

# Embe Halijamenywa: The unpeeled mango

A Qualitative Assessment of Views and Preferences  
concerning Voluntary Medical Male Circumcision in  
Iringa Region, Tanzania

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**Authors:**

**Marya Plotkin\***  
**Jan Küver†**  
**Kelly Curran\*\***

**Hawa Mziray\***  
**Judith Prince††**  
**Hally Mahler\***





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These symbols denote the authors' organizational affiliations:

\* Jhpiego Tanzania

† Tumaini University, Iringa, Tanzania

‡ Independent consultant

\*\* Jhpiego headquarters (United States)

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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

*The title of this report was taken from a quotation of one of the participants, who asked, "why would you prefer to eat a mango which was not peeled?"*

*The men on the cover are not participants in this study.*

## **Abbreviations and Acronyms**

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CHAC	Council HIV/AIDS Coordinators
FGD	Focus Group Discussion
MC	Male Circumcision
MCHIP	Maternal and Child Health Integrated Program
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

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## Executive Summary

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Men's decisions about seeking voluntary medical male circumcision (VMMC) services are complex, influenced by culture and history, traditional beliefs, education, sexuality, gender relations, economic and marital status, exposure to urban or modern culture, past experiences with health care services and many more factors.

This qualitative assessment was conducted in February 2011 in three districts of Iringa region to inform the VMMC program implemented in Iringa, Tanzania, by the Ministry of Health and Social Welfare, with support from the President's Emergency Plan for AIDS Relief (PEPFAR) through the Maternal and Child Health Integrated Program (MCHIP) (managed by Jhpiego), a USAID funded project. This formative work aimed to improve the understanding of the attitudes and beliefs of adult men and women that may enhance or hinder uptake of male circumcision (MC) in Iringa region and explore their people's views on service delivery. Although the VMMC program is still relatively new, only 20% of recent MC clients were aged 20 and above. VMMC for HIV prevention will have the greatest immediate impact if adult males are also accessing MC services. The need to promote MC in men over 20 years of age is supported by the fact that HIV prevalence is highest in men ages 35–39 in Tanzania [THMIS 2009].

One hundred and forty-two men and women in the three districts participated in 13 focus group discussions and three participatory exercises, which included creation of timelines and seasonal calendars.

The majority of the participants could accurately describe VMMC and its benefits, including biological ones such as cleanliness, and disease prevention (including HIV/AIDS prevention), as well as perceived ones such as perceptions of increased virility.

In general, participants stated that ideally, men should get circumcised before puberty. Some were proponents of infant circumcision, but most felt that circumcision is best performed during childhood. VMMC during adulthood (defined by participants as married men, and those over the age of 24) was described as something unusual and perhaps embarrassing. MC was seen as something associated with modernity and urban environments, as well as secondary education, which usually involves the mixing of children from different ethnic groups – often in a boarding situation.

Defining the “older client” for VMMC is a challenge. In terms of age, the consensus was that someone in their late 20's onwards would be considered old for seeking circumcision. In addition, being married with children also plays into a definition of who is old or unusual to choose to be circumcised: the marriage status alone did not seem to be a deterrent, but a man who has had a number of children and is married did. A number of comments and discussion about loss of sexual appetite in men refer to men who are in their 40s and older. Thus, discussion about the older client for VMMC must be viewed with some flexibility.

A number of barriers for older clients seeking VMMC were identified by the participants, including: they didn't think that MC was relevant to their age group; seeking VMMC at an older age was seen as shameful and inappropriate; there was no point in a man who has already

fathered children to seek VMMC: VMMC (and condom use) is only appropriate for young men because they are more sexually active than older men.

Facilitating factors most commonly noted by men were peer pressure from other men, that women prefer circumcised men, cleanliness and disease prevention. The facilitating factors most commonly expressed by women were disease prevention, women's preference for a circumcised man and cleanliness.

Some of the important findings on preferences for service delivery included: a very clear sentiment that providing services that mix young boys and older men is socially unacceptable to the older men, and constitutes a barrier to service. A clear preference was also stated, largely by men in their early 20s, for male providers to perform circumcision services. The primary reason given was fear of embarrassment should an erection occur in front of a female provider. Provision of male-only MC services may not be realistic given the human resource constraints in the Tanzanian medical system; however, some options should be explored.

The findings also suggest that seasonal considerations are of major importance to people in Iringa when making the decision as to whether to seek circumcision services. There is a clear and strong preference for circumcision to be done in June, July or August (the local "cold season") during which time it is believed that healing is better. In response to this finding, circumcision services in Iringa should continue to be offered in a campaign setting during these preferred months, while at the same time, demand creation activities should seek to communicate the safety of circumcising at other times of the year.

Despite the potential barriers identified in this report, the authors believe that with some changes to service delivery, it will be possible to attract more adult males to male circumcision for HIV prevention services. Education is needed for communities in Iringa on the importance of prevention measures (including VMMC) for men who are over 20 years of age, for men who are married, and/or for men who have children. In order to attract more older men to services, offering separated services (either in different facilities, using separate space within facilities or on different days) will be important.



# 1. Introduction

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## 1.1 National Male Circumcision Response

The results of three randomized clinical trials (Orange Farm, South Africa; Rakai District, Uganda; and Kisumu, Kenya)[1,2,3] have shown that voluntary medical male circumcision (VMMC) is a safe and effective method of reducing a man's risk of acquiring HIV during vaginal sexual intercourse by approximately 60%. VMMC was endorsed for HIV prevention by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in March 2007, and the first VMMC technical working group was formed in Tanzania in 2009.

In 2009, VMMC services following WHO/UNAIDS guidelines and recommendations were launched as part of a three-region pilot program. Additionally, national situation assessments investigating circumcising practices in traditionally circumcising communities and in non-traditionally circumcising regions were undertaken. The Tanzania National Strategy and Implementation Plan for Scaling up MC for HIV Prevention was launched in December 2010 [4]. Mathematical modeling data cited in the national strategy suggested that reducing HIV incidence for public health impact would require approximately 2.8 million circumcisions of males between 10 and 34 years in Tanzania by 2015. Eight focus regions with high HIV prevalence and low MC prevalence, which included Iringa, were identified as priority settings for implementing VMMC. Boys 10–24 years old and men aged 25–34 were identified as the primary and secondary priority audiences for VMMC services in Tanzania, respectively. From a service provision vantage point, the strategy allowed trained nurses and clinical officers to serve as circumcision surgeons. VMMC services were also deemed free of charge in public sector facilities.

With funding from the US President's Emergency Fund for AIDS Relief (PEPFAR), the US government has been supporting the initiation and scale-up of MMC services in Tanzania. USAID/Tanzania selected the MCHIP program, implemented through Jhpiego in Tanzania, to provide technical support to the Ministry of Health and Social Welfare ( and implementing partners, and support service delivery in Iringa and Tabora regions in Tanzania.

## 1.2 Tanzania and MC

Tanzania, with an estimated population of 45 million people [5], has a national adult HIV prevalence of 5.7% [6]. Regional prevalence within Tanzania's 23 regions varies substantially. The highest HIV prevalence is found in Iringa region (15.7%), and the lowest in mainland Tanzania is in Manyara (1.5%) [6].

Nationally, Tanzania's MC prevalence is approximately 67%. However, there is considerable regional variation. Circumcision levels are as high as 98% in Dar es Salaam, the country's largest city, and as low as 21% in the inland region of Shinyanga [7]. Circumcision is higher in urban than rural areas. The eastern half of Tanzania has higher circumcision levels than the west. This geographic difference can be partially explained by religious, ethnic and cultural factors. For example, Tanzania's traditionally circumcising Muslim population (approximately 35% of the national population) is largely concentrated in the eastern coastal regions. The ethnic groups that populate the largely pastoral northern highlands of Tanzania traditionally circumcise adolescent

boys as an initiation into adulthood. Also, circumcision appears to be associated with education level, with more educated men more likely to have been circumcised [7].

A National Situation Assessment on Male Circumcision carried out in 2009 found that men and parents of boys in traditionally non-circumcising areas of Tanzania are not generally opposed to circumcision, and in fact would take their children to be circumcised or go for circumcision themselves if the services were available. The main reasons given for not circumcising included not being the usual cultural practice and the financial costs associated with VMMC [7].

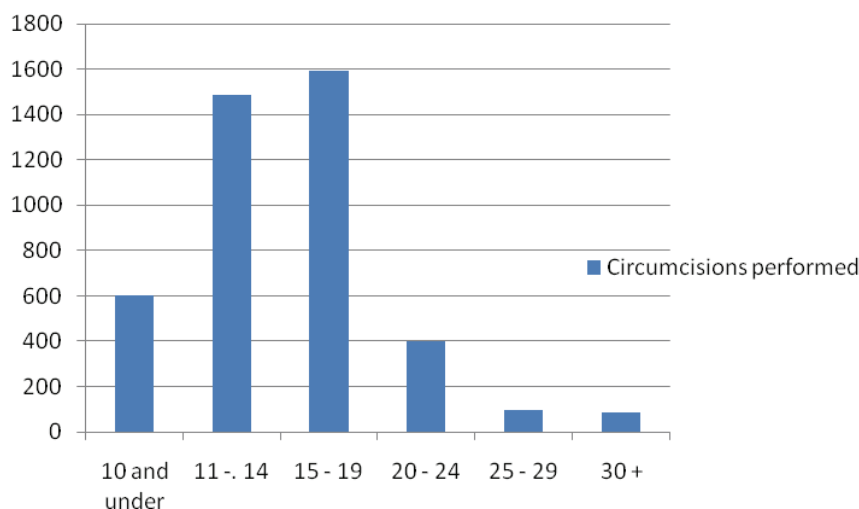
### **1.3 Iringa Region and MC**

Iringa region, which hosts the Tanzania-Zambia highway, is situated in the southern highlands of Tanzania. Iringa has the highest adult HIV prevalence (15.7%) (compared with the national average of 5.7%) and one of the lowest levels of MMC (29%) in Tanzania [6]. The region is a largely rural area of 1.9 million people, with farming (tomatoes, onions, and sunflower seeds), plantation agriculture (tea, timber, wattle), fishing and some mining as the main productive activities. Cost and impact modeling conducted using the United States Agency for International Development (USAID)/UNAIDS Male Circumcision Decision Makers Program Planning Tool (DMPPT) suggests that in Iringa one HIV infection will be averted for every 4.5 VMMCs performed [8]. In recognition of the importance of VMMC in regional HIV prevention efforts, VMMC has been incorporated into the Iringa Regional Action Plan for the Prevention of New HIV Infections. Regional officials have adopted and actively participated in the rollout of VMMC service delivery efforts [9]. The National AIDS Control Programme's target for VMMC in Iringa region is 264,990 circumcisions in three years.

The primary goal of VMMC for HIV prevention is to reach men or boys with the service before they get HIV and irrespective of marital status. The peak age of HIV prevalence among men in Tanzania is 35–39 years old [6]. Also, anecdotal evidence suggests that condom use among married couples is very low, although HIV transmission often occurs within marriage. VMMC for HIV prevention services were initiated at Iringa Regional Hospital in October 2009, and routine VMMC services have been introduced into 11 sites, covering all districts, as well as provided via outreach services to an additional 10 rural health centers and dispensaries. To date, two VMMC campaigns have taken place in Iringa—the largest having taken place in June and July 2010 at five health facilities in three districts—which circumcised 10,352 clients in the span of six weeks. Overall, since VMMC was introduced in Iringa in September 2009, over 25,000 men and boys have been circumcised following the WHO VMMC for HIV Prevention package. MCHIP works in partnership with the regional and district health authorities to implement all of these MC activities.

Despite these successes, trends in client attendance suggested that more data were needed on decision-making and care-seeking behavior around the VMMC target audience. For example, very high client volume was seen in the June–July campaign (over a hundred clients a day at some facilities), and lower turnout at a December mini-campaign (30–40 clients per day at the same facilities). Was this because of local beliefs around seasonality and wound healing, or because a majority of eligible people had already been circumcised in the nearby surrounding area of the campaign sites or something else? In addition, the majority of the clients served during the campaign were under the age of 19 (Figure 1). Why were “older” MC clients (men 20 and older) coming in such low numbers?

**Figure 1. Age distribution of MC services, Iringa, December 2010–February 2011**



This study was designed to learn more about the perspectives of adult men and women in the community that may facilitate or hamper uptake of VMMC services, particularly service uptake among older men, as the early service trends suggest. The study team was particularly interested in participants' views on age appropriateness for MC, the role of seasons in MMC-seeking behaviors, and overall benefits and drawbacks. The results from this study will be used to inform the MMC program in Iringa in order to increase the number of older VMMC clients (those in their 20s and 30s) and improve community understanding of the relevance of MMC for older clients. Reaching older men before they become HIV-infected is an imperative in this program as it will help effect substantial and immediate HIV prevention benefits for Iringa region overall.

## 2. Methods and Sampling

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### Sampling

Participants were conveniently sampled from rural, peri-urban and urban settings. The locations included Iringa Municipality (main market and Igumbilo); Njombe District (Njombe town and Matembwe village); and Mufindi District (Mafinga town and Iramba village). Participants were recruited with assistance from the local government Council HIV/AIDS Coordinators (CHACs), who advised on the location where the research would be conducted and helped to recruit people in the correct age groups. CHACs were informed to recruit between seven and 10 people for each of the relevant age/gender groups: women (18–39 years); younger adult males (18–29 years); and older adult males (30 and older). The criteria CHACs were given were that the people should be selected on their age and gender, availability for the time of the exercise, and being within walking distance of where the assessment was being conducted. No screening questions were used to screen out participants who had been selected by the CHAC.

In all of the six locations visited, one older male focus group discussion (FGD), one younger male FGD and one female FGD was conducted. In all of the three districts, one participatory exercise with a mixed gender group was conducted; this exercise contained both the timeline and the seasonal calendar.

## **Data Collection**

Field work was conducted from February 21–26, 2011. The assessment methodology consisted of FGDs and participatory research exercises. The FGDs, which consisted of 7–10 participants, were facilitated by two or three facilitators. All FGDs were conducted in Kiswahili (all facilitators are fluent in both Kiswahili and English) using an FGD guide, which outlined the research questions. One facilitator facilitated the discussion, while the other one or two took notes and asked guiding questions if the main facilitator forgot points. Female FGDs were facilitated and recorded only by female facilitators. Male FGDs were led by a male facilitator but had a recorder or other facilitator who was female. All FGDs were held in either closed rooms or public spaces, which afforded some audio privacy. FGDs were recorded onto digital voice recorders, and extensive handwritten notes were taken by the recorders (one or two facilitators who were not leading the exercise). Exercises (both the FGD and the participatory exercise) generally took just over one hour.

Exercises (both FGDs and participatory exercises) started with a verbal informed consent statement being read to participants, giving them the option of leaving if they did not want to stay for the exercise. After verbal consent was obtained from the participants, they filled in an anonymous questionnaire, which captured basic background information in Kiswahili on age, sex, relationship status and whether the individual was a parent. Facilitators circulated to help those who were not literate or who struggled with reading to fill in the form. Men were asked in that anonymous questionnaire if they were circumcised and, if so, when the circumcision occurred; clinical exams were not performed to confirm self-reported circumcision status. These anonymous questionnaires were collected in an envelope and stored securely until data entry.

Participatory exercises, which were conducted with mixed-gender groups, consisted of a life-cycle exercise in which participants remarked on the appropriateness of MC at different times in a male's life span, as well as a seasonality calendar in which participants discussed the benefits of getting circumcised at different times throughout the year. Some of the participants also took part in a ranking exercise in which they gave scores to different service delivery options and explained why they gave those scores.

## **Analysis**

Following the focus group discussion session, a review meeting was held on the same day in which all facilitators who had participated in a session read back their notes and the team agreed upon the key point emerging from the session, and noted points in the digital recorders that had good quotes to capture. The handwritten notes and key points statements were heavily relied upon for compiling findings and locating direct quotes. Word-for-word transcription from the digital recorders was done only in cases where written notes were felt to be inadequate, and to get the exact phrasing of the quotations.

To analyze the data, larger subthemes were identified by the assessment team (example: sexuality and circumcision, appropriate age for circumcision, post-circumcision abstinence) and two members of the assessment team went through all of the exercises notes and audio recordings, pulling out findings and quotes related to that theme. This was then shared with the larger assessment team for review, and other members of the assessment team pointed out missing areas and worked together on appropriate translation of the quote into English.

Quantification of the themes was done with the same two team members going through the sections on a topic, counting the number of times the topic was spontaneously mentioned in the group.

The anonymous questionnaires were entered by a member of the assessment team into SPSS version 16 and simple frequencies run.

The assessment was conducted with ethical oversight from the Johns Hopkins University Bloomberg School of Public Health Institutional Review Board, and with the support of the Iringa Regional Medical Officer's office.

### 3. Description of Participants

Among the 142 participants, 74 were men and 68 women. Participants were 31 years old on average (range of 18–68).

A total of 13 FGDs and three participatory research exercises were held. Details are presented in Table 1, below.

**Table 1. Types of exercises conducted as part of the study**

District/ Town or Village	Female FGDs		Older Male FGDs		Younger Male FGD		Participatory Research Exercise	
	No. conducted	Total no. of participants	No. conducted	Total no. of participants	No. conducted	Total no. of participants	No. conducted	Total no. of participants
<b>Njombe District</b>								
Njombe town	1	8	--	--	1	8	--	--
Matembwe village	1	8	1	9	--	--	1	9
<b>Iringa Municipal Council</b>								
Main market	1	7	--	--	1	7	--	--
Igumbilo sub-area	1	9	1	8	1	7	1	10
<b>Mufindi District</b>								
Mafinga town	1	10	--	--	1	10	--	--
Iramba village	1	10	1	11	--	--	1	11
<b>Total</b>	<b>6</b>	<b>52</b>	<b>3</b>	<b>28</b>	<b>4</b>	<b>32</b>	<b>3</b>	<b>30</b>

### 3.1 Participants

Male participants were 32.6 years on average (range 18–68). Sixty-six percent of men reported that they were married; 77% reported that they were parents. Marital status, and parental and self-reported circumcision statuses of male participants are presented in Table 2 below. Among the 71% of participants (53 men) who reported being circumcised, the circumcisions took place between 2 and 25 years of age, with an average age of 13.5 years.

The average age of female participants in the assessment was 29.2 years (range 18–47). Fifty-seven percent reported that they were married; 82% reported that they were a parent.

Ethnicity was not asked because the study was conducted in an area largely settled by one ethnicity (the Hehe tribe).

**Table 2. Characteristics of participants in the study**

	Men*		Women**	
	n	%	n	%
<b>Relationship status</b>				
Married	49	66.2	39	57.4
Not married	15	20.3	21	30.9
In a relationship but not married	8	10.8	8	11.8
<b>Parental status</b>				
Yes, a parent	57	77.0	56	82.4
No, not a parent	15	20.3	11	16.2
<b>Circumcised</b>				
Yes	53	71.6	--	--
No	21	28.3	--	--

\*2 participants left information blank, so percentages do not total 100%

\*\*1 participant left information blank, so percentages do not total 100%

## 4. Findings

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### 4.1 Understanding MC

All exercises began with a query to the participants to describe what was meant by “male circumcision” (*tohara ya wanaume* in Kiswahili). Participants correctly described male circumcision as the removal of the foreskin unanimously, and a majority of participants also spontaneously mentioned hygiene and prevention of sexually transmitted diseases, including HIV /AIDS. Only one participant, a female participant in one of the rural sites, had an incorrect understanding of what MC was (she described it as a sexually transmitted infection).

*“Tohara ni kukata govi kwenye ume.”*

*“Circumcision is to remove the foreskin.”*

*“Tohara ni mwanaume kutolewa ngozi yake kwenye uume...ile ngozi inahifadhi uchafu, wadudu wanaficha kwenye ngozi.”*

*“Circumcision is for the man to have some skin on his penis removed...that skin can harbor illness, such as microorganisms which can hide in the skin.”*

It was clear that not only were people quite aware of the meaning of male circumcision and some biological benefits (disease prevention and hygiene) but that MC also had social meaning and associations, many of which included value judgments. Table 3 below presents some of the positive and negative terms used to describe circumcised and uncircumcised men.

**Table 3. Terms for understanding MC**

Positive Terms Used to Describe MC or a Circumcised Man	Negative Terms Used to describe MC or an Uncircumcised Man
<b>Laini</b> (translation = smooth) to describe a circumcised penis	<b>Mzee wa chujio</b> (translation = man with a tea strainer) to describe a man who has not been circumcised
<b>Kujisafi</b> (translation = to make oneself clean) to describe circumcision	<b>Vuvuzela</b> (i.e., a long, monotone horn commonly used by fans during South African soccer matches) to describe an uncircumcised penis
	<b>Mzee wa mfuko</b> (translation = the man with a bag) to describe a man who has not been circumcised
	<b>Kuvaa kofia</b> (translation = to wear a hat) to describe a penis that has not been circumcised
	<b>Filimbi</b> (translation=flute or whistle) To describe a penis that has not been circumcised

## 4.2 Socio-Cultural Perceptions

### 4.2.1 MC and Culture Change

#### ▪ MC in the past

All participants reported that MC was not a normal procedure in the past for tribes from Iringa region such as the *Wahebe* and the *Wabena*. Participants associated MC instead with other cultural groups such as *Wagogo*, *Wamaasai*, *Wajita* and people from the coast.

One participant in the younger men’s group described his experience when he wanted to get circumcised (this participant appeared to be in his 20s and was circumcised before MCHIP’s VMMC program started).

*“Mimi nilipoanza fomu one nikaanza kujua sasa tohara ni nini, wenzangu wengi walikuwa wametahiriwa, namimi nikataka kupata tohara. Sasa, mwalimu mmoja aliniunganisha na daktari tulishapanga utaratibu, ila kabla ya kwenda nikawambia wazazi wangu mpango niliokuwa nao. Wazee wangu hawakunielewa kabisa, ni kitu geni hapa kwetu hatufanyi hivyo. Wakanikataza ikabidi niache mpango – sikutahiriwa wakati ule. Ila nilipoanza form five nilisoma Tosamaganga na nilifahamu daktari moja huko hospitalini. Nae nikafanya mpango, na wakati huo sikuwambia wazazi wangu, kasha nikafanyiwa tohara. Wazazi wangu hadi leo hawajui kuwa nimetahiriwa.”*

*“When I started high school I learned about circumcision because many of the other students were circumcised, and I wanted to get circumcised as well. One of my teachers contacted a doctor and we planned to do it, but before I did it I told my parents about my plan. My parents didn’t understand me at all. They said, ‘In our society we don’t do that.’ They forbade me, and so I didn’t get circumcised at that time. But when I entered a higher grade at Tosamaganga Secondary School, I made arrangements with a doctor I knew in the hospital. This time I didn’t tell my parents, and I got circumcised. Until today, my parents don’t know that I’m circumcised.”*

MC was also described as an Islamic tradition for initiating adolescents into adulthood (*jando*). Muslims are a minority in Iringa; although participants were not systematically asked their religion, a few participants in the urban sample volunteered this information.

One older man felt, especially in rural areas, that the tradition of not circumcising would be hard to overcome:

*“Mimi kama ninavyoelewa ni elimu ya asili imeingia ndani mno ... walio wengi wanaitumia sana katika kuendesha jamii yao ... hasa ni mazingira sisi watu ni wa bondeni sana barabara mbali ... bado kuna watu iko damuni yaani ni wabishi ambao yaani bado ukiwambia ina faida gani hawaikubali hata ukiwapa bure au kuwapa hela hawakubali.”*

*“I think that traditional values have still been internalized too much. Many people still use these traditional beliefs to run their society. Especially our area, we are remote people far away from the main road ... still here the traditional culture is in the blood of the people. They are stubborn, so even if you were to tell them the benefits and give them for free or even give them money for getting the service they won’t do it.”*

Many others, however, described a situation where the acceptability of being circumcised had gone up dramatically as a result of urbanization (this is discussed later in depth).

Male circumcision was categorically described as something that was not sought by or done to adults.

#### ▪ **VMMC at present**

There was a broad general awareness and acceptance among participants that MC is part of societal norms in the study area today. There was a recognition that MC had been adopted through inter-ethnic contact, intermarriage and travel (this largely referred to VMMC). Urban settings have become multi-ethnic, and rural areas absorb urban culture to some extent. In the



modern setting, MC has been adopted as a means to protect oneself against the spread of diseases, to gain social status, to make oneself more attractive to women and to avoid ridicule. As the younger male group discussed in Mafinga:

*“Aliotahiriwa anapata heshima zaidi...unajisikie huru kusogea mwanamke...Haijakuwa utamaduni, lakini sasa kwenye miji inachukuliwa kama kitu cha kawaida.”*

*“Circumcised men are given more respect...feel proud and free and can easily approach girls...It was not our tradition, but now it is accepted as normal practice, especially in towns.”*

Participants reported first hearing about VMMC in the 1980s and early 1990s. Some of the mothers reported hearing about it first when their sons went to secondary school, from their sons. Some people reported that their knowledge of VMMC came from educational campaigns by governmental and nongovernmental health organizations.

However, even in the context described above, adult VMMC is still viewed with some hesitation. Participants’ responses indicated that they could imagine young adult men seeking VMMC, but still would register surprise at older adult men seeking VMMC.

#### ▪ **Adaptations of traditional cultural patterns in modern culture**

In addition to the distinction between past and present VMMC practices, VMMC can also be thought of in a traditional versus modern cultural framework. In traditional culture (which could be described as more authoritative, intrinsic, customary, collective and inherited in blood and heart), VMMC was known largely as something that other ethnic groups did. In the modern culture (which could be described as more independent, rational, reasonable, individual, extrinsic and voluntary), VMMC is seen as something that may be done based on perceived health benefits, aesthetics, social status and self-confidence.

*“Ni swala la jamii, wengine wanafanya kimila, wengine wanafanya kwa njia ya kisasa, wengine wanafuata dini, na kuna jamii nyingine haziamini kabisa hilo swala la utahiri, sasa zile jamii ambazo haziamini katika swala la kutahiri kuna watu ambao ...wanapozunguka wanapokutana na watu, mtu binafsi anaamua atahiri.”*

*“It’s a question of society. Some societies do it as traditional culture, some do it the modern way, others follow religion, and some societies don’t believe at all in circumcision. Also, someone can decide to do it individually [regardless of their society].”*

Using the traditional/modern construct, MC in the traditional sense could be seen as a collective norm for everyone (e.g., traditional *jando* [initiation into adulthood], religion-motivated circumcision, etc.); whereas in the modern construct, MC could be seen as a rational, individual choice to be made as a result of reasoning.

In the traditional/modern framework, MC could be construed as a symptom of a trend toward a more modern culture that is posing a threat to the traditional order. To some extent, change toward a more modern culture is associated with moral decay, to be observed among other things in an increasing lack of sexual restraints.

Interestingly, the participants in several sessions proposed that VMMC should be a compulsory operation, to be done after birth to all male children in the health facility. This was not unanimous, but when raised by a few individuals, was found to be an agreeable option by many of the participants. Those who supported infant circumcision felt that a child heals faster, has a lower recollection or experience of pain, and that infant circumcision would avoid difficult issues such as abstinence and erections. The agreement of participants may reflect the traditional concept of a collective norm in Tanzanian culture, which tends to be more compelling than individual choice.

#### ▪ **MC in urban and rural environments**

Participants agreed that in general, most of the men in villages are not circumcised, while many in town are.

Participants' comments indicated that rural life revolves around agricultural seasons, with socio-cultural activities being dependent on these. In urban areas the seasonal cycle is less binding or important; people adjust their lives to a broad range of activities. However, strong views on seasonality for MC-seeking behaviors persist in both urban and rural settings (see Section 4.4.3).

#### ▪ **MC in older and younger generations**

Participants' responses showed that the older generation is much more resistant to culture change than the younger generation. In particular, elders feel more threatened by a potential change to their social status (see Section 4.2.2). In the context of VMMC, this means that fewer of the older men were circumcised or would consider getting circumcised.

Some negative responses were noted among older adult men towards child circumcision. One participant told of his experience with his five-year-old boy, who was born in Morogoro and circumcised there before returning to Iringa. One of his relatives asked him, *“What did you do to this child? Look at the extent to which you have damaged him!”*

Responses from the younger focus groups revealed that their acceptance of MC is much stronger than older adults, especially in terms of action (i.e., seeking the circumcision for oneself). This was reinforced by the findings from the participant questionnaire, which showed that six of the eight participants 22 years and below were circumcised.

#### ▪ **Religious associations with MC**

MC is accepted as an obligatory norm for Muslims. Some participants made reference to the Bible, which mentions MC but does not require it. Some participants argued that since Jesus was circumcised, we should follow his example. Other participants stated that human beings should not interfere with God's creation, and therefore should not get circumcised. The religious references were made more frequently in the older or the mixed groups than in the young men's groups.

*“[Kutahiri] Utabaribu maumbile aliopanga Mungu.”*

*“[By conducting circumcision] You are going to ruin that which God has created.”*

## 4.2.2 MC and Social Status

### ▪ Symbolic value attached to MC

Table 4 below presents some summary findings of participants' value statements about MC. These statements represent supportive opinions of participants based on their comments in the exercises.

**Table 4. Symbolic value attached to MC**

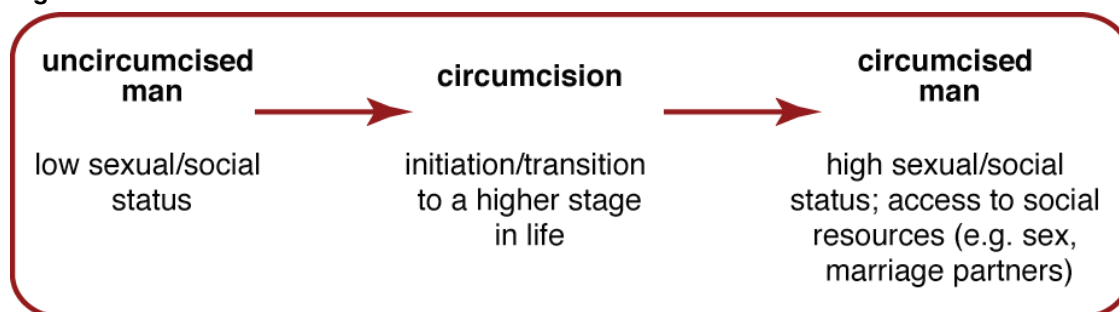
Circumcised	Uncircumcised
Being circumcised is connected with a <b>higher social status</b> than being uncircumcised	Being uncircumcised is associated with the stigma of being <b>more prone to sexually transmitted infections</b> such as <b>HIV</b>
Being circumcised carries values of <b>masculinity, manhood, virility and sexual performance</b> ; circumcised men are more potent, stronger, have more stamina	Being uncircumcised has a negative association of being <b>unsophisticated</b>
<b>Women prefer</b> sex with circumcised men, and are supportive of men getting it done	Being uncircumcised causes <b>pain</b> during intercourse
Being circumcised enhances a man's <b>self-confidence</b>	
MC symbolizes <b>initiation to adulthood</b> , i.e., to a higher stage in life ( <i>jando</i> )	
MC represents <b>access to sexual resources</b>	

All participants, to varying degrees, reported that a circumcised man has higher access to sexual power and resources (see Figure 2). Men felt this most strongly.

*“Aliyetahiriwa ni mtu ambaye anaonekana kwamba ametoka katika stage fulani ameenda sehemu nyingine, ni mtu ambaye an wadhifa fulani, katika kitendo kile ni mtu ambaye yuko tofauti na yule ambaye hajatahiriwa.”*

*“The circumcised one seems to have advanced from one stage to another. He has a certain status. Concerning sex he is different from an uncircumcised one.”*

**Figure 2. Modern social status and circumcision**



### ▪ **Social status as a barrier to MC**

A delicate social hierarchy is very important and widely internalized in the study area. In this hierarchy, older adult men occupy a distinguished status, which they must reinforce with appropriate behavior. Real or perceived age-inappropriate behavior by older men can thus be viewed as a threat to their status within the family and in society.

Participants reported that MC exposes older men to shame in several ways:

- It is considered to be an age-inappropriate activity;
- It publicly acknowledges an activity related to sexuality, which may also be associated with promiscuity; and
- It requires exposing one's genitals.

However, status protection does not apply to the younger generations in the same way that it does to older generations. MC seems to be widely accepted in younger generations, and many young men are seeking circumcision, especially in towns.

### ▪ **MC in urban/rural environments**

Responses of the participants indicated that they felt that status considerations are stronger in villages because people are closer and know each other more intimately. The participants in rural areas showed more traditional behaviors, such as stating that women would be less likely to discuss circumcision for fear of looking promiscuous. Comments also indicated that in villages, people tend to be more aware of activities of the individual, allowing for less privacy or anonymity in the decision to seek MC. Participants' responses indicated that, in villages, traditional culture patterns have a stronger grip—including on young people—than in urban areas, and this can prevent them from seeking MC.

The quote below is from an older, rural, male FGD participant.

*“Hata hivyo mke wake hawezi kulijibu hili ... ataogopa kwa sababu utamwambia we mhuni au malaya ... ataulizwa ulionja kwa nani?... Kama mwanamke atalitambua hilo, ni kweli hataligusa hata siku hii (moja), lazima, kule akishagusa tu, amegusa pabaya.”*

*“A wife cannot answer that question (who is better, circumcised or uncircumcised). She will be afraid because you [the husband] will ask her is she a whore or a cheat, which man did you learn that from? A woman who is aware of this cannot talk about it at all because she is walking on thin ice.”*

### 4.2.3 MC and women

An analogy was made multiple times between VMMC and childbirth; both are intimate interventions, and both require people to show their genitals in front of health care providers. In addition, both require careful consideration of social and gender issues.

### ▪ **Women's influence on the decision to seek VMMC**

Gender relations are relevant to VMMC in terms of if and how a female partner should be involved in the decision to seek VMMC, and how she may or may not support the decision.

Traditionally, women had no influence on sexuality-related decisions, since sexuality was understood to be a sphere of male supremacy. Nowadays, it is more common for female partners to be involved in decisions related to sexuality, including the decision for MC, for the sake of a peaceful relationship and so that women can support their partners appropriately (it must be stated that not many participants have actually undergone circumcision as adults, so much of this would be speculation on their parts). According to participants, this applies only to marriage or marriage-like relationships, and not to more casual sexual relationships.

In casual relationships, women might also make an impact in that, according to many of the younger male participants, younger women prefer circumcised men. Their selectivity thus may have an impact on men's decision to get circumcised.

In addition, men's decisions around VMMC appear to be influenced by women's sexual preferences. For example, modern women are perceived to demand foreplay and to decline sex with uncircumcised men. In this case, VMMC allows men to gain access to sexual resources. The Mafinga younger men's group participants agreed that:

*“Mwamamke atapenda zaidi mwanaume aliotahiriwa.”*

*“Women prefer men who are circumcised.”*

Women participants also stated a preference for men who had been circumcised. Although older women were not in separate FGDs, it was noted that women in their 30s and 40s were more forthright in their discussion of preferences.

*“Nitamchagua aliyetahiriwa ... kwa hivyo tu anaonekana ni mwanaume kamili.”*

*“I will take the circumcised one ... because he looks like a real man.”*

*“Yule ambaye hajatahiriwa, uume wake si mzuri ... ametepetepeta kwa sababu ana lingozilingozi...”*

*“An uncircumcised man doesn't have a nice penis ... it is wobbling around because of that piece of skin.”*

One woman participant even stated that she has always been curious about sleeping with a Maasai man because she had been informed that Maasai have a different style of circumcising their men.

*“Ingawa sijawahi kukutana nao nasema siku moja nataka kukutana na mmaasai ambaye ametahiriwa kimaasai kwa vile ngozi ipo tu haijatoka.”*

*“Even though I have not yet done so, one day I want to have sex with a Maasai who is circumcised the Maasai way, with that a piece of skin still there.”*

### ▪ Gender relations in different generations and settings

Participants indicated that older women and women in rural settings are much less likely to express sexual demands. In rural areas, women's influence on men's decisions related to sexuality is still limited.

From the male FGDs, especially the younger male FGDs, it emerged that younger women, especially those living in urban or peri-urban environments, are more assertive and force men to make concessions. In urban settings, women are more free to express their sexual demands. Sometimes women's preferences are not made directly to the men; for example, a woman may find out if a man is circumcised or not before she begins dating him, and then refuse to date a man who was uncircumcised.

## 4.3 Sex and Sexual Relationships

A discussion of MC must be put in the context of sexual practices and relationship norms in the community. This section presents some key points of that discussion.

### 4.3.1 Partnership commitment

Many participants felt that premarital relations are primarily casual, with no significant level of commitment for either partner. Participants were asked how they would feel if their partner told them they were going to get circumcised. One woman felt happy that private information would be shared with her.

*“Nitajisikia vizuri kwa sababu ataniambia, maanake ... Kwa sababu, katika usichana, sio wote ambao.”*

*“I would feel happy also because it means that he will tell me ... Because when you are a young woman, not everyone will.”*

The younger men's FGDs revealed that young men experience a certain level of pressure to be available sexually, and can easily lose their partner if they are unable to perform. This was widely agreed upon by the other young men's groups, and younger women reported similarly.

One young male participant explained that relationships in Tanzania were different compared to Eurocentric-modeled relationships. One of the younger male FGD participants in Mafinga described it this way:

*“Sisi urafiki wetu bwana, ah! Ni wakujamiana tujue ... (anacheka) ... Sisi urafiki wa kwetu sisi, yaani upo kama mpenzi [ngono] kabisa, urafiki wetu sisi yaani mpenzi kabisa.”*

*“Mimi nitakapokwenda kumwambia, sweetie, natakanifanye hiki, anaweza akawa hakupendezewa, anyway, tuchukuwe amependezewa. Hajakuuliza muda ..mimi sijui muda kwa sababu sisi hatukai pamoja ndani. Nije kwako daktari, nifanyie hiyo issue narudi, 'dia umeona, tayari! Kwa sasa hivi mambo yatakuwa safi.' Haya atasubiria wiki ya kwanza, ya pili. Halafu anaanza kukuuliza. Vipi? Hujapona tu? Ukimwelekeza: “Daktari ameniambia wiki sita,” ah inaonekana umeshapata mwanamke mwingine ... jinsi ya kumshawishi hata*

*kwa mfano ntamwambiwa kwamba 'kamwambie mwenzio hivi, kabla hujafanya hivi', utakapomwelekeza, anaweza kasema ndio, kwamba sawa ntakaa hizo wiki sita lakini uhakika asilimia mia moja, yule sio wako."*

*"Our relationships, are to have sex with each other, you know ... (laughter) ... For me, when I say 'girlfriend' it's different from when he [foreigner] says that she is my girlfriend. Our relationships here, I mean, are strictly sexual."*

*"For me, when I would tell her, 'Sweetie, I want to get this done,' it could be that she doesn't like the idea. Anyway, let's just say that she likes the idea. She doesn't ask you the time frame. I don't know the time frame because we don't live together. I just go to the doctor's and get it done. Then I go back and tell her, 'You see dear? It's done! It's all good now.' OK, she will wait the first and second week. Then she will start to ask you. 'What's up? You haven't healed yet?' If you explain to her, 'The doctor told me six weeks,' it looks like you found another woman. Even if, for example, the doctor told me to say, 'Tell your lover six weeks before you have sex,' when you explain it to her, she could say yes, ok, I will wait those six weeks – but you can be 100% sure that she's no longer yours."*

Commitment accompanies marriage, but this does not mean that a husband or wife will be completely open with each other in sharing information, or that they will not engage in extramarital affairs. One woman explained that in marriage, she would be happy if her husband decided to seek VMMC because it would reduce her chance of contracting diseases as a result of her husband's extramarital affairs (very little discussion was held on the fact that the risk is actually just reduced, and not eliminated, with VMMC).

*"Mimi nitafurahi tu kwa waamuzi wake kwa sababu mimi mwenyewe tayari itakuwa nazijua faida za tohara. Na jua wanaume wa sasa hivi kwanza wamekuwa sio uaminifu, anaweza kaenda huko labda akakutana na binti au hata na mama mwenzangu, akamtamani akafanya naye mapenzi labda akawa na ugonjwa, kwa hiyo pale pale na chukua ugonjwa haraka sana. Kuliko ... ambavyo angekuwa ametahiriwa. Kwa hiyo akiniambia hivyo mimi na furahi tena ntampa tu ushauri kwamba, nashukuru kwa waamuzi wako."*

*"I would be just happy for his decision because for me, I already know the benefits of circumcision. I know that men today are not trustworthy. He could go out there and meet with a young girl or a woman, he could go after her and have sex with her, and maybe she could have a disease and then I would get the disease very fast. Instead of... if he was circumcised. So if he told me that [he was getting circumcised] I would be happy and I would tell him that I am grateful for his decision."*

From the responses of participants, a view was clear that men are the unwavering leaders of families; it is expected that their sexual demands be met. Most participants portrayed a view in which women have very little say in a marriage relationship and assume the role of caretakers. Most participants also felt that sexual activity within a marriage generally tapers off as children grow older.

### 4.3.2 Multiple sexual partners

Again, the sexual norms of relationships have an impact on people's decision-making around whether to seek MC. This section presents findings on multiple concurrent partnerships, which were presented by both male and female participants as having an impact on men's decisions about VMMC.

Because the disease prevention aspect of VMMC was well known by participants, VMMC was described often as something that will mitigate the possibility of infection with sexually transmitted diseases, and viewed with enthusiasm by both male and female participants for that very reason.

#### ▪ Men

It was generally accepted by both men and women that men would have multiple sexual partners, both inside and outside of marriage. Men were seen to be more promiscuous than women and this behavior was socially accepted.

*“Wanaume kwa kweli asilimia kubwa kama wamefanyiwa tohara au hajafanyiwa tohara nje wao wanatoka tu.” (anacheka)*

*“Honestly, a huge percentage of men, whether if they are circumcised or not, will go out and sleep around.”*

*“Yaani, sisi tumezoea kuwa na wanawake watatu.”*

*“I mean, we are used to having three women.”*

#### ▪ Women

Although there was no overall consensus about women's level of promiscuity, there was a general agreement that some portion of women would have multiple sexual partners. Some women referred to a practice called “*mafiga matatu*.” This is a reference to a three-stone fire, in which all three stones are needed to balance the cooking pot. One participant explained that this was primarily for economic reasons. In all cases, women discussed this in a theoretical sense rather than in relation to themselves, but it was discussed with widespread agreement among participants that it was presented almost as fact.

*“Kwanza moja hapo kuna kitu ambacho tunachoitwa mafiga matatu. Sisi wanawake. Kwa hiyo hapo inaweze ikaja kutokea kama vile inaweze ikawa na mpenzi au mme ambaye ndo akatahiriwa. Kwa hiyo ile kumsubiria wiki sita mpaka apone itawezekana kwa vile wewe unafanya, mizunguko. Tayari si ndio una mafiga matatu?” (anacheka)*

*“Hiyo ipo bwana. Hiyo ipo kwa wasichana na hata kwa wanawake walioolewa hiyo ipo ... Kwanza moja unakuwa na mahitaji yako. Unataka uvae, upendeze, kama salooni uende. Lakini inawezekana uwezo wa mme wako ni mdogo. Lakini ukisha kuwa na mafiga yako yale, kwanza lazima uweke mafiga ya uhakika. Kwamba, hapa na kuwa na mwanaume hata kama hana uwezo, unakuwa na mchumba wako wa nje ambaye anauwezo kwa hiyo unamwekea kabisa yule pale atanipa hela ya mavazi au huyu hapa hela ya salooni. Unakuwa na mahitaji yako unayopata kwao.”*



*“First off here there is what we call three stones to balance the cooking pot. It is for us women. It could happen that your lover or your husband gets circumcised. So to wait six weeks for him until he heals is quite possible because you are going around. Don’t you already have three cooking stones?”*

*“It’s there for young women and even for married women. First off you have your needs. You want to be well-dressed, to look good, to go to the hairdresser. But it could be that your husband’s ability to provide is insufficient. So you have your boyfriend on the side who can provide for you. So you put him in place so that one there will give me money for clothes or that one here, money to go to the hairdresser. They are there to take care of your needs.”*

Women’s sexual needs were also seen to be relevant to the discussion of VMMC, especially on the subject of the post-procedure abstinence period. One participant provided two reasons why a woman would be promiscuous and may have difficulty waiting the six weeks during the abstinence period. The first (built on misinformation, but not really disputed by other participants) is that she has a physiological condition that gives her the urge to have sexual intercourse. The second was that a woman had simply cultivated the habit of having sex frequently.

*“Maumbile zinatofautiana, ... hivi vitu vipo kwamba maumbile ya mwanamke huwa saa nyingine inakuwa na wadudu. Katika sehemu zake za siri. Kwa hiyo wale wadudu, huwa wanamsababisha kufanya nini, kupenda kusexi. Kwa hiyo huwa hawezi kuvumilia. Atakapoenda kusexi anaweza akaanza kujisugua baadaye akajikojolea. Lakini lazima ahakikishe anafanya nini? Anapata mwanaume ili aweze kusexinae. ... Na mwingine anajiendekeza. Kwa vijitabia ambayo anayo hulka ya kujiendekeza ambayo ni lazima nifanye hivi.”*

*“We are all built differently. These things exist where a woman’s private parts at times have bacteria. So this bacteria cause her to do what? To enjoy sex. So she can’t control herself. She needs to find a man to have sex with. Others just develop a habit of needing to have sex all the time. She has just built it up like a personal characteristic that I must do this.”*

She also pointed out that a woman could also have a stronger sex drive than her partner.

One myth present in Iringa region is that a woman’s energy and behavior determined whether or not a circumcised man’s wound would heal. One example was that if a woman cheated while her husband’s circumcision wound was healing and then came home and cooked for her husband, the wound will not heal properly. This was mentioned by women in multiple focus groups, mainly older women. Younger women all indicated that they had heard this as well, but some stated that they did not believe it.

*“Unavyotoka kule, unakuja na joto la yule mwanaumehalafu tena unampikia, unamuumiza mwenzio. Unamletea maumivu makali.”*

*“When you come from there [your lover] with the energy of the other man, then on top of it you cook for him, you will give him problems and hurt him. You are really bringing him much pain.”*

*“Ukitoka nje halafu ukaenda kumpikia mume wako, inakuwa kile kidonda hakiponi. Yaani joto la yule ulikuwa naye unalileta kwa mume wako.”*

*“If you have sex on the side then you go and cook for your husband, that wound will not heal. I mean, you bring the heat and energy of the other man to your husband.”*

Other participants brought up a variation of this idea as they described a belief that if a man or boy is cared for and especially has food prepared by a woman who is sexually active, the wound will not heal properly. These people insisted that a grandmother or older aunt who is not sexually active is the best person to care for a man or boy who has been circumcised.

#### ▪ **Alcohol**

Many participants pointed out that the local brew, “*ulanzi*,” which is distilled from bamboo, contributes to an increased level of promiscuity among both male and female drinkers. Some participants insisted that if you drink *ulanzi*, you have to have sex. Some participants even felt that there were some men in the village setting who would not go for VMMC because they would fear that the doctor would tell them not to drink *ulanzi* for some weeks, and it would not be possible for them to refrain from drinking for that long.

### 4.3.3 Communication and sexual relationships

The attitude of many people in the region towards sexuality and intimacy points to a lack of communication between partners. The study revealed a general lack of openness between partners in sexual relationships. Many viewpoints suggested that private matters are kept secret from sexual partners or close relatives. This ranges from not exposing one’s private parts to a partner to not telling partners about other sexual partners to not wanting to discuss ways to improve sex.

*“Wengine wanasikia aibu, kuonesha sehemu za siri mwanamke, pale kweli ni ngumu kidogo, ndio maana ndani kama taa inawaka hawezi kukutana nae, atazima taa lazima kila wakati zaa izimwe, ni aibu, kama hajiamini kwenye tendo.”*

*“Others are ashamed to expose their private parts to women. It is difficult for them. If the light is on he cannot have sex; the light must be off all the time.”*

The reluctance to show private parts on the part of men was mentioned more in rural areas than in the urban or peri-urban FGDs.

### 4.3.4 Sex and VMMC

Some of the younger women in villages spoke of pain or pinching during sex and linked this with uncircumcised men.

*“Yani mtu asipotahiri, mapenzi kwa kweli michubuko inakuwa mingi sana.”*

*“If someone isn’t circumcised, during sex, really, you get lots of sores.”*

While around half of the women felt that sex during intercourse with a non-circumcised man could be more painful, an older woman in one session pointed out that pain during sex is often because there is no foreplay and women are not “ready” for intercourse.

Being physiologically unprepared for sex was said by some to be worse with an uncircumcised man. Lubrication with saliva or with oil was mentioned as one way to address this.

*“Kama unajua huyu hajatabiriwa, ile stage ya kuingia huko kwangu inabidi nifanye vipi, kwa mfano naweza kujichezeachezea vitu kama mafuta au kujitemea mate kwangu ... unakuta asilimia kubwa kweli kule sehemu ya uke ni kukavu, mwanaume hajakuandaa kwa vili ankuja kukutana, unapata maumivu kwa hiyo unapaka mafuta unapaka mate ile upunguze maumivu...”*

*“If the man is not circumcised I use something like oil or saliva at the point of entry. You know most of the time that female parts are dry, and the man doesn't bother to prepare you for sex. You get hurt so you have to apply oil or saliva to reduce pain.”*

It was largely agreed that women living in towns have access to more information and are more assertive. Therefore, their power to negotiate with men sexually is increased, and they are more at liberty to choose their sexual partners. One woman reported that if their partner is not circumcised, women in town find ways to make the sexual encounter more enjoyable, such as by applying lubrication or masturbating first.

This is less evident in rural communities where women's social position remains largely subordinate.

Both men and women had opinions about the positive and negative effects of VMMC on the actual sex act. One perspective, mentioned above, is that a man whose penis is circumcised causes less pain during intercourse. This was more frequently expressed by women.

Another perspective, more frequently expressed by men, is that circumcision can cause a reduced sexual sensation among men.

*“Kuna jamii zingine, zianamini kwamba, unapokwenda jando, ile ngozi unayotoa ile, ile ngozi huwa inaongeza ladha ya mapenzi, wanavyodai wao, sasa wanaamini ukitoaile, unakosa mvuto, hisia za kimapenzi.”*

*“Some societies believe that if you are circumcised, if you cut off that piece of skin, that piece is adding to the taste of love they say. So if you take it off you lose some sexual feelings or the strength of sexual sensation.”*

Reduction of sexual sensation was noted by both men and women and noted both positively and negatively.

In one men's group, it was stated that circumcised men climaxed earlier, and that some women preferred this if the sex was just perfunctory or for money or other goods. Others felt that men who were circumcised took longer to climax and that was regarded as being a good thing.

Overall, more men and women, across the age strata, felt that sexual performance would be better in the circumcised versus uncircumcised man, but for various reasons.

According to one of the male focus group participants, hazardous sexual practices such as gang rape and group sex (“*mtungo*” or “*mande*”) do occur in Iringa region.

#### 4.3.5 Post-Surgical Abstinence

Following circumcision, men are provided with extensive behavioral counseling. In the messages they receive, among other messages, they are advised to refrain from sexual activity, including masturbation and penetrative sex, for six weeks, as well as using a condom with any non-regular or HIV status unknown partner for up to six months following the operation. Discussion was held with participants on their views on the six-week abstinence period.

Overall, the views on abstinence in the post-circumcision period were varied. Many men and women noted that six weeks of abstinence should not be a problem, especially for the man, given that he has a wound to tend to. However, many participants—both men and women—did feel that the post-circumcision abstinence period presents a challenge, and in some cases might constitute a barrier to seeking VMMC services. Influences on a man’s ability to remain abstinent for six weeks following circumcision included: promiscuous behavior, alcohol abuse, lack of open communication in relationships, poor use of condoms and belief in myths. Findings according to group are presented below.

All groups agreed that adequate counseling and education provided to both partners by a doctor or medical professional could be very helpful in getting men to adhere to post-VMMC guidelines. A follow-up visit halfway through the six-week abstinence period could also be helpful.

##### ▪ Older adult men

Married men felt that they needed the support of their spouses in order to help them get through the healing period. They spoke of the importance of providing adequate counseling and education to spouses so they could understand and support men through the process. Men in marriage relationships stressed the importance of openly informing their spouses because married women were often described as impatient and sexually demanding. At the same time, it was presented that women are very understanding by nature and educating them about the abstinence period could lower the chance of women going outside of the relationship for sex. Polygamous relationships present their own challenges, as there would be more women placing sexual demands on the man. There was some acknowledgment that a spouse’s physical presence (for example, lying next to them in bed) during the healing period could also make things difficult. Some said that they would have to live separately from their wives to avoid getting painful erections.

One man told of a remedy for preventing erections, in which the affected man either hits his Achilles tendon with a stick or raps his knuckles on his knee and the erection would instantly subside.

Some men stated that they would wait for only about three weeks to resume sex or until there were sufficient visible signs of healing. Many felt that a six-week abstinence period was unrealistic based on the lifestyles of many people. Women will cheat and visit one of their “*mafiga matat*” (other lovers).

### ▪ **Younger adult men**

Younger adult men indicated that it was important to establish enough physical space between themselves and their spouses or partners, and that they should keep up an active lifestyle (e.g., play sports) to keep their minds off of sex. They believed that women could easily be kept busy and distracted from also wanting sex.

Participants believed that most unmarried young women would simply find another partner during the six-week abstinence period; however, if a woman really cares for her partner she will wait.

Participants also indicated that it would be difficult for someone who is a regular drinker to abstain from drinking alcohol for six weeks. It is commonly understood that drinking the local “*ulanzi*” beer increases sex drive.

### ▪ **Women**

Women’s views reinforce the difficulties of adherence to the six-week sexual abstinence period and the importance of thorough counseling for couples. Women also believed that many men would not be able to wait the six-week period. Most said that three weeks was the maximum time that a man could wait, or else until the stitches were visibly healed.

Many women expressed that men have high sexual needs and this is what prevents them from being able to wait. One young woman was laughing as she said that some men would try to have sex even if it hurt his penis.

*“Kuna ile mtu kabisaa! Unajua kuwa hii mboga ni ya moto, na kuna pilipili ndani lakini mtu anakula hata kama anatoa machozi anakula.” (anacheka)*

*“That type of man is out there! He knows that the food is steaming hot, and on top of that there are hot peppers in it, but he keeps eating it even when the tears are running down his face.” (laughter)*

Some women pointed out that post-surgical abstinence could be one thing that prevents men from seeking the service.

*“Ndio maana walio wengi utakuta wakisikia tohara wanakimbia kwa sababu masharti yale anaona kama ni magumu kwake. Si amezoea kufanya matendo hayo kila siku, kila mara. ‘Sasa wiki sita nitaweza kweli?’”*

*“This is why many men, if they hear about circumcision, they run because they see that the rules are too difficult to follow. Isn’t he used to doing it [sex] every day, all the time? He thinks, ‘Can I really wait six weeks?’”*

However, many women were prepared to take the necessary steps to ensure that their partner gets through the six-week abstinence period. Some suggested that they would do whatever it takes to care for him and keep him home, for example, sleeping in a different room. One woman stated that she would buy his favorite drink and make it fun for him to be at home with his family.

Women, in general, felt that they would be able wait the entire six weeks. This was especially true for older or married women, although they did admit that there were some women who had “*kidumu*” (lovers outside of their marriage), who would be less likely to wait.

Many women felt that young, unmarried women would simply find another partner, reflecting the transitory nature of non-marriage relationships.

There was a view that proper education and communication will help reduce the likelihood that women cheat, while helping the woman to be more empathetic. Some women said that pain and fear are enough to motivate men to wait the six weeks.

#### 4.3.6 Post-Surgical Condom Use

Condom promotion is an important part of the VMMC package. Condom use after VMMC is promoted, with clients being counseled and condoms given to VMMC clients. Condoms are promoted as a critical prevention measure for sex with all non-regular or HIV status unknown partners. It is stressed that this is particularly important for six months following the surgery, when the wound may appear to be healed, but while the site may still be at increased risk of infection.

Condom use was seen to be a challenge. Both men and women emphatically expressed that using a condom in marriage was not a realistic option. While a very few participants indicated that they knew couples who use condoms as a method of birth control, the majority of the women saw condoms as something that only young, unmarried people used.

*“Madude hayo wanatumia vijana wa sasa hivi. Sisi hatuyajui madude hayo.”*

*“Those things are used by young people these days. We don’t know about using those things.”*

It was stated that women who insist on condom use have to deal with an unpleasant backlash from their husbands.

*“Mwengine anaweza kusema hivi, sawa na unavyosema, ‘Eti, tufanye leo na kondom.’ Inamaana wewe umeathirika. Basi umefanya ukorofi nje. Kwa nini unataka tuvai leo wakati siku nyingine ilikuwa hatulivai.”*

*“Many men, if you said, ‘Let’s use a condom today,’ will think that means that you have an infection because you’ve been sleeping around. [He’ll say] ‘Why do you want to use a condom today when previously we didn’t use one?’”*

Another woman explained that she would be insulted if her partner offered to use a condom.

*“Kama unalazimisha kutumia mpira inamaana hunipendi.”*

*“If you insist on using a rubber it means you don’t love me.”*

## 4.4 Care-Seeking Behavior for VMMC

Because VMMC is an elective procedure, it was seen to be different from surgery or treatment related to disease or illness. In order to get circumcised, a man must make the decision to get circumcised, find out where services are provided, make the time to have it done and adhere to post-surgical guidelines. VMMC requires both direct and indirect costs, as well as opportunity costs during the time that one is unable to work. This decision-making and the action of going to the facility to get circumcised are referred to here as the man’s care-seeking behavior for VMMC.

### 4.4.1 Barriers to VMMC

Barriers to VMMC care-seeking could include physical, emotional, cultural or psychological elements that would hinder a man’s decision to have circumcision and to seek VMMC services. Table 5 lists the barriers that were spontaneously mentioned by participants in this assessment, both by category of respondent and overall.

**Table 5. Spontaneously mentioned barriers to VMMC**

Barrier	Number of Times Mentioned (6 Women’s Sessions)	Number of Times Mentioned (3 Older Men’s Sessions)	Number of Times Mentioned (4 Younger Men’s Sessions)	Number of Times Mentioned (3 mixed Group Sessions)	Overall Number of Times Mentioned (16 Sessions)
<b>Fear</b>	5	3	4	3	<b>15</b>
<b>Post-operative abstinence</b>	5	3	3	2	<b>13</b>
<b>Shame</b>	3	2	4	2	<b>11</b>
<b>Service delivery</b>	2	3	2	3	<b>10</b>
<b>Economic constraints</b>	2	1	4	3	<b>10</b>
<b>Lack of education/knowledge on the benefits of VMMC</b>	1	3	4	2	<b>10</b>
<b>Age/sexual inactivity</b>	2	1	1	1	<b>5</b>
<b>Traditional culture</b>	2	1	1	1	<b>5</b>
<b>Superstitious beliefs</b>	2	1	-	2	<b>5</b>
<b>Partner’s jealousy</b>	-	-	2	-	<b>2</b>
<b>Alcoholism</b>	1	1	-	-	<b>2</b>

Table 5 shows that fear, post-operative abstinence and shame were the most frequently mentioned barriers to care-seeking of VMMC.

If taken on their own, the men's groups showed the same distribution, with the exception that the lack of education/knowledge on the benefits of VMMC occupies as high a status as fear. Also, the barrier of partner's jealousy was raised only by the young men. For men, post-operative abstinence and shame were mentioned with the same frequency.

Table 6 below provides more information on the specific references made within each type of barrier, according to the different focus groups. These topics were spontaneously mentioned by participants.



Table 6. Description of barriers according to groups

Barrier	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<b>Fear</b>	<p>Pain</p> <p>Loss of sexual feeling</p> <p>HIV discovery in the course of VMNC</p>	<p>Reduced sexual satisfaction</p> <p>Erections during or after surgery</p> <p>Damage to penis</p> <p>Slow healing</p> <p>Pain/needle/scissors</p> <p>Unsterilized instruments</p>	<p>Pain for circumcised person from erections</p> <p>Damage to the penis</p> <p>Slow healing</p> <p>Poor quality of services</p>	<p>Pain</p> <p>Slow healing</p> <p>Loss of virility</p>
<b>Post-operative abstinence</b>	<p>Six-week healing time is not easy in relation to marriage responsibilities.</p> <p>Men face the risk of resuming sex too early and causing long-term damage.</p>	<p>Some people (men and women) are used to having sex frequently; six-week abstinence period can pose challenge to them.</p> <p>Especially in marriage or marriage-like relationships, man must seclude himself in order not to be tempted and to avoid sexual arousal.</p> <p>Man needs to plan with partner and seek approval.</p>	<p>Some women need sex as a natural disposition and would cheat if their partner had to abstain from sex during the healing period.</p> <p>Generally, young women are eager for sex and more likely to cheat.</p> <p>For older women, alcohol consumption would be a facilitating factor to cheat.</p> <p>Some women wouldn't wait because having multiple sex partners is an economic subsistence strategy.</p>	<p>Women from the Hehe ethnic group are promiscuous; many will go out and cheat.</p> <p>After circumcision, there will be a healing period in which the man cannot provide for his girlfriends' economic needs; therefore they will cheat.</p>

Barrier	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<b>Shame</b>	<p>Inappropriate age, status protection, embarrassment, hiding</p> <p>An elder should respect himself and control his sexual desires and prevent diseases even without VMMC.</p>	<p>In older age it is not appropriate to undergo MC; a man who does it will be laughed at.</p> <p>Status restricts older men from sharing intimate issues in front of society, neighbors, younger people and their children.</p> <p>An age-inappropriate activity (description of how pitiful it would be to see an older man wearing the wrap—<i>kanga</i> or <i>kitenge</i>—that boys often wear after circumcision).</p>	<p>Undergoing VMMC is not status-appropriate for older men.</p> <p>Uncircumcised boys and adolescents are teased by their peers and have to hide their secret.</p>	<p>If a man has passed the appropriate age for VMMC, it is considered to be shameful and to admit his “incomplete” status in front of society.</p> <p>To undergo VMMC is especially shameful in front of his children, as he exposes intimacy and weakness to them.</p>
<b>Service delivery</b>	<p>Lack of gender and age status consideration in service delivery will be a barrier to potential clients.</p> <p>Far distance to the services prevents people from seeking VMMC.</p> <p>Lack of confidentiality in service delivery may also be a barrier.</p>	<p>VMMC services often don't take into account social status of potential care-seekers, specifically age and gender status. For example, older men are circumcised by young women, and may have to wait in line with children and youth.</p> <p>Young men feel ashamed to be served by women, to expose their nudity, be touched, etc. Also they fear sexual arousal if service providers are female.</p> <p>Services are too far away; they should be brought to villages, maybe to dispensaries whose employees should be educated sufficiently.</p> <p>Poor service provision, e.g., unsterilized tools.</p>	<p>Lack of gender and age status consideration in service delivery will deter potential clients.</p> <p>The delicate nature of circumcision for men and the attached gender dilemma (comparison made to labor/delivery where women also would prefer to be served by female [i.e., same sex] health care providers).</p> <p>Far distance to the services prevents people from seeking VMMC.</p>	<p>Lack of gender and age status consideration in service delivery will be a barrier to potential clients.</p> <p>Far distance to the services prevents people from seeking VMMC.</p>

Barrier	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<b>Economic constraints</b>	<p>Risk of losing job or day-labor opportunities</p> <p>Financial loss for family providers difficult to bear</p> <p>Direct costs for the operation and travel</p>	<p>The costs of VMMC might prevent otherwise willing people to actually do it. Costs were described as either direct or indirect costs.</p> <p>Direct costs include the cost of the operation, transport to the service delivery site and occasional bribes to be paid to hospital personnel (doctors and nurses).</p> <p>Indirect costs can be described as "no hustling." This means that someone is not able to earn money during the time of recovering from the operation.</p> <p>Often, young men in the region do not work in a well-regulated employment relationship, but rather do casual labor or small-scale self-employment. Not being able to work for two weeks may be a crippling loss of income.</p>	<p>A man knows that he must satisfy his girlfriends economically. He might lose them if he cannot buy them gifts, etc. and might not take the risk of income loss through VMMC.</p> <p>Direct costs for the operation and travel</p>	<p>Risk of losing job</p> <p>Financial loss for family providers difficult to bear</p> <p>Failure to be able to support partners/girlfriends</p> <p>Direct costs for the operation and travel</p>
<b>Lack of education on benefits of MC</b>		<p>Participants agreed that current educational efforts about benefits, risks, procedures, etc. regarding MC do not reach society sufficiently.</p> <p>Rural areas are undereducated on VMMC, resulting in poor response.</p> <p>Children should be educated about VMMC in school to build awareness early.</p> <p>In the future, educational campaigns should target women because they currently have less knowledge and play a significant role in decision-making.</p>		<p>The older generation in particular lacks education about importance and benefits of MC.</p>

Barrier	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<b>Age/sexual inactivity</b>	After having children, sexual activity decreases; therefore, circumcision no longer makes sense for disease prevention.	Older men do not need to undergo circumcision any more. After fathering children, sexual activity would decrease and if they have missed circumcision earlier they should remain as they are.	In old age, circumcision is not necessary any more as men are less sexually active.	In old age, circumcision is not necessary any more as men are less sexually active.
<b>Traditional culture</b>	Inherited collective culture still has a stronger effect on older men than modern culture, and prevents them from getting circumcised.	Some participants argued that because there is no traditional custom of circumcision in the region, many people would not see a compelling reason to do VMMC. Furthermore, if they decide to do it, they can face conflict with elders who do not approve of contravening traditions, or they may have to hide it from their parents.	Women's articulation of sexual preferences is still restricted; men hold most of the power in sexual matters.	Women's articulation of sexual preferences is still restricted. Some people follow the tradition in such a way that "if baba [father] didn't do it then I won't do it either."
<b>Superstitious beliefs</b>	Parents' abstinence is necessary after child's circumcision.		Some believe that a circumcised child's parents or anyone taking care of and cooking for the child are not permitted to have sex until the wound of the offspring has healed; otherwise the healing is slowed down. If an adult man undergoes circumcision, some people believe that if his wife cheats on him while cooking for him, his wound won't heal. Many people believe that it is improper for a person to change God's creation.	Some people believe that VMMC will reduce their virility/sexual power. Some believe that a circumcised child's parents are not permitted to have sex until the wound of the offspring has healed; otherwise the healing is slowed down. If an adult man undergoes circumcision, some people believe that if his wife cheats on him his wound won't heal. Many people believe that it is improper for a person to change God's creation.

Barrier	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<b>Partner's jealousy</b>		Despite the absence of a tradition of MC, the study area's society holds the notion that a circumcised man is more desirable than an uncircumcised man. Some of the young male participants presumed that women might prevent their partner from getting circumcised because of self-interest. If he is not circumcised, it would be easier for them to secure him for themselves as he would be less attractive to others. Also, the low status of being uncircumcised would prevent him from cheating; if he intends to get circumcised, the women would suspect that he wants to cheat.		
<b>Alcoholism</b>	Especially in villages, many men are drunkards and wouldn't be able to follow the necessary precautions after the operation.		Many men are alcoholics and cannot refrain from drinking, even for a short period in order to follow post-VMMC procedures.	

## ▪ Shame

VMMC is seen as a delicate and intimate intervention; therefore it is affected by social and gender norms. Concepts of shame seem to center around two areas:

- Shame of exhibiting status-inappropriate behavior
- Shame of having passed the appropriate age for circumcision

*Younger men's perspective:*

*"Ile siku ya kwanza lazima utamcheka (mzee alitabiriwa), mbona umekuwa mzembe bwana, utamcheka, utamponda kidogo, nae atamponda mwingine atakayekwenda."*

*"The first day, you will definitely laugh at the old guy who went for circumcision. 'Why did it take you so long?' you will laugh at him. You will put him down a little, and he will put someone else down who will go for circumcision later."*

*"Mimi nina miaka 37, nina watoto wanane na wake wawili. Namimi nataka sana hiyo huduma ila nimedanganya kwenye form kwa kuona aibu mbele ya wadada warembo waliotusaidia kujaza dodoso." (anacheka)*

*"I am 37 years old, I have eight children and two wives. And I really need to get circumcised. Actually I lied on the form saying that I am circumcised because I was embarrassed to admit that I am not circumcised to the two nice-looking girls who helped us to fill in the questionnaire." (laughing)*

## ▪ Service delivery

Several aspects of service delivery were pointed out as potential barriers, from not trusting the quality of services in terms of cleanliness and confidentiality, to fear of a female provider, to a fear that the layout of the services would not support cultural and social norms, such as the elevated status of older men.

The issue of a female provider constituting a barrier to service came up multiple times in the younger men's FGD. The fear mentioned was that a woman might cause an erection, which would be seen to be shameful. One participant actually reported leaving a circumcision service because of a female nurse.

*Young men's perspective:*

*"Mimi nilitabiriwa kwanza nikiwa mkubwa. Nilipokwenda kutabiri mara ya kwanza, nilikuwa na nia ya kutabiri kwa muda mrefu. Nilikuwa naishi sana kijijini, baada ya kuingia mjini nikaona hii kitu siwezi kuendelea nacho kwa muda mrefu. Nikaenda hospitali, rafiki yangu mmoja alinishauri, tulipoifika pale tulikuta nurse mwanamke, halafu mdogo mdogo tu. Nikamwambia mimi siwezi, siwezi kumvulia nguo zangu, nikarudi, nikakaa kama wiki mbili hivi nikaenda tena, nikamkuta daktari wa kiume, yule ndio aliyemaliza shughuli yote."*

*"I got circumcised as an adult. The first time I went to get it done, I had intended to do it for a long time. I used to live in the village, and after coming to town I saw that I can't go on with that thing [foreskin] for a long time. I went to the hospital, a friend had asked me to go*

*with him. When we arrived there we found a female nurse, in fact a young one. I told my friend, 'No way, I can't undress in front of her,' and I went home. After two weeks I went again. I found a male doctor, and he was the one who actually did it for me."*

### ▪ **Economic constraints**

Economic constraints were seen as very real barrier, particularly for younger men. VMMC requires both direct and indirect costs, as well as opportunity costs during the time that one is unable to work. Corruption within health facilities was described as common, which impacts one's ability to afford VMMC. Women made an analogy to delivery services, which are supposed to be free at government hospitals; however, indirect costs associated with childbirth are prohibitively high for some women. One woman reported skepticism when told that VMMC services are being provided for free.

*Young men's perspective:*

*"Hospitali zetu za serikali siku hizi huduma zao zimefifia, zimefifia sana, zimefifiaje, kwa mfano ukienda kwa daktari kupata tohara, daktari anataka pesa. Akishapata pesa anakutahiri, kinochofuata ukihitahi ushauri au una shida na kidonda chako unaenda tena hospitali unamkuta daktari mwingine atakuuliza ulitibiwa na nani? Unamwambia anakuambia msubiri tena yule yule."*

*"In government hospitals nowadays, services have deteriorated a lot. For example if you go to a doctor to get circumcised, the doctor wants money; if he gets money from you he circumcises you. Afterwards if you have a problem with your wound and need consultation, you go to the hospital again and find another doctor who asks you, 'Who did the operation?' He will then tell you to wait for the one who circumcised you to get treatment."*

### ▪ **Age/sexual inactivity**

Many participants felt that older men (especially those who had already fathered children) do not really need circumcision because they were less sexually active. One man (apparently in his 50s or so) described it this way:

*Older men's perspective:*

*"Sisi ni wazee sasa, lakini waliotuzidi umri waliotutangulia, yaani ukiwashauri habari ya kutahiri wakati wamezaa watoto wote wakiwa na magovi, ni kitu kimoja kigumu sana. Hawezi kukuelewa, kwa sababu tendo la ngono hana furaha nalo tena, sasa ukimshauri kutahiri anafikiri ni usumbufu tu."*

*"We are old now, but those who are older than us, if you tell them to get circumcised after they have already fathered all their children while having a foreskin, that will be a very difficult task. He will not be able to understand why. Sex is not really exciting him any more. If you tell him to get circumcised now he will see it as a an unnecessary bother."*

Furthermore, some participants believe that after a certain age, veins are more fragile and that cutting them can cause permanent damage to virility.

#### 4.4.2 Motivators and Facilitators for Seeking VMMC

Motivators and facilitators to VMMC care-seeking could include physical, emotional, cultural or psychological elements that would encourage a man to decide to seek circumcision services.

Table 7 lists the facilitators that were spontaneously mentioned by participants in this assessment, both by category of respondent and overall.

**Table 7. Spontaneously mentioned facilitating factors for seeking VMMC**

Facilitating Factor	Number of Times Mentioned (6 Women's Sessions)	Number of Times Mentioned (3 Older Men's Sessions)	Number of Times Mentioned (4 Younger Men's Sessions)	Number of Times Mentioned (3 Mixed Group Sessions)	Overall Number of Times Mentioned (16 Sessions)
Prevention of diseases	6	3	2	3	<b>14</b>
Women's preferences	5	2	4	2	<b>13</b>
Cleanliness	5	3	2	2	<b>12</b>
Peer pressure	2	3	4	1	<b>10</b>
Education on VMMC	1	1	3	3	<b>8</b>
Better sex	4	-	2	1	<b>7</b>
Religious motivation	-	-	-	1	<b>1</b>

When looking at men's and women's responses together, the top facilitating factor was prevention of diseases. The second most frequently mentioned facilitating factor was women's preferences. With regard to men's responses, the distribution of most frequently mentioned facilitating factors is somewhat different: their most mentioned facilitator was peer pressure, followed by women's preferences, followed by prevention of diseases and cleanliness.

A description of the facilitators, according to different groups, is presented in Table 8 below.



**Table 8. Description of facilitators**

Facilitators	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<p><b>Prevention of diseases</b></p>	<p>Participants agreed that prevention of HIV and STIs would be a motivator to undergo VMMC.</p> <p>Prevention of diseases would be particularly important for men in polygamous marriages.</p> <p>It is a fact that people cheat in the study area, so precautions need to be taken.</p>	<p>The participants acknowledged the necessity to protect themselves from diseases, as they admit that having multiple sex partners is a common habit in their society.</p> <p>After one has experienced a sexually transmitted infection, the desire for self-protection rises significantly.</p>	<p>It is a fact that people cheat in the study area, so precautions need to be taken.</p> <p>Condom use in marriage is not realistic in the region, so VMMC can be an alternative.</p>	<p>Some participants were aware that VMMC reduces the risk of HIV infection by 60%.</p> <p>Prevention of diseases would be particularly important for men in polygamous marriages.</p> <p>It is a fact that people cheat in the study area society, so precautions need to be taken.</p>
<p><b>Women's preferences</b></p>	<p>Participants agreed that this factor is more important for the younger generation where some women wouldn't marry an uncircumcised man. In the older generation, it was no motivation since women didn't articulate their preferences.</p>	<p>An uncircumcised man would not be confident in approaching women, or during the sexual encounter itself.</p> <p>They supposed women want to protect themselves from diseases and also demand better sex.</p> <p>Women would not agree to have sex with an uncircumcised man (at least educated, urban or "modern" women).</p> <p>Implication: uneducated or village women are not in the position to express their preferences and influence a man's decision to a similar extent as modern, urban women.</p>	<p>Especially younger women wouldn't marry an uncircumcised man.</p> <p>Even as a casual sexual partner, women prefer a circumcised man and will persuade potential partners to get it done.</p>	<p>Women demand safe and clean men, hence they put pressure on men to conform.</p> <p>Even older women might be attracted to an age-mate who underwent circumcision, which could motivate him to do it.</p> <p>A man who is not circumcised is always under pressure to hide his foreskin during sex.</p>

Facilitators	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<b>Cleanliness</b>	To be clean is an important virtue for a man.	To be circumcised is to feel clean, which in turn would give a man more self-confidence.	After circumcision, the penis doesn't smell nor contain dirt.	--
<b>Peer pressure</b>	According to participants, this factor is relevant in towns, boarding schools and mixed cultural settings in general.  In these settings, uncircumcised boys or men would be laughed at and ridiculed.	It would be very embarrassing for an uncircumcised youth or adult to expose his foreskin in front of peers, e.g., while bathing in the river, or at sports events, or when urinating as one has to do when on a bus trip.  An uncircumcised young man would be viewed as a dumb village person and would be ridiculed.  In order to acquire acceptance and gain self-esteem, an uncircumcised young man would quietly go and be circumcised.	Men get circumcised to gain confidence.	Schoolboys are under immense peer pressure to look like the others and thus be circumcised.

Facilitators	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<b>Education</b>	Some participants emphasized the importance of media education campaigns on VMMC, such as on the radio.	<p>Participants agreed that educational efforts on the benefits, risks, procedures, etc. of VMMC still do not reach certain groups in society sufficiently.</p> <p>Rural areas are still undereducated on VMMC, resulting in reluctance to respond more positively.</p> <p>Children should be educated about VMMC in school to build awareness early.</p> <p>Educational campaigns should increasingly target women as they have less knowledge and play a significant role in decision-making.</p>		<p>Strengthened education efforts would motivate many to do it.</p> <p>Education could be provided in village dispensaries.</p>
<b>Better sex</b>		Circumcision would make sex more enjoyable sex for both men and women.	<p>Circumcision reduces pain during intercourse for men and women.</p> <p>Uncircumcised men need to use lubricants.</p> <p>VMMC can replace condom use, which is associated with less sexual pleasure.</p> <p>Uncircumcised penis wobbles around.</p> <p>Uncircumcised men are not strong/do not have stamina/need to use love potion</p>	Circumcision would lead to more stamina on the man's side and less pain for both in sexual act.

Facilitators	Older Men's Groups	Younger Men's Groups	Women's Groups	Mixed Groups
<p><b>Religious motivation</b></p>				<p>The Bible gives guidance on the appropriateness of men being circumcised.</p> <p>Jesus was circumcised so this should be motivation for his believers to do the same.</p>

## ▪ **Prevention of diseases**

Prevention of diseases (including HIV/AIDS) was one of the top reasons given as a motivating factor for seeking VMMC. All of the sessions had some mention of the protective effect of VMMC against sexually transmitted infections.

*Young man's perspectives:*

*“Babu yangu, babu wa karibu, amefanyiwa [tohara] akiwa na miaka arobaini. Yule mzee alikuwa na tatizo alishauriwa na daktari afanyiwe, akiwa mzee akafanya, kwa hiyo umri mkubwa si tatizo.”*

*“My granddad, a close granddad, he got circumcised at 40 years of age. He had a problem (STI) which he got in older age so he got it done [circumcision]. I don't think that circumcision in older age is a problem.”*

*Young man's perspective:*

*“Mwaka 1995, nikiwa na miaka 17, mwalimu mmoja alitufundisha na kutushauri kupata tohara. Ila sikuelewa hiyo tohara ni nini kipindi kile, kwa hiyo nikakimbia na sikufanyiwa. Ila baadae nikapata kuelewa. Nikiwa na miaka 24, nilikuwa na rafiki na nikauguaugonjwa wa zinaa. Sasa nikakumbuka maneno ya yule mwalimu pamoja na kuyaelewa sasa. Kwa hiyo nikaenda kupata tohara.”*

*“In 1995, when I was 17 years old, one of our teachers offered to take us to get circumcised. But I didn't really understand what it was at that time, so I ran away and didn't do it. But I came to understand later. When I was 24, I had a girlfriend and I got a sexually transmitted infection. Then I remembered the words of that teacher and now they made sense to me. So I went to get circumcised.”*

## ▪ **Women's preferences**

Women's preferences for a circumcised man was a much discussed topic, and were clearly viewed as an influencing factor in men's decision to get circumcised. In particular, young men were clear that “modern” young women preferred men who were circumcised.

*Young men's perspectives:*

*“Ambaye hajatabiriwa hata akiwa na mwanamke, anaingia nae anataka labda kufanya mapenzi, lazima akimbilie kuzima taa, kwa sababu lazima atamtambua, unaona, na wengine wanatumia njia mmoja, wakishazima taa, anaivuta, ili yule asigundue mapema, kwa sababu akigundua lazima amtangaze.”*

*“An uncircumcised man, if he's with a woman, and they are going to have sex, that guy definitely will run to switch off the light so she can't see him. Others use another strategy: after switching off the light they pull back their foreskin so that the girl will not notice. If she notices she will tell others that he is not circumcised.”*

## ▪ **Cleanliness**

In most of the sessions, participants translated to get circumcised as “*kujisafi*” in Swahili, which means “to make yourself clean.” This word underlines the centrality of cleanliness in the context

of VMMC. Both men's and women's groups felt that cleanliness was a strong reason to seek VMMC. One older man described problems with cleanliness for uncircumcised men this way:

*"Ile ngozi inaweka uchafu, kama unga wa ugali hivi."*

*"That foreskin accumulates dirt which looks like crumbs of maize porridge."*

### ▪ **Peer pressure**

Peer pressure can be regarded as another aspect of shame, which is one of the barriers to VMMC. In the case of peer pressure, however, boys and men are motivated to seek VMMC to avoid the shame of revealing themselves to their peers as uncircumcised.

Despite the fact that Iringa is a region that traditionally did not circumcise men and boys, the spread of a more mixed urban culture has brought circumcision to Iringa region. Younger men spoke of peer pressure to get circumcised:

*"Unajua kuna aibu fulani, mpaka kwenye kwenda Ruaha kuogelea, kwa hiyo ukishakuwa hivyo, lazima utanza kujifichaficha, sasa wenzio wakashakugundua wataanza kukucheka, wakashakucheka mwenyewe utapata nini, tuseme aibu fulani na ile aibu itakutuma uweze kufanya hicho kitu [tohara] uweze kuwa sawa na wenzio."*

*"You know there is a certain shame. For example, take bathing in the Ruaha river together. If you are uncircumcised you must hide yourself. If the others discover you are uncircumcised they will laugh at you. If they laugh at you, you want to get it done [circumcision]. That shame will drive you to do it in order to be like the others."*

*"Kuhusu washikaji saa hizi kuna majina yametoka ya ile, inaitwa vuvuzela, yaani kama unaonekana una hiyo kitu unaitwa vuvuzela."*

*"Among the guys these days there are names for that [being uncircumcised], it is called vuvuzela, that means if you have a foreskin you are called vuvuzela." [A vuvuzela is a long, monotone horn commonly used by fans during South African soccer matches.]*

### ▪ **Better Sex**

There was a lot of discussion around sex and circumcision. From the women's perspective, this had to do with enjoyment of sex. From the men's perspective, this would be seen as either pleasing his partner, or enjoying sex more himself.

*Women's perspectives:*

*"Yaani labda wengine labda wanatumia nguvu, kwa hiyo wakiwa na ile ngozi inayotangulia inapovutika tena inakuwa anachubuka au anapasuka ... na mwanamke pia."*

*"Some men use force, so if they have that skin it gets pulled back and forth and abrasions can occur for both man and woman."*

*“Yule ambaye hajatahiriwa, uume wake si mzuri ... kwanza inatepetatepeta kwa sababu ana lingoziilingozi.”*

*“An uncircumcised man’s penis is not good ... it wobbles around because of that piece of skin.”*

A largely agreed-upon perspective for men was that lovemaking would be better for men who had been circumcised. One older man put it this way:

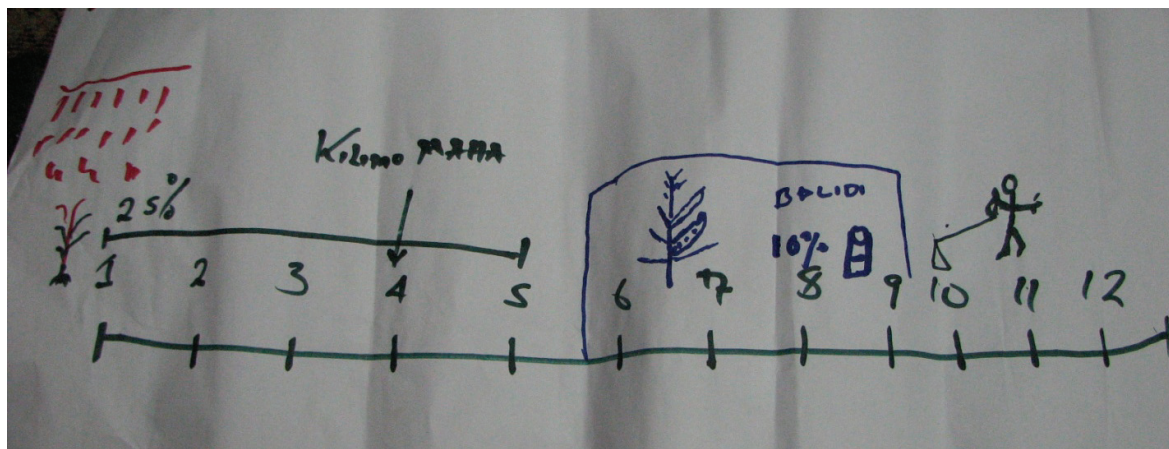
*“Alieyetahiriwa atakuwa huru kufanya mapenzi...mapenzi ni gizani kwa mwenye govi.”*

*“A circumcised man is free in love-making...love will always remain in the darkness for those who still have a foreskin.”*

#### 4.4.3 Seasonal Preferences for VMMC

Participants almost unanimously expressed a preference for circumcision to be done in the months of May, June, July and August. Three main reasons, which are discussed in greater length below, were given in support of why VMMC is best done in these months:

- The cold season takes place during these months,
- The harvest occurs in May, and
- School holidays fall in these months.



Seasonal calendar drawn by participants, with representations of temperature, rainfall and agricultural activities

#### ▪ Cold Season

Participants agreed that cooler weather promotes wound healing. Some participants explained that the cooler months are historically and traditionally the most appropriate time to perform male circumcision. However, most participants linked it specifically with wound healing. No one could provide a detailed explanation of why wounds heal better in the cold weather, but it was accepted as fact by all participants. One participant explained that while a wound would heal within two weeks in the cold season, it could take up to one month to heal in the hot season.

*“Sasa hapa tuweke wastani kwamba mwezi wa tano kwenda wa sita mpaka wa saba ndio kipindi hicho kizuri. Joto lile likiwepo mara nyingi vidonda haviponi.”*

*“Let’s just say that in general May to June and until July is the best time. In many cases, wounds don’t heal in hot weather.”*

Another participant went on to explain that it would be difficult to change this understanding of the appropriate time to seek VMMC services:

*“Hivi saa hizi wewe ukienda hata kijiji chochote ukiwaombea unataka mtu kuwafanyie tohara hata bure, watasema, ‘Hamna msimu bwana joto lile!’” Lakini sasa, kwa yaani tuseme, kwa wanavyoishi huku, ili jamii kuelewa, usitaki unavyotaka wewe! (anacheka) Unalingana na unavyotaka wote.”*

*“Right now [February] if you go to any village and offer circumcision to anyone, even for free, they will tell you, ‘It’s not the season, man, it’s too hot!’ But now, with the way people live here, in order for the community to understand, it can’t be just how you want it to be! (laughter) You must make concessions to what the community wants.”*

The same participant further recounted his experience circumcising his three-month-old son outside of the conventional circumcision season, and the challenges he faced during the boy’s healing period.

*“Mimi mwenyewe nimetahiri mtoto wangu mwezi wa nane. Wapo kazini waliopo kunikatalia: ‘huu mwezi saa hizi mwaka huwezi ukawahi! Joto limepanda.’ Tena kamtoto kadogo, kalikuwa miezi mitatu. Nimehangaika kwa sababu nimetahiri Njondo huko. Lakini nimeenda mpaka Nanyimbe, nimeenda Mafinga ... Yaani badaaye itengeneza usafi. Kwa hiyo nimepata shida sana. Badaaye wameniambia ni ... mwezi huu, ilikuwa mwisho wa mwezi wa tatu, umemchelewesha mno. Tena unajua madakta wameniambia sasa! Sasa nilimu kwa wenzangu hili kwamba jamani mwezi kutahiri inakuwa mwezi wa nane kurudi nyuma. Madaktari wamepata shida kwamba, ‘Kwa nini ulienda kule? Nenda katika eneo la hudumu uliomtahiri!’ Sasa mimi kule jamani ilikuwa kubwa kwenda Njombe. Ndo maana nimeenda kwa hospitali za jirani.”*

*“I took my son for circumcision in August. People at work tried to discourage me by saying, ‘You are too late for circumcision! It’s already hot.’ And he was really a young guy, only three months old. After the circumcision, which was in Njondo, the wound didn’t heal. Then I took him to Nanyimbe, I took him to Mafinga after the circumcision to clean the wound. So I was really distressed. Afterward, they told me that I made him wait way too long. It was the end of March. And you know it was the doctors who were telling me this! The doctors at other health facilities when I brought my son in told me: ‘Why did you come here? Go back to the health facility where he was circumcised!’ And by now it was difficult for me to get to Njombe. That’s why I went to hospitals nearby.”*

This story illustrates the strong opinion of community members that undergoing circumcision during the hot and humid season is not well-advised.



Participants did not completely rule out seeking VMMC services in the hot season. Some participants felt that they would be open to circumcision services in the hot season if it could be demonstrated that the wound healing process was comparable to the cold season. Some participants suggested that people may be more receptive to receiving the service in March and April when the weather is begins to change.

#### ▪ **Agricultural and school calendar**

The agricultural calendar had a role to play in the preference for June, July and August. This was more frequently mentioned among rural areas where people are more tied to the agricultural cycle.

Iringa is a very productive agricultural region that provides produce for all of Tanzania. The region relies on two closely spaced rainy seasons: the short rains, which generally begin in December, and the long rains, which begin in March and continue until April. During this period, many people are absorbed into agricultural activities—even some people who live in town will close down their businesses to go to their farms to work. After the harvest in May, agricultural activities slow down and people shift to more festive obligations. Marriage ceremonies and harvest festivities usually take place at this time and continue until warm weather returns in late August and September. At the end of the main cultivating season, people have more time and financial resources to seek VMMC services.

In addition to the agricultural cycle mentioned above, the school calendar affects people's care-seeking behavior for VMMC. Male circumcision for children usually takes place in June when there is a school holiday and students can be properly cared for at home during the recovery period.

#### 4.4.4 Age Preferences for VMMC

Participants' views on the appropriate age for circumcision were explored using a timeline exercise and through questions in the focus groups.

The prevailing view among participants, regardless of gender, was that the best time for VMMC is before puberty. Adult circumcision was not a familiar concept to participants. Their reactions were mixed, but many felt that with the right education in the community, people could be convinced that seeking VMMC as an adult is acceptable.

In general, in Tanzania and in Iringa, if male circumcision was done, it was traditionally done during infancy, during childhood or in the course of initiation from childhood to adolescence (*jando*). Even traditionally non-circumcising ethnic groups such as Wahehe and Wabena in Iringa are aware of these customs and their understanding of appropriate age for male circumcision is influenced by them.

#### ▪ **VMMC in infancy**

There were a number of participants, though not the majority, who supported VMMC immediately after birth (neonatal period) or during infancy. The discussion was often in the context of religious implications, and suggestions for appropriate timing ranged from seven days (as

many Muslims practice), to within 40 days (also related to Muslim practice) to during the first year. It was supposed that an infant doesn't feel much pain (or is not really aware of the pain) and heals quickly.

Another view took into account the traditional belief that caretakers of the circumcised child should abstain from sexual intercourse until the wound is healed. After birth a mother is expected to abstain for about three months, so she would be the ideal caretaker of a circumcised infant child.

### ▪ **VMMC in childhood**

Many participants believed that the best age for circumcision was during childhood, between the ages of three and 14 years. This was qualified by a group of participants (largely women) who stated that between three and five years of age, little boys could not sit still or refrain from rough activities long enough for the wound to heal, which would make this a poor age to seek VMMC.

Supporting factors for childhood circumcision included the belief that children's wounds heal faster than adults', and that VMMC causes less pain and stress for children as opposed to adults. Children of this age were seen to be stronger and more capable of enduring the surgery than infants, and they can communicate problems occurring in the healing process. Furthermore, children of that age have a certain extent of awareness, and if they are given an explanation they probably will remember and internalize the experience.

Finally, many participants supported the concept that circumcision should occur before sexual maturity. The underlying assumption was that sexual feelings cause trouble in recovering from the operation, both in terms of getting erections and resuming sexual activity too soon. Additionally, children would not yet be exposed to HIV through sexual activity, and thus the circumcision would have the maximum benefit.

Some participants went as far as to suggest that, to make the practice widespread, VMMC should be a legal requirement or collective norm.

*“Serikali ingeiweka kama sheria, mtoto wa kiume anapozaliwa hospitali, afanyiwe tohara kabla ya kumaliza tu zile siku za hospitali, afanyiwe tohara kama sheria.”*

*“If the government would make it a law, when a boy child is born in hospital he must be circumcised before leaving the hospital.”*

One participant from a neighboring tribe described his circumcision experience during childhood.

*“Mimi nimezaliwa ugoni na nimelewa huko, ilikuwa ni sheria, mtoto wa kiume akitimiza siku kumi na mbili mpaka ishirini lazima baba amnunulie kondoo, aende nae kufanya tohara, ... kwa hiyo nilipelekwa na kondoo, ... unakalishwa chini, anakuja baba mkubwa yaani mtu mzima anakukalia halafu, anakushika anatumbukiza kidole ndani ya govi halafu anakata, anakata anaacha kiini cha chini hivyo ule mshipa wa chini, bila dawa yo yote kutumia, ... ukishachinjiwa kondoo, inakatwa mkia unachemshwa, ile supu, mchuzi wa kwanza unamwagiwa, unaungua mpaka kwenye makalio huko kwa makarani na mahusigwa hiyo!”*

*“I was born and raised among the Wagogo. It the custom that for a boy, when he is between 12 and 20 days old his father has to buy him a sheep and go with him for circumcision. So after I was born I was brought with a sheep. An adult man puts you on the ground in a seated position, holding you, he puts his finger in your foreskin and cuts it off, leaving one vein, the lower one, without any medicine at all. The sheep is slaughtered for you, the tail is cut off and boiled, and the first bowl of soup is poured over you. You get your buttocks and private parts scalded!”*

#### ▪ **VMMC in adolescence**

Though the majority of participants felt that childhood is the best time for circumcision, many participants agreed that adolescence could be appropriate as well. Their argument was that if the boys have missed circumcision during childhood, they should at least get it done before entering marriage.

The discussion on VMMC during adolescence was marked by a lot of speculation and anxiety that getting erections could dramatically interfere with wound healing. Dramatic terms were used to express the effects of erections on healing, such as stitches bursting, damage to the penis and wound not healing.

Education is needed so that communities are aware that erections during the wound healing period do not constitute a major barrier to proper healing of the circumcision site.

In the studied communities, the wish to marry was said to develop during adolescence. Marriage itself marks the end of adolescence and the beginning of adulthood. Additionally, disease prevention becomes more relevant in marriage because marriage entails more responsibilities and obligations compared to premarital sexual relationships.

#### **4.4.5 Preferred Service Delivery Models for VMMC**

In order to gain information on people’s views on new service delivery models, a ranking exercise was conducted in which participants were given the opportunity to vote on different service delivery models. This was done with a subset of approximately 30 participants in Iringa municipal.

The service delivery models were the following:

1. Providing VMMC services on weekends and at night
2. Offering VMMC services to couples
3. Separating older men from younger men in VMMC service delivery settings
4. Offering VMMC services from only male providers

The service delivery model options were designed after hearing people’s views during the study (for example, the concern with female providers), as well as speaking with various stakeholders. Table 9 below shows the distribution of votes. Reasons for preferences are explained below.

**Table 9. Preferences for service delivery models**

	<b>VMMC- Service Provided on Weekends and at Night</b>	<b>Offering VMMC Services to Couples</b>	<b>Separating Older Men from Younger Men in VMMC Service Delivery Settings</b>	<b>Offering VMMC Services from Only Male Providers</b>
Igumbilo older men	1	5	1	1
Igumbilo young men	-	-	2	5
Igumbilo mixed group	-	-	7	2
Iringa Town women	-	2	7	-
Iringa Town young men	-	-	1	6
<b>Total</b>	<b>1</b>	<b>7</b>	<b>18</b>	<b>14</b>

▪ **Separation of VMMC services for youth, children and men**

The most “voted for” model of service delivery was the one in which adult men would be separated from boys. The type of separation was not specified, but it could be separate space, separate days, separate waiting areas or separate operating rooms. This was stated to be useful because it allowed for maintenance of social status for older men, and avoided embarrassing situations where a man might run into his son or a friend of his son at the VMMC clinic.

▪ **Male service providers**

The model that proposed having only male service providers, which may pose a logistical difficulty, was nonetheless very popular.

The support for this model was most apparent with young men. Specific reasons given were:

- Undressing in front of women is attached to shame
- Fear of sexual arousal by the presence of female providers (getting an erection or ejaculating, which would be very shameful)
- Low level of trust in women’s professional abilities
- Sentiment that women might purposely hurt the patient, depending on their mood (women were seen to be more moody)
- Fear of breach of confidentiality by female service providers

Relating to the socio-cultural findings of this study, the preference for this model ties in to the concept that at their age (19–29), younger men seem to still be positioning themselves, negotiating relationships with women and building self-esteem. They are struggling with issues related to the transition from adolescence to manhood, and are responsive sexually.

Participants in other groups could understand the youths’ worries, but they didn’t feel that the sex of the provider should be the most important factor for attracting more clients to VMMC services. Some argued that it would be more important to match service provider’s age with that of clients, compared with matching sex. Others denied any importance of age or sex, and emphasized that health care providers are health care providers no matter which sex they are.

### ▪ **Couples day for VMMC**

This model was presented for discussion based on the sentiments expressed throughout the study (largely from men) that female partners should receive more education on VMMC, especially regarding the abstinence period. However, when discussed as a service delivery model, it was not a very popular option, even among women.

The most support for this model came from older men. In one FGD, they seemed to be comfortable sharing private matters with their wives. In this FGD, the men felt that attending VMMC service together would strengthen a relationship and contribute to mutual respect. Also it would result in women being educated about circumcision, putting them in a position to support and help more effectively during the recovery period. There was not in-depth discussion of what the attendance of the wife would look like—for example, whether it would include testing for HIV together or staying through the post-operative visit, follow-up visits, etc.

Many of the younger men felt that these benefits did not apply to the type of relationships they were engaged in. There was a sentiment that their own relationships are not yet that stable and it would not be good to exhibit weakness to your wife or girlfriend or to elicit her pity.

Women were largely unsupportive of the option, feeling that it was not their business to accompany their partner; it is something they would prefer he just did on his own. However, some women felt that it would be helpful for spouses to see the pain the man is going through, to enable them to be more understanding during the abstinence period. In addition, it would provide women with a motivation to get their male children circumcised early, in order to avoid the pain caused by an adult circumcision.

### ▪ **Extended hours for VMMC (weekends and evenings)**

This model did not appear to hold any particular relevance for any of the groups. All of the participants, from both urban and rural areas, did not have jobs in the formal sector that forced them to work during certain days and hours. This is largely reflective of the Iringa population, in which formal employment is very low and engagement with agriculture and casual employment is the norm. There are some more formal employment situations on tea, wattle and timber plantations, which may have to be explored separately.

Transport was seen as a major barrier to seeking VMMC at night. Local transport does not generally run at night and none of the participants had access to private transportation.

Some women added that by night a number of the men might already be drunk.

## 5. Limitations

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The strength of this assessment is that it provides some new and valuable insight into community perspectives on VMMC in Iringa, which can directly feed into better programs. The findings are broad and cover a wide range of topic areas and provide a rather comprehensive set of viewpoints and considerations. However, there were a number of limitations associated with this assessment, which are described here.

A higher number of female versus male FGDs were conducted due to the assessment team having a higher number of female facilitators and the decision that the male FGD was best led by a male facilitator. Future assessments should include more male facilitators in order to boost the number of male FGD participants. Breakdowns of concepts by age groups are limited in this report due to a relatively small number in each of the age strata for male FGDs.

The female FGDs were not broken down into age strata, meaning that the full range of ages from 18–47 were in the same group. This may have caused an over-representation of older women's views, since younger women were sometimes reluctant to speak up.

The concept that circumcision provides only partial protection for female-to-male sexual transmission of HIV was not widely discussed during the assessment and needs to be further explored.

## 6. Discussion

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Almost all participants in this study could describe what circumcision is and its benefits. Benefits named included cleanliness, disease prevention (including HIV/AIDS), and perceptions of increased virility. It was not clear where this knowledge came from.

Many participants identified circumcision as being a disease prevention measure. The familiarity of participants with the benefit of HIV prevention is good, but also must be viewed with caution. This is especially true since the concept that VMMC provides only partial protection against HIV was not fully explored in this assessment. Multiple concurrent partnerships were described as a norm for both men and women, but especially for men. Also, low levels of discussion and involvement of partners in decision-making about sexuality were described almost universally. In this context, it will be important for educational campaigns to stress the importance of testing and continuing other prevention measures, so that, for example, people do not start equating circumcision for full protection against HIV. In addition, further exploration is needed to understand to what extent people understand that VMMC provides only partial protection against HIV transmission.

In general, most people felt that the best time for a male to get VMMC was before puberty. There were some proponents of infant circumcision, but most felt that it is something to be done during childhood. The reasons given were that the wound would heal more quickly in children, and that erections, which occur in adolescence or adulthood, would not interfere with wound healing. **Education needs to reach communities on the benefits, drawbacks and advantages**

**of circumcision at different ages, focusing on the fact that occasional erections do not generally interfere with the healing process.** Special attention should be paid to the benefits of older men getting circumcised to boost the numbers of older men coming for circumcision services.

The findings suggest that seasonal considerations are of major importance to people in Iringa when making the decision as to whether to seek circumcision services. There is a clear and strong preference for circumcision to be done in June, July or August. This was backed up by supporting evidence (personal testimonies of people who had had adverse experiences when circumcised outside of these months), accepted as fact by the participants, and further presented as something about which it would be difficult to change community perceptions. Participant's responses suggest that even health care providers believe this myth. In response to this finding, circumcision services in Iringa must both **concentrate large-scale circumcision campaigns in these months**, and also **include educational components (with supporting evidence) on the risks, benefits and advantages of circumcision at different times of the year.**

In the eyes of most participants, marriage is the most obligatory form of sexual relationship. Other sexual relationships are more or less casual and do not bear the same obligations and responsibilities as marriage. This has implications for VMMC. For example, people who are married or in marriage-like relationships will be more likely to discuss and negotiate VMMC with their partners. **Promotion of VMMC among older clients should include some life-skills approaches to communication within relationships, and should have a strong emphasis on providing information on the benefits of VMMC to women.**

Although not sampled to detect differences in opinion between men and women, the findings lean towards different priorities between men and women on the facilitating factors for men seeking VMMC. For women, prevention of diseases was the most frequently mentioned facilitator, while for men, it was third, with preference of women being the most frequently mentioned. These views can be used to shape information going to communities on VMMC.

One reason that older men do not seek VMMC services was that they either had not thought of it, or they did not think that it applied to them. Participants also described seeking VMMC at an older age as shameful and inappropriate. Many people felt that if a man had already had children, there was no point in him seeking VMMC. VMMC (and condom use) was described as something appropriate for young men because they are more sexually active than older men. Despite the conventional wisdom that sexual activity among younger men is higher, sexual activity for older, married men with children is no less important to the lives of those men and their families. **Education is needed for communities in Iringa on the importance of prevention measures (including VMMC) for men who are over 20 years, for men who are married, and/or for men who have children.**

A very clear sentiment was presented by the participants that providing services that mix young boys and older men is socially unacceptable to the older men, and constitutes a barrier to service. In order to attract more older men to services, **offering separated services (either in different facilities or on different days) will be important.** Using various media outlets to let people know about the separated services will be important as well.

A clear preference was also stated, largely by the young adult men, for all-male health care providers of circumcision services. There is a fear of embarrassment of exposing one's genitals to providers of the opposite sex, especially for young men who fear that they could have an erection if their penis is handled by a female health care provider. One participant even stated that he left a health care facility after seeing that that a young female nurse was providing the service. Provision of male-only VMMC services could be difficult to provide, given human resource constraints and the availability of health care providers. However, some options could be provided, such as infrequent (once per month) all-male provider clinics, with clients being given the option of waiting for the clinic if they really feel unable to be circumcised by female health care providers.

People's decisions about seeking VMMC services are complex. They are influenced by culture and history, traditional beliefs, sexuality, gender relations, economic and marital status, exposure to urban or modern culture, past experiences with health care services and many more factors. Interventions that work with communities in Iringa on changing care-seeking behavior for VMMC must undergo much in the way of field- and pilot-testing in order to make sure that they are effective at raising demand as well as contributing to an overall culture of HIV prevention.



## References

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1. Auvert B, Taljaard D, Lagarde E, et al. 2005. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. *PLoS Medicine* 2(11): e298.
2. Gray, RH, Kigozi G, Serwadda D, et al. 2007. Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. *The Lancet* 369: 657–666.
3. Bailey RC, Moses S, Parker CB, et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *The Lancet* 369: 643–656.
4. National AIDS Control Programme. 10 June 2010. National Strategy for Scaling Up Male Circumcision for HIV Prevention: Enhancing Men’s Role in HIV Prevention. Dar es Salaam.
5. Population Reference Bureau. *2010 World Population Data Sheet*. Washington, DC.
6. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International, Inc. 2008. *Tanzania HIV/AIDS and Malaria Indicator Survey 2007–08*. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc.
7. Tanzania National Situation Assessment on Male Circumcision, NIMR Mwanza. 2009.
8. The Potential Cost and Impact of Expanding Male Circumcision in Tanzania. 2009. Health Policy Initiative, Futures Group, Washington, DC.
9. Iringa Regional Action Plan for the Prevention of New HIV Infections (July 2010–June 2012). The United Republic of Tanzania Prime Minister’s Office Regional Administration and Local Governments Authorities, Regional Commissioner’s Office, Iringa.