as well as for changing ideas and beliefs about HIV, it also suggests that if MMC would be linked to other prevention methods, such as condoms, and to additional services, such as education and training, the introduction and roll-out of medical male circumcision for HIV prevention could have a protective factor for women.

WOMEN'S INVOLVEMENT

A number of questions were designed to assess the extent to which women are involved in discussions and decision-making processes on medical male circumcision for HIV prevention. For this purpose, respondents were asked if they talk about MMC for HIV prevention with their partners; who makes the decision about men getting circumcised (open-ended question); and whether or not women are, or would want to be, involved in the decision-making processes about male circumcision.

When asked if women are talking with their partners about MMC for HIV prevention, the majority (71%, 65[124]) said 'no' and less than a third of respondents (29%, 26) indicated that women are talking about it with their partners.

Responding to 'who makes the decision about men getting circumcised for HIV prevention', the majority of respondents (62%) clearly indicated that it was men who made the decision about circumcision. While responses in KZN identified 'men', many of the Eastern Cape respondents (30) qualified their answers by making a distinction between men/husband/father, and the boy/man making their own decision to circumcise.

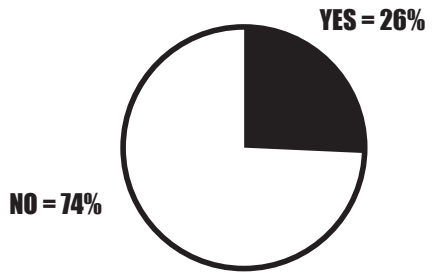
In addition, respondents from the EC sample also identified parents/partners (12) as the ones who make the decision, as well as health providers (11) as being involved in this decision-making process. There was 1 response from the EC that said the mother made the decision.

The data seem to show that EC respondents were responding to traditional male circumcision, as the majority responded to their children getting circumcised; hence the reference to parents and partners, whilst the KZN responses seemed more focussed on men getting circumcised.

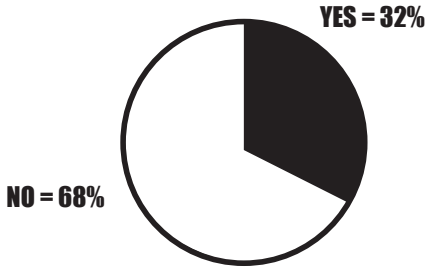
In order to assess women's actual and desired involvement in the decision-making processes about MMC for HIV prevention, respondents were asked if women are involved, as well as if women would want to be involved, in this decision. Of all respondents, 29% (26)[125] indicated that women are involved, and 75% (70)[126] indicated that women would want to be involved in decisions about male circumcision, with marked difference between the two samples.

Whilst the data suggest a greater current, as well as desired, involvement of women in decisions about male

Chart 9
Women talk about MMC with partners



EASTERN CAPE (EC)

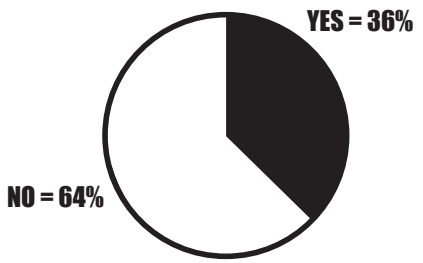


KWAZULU NATAL (KZN)

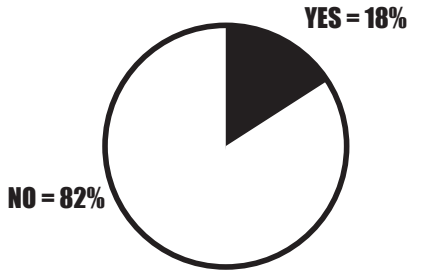
circumcision in the EC sample, it is important to bear in mind that women in the Eastern Cape are, to an extent, involved in traditional male circumcision processes, and thus are very differently relating to questions of women's involvement in male circumcision. As mentioned above, respondents from the EC sample are more likely to respond in their role as mothers, as compared to engaging with questions of MMC as sexual partners.

…it is a risky process and needs both parents…[127]

Chart 10
Women are involved in MMC decisions



EASTERN CAPE (EC)



KWAZULU NATAL (KZN)

Asked to explain why respondents thought that women would want to be involved in the decisions about MMC, more than half (30, 55%) of EC respondents mentioned that they want to advise and help, particularly on issues of HIV. Women also noted that men as fathers focus more on *'turning their boys into men'*, and do not address the health risks or speak to their children about HIV before circumcision.

Only 4 EC responses (7%) addressed the need for women to be involved in MMC decisions in order to protect themselves from HIV from partners or men who come back from circumcision and want to have unprotected sex.

The need to be involved in planning, public education and after care; to know more about MMC for HIV prevention; and to partake in decisions regarding the family (5 responses) were highlighted in the KZN sample.

…women need to be a part of taking this important decision, education and after care…[128]

…yes, because women are part of the family, women are at risk of getting STIs…[129]

In both samples (73% EC and 50% KZN), cultural reasons were highlighted explaining why women do not want to be involved in the decisions about medical male circumcision; saying that it was '*men's work*' and that '*women have nothing to do with circumcision*'.

…women want to be involved, but are isolated because this is a man's secret…[130]

HIV PREVENTION OPTIONS

Levels of preparedness and support for the introduction and roll-out of medical male circumcision for HIV prevention is arguably closely linked to existing HIV prevention options and challenges. Thus, the questionnaire included a number of items designed to assess available HIV prevention options (open-ended question), as well as respondents' perceptions of condom acceptability, usage and negotiation skills.

Asked to identify HIV prevention options available currently, 71% (69) of the total sample mentioned condoms, with 43 (78%) responses in the EC sample and 23 (55%) responses in KZN to this effect. Although, this high response rate referring to condoms as an HIV prevention option is noteworthy, it is of concern that only 3 respondents (KZN) made specific reference to female

condoms – arguably indicating a lack of female condom availability and access.

> *…female condoms need to be more and well designed, not big like it is now, there are not enough…*[131]

In the KZN sample, a number of respondents (7, 17%) also stressed the lack of prevention options for women.

> *…there are none for women…*[132]

> *…for me there is nothing available for now, there is nothing available for women, nothing…*[133]

Other options identified included abstinence (26), '*be faithful*' (7), HIV testing (3), and protective gloves in relation to being in contact with blood. One respondent from the EC sample cited '*oral sex*' as a preventative method.

In order to assess perception of women's '*ability*' to negotiate condom use, respondents were asked to indicate how comfortable they thought women are in negotiating condom use on a five point scale, ranging from 'not at all' (1) to 'very much' (5). Of the 92 (95%)[134] respondents who completed the ratings, 37% (34) indicated that women are 'not at all' comfortable, while 22% (20) respondents believed that women are 'very much' comfortable in asking their male partners to use condoms. Seventeen percent (16) indicated that women are 'somewhat' comfortable. There were also significant differences between the two samples (Chart 11), in that more than twice as many respondents in KZN (54%, 20) thought that women are 'not at all' comfortable to negotiate condom use, as compared to EC respondents (25%, 14).

Respondents indicating that women do not feel comfortable at all to discuss condom use further elaborated on their ratings, mainly stressing that men are the ones making sexual decisions.

> *…females let males take control over sex…*[135]

> *…they are afraid of their partners and of what they would think…*[136]

> *…because women are not making decisions in their relationships…*[137]

> *…women don't discuss sexual issues with male partners…*[138]

Respondents who thought that women are 'very much' comfortable to ask their male partners to use condoms explained their ratings mainly with references to the need for protection and the fact that women are more vulnerable to HIV infection.

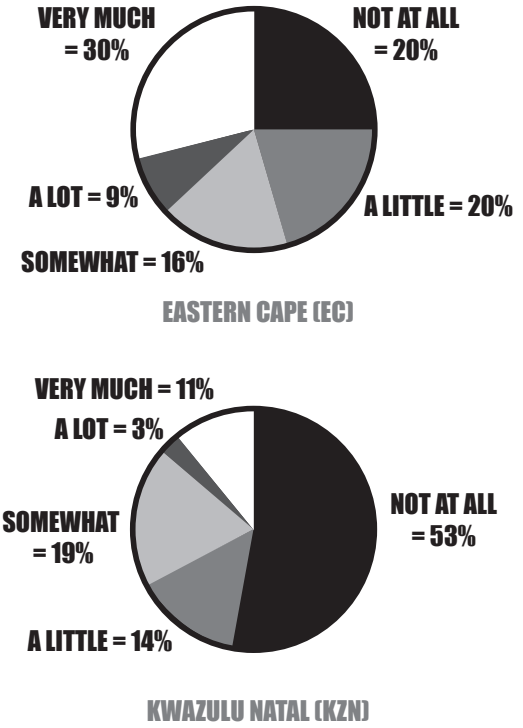
> *…so that we can be prevented from infections…*[139]

> *…because it is important that he uses condoms…*[140]

> *…they are the ones that are at risk of getting infected…*[141]

> *…my safety is my priority…*[142]

Chart 11
Comfortable in asking for condom use after MMC



Assessing condom use further, respondents were asked whether or not they are currently using condoms with their partners[143], and what they thought their partners would say if asked to use a condom after being circumcised

(open-ended question). More than half of the respondents (56%, 54) were very clear that they could not insist on using a condom, and 24 respondents (25%) said that their partners would or '*might*' (4, 4%) agree to do so.

Explanations as to why partners would refuse condom use after being circumcised were broadly based on the following themes:

- Men reacting to issues of mistrust and interpreting requests for condom use as suspicions that women or men had been with other partners

  …they tell you that why you tell me that I must use a condom, you've got another boyfriend or what…[144] (40-49yrs)

  …he would say I take him as a person that is not faithful to me because of he was circumcised…[145] (18-20yrs)

  …he won't allow it, he'll tell me that he's circumcised and should I be infected that will mean that I got it from other men…[146] (21-29yrs)

- Men refusing to consider condom use, due to unequal power relations

  …no, since we women let men take control of sex…[147] (21-29yrs)

  …what are you talking about? I don't have a right to say anything…[148] (21-29yrs)

- Men believing they are fully protected through circumcision

  …he tells me that there's no chance of him having HIV, because his foreskin has been cut off…[149] (30-39yrs)

  …I think he would say I did check-ups, and I go to the bush, why do we have to?...[150] (21-29yrs)

  …he will say what is the use, I am already circumcised…[151] (21-29yrs)

  …he will say that he doesn't have HIV therefore he won't wear a condom…[152] (21-29yrs)

The issue of gender-based violence came through also in this section with six respondents (KZN) saying that there would be violence/abuse and/or fights if women requested condom use.

…he will say that I am a bitch, sleeping around, not faithful and beat me up…[153] (21-29yrs)

…we will get into a fight, because now they have the wrong information that circumcision prevents HIV…[154] (50-64yrs)

Respondents who felt that their partners would agree to condom use after MMC were largely referring to open and trusting relationships with partners where these issues could be discussed and agreed upon, with two respondents (KZN) clearly indicating that condom use was acceptable and negotiable in their relationships.

…we will discuss and agree on what's best for both of us…[155] (50-64yrs)

…he will have no problem as we are concerned about spread of HIV/AIDS…[156] (21-29yrs)

…he'd never say no, we should not use a condom just because he is circumcised, as there are diseases…[157] (30-39yrs)

…it is a wise choice as we know that MC doesn't have a 100% protection…[158] (30-39yrs)

Discussion

The data suggest that currently available HIV prevention options, such as female and male condoms, provide limited benefit to women in a societal context of gendered inequalities and power imbalances. The data also confirm that most women are not in the position to negotiate condom use and are least in control over HIV prevention options. Taking into account that medical male circumcision for HIV prevention is not a stand alone HIV prevention method, and that MMC can only be an effective addition to available HIV prevention options when combined with other preventative methods, such as condoms, it is, thus, crucial to ensure that condom

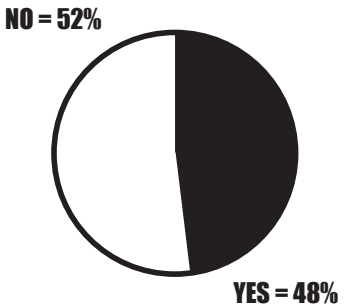
promotion and distribution becomes an integral part of MMC for HIV prevention processes.

GENDER-BASED VIOLENCE AND MMC FOR HIV PREVENTION

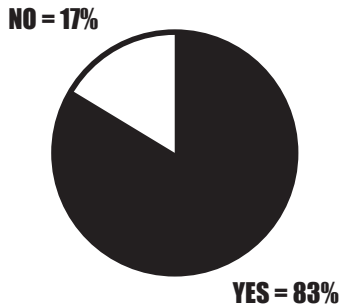
Since the risk of an increase in gender-based violence is often associated with the introduction and roll-out of medical male circumcision for HIV prevention, the questionnaire included questions designed to assess respondents' perception of existing levels of gender violence in their communities, as well as the perceived impact of MMC on gender-based violence.

When asked whether or not respondents thought that gender-based violence is a 'problem' in their community, 63% (54) agreed and 37% (32) of respondents did not think that gender-based violence is a problem.[159] However, there are significant differences in the response rates between the two samples, in that 83% (30) of KZN respondents perceived gender violence to be a problem in their community, whilst 52% (26) in the EC sample believed that gender-based violence is not a problem in their community.

Chart 12
Gender-based violence a problem in community



EASTERN CAPE (EC)



KWAZULU NATAL (KZN)

Respondents were also asked to indicate if and how they thought that MMC for HIV prevention would impact on gender-based violence.[160] In total, 55% of respondents (44) agreed that MMC for HIV prevention would impact on gender-based violence in their communities, and 45% (36) did not think that it would have an impact. Corresponding to the higher percentage of respondents who thought gender violence is a problem in their community, 63% of KZN respondents further believed that MMC would impact on gender-based violence.

Responses explaining as to how MMC for HIV prevention would impact on gender-based violence in their community referred to men refusing to use condoms (EC), women being blamed for any infections, and women being forced into unprotected sex (KZN).

> *…it would, as men will carry on with abusing women as they won't use condoms and shift blame onto women…*[161]

> *…as it will make men abuse women more…*[162]

> *…incidents of gender-based violence will increase, as men will use it as if they are cured…*[163]

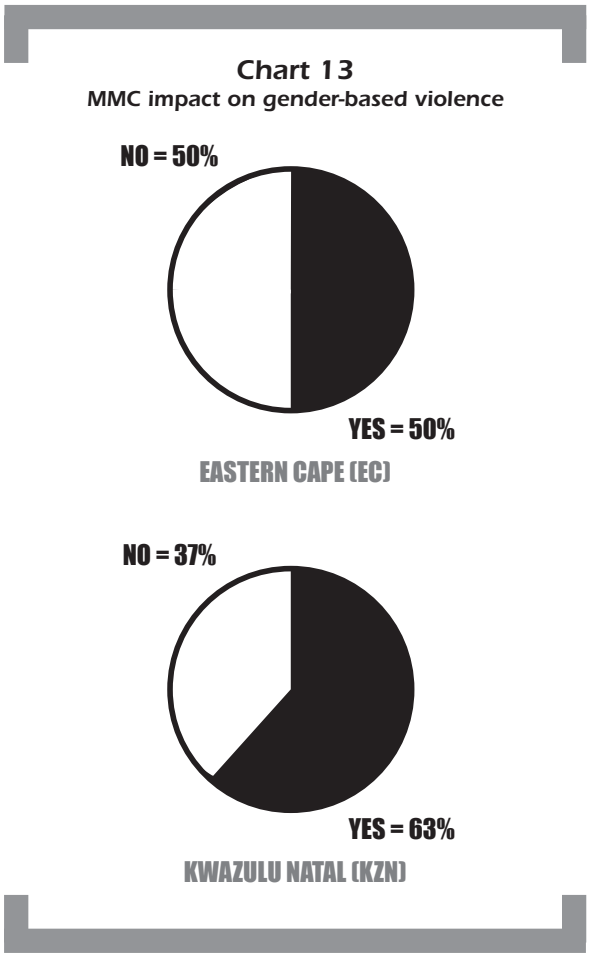
> *…they (community and couples) will fight over condoms after being informed that MMC is prevention for HIV…*[164]

> *…whatever diseases arise, fingers will be pointed at women…*[165]

> *…women will be beaten up, as they will be refusing unsafe sex...*[166]

> *…yes, because they will refuse to use protection since they believe that they are safe because of circumcision…*[167]

Though not directly related to gender-based violence, it is important to note that 7 (29%) of EC respondents felt strongly that MMC would increase violence in their community, due to the risk of men reacting to MMC as



it was against their traditional circumcision practice, and thus create a particular conflict between men/boys who get circumcised traditionally versus those who get circumcised medically.

> *…there will be a division amongst men, those circumcised in clinics/hospitals will be called mama's baby and not really men…*[168]

> *…the one's who were circumcised in hospitals will not be recognised as real men by the others who went to the bush…*[169]

> *…it's taken place, because recently our boys that have medical circumcision are attacked by those that have done it at the bush...*[170]

Discussion

The data highlight relatively high perceived levels of gender-based violence, which arguably reflects communities' realities of high levels of violence and abuse. However, the data also strongly suggest that the introduction of MMC for HIV prevention may lead to increasing levels of gender-based violence, as men may refuse condom use after MMC and women are likely to be blamed for HIV and STIs – arguably indicating the need to address these risks as an integral part of MMC for HIV prevention initiatives and programmes.

PERCEIVED PRIORITIES AND NEEDS FOR REDUCING HIV RISKS

In order to ascertain if medical male circumcision for HIV prevention is indeed a perceived priority amongst women at a community level, respondents were asked to indicate what their priorities, visions and needs are for reducing the risks of HIV transmission at an individual, a family, and a community level. Responses to this open-ended question highlighted the following priorities.

Community education

Respondents in both samples identified '*community education*' as one of the priorities for reducing the risks of HIV transmission; specifically mentioning the need for education and empowerment around HIV (21 EC responses), workshops for men to change mindsets (EC) and public awareness to change behaviour (4 KZN responses), educating communities which will lead to behavioural change and respect for women (KZN), educating the youth before they are sexually active, community awareness around MMC until people see the point of using it (EC), and parents must encourage young boys to circumcise (KZN).

HIV prevention interventions

The need for intensified *HIV prevention interventions* were equally mentioned by EC and KZN respondents. The responses were primarily focussing on condom use/safe sex (11 EC and 4 KZN responses), being faithful (7 EC responses), abstinence (4 EC and 3 KZN responses), and testing in order to know your HIV status (3 EC responses).

Respondents in the KZN sample also highlighted the

need for '*more prevention methods*'[171] and '*prevention methods for all*'[172], as well as for '*provision of safer sex supplies, gloves and condoms and education on safety methods*'[173].

Female controlled HIV prevention methods

Respondents also clearly indicated the need for greater access to, and availability of, women-controlled HIV prevention methods (11), calling for '*prevention methods focussing on women*'[174], '*a support system for women*'[175] and '*something I will control*'[176]. In addition, the need to address the unequal power relations between women and men was mentioned, so as to ensure that '*women have equal power with men on sex issues*'[177].

Women empowerment

The specific need to organise and empower women on issues of medical male circumcision and its impact for women was raised in the KZN sample, with particular reference to more and correct information and knowledge on HIV and male circumcision (6), as well as organising women to challenge/'*crush this idea of King Zwelinthini in a legal way*'[178] (3). Respondents also highlighted the need for awareness raising and workshops for women only on issues of MMC for HIV prevention and the '*dangers for women*'[179].

> *…women should stand up against abuse from men and forced sex and be independent…*[180]

FOCUS GROUP DISCUSSIONS

Focus group discussions were facilitated in both areas to gain a deeper understanding of participants' knowledge of medical male circumcision for HIV prevention, as well as the perceived impact of MMC for HIV prevention on women.

KwaZulu Natal

In one of the KZN focus group discussions[181], participants explored how difficult it was to negotiate safer sex with their partners, primarily focussing on risk behaviours in men, as well as concerns that MMC would essentially be a risk factor for women and women will be blamed for HIV.

> *…it can be introduced, but not as a prevention method, because as a Zulu woman you know how stereotyped Zulu men are? He won't allow us to use a condom when we are having sex, because he will say he is protected because he has removed the foreskin, which means we are both protected…*[182]

> *…women will be in a corner whereby we cannot say no. He will say he is circumcised and I don't have his HIV results. A woman will still get sexually transmitted infections and not a man. What about me who is already HIV positive? How would you know that this man is HIV negative, because you don't have his results? Male circumcision is a risk for women…*[183]

Discussing further the impact of introducing MMC for HIV prevention on women, participants also expressed their concerns about the risks of violence and abuse, as circumcised men may feel '*safe*' from HIV infection and insist on unprotected sex.

> *…as I volunteer at the crisis centre and I've attended a lot of domestic violence cases. The women are oppressed by men and sometimes the cause of domestic violence is HIV and AIDS. I don't think circumcision will help because men are always superior…*[184]

> *…it is males who will always claim that they are circumcised and cannot contract HIV. They will force female partners to have sex without a condom. If they refuse they will beat them or dump them, to be on the safe side, you have to agree on submission…*[185]

> *…if men are circumcised they will say that they cannot contract HIV. And so, they will want skin-to-skin because they are circumcised…*[186]

Eastern Cape

The focus group discussions in the Eastern Cape[187] clearly confirmed and re-emphasised the numerous

challenges of introducing medical male circumcision in communities that practice male circumcision as the rite to manhood, and also identified some of the socio-cultural barriers.

> *…Another thing is that to Western male circumcision children can be circumcised while they are still young by the time he grows up he is already a man. It won't work with Xhosas, we are black people and we have our own culture that we follow…*[188]

> *…I don't want my child to be circumcised medically forgive me, he must use his forefathers' ways. I accept that he must be protected against diseases, but I don't accept medical circumcision. Children refuse to be circumcised in hospital, because they say my big brother or my father when they speak. What has changed now? That's where the problem lies. Or they say, was my uncle circumcised in hospital? Is that why I hear you asking me to be circumcised in hospital Ma…*[189]

Similar to the questionnaire data, respondents expressed their concerns about the risks associated with traditional male circumcision practices, and shared ideas of how traditional circumcision could be made safer and elements of medical male circumcision introduced into traditional practices.

> *…the observer (umakhankatha) will be trained and given a certificate for circumcision. Any boy who do circumcision and the observer does not have a certificate will be arrested. That's what I heard at the moment…*[190]

> *…the only thing I think is to improve the way the old or traditional way, they should improve the way of doing it by involving the medical doctors, because this is culture and culture is culture…*[191]

The challenges about introducing MMC for HIV prevention into a community where traditional male circumcision is practiced were evident when participants spoke about the need to educate men around MMC, and emphasised that this should be done without women present in order to place MMC in the male domain to make it more acceptable; or conversely that only women would accept MMC for HIV prevention.

> *…so now they can come as a team to talk medical male circumcision. They must aim at young people. Maybe, it would be better if it were to be facilitated by a man. The young boys themselves will have to attend the training and women must be left aside, they can even seat in the toilet during the session…*[192]

> *…people must be given information; although there are few people who would accept medical male circumcision maybe it will only be accepted by women…*[193]

Though feeling strongly about socio-cultural barriers to introducing MMC for HIV prevention, the need for women to be involved and to overcome these barriers by talking to their sons was also expressed.

> *…I think women are affected at the end of the day, because these are our children. Each woman must speak to her son about this training on medical male circumcision and explain that as women we don't know what is happening at the initiation school, we don't even know if you are ok or not and we worry a lot; maybe in this way our children will listen to us. Women are affected, if something goes wrong men are never around; it is up to a mother to make means to amend the situation…*[194]

In one of the focus group discussions[195], participants talked about how the exclusion from traditional male circumcision practices made women feel, and identified ways of how they could intervene to change the mindset of men in this regard. These included putting legislation in place regarding initiates and their safety, as well as involving the Department of Health in training women on issues of male circumcision, so that women in turn could educate and raise awareness in their communities on male circumcision and thus ensuring:

> *…that they don't die, and that the boy who has been circumcised at the hospital can complete the process in the bush…*[196]

Discussion

The focus of the discussions and the concerns raised during the focus groups in both areas confirm and strengthen the dominant discourse that has emerged in this pilot study on women's perceptions of MMC for HIV prevention.

In communities where traditional male circumcision is part of culture and tradition, women are primarily concerned about their children and their safety whilst undergoing traditional rites of passage to manhood, which includes traditional circumcision practices. Women in these communities are clearly expressing their concerns about the exclusion of women in this ritual, which has historically been a secret male domain, and the fear about their sons being exposed to HIV during the traditional male circumcision process. Recognising that medical male circumcision is safer for their children, women have indicated that they would want to seek a compromise between traditional and medical male circumcision in order to mainly protect their sons from infections and complications. Thus, study participants in the Eastern Cape were primarily responding to the introduction of medical male circumcision for HIV prevention in their role as mothers and not partners and/or wives, and sharing limited insight into how MMC for HIV prevention could impact on women as partners.

To the contrary, study participants in KwaZulu Natal focussed primarily on the impact of MMC for HIV prevention on women as partners. The data show a clear concern for the increased risk behaviour of men and the associated risks for women, including the risk of violence and abuse.

4 Conclusion and Recommendations

The study clearly indicates women's concerns about the introduction and roll-out of medical male circumcision as an HIV prevention strategy, particularly in relation to how this strategy will impact on their HIV risks and vulnerabilities. Women do perceive that MMC will lead to an increase in risk behaviour in men with an associated increase in gender-based violence and stigma for women. A call for more female controlled prevention methods to address women's concerns was evident.

CONCLUSION

In summary, the data highlight a need to develop strategies that will engage women in all aspects of MMC as an HIV prevention strategy to ensure that women's needs, concerns and HIV risks and vulnerabilities are addressed. Moreover, there seems to be a general lack of knowledge, and some level of embedded misconceptions, about MMC for HIV prevention amongst women in the study.

The data further point to concerns about women's inability to negotiate condom use, coupled with an increase in risk behaviour in men after MMC, resulting in an increase in gender-based violence, as well as an increase in stigma and blame being directed at women with regards to HIV infection. The concern that men were even less likely to use condoms after MMC made the women call for increased access to, and availability of, women-controlled HIV prevention strategies.

While the data suggest overall trends for the total sample, it is important to note the distinct differences between the two samples; women in circumcising communities (Eastern Cape) and women in non-circumcising communities (KwaZulu Natal). Within the socio-cultural context of traditional male circumcision practices, women's levels of involvement in, and engagement with, the introduction and roll-out of medical male circumcision for HIV prevention is, as indicated by the data, distinctly different to women in communities in which male circumcision as rite to manhood is not an integral part of culture and tradition.

As such, women in the Eastern Cape sample largely responded to MMC for HIV prevention in their role as mothers, with little engagement on the impact of MMC on women's sexual health and rights as partners to men who will or have been medically circumcised. To the contrary, in KwaZulu Natal, a non-traditionally circumcising community, women engaged with the concept of MMC for HIV prevention primarily as partners and hence, more focussed on the impact of medical male circumcision for HIV prevention on their sexual health and rights. The KZN data also clearly highlight women's concerns and fears about the introduction and roll-out of MMC for HIV prevention, including that MMC only benefits men and will impact on risk behaviour in men, and women's needs for rights protection and HIV prevention methods that women can control.

Concerns about women's lack of involvement in decisions about male circumcision, as well as its impact, are arguably also reflected in the expressed desires of women to be actively involved in discussions and decision-making processes on medical male circumcision for HIV

prevention. Although the perceived need and reasons for women's involvement may differ, the data strongly suggest that women's involvement in all aspects of MMC for HIV prevention is essential, so as to adequately respond to women's concerns and needs and to ensure that women's HIV risks and vulnerabilities are addressed with this new HIV prevention strategy.

The data arguably also suggest a link between women's recognised lack of power to negotiate condom use, expressed concerns about the impact of MMC on risk behaviour in men, and perception of an increased risk of gender-based violence following the introduction of medical male circumcision for HIV prevention.

Linked to women's perception that men may feel protected from HIV, the data reflect women's fear of being blamed for HIV infection in circumcised men, as well as subjected to increased violence, as a direct result of MMC for HIV prevention.

Women's perceived impact of introducing MMC as an HIV prevention strategy, namely that men are even less likely to agree on condom use, is also reflected in data highlighting women's concerns that MMC would further reduce women's *'ability'* to negotiate condom use. Though not opposing MMC for HIV prevention per se, women strongly expressed the need for increased access to, and availability of, women-controlled HIV prevention strategies.

Taking into account that the roll-out of MMC for HIV prevention is imminent, data indicating that a third of all women participating in the study had never heard about this new HIV prevention strategy is of great concern. Furthermore, the data clearly highlight a lack of adequate knowledge and understanding among women who have heard about MMC for HIV prevention, especially in the context prescribed abstinence after '*surgery*'.

Whilst not necessarily significant in numbers, the study revealed embedded misconceptions about the efficacy of MMC as an HIV prevention method, which can arguably be linked to the dissemination of unclear and confusing messages about MMC for HIV prevention.

RECOMMENDATIONS

Recognising the multiplicity of challenges highlighted in this study, the following recommendations are based on the principled understanding that the active engagement with, and involvement of, all stakeholders are required to ensure that the introduction of medical male circumcision as a new HIV prevention strategy has no adverse impact on women and women's risk to HIV transmission and related rights abuses, but instead addresses women's specific risks and vulnerabilities to HIV as an integral part of MMC for HIV prevention policy and programme implementation.

In light of a lack of a policy framework, there is a need to engage policy makers so as to ensure

- timely finalisation of the national policy framework regulating MMC for HIV prevention; and
- alignment with, and adherence to, existing human rights obligations and principles at a national level in MMC policy development and implementation plans.

Recognising the expressed need for increased access to, and availability of, women controlled HIV prevention options, it is crucial to

- monitor that resources allocated for MMC roll-out are not diverted from HIV prevention programmes for women; and
- advocate for increased programming and implementation of HIV prevention programmes for women both parallel to, and as an integral part of, MMC for HIV prevention programmes.

Acknowledging the need for adequate education and awareness raising campaigns on MMC for HIV prevention, it is essential to

- ensure the dissemination of accurate and factual information, highlighting advantages and disadvantages of MMC for HIV prevention;
- develop and disseminate information and communication messages specifically emphasising the fact that medical male circumcision only provides partial protection of HIV infection; and
- design specific information and communication messages, as well as education and awareness campaigns, particularly addressing women's realities, risks and potential benefits in the context of MMC for HIV prevention.

Taking into account the challenges and inherent tensions between traditional and medical male circumcision practices, there is a need to

- facilitate broad stakeholder consultations addressing the concerns and fears of MMC '*interfering*' with cultural and traditional practices of rites to manhood;
- further investigate potential mechanisms of combining the two male circumcision practices; and
- research especially women's actual and desired role and involvement in discussions and decisions about male circumcision within circumcising communities.

Lastly, for medical male circumcision to effectively impact on HIV prevention, it seems crucial to address the existing challenges of, and barriers to, HIV prevention, such as gendered power imbalances and inequalities, so as to ensure women's access to, control over, and participation in HIV prevention options that truly reduces women's risks and vulnerabilities. Thus, addressing women's risks to HIV prevention, as well as underlying factors both determining and perpetuating women's HIV risks and vulnerabilities, need to become an integral part of medical male circumcision for HIV prevention programmes.

References

1. AVAC & Caucus for evidence based Prevention. August 2008. *Fact Sheet: Male Circumcision for HIV Prevention*.
2. The studies took place in Kisumu (Kenya), Rakai (Uganda), and Orange Farm (South Africa). For further details see Bailey, R.C. et al. 2007. 'Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial'. In: *Lancet*, 369, pp643-56; Gray, R.H. et al. 2007. 'Male circumcision for HIV prevention in young men in Rakai, Uganda: A randomised trial'. In: *Lancet*, 369, pp657-66; Auvert, B. et al. 2005. 'Randomised, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. In: *PLoS Med*, 2(11):e298.
3. AVAC & Caucus for evidence based Prevention. August 2008. *Fact Sheet: Male Circumcision for HIV Prevention*.
4. *Ibid*.
5. WHO/UNAIDS. December 2007. *Information Package on Male Circumcision and HIV Prevention.* Insert 5.
6. [www.malecircumcision.org/programs/documents/MC_OpGuideFINAL_web.pdf]
7. [http://data.unaids.org/pub/Manual/2007/070613_humanrightsethicallegalguidance_en.pdf]
8. [www.malecircumcision.org/programs/documents/UNAIDS_safe_voluntary_MC.pdf]
9. [www.un.org/Pubs/chronicle/2006/issue2/0206p12.htm]
10. AVAC & Caucus for evidence based Prevention. August 2008. *Fact Sheet: Male Circumcision for HIV Prevention*.
11. Matwa, D. 2009. 'The safety of women should be made a priority'. In: *ALQ*, March 2009, pp16-22.
12. [http://malecircumcision.org/advocacy/male_circumcision_advocacy_women.html]
13. Matwa, D. 2009. 'The safety of women should be made a priority'. In: *ALQ*, March 2009, pp16-22.
14. [http://malecircumcision.org/advocacy/male_circumcision_advocacy_women.html]
15. Bateman, C. 2010. 'Male Circumcision roll-out certain - now for 'the how'. In: *The South African Medical Journal*, Volume 100, No 2, pp84-86.
16. [www.malecircumcision.org/publications/documents/South_Africa_MC_case_study_May_2008_002.pdf]
17. Garenne, M. 2008. 'Long-term population effect of male circumcision in generalised HIV epidemics in sub-Saharan Africa'. In: *African Journal of AIDS Research*,7(1), pp1-8.
18. Male circumcision: Why the delay?' In: *PlusNews,* 3 December 2009. [http://www.plusnews.org/report.aspx?ReportId=87315]
19. [www.slideshare.net/NicoPaul/male-circumcision-research-into-policy-final-s-a-h-a-r-a-dec-09-2009]
20. [www.sahara.org.za/index2.php?option=com_docman&task=doc_view&gid=293&Itemid=85]
21. Mthembu, B. 2010. 'KZN backs circumcision programme to combat HIV'. In: *Mail & Guardian*, 19 January 2010. [http://www.mg.co.za/article/2010-01-19-kzn-backs-circumcision-programme-to-combat-hiv]
22. 'KZN Govt needs R700m to roll out circumcision'. In: *The Citizen*, 17 March 2010. [http://www.citizen.co.za/index/News/1025945.page]
23. Mbonambi, B. 2010. 'Hospital circumcision procedures a success'. In: *IOL*, 7 March 2010. [http://www.iol.co.za/index.php?art_id=vn20100307091536685C170950]
24. [www.sabcnews.com/portal/site/SABCNews/menuitem.5c4f8fe7ee929f602ea12ea1674daeb9/?vgnextoid=7a7f2a2b1fe27210VgnVCM10000077d4ea9bRCRD&vgnextfmt=default]
25. It is important to note that the ALN has ongoing

working relationships with the identified organisations in the provinces.

26. Only respondents who had heard of MMC for HIV prevention continued with the questionnaire.
27. EC, 21 January 2010, Questionnaire 32.
28. EC, 21 January 2010, Questionnaire 1.
29. EC, 21 January 2010, Questionnaire 4.
30. KZN, 14 December 2009, Questionnaire 67.
31. EC, 21 January 2010, Questionnaire 38.
32. The response rate for this question was 92% of the total sample.
33. EC, 22 January 2010, Questionnaire 17.
34. EC, 21 January 2010, Questionnaire 32.
35. EC, 29 January 2010, Questionnaire 69.
36. EC,28 January 2010, Questionnaire 70.
37. EC,21 January 2010, Questionnaire 6.
38. EC,23 January 2010, Questionnaire 61.
39. EC, 22 January 2010, Questionnaire 3.
40. EC, 21 January /2010, Questionnaire 15.
41. Facilitators notes.
42. EC, 21 January 2010, Questionnaire 19.
43. EC, 21 January 2010, Questionnaire 24.
44. EC, 21 January 2010, Questionnaire 32.
45. EC, 27 January 2010, Questionnaire 56.
46. KZN, 09 January 2010, Questionnaire 24.
47. KZN, 17 December 2009, Questionnaire 17.
48. KZN, 15 December 2009, Questionnaire 22.
49. KZN, 15 December 2009, Questionnaire 59.
50. KZN, 23 December 2009, Questionnaire 30.
51. KZN, 18 December 2009, Questionnaire 9.
52. EC, 27 January 2010, Questionnaire 53.
53. EC, 21 January 2010, Questionnaire 25.
54. EC, 21 January 2010, Questionnaire 36.
55. EC, 23 January 2010, Questionnaire 62.
56. EC, 21 January 2010, Questionnaire 19.
57. EC, 21 January 2010, Questionnaire 33.
58. KZN, 18 December 2009, Questionnaire 1.
59. KZN, 18 December 2009, Questionnaire 7.
60. KZN, 17 December 2009, Questionnaire 17.
61. KZN, 23 December 2009, Questionnaire 29.
62. KZN, 15 December 2009, Questionnaire 22.
63. KZN, 23 December 2009, Questionnaire 53.
64. KZN, 21 December 2009, Questionnaire 43.
65. EC, 27 January 2010, Questionnaire 53.
66. EC, 22 January 2010, Questionnaire 46.
67. EC, 21 January 2010, Questionnaire 28.
68. KZN, 22 December 2009, Questionnaire 48
69. KZN, 18 December 2009, Questionnaire 1.
70. KZN, 18 December 2009, Questionnaire 35.
71. EC, 27 January 2010, Questionnaire 56.
72. EC, 21 January 2010, Questionnaire 24.
73. EC, 21 January 2010, Questionnaire 13.
74. EC, 22 January 2010, Questionnaire 17.
75. EC, 22 January 2010, Questionnaire 26.
76. EC, 21 January 2010, Questionnaire 11.
77. EC, 21 January 2010, Questionnaire 11.
78. EC, 21 January 2010, Questionnaire 26.
79. It is important to note that 24% of respondents supporting MMC did so in relation to safer circumcision practices to protect their sons.
80. EC, 21 January 2010, Questionnaire 13.
81. EC, 21 January 2010, Questionnaire 32.
82. EC, 21 January 2010, Questionnaire 36.
83. KZN, 15 December 2009, Questionnaire 65.
84. KZN, 18 December 2009, Questionnaire 35.
85. KZN, 10 December 2009, Questionnaire 23.
86. EC, 26 January 2010, Questionnaire 57.
87. EC, 21 January 2010, Questionnaire 30.
88. EC, 22 January 2010, Questionnaire 66.
89. KZN, 14 December 2009, Questionnaire 62.
90. EC, 21 January 2010, Questionnaire 32.
91. EC, 28 January 2010, Questionnaire 48.
92. KZN, 10 December 2009, Questionnaire 23.

93. KZN, 17 December 2009, Questionnaire 17.

94. KZN, 18 December 2009, Questionnaire 8.

95. KZN, 14 December2009, Questionnaire 26.

96. KZN, 17 December 2009, Questionnaire 10.

97. KZN, 14 December 2009, Questionnaire 68.

98. KZN, 14 December 2009, Questionnaire 74.

99. EC, 21 January 2010, Questionnaire 1.

100. EC, 21 January 2010, Questionnaire 16.

101. EC, 21 January 2010, Questionnaire 38.

102. EC, 22 January 2010, Questionnaire 2.

103. EC, 22 January 2010, Questionnaire 42.

104. EC, 22 January 2010, Questionnaire 34.

105. KZN, 16 December 2009, Questionnaire 60.

106. KZN, 22 December 2009, Questionnaire 48.

107. EC, 28 January 2010, Questionnaire 70.

108. EC, 21 January 2010, Questionnaire 12.

109. EC, 21 January 2101, Questionnaire 5.

110. EC, 21 January 2010, Questionnaire 4.

111. EC, 21 January 2010, Questionnaire 25.

112. KZN, 23 December 2009, Questionnaire 49.

113. KZN, 18 December 2009, Questionnaire 4.

114. KZN, 17 December 2009, Questionnaire 18.

115. KZN, 14 December 2009, Questionnaire 67.

116. It is important to note that though the majority of comments indicate respondents' disbelief in MMC changing ideas about HIV risks, the quantitative data does not necessarily support this, with 54% of respondents saying 'yes' and 46% of respondents saying 'no'.

117. EC, 22 January 2010, Questionnaire 31.

118. EC, 22 January 2010, Questionnaire 32.

119. EC, 27 January 2010, Questionnaire 56.

120. KZN, 16 December 2009, Questionnaire 19.

121. KZN, 15 December 2009, Questionnaire 22.

122. KZN, 23 December 2009, Questionnaire 30.

123. EC, 26 January 2010, Questionnaire 55.

124. The overall response rate for this question was 94% of the total sample.

125. The overall response rate for this question was 94% (96% EC, 90% KZN) of the total sample.

126. The overall response rate for this question was 96% (100% EC, 90% KZN) of the total sample.

127. EC, 21 January 2010, Questionnaire 32.

128. KZN, 23 December 2009, Questionnaire 29.

129. KZN, 15 December 2009, Questionnaire 59.

130. KZN, 22 December 2009, Questionnaire 48.

131. KZN, 10 December 2009, Questionnaire 23

132. KZN, 18 December 2009, Questionnaire 5.

133. KZN, 23December 2009, Questionnaire 30.

134. The response rate was 100% in EC and 88% in KZN.

135. EC, 22 January 2010, Questionnaire 21.

136. EC, 21 January 2010, Questionnaire 30.

137. KZN, 18 December 2009, Questionnaire 1.

138. KZN, 23 December 2009, Questionnaire 30.

139. EC, 22 January 2010, Questionnaire 2.

140. KZN, 15 December 2010, Questionnaire 65.

141. EC, 21 January 2010, Questionnaire 38.

142. EC, 27 January 2010, Questionnaire 46.

143. Based on the fact that 19% of respondents 'refused' to answer this question, combined with the challenges of self-reported condom use data, a decision was taken not to analyse these responses.

144. EC, 21 January 2010, Questionnaire 23.

145. EC, 21 January 2010, Questionnaire 28.

146. KZN, 14 December 2009, Questionnaire 69.

147. EC, 22 January 2010, Questionnaire 21.

148. KZN, 23 December 2009, Questionnaire 30.

149. EC, 21 January 2010, Questionnaire 6.

150. EC, 21 January 2010, Questionnaire 19.

151. KZN, 16 December 2009, Questionnaire 60.

152. KZN, 23 December 2009, Questionnaire 49.

153. KZN, 23 December 2009, Questionnaire 29.

154. KZN, 17 December 2009, Questionnaire 14.

155. EC, 27 January 2010, Questionnaire 45.

156. EC, 27 January 2010, Questionnaire 46.

157. KZN, 15 December 2009, Questionnaire 65.
158. KZN, 14 December 2009, Questionnaire 26.
159. The overall response rate for this question was 87% (91% EC and 86% KZN) of the total sample.
160. The overall response rate for this question was 82% (87% EC and 76% KZN) of the total sample.
161. EC, 21 January 2010, Questionnaire 25.
162. EC, 27 January 2010, Questionnaire 56.
163. KZN, 18 December 2009, Questionnaire 9.
164. KZN, 17 December 2009, Questionnaire 10.
165. KZN, 14 December 2009, Questionnaire 69.
166. KZN, 23 December 2009, Questionnaire 53.
167. KZN, 15 December 2009, Questionnaire 65.
168. EC, 21 January 2010, Questionnaire 32.
169. EC, 21 January 2010, Questionnaire 33.
170. EC, 28 January 2010, Questionnaire 70.
171. KZN, 15 December 2009, Questionnaire 65.
172. KZN, 23 December 2009, Questionnaire 29.
173. KZN, 14 December 2009, Questionnaire 67.
174. KZN, 16 December 2009, Questionnaire 19
175. EC, 21 January 2010, Questionnaire 13
176. KZN, 18 December 2009, Questionnaire 5
177. EC, 22 January 2010, Questionnaire 21
178. EC, 22 January 2010, Questionnaire 21
179. KZN, 17 December 2009, Questionnaire 14; and 23 December 2009, Questionnaire 49
180. KZN, 14 December 2009, Questionnaire 69
181. KZN Focus Group Discussion in KwaMakhuta on 13 January 2010. Women participating in this discussion were between 25 and 30 years old.
182. KZN Focus Group Discussion, 13 January 2010.
183. KZN Focus Group Discussion, 13 January 2010.
184. KZN Focus Group Discussion in KwaMakhuta on 14 January 2010. Women participating in this discussion were between 35 and 40 years old.
185. KZN Focus Group Discussion, 13 January 2010.
186. KZN Focus Group Discussion, 14 January 2010.
187. Focus group discussions in the Eastern Cape were facilitated on 27 January 2010 in Port Elizabeth and on 29 January 2010 in New Brighton.
188. EC Focus Group Discussion, 29 January 2010.
189. EC Focus Group Discussion, 29 January 2010.
190. EC Focus Group Discussion, 27 January 2010.
191. EC Focus Group Discussion, 27 January 2010.
192. EC Focus Group Discussion, 29 January 2010.

Published by the AIDS Legal Network (ALN)

Suite 6F, Waverley Business Park, Mowbray, 7700 • PO Box 13834, Mowbray 7705, Cape Town, South Africa
Tel: +27 21 447 8435 • Fax: +27 21 447 9946 • E-mail: alncpt@aln.org.za
Website: www.aln.org.za