

Making Medical Male Circumcision Work for Women

Women's HIV Prevention Tracking Project (WHIPT)
December 2010



This report is dedicated to

Lynde Francis

1947–2009

Founder of the first AIDS treatment clinic in Zimbabwe.

Influencer of formative dialogue around women and medical male circumcision.

ABOUT WHIPT

The Women's HIV Prevention Tracking Project (WHIPT) is a collaborative initiative of AVAC and the ATHENA Network launched in 2009 to bring community perspectives, particularly women's voices, to the forefront of the HIV and AIDS response. The specific purpose of WHIPT is to advance and facilitate the monitoring of HIV prevention research, advocacy and implementation by women who are the most affected by the epidemic.

ACKNOWLEDGEMENTS

This report and the success of piloting the Women's HIV Prevention Tracking Project (WHIPT) would not have been possible without our extraordinary country team leaders Johanna Kehler, AIDS Legal Network, South Africa; Cebile Dlamini, Swaziland for Positive Living, Swaziland; Jennifer Gatsi, Namibia Women's Health Network, Namibia; Carole Odada, Women Fighting AIDS in Kenya, Kenya; Milly Katana, Uganda; Allen Kuteesa, Health Rights Action Group, Uganda; and Marion Natukunda, Mama's Club, Uganda.

Thank you to the WHIPT Advisory Group: Kim Dickson, World Health Organization; Cynthia Eyakuze, Open Society Institute Public Health Program; Dean Peacock, Sonke Gender Justice Network; Ida Susser, School of Public Health, Columbia University; Alice Welbourn, Salamander Trust; and Sarah Zaidi, International Treatment Preparedness Coalition.

Special thanks to those who provided information and input at various stages of the process: Kelly Curran, Jhpiego; Marie de Cenival; Tim Farley, World Health Organization; Fatima Hassan, International Treatment Preparedness Coalition; Kwashie Kudiabor, Elizabeth Glaser Pediatric AIDS Foundation; Betsi Pendry, Living Together Project; and Rebeca Plank, Harvard School of Public Health.

The ATHENA Network would like to thank Jeni Gatsi, Johanna Kehler, and Ida Susser for helping to conceptualize WHIPT and to Alice Welbourn for her shared expertise along the way.

This publication and AVAC's continuous policy, advocacy and outreach work is made possible by the dedicated labor of AVAC advocates and support from the Blum-Kovler Foundation, Broadway Cares/Equity Fights AIDS, the Bill & Melinda Gates Foundation, the International AIDS Vaccine Initiative, the International Partnership for Microbicides, UNAIDS, Until There's a Cure Foundation, WHO and many generous individuals who have become AVAC Members and contributors. AVAC does not accept funding from the pharmaceutical industry.

Photo Credits: Cindra Feuer

Front cover: Women from Sigwe village gather while SWAPOL introduces the WHIPT project and provides an introduction to the status of male circumcision for HIV prevention rollout in Swaziland.

Contents

Executive Summary	4
Kenya	10
Namibia	18
South Africa	27
Swaziland	42
Uganda	49



Thembi Manana, a SWAPOL caregiver and resident of the village of Sigwe, gathering women to be interviewed for their opinions on the implementation of male circumcision for HIV prevention.

EXECUTIVE SUMMARY

KEY FINDINGS

- There is general support from women participating in WHIPT for the implementation of medical male circumcision (MMC) as an HIV prevention strategy. However, these women qualified their support with various statements.
- In general, women who participated lack detailed factual knowledge of the benefits and risks of MMC for HIV prevention.
- Many women interviewed believe erroneously that they would be *directly* protected against HIV if their partners were medically circumcised.
- Country studies highlighted a perceived belief among women interviewed that traditional male circumcision (which has not been evaluated for its HIV prevention benefits) might afford the same protection as MMC for HIV prevention.
- Women from some communities participating in WHIPT reported a conflation of female genital mutilation¹ and medical male circumcision, including the perception that both would reduce the risk of HIV infection.
- For women to access and act on information related to MMC and HIV, the information needs to be tailored to women. Also, the socio-cultural context and the realities of women, particularly in traditional male circumcising communities, need to be taken into account.

1. BACKGROUND

The Women's HIV Prevention Tracking Project (WHIPT) is a collaborative initiative of AVAC and the ATHENA Network launched in 2009 to bring community perspectives, particularly women's voices, to the forefront of the HIV and AIDS response. The specific purpose of WHIPT is to advance and facilitate the monitoring of HIV prevention research, advocacy and implementation by women who are the most affected by the epidemic.

The pilot phase of WHIPT has focused on strengthening women's knowledge about, engagement with, preparedness for, and monitoring of medical male circumcision (MMC) for HIV prevention in countries where roll-out was underway or imminent. Community-based teams of women in Kenya, Namibia, South Africa, Swaziland and Uganda assessed women's knowledge, perceptions and involvement with MMC as an HIV prevention strategy, with a strong emphasis on women living with HIV. The work was predominantly done in collaboration with networks of HIV-positive women. Additional work is needed and will be undertaken with women who are HIV-

1. The authors acknowledge this diversity in language and the various implications of alternatives like female genital cutting and others. The consensus among teams was to use "female genital cutting" in the report.

negative and/or do not know their status. However, HIV-positive women are at the forefront of health-related advocacy and information in their communities and are critical allies in implementation of any new prevention strategy. In all but one region of focus (Nyanza in Kenya), MMC for HIV prevention had not yet been rolled out; therefore, most of the women documented perceptions and concerns around MMC's pending rollout, not actual or anecdotal experiences of the rollout.

The Women's HIV Prevention Tracking Project emerged from the June 2008 Mombasa Civil Society Dialogue on Male Circumcision for HIV Prevention: Implications for Women, convened by AVAC in advance of the World Health Organization's consultation on the same topic. The Mombasa Civil Society Dialogue was a critical milestone in the effort to create opportunities for women, particularly HIV-positive women, to engage with male circumcision for HIV prevention and related topics of HIV prevention research and advocacy. The Mombasa Dialogue specifically responded to the desire for community stakeholders to understand the findings from the MMC clinical trials and for these same stakeholders to be able to debate and discuss the implications of the research for women.

This report is one component of ongoing civil society work in countries to elevate women's concerns and to ensure that the rollout of MMC as an HIV prevention strategy is beneficial and safe for women. Over the next year, WHIPT teams will execute advocacy plans based on the findings reported here.

2. METHODOLOGY

The intent of the WHIPT five-country pilot was to document and analyze women's perspectives and levels of participation in discussions and decisions about MMC for HIV prevention; and to build qualitative research capacity and knowledge of MMC among various stakeholders, particularly women in communities.

Project activities included training in community-led research; research literacy with respect to HIV prevention science including the scientific evidence for MMC as an HIV prevention strategy; literature review; information and data collection through multiple means, including a questionnaire, facilitated focus group discussions, and formal and informal interviews with key stakeholders; and information dissemination on MMC for HIV prevention among community-based women's organizations and networks.

Each country team consisted of one or more point people at the organizations charged with conducting the surveys; the executive director of the organization; staff or volunteer members trained in the survey methodology; and, in all but one case, a consultant providing technical analysis in quantifying and analyzing the findings.

The WHIPT teams developed two tools to ascertain impressions of and knowledge about MMC for HIV prevention from women in communities. (For questionnaires, visit www.avac.org/WHIPT). Some country teams then trained women in the respective communities to undertake the research among their peers, or the teams themselves conducted the research.

In total, 494 women completed the questionnaire across the five countries and almost 40 focus groups were convened. In each country, the research was carried out in diverse locales, selected to reflect a diversity of practices, including traditionally circumcising and non-circumcising communities as well as those practicing female genital mutilation.

3. KEY CONSIDERATIONS OF WHIPT SCOPE AND STRUCTURE

The goal of the WHIPT project was to expand the community of women engaged with male circumcision for HIV prevention and broader related topics in biomedical prevention. AVAC and ATHENA's capacity building included ongoing dialogue around MMC research and the conduct of biomedical prevention trials. Perceptions and understanding of issues and, therefore, presentation of information to key informants and focus groups may have shifted over time.

This was a pilot project designed to build capacity and understanding of key issues affecting women. It was not designed as a formal qualitative study.

A diverse array of women participated in the research, both as researchers and as participants, thereby creating variability across those who undertook the research and those who were interviewed. This variability (or heterogeneity) likely influenced the findings due to the range of experience in undertaking qualitative and quantitative research as well as the sensitive nature of the topics under discussion such as sex, sexuality and gender-based violence.

The work was grounded in networks of HIV-positive women but did not exclusively involve HIV-positive women. As no one's HIV status was disclosed, it is impossible to control for the responses of HIV-positive and HIV-negative interviewees. However, HIV-negative women may have different views or concerns. Additional dialogue and issue exploration is needed to learn about perceptions and concerns of the findings to HIV-negative women.

The Executive Summary presents aggregated data in order to document overall trends across the five countries. The WHIPT team members feel this provides an accurate picture of crosscutting issues. However, given the previously listed structural considerations, there are limitations to the conclusions that can be drawn from pooled data.

4. SUMMARY OF FINDINGS²

WOMEN'S AWARENESS OF AND INVOLVEMENT IN MMC

Out of all the women interviewed, 79 percent (of 494 women) had heard about MMC. When probed, women had varying levels of knowledge but sought to be involved in the process.

- 40 percent of women talk to their sexual partners about MMC
- 74 percent would want to be involved in the process of their partner's MMC
- 36 percent of women perceive themselves as potentially involved in the decision-making process around MMC

RECOMMENDATIONS

- Given the gap between women's interest in engaging with male circumcision for HIV prevention, and their reported lack of involvement, there is an urgent need to ensure that MMC programs and policies actively create opportunities for women to engage with and inform MMC implementation.

2. The percentage figures represent the aggregated total across all five countries, but the total number of interviewees within each country is not consistent across countries. Individual country figures can be found in the country chapters.

WOMEN'S SUPPORT FOR THE INTRODUCTION OF MMC

Among the women interviewed, there is general support for the implementation of MMC as an HIV prevention strategy in their communities. (A range of specific concerns was also raised and is explored below.)

- 87 percent would support the introduction of MMC
- 85 percent believe that it could be introduced into their communities
- 77 percent believe that men would volunteer to become circumcised

UNDERSTANDING PROTECTION

A total of 46 percent of the women interviewed believe that MMC is protective for them. Out of these, some believe correctly that they would be indirectly protected over time once a critical mass of men in the population are circumcised; others incorrectly think they'd be directly protected. Others did not specify how they might be protected. There were also reported misconceptions that medically circumcised men are by definition HIV-negative.

- 72 percent understood that MMC is partially protective or not 100 percent protective
- 58 percent understood that condoms should be used even with circumcised men
- 58 percent understood the need to abstain from sex during the wound-healing period post circumcision

RECOMMENDATIONS

- Advocates, grassroots women's groups, implementers and governments through national plans must provide clear and correct messages to men and women and train the media with factual information, highlighting risks and benefits of MMC for HIV prevention overall and the specific implications for women. Correct messaging should emphasize the lack of a *direct* HIV risk-reduction benefit for women with circumcised partners.
- Advocates, implementers and national plans should emphasize MMC as a complementary HIV prevention method rather than as a stand-alone method.

IMPLICATIONS FOR SEXUAL DECISION-MAKING AND GENDER-BASED VIOLENCE

Of the respondents, 64 percent believe MMC would change ideas around HIV risk either negatively or for the better. These perceptions range from concerns that men would increase behavior risks to the hope that information and education for men during MMC would decrease men's risk behaviors—increasing condom use and decreasing sexual partners.

The majority of WHIPT participants perceive that MMC might lead to an increase in gender-based violence (GBV) and heightened stigma for women living with HIV. This would be a result of circumcised men's misperceptions that they are not HIV-positive and/or cannot transmit the virus. Thus sex and/or safer sex would be less negotiable than before circumcision, putting women at greater risk for GBV.

- 74 percent of women reported existing gender-based violence in their communities
- 54 percent of respondents say MMC could increase gender-based violence
- 8 percent say they're currently very comfortable asking their sexual partners to use condoms
- 48 percent are not at all comfortable asking their partners to use condoms

RECOMMENDATIONS

- Implementers, advocates and national plans should ensure that MMC programs are implemented as part of comprehensive HIV prevention programs that also integrate female condom access and empower women to be involved in sexual decision-making.
- Implementers must offer comprehensive MMC packages that will integrate sexual and reproductive health services for men, including condom counseling and gender transformative education.
- Implementers must include gender indicators in MMC rollout monitoring and evaluation efforts.
- Advocates must monitor that resources allocated for MMC rollout are not diverted away from HIV prevention programs and research for women.

CONFLATION OF MEDICAL MALE CIRCUMCISION AND FEMALE GENITAL MUTILATION (FGM)

Women, particularly those from regions of Kenya and Uganda where female genital mutilation (FGM) is practiced, report a conflation of FGM and MMC, including the assumption that both reduce risk of HIV infection:

- 23 percent surveyed incorrectly think FGM could protect women from HIV
- 25 percent believe that the promotion of MMC might also promote FGM among girls and women

RECOMMENDATIONS

- Implementers must clearly distinguish MMC from FGM in all program literature and communications in relation to its benefits for HIV prevention.
- Advocates must monitor efforts to clarify the distinction between MMC and FGM.
- All stakeholders must ensure that the rollout of MMC does not lead to an increase in FGM.

CONFLATION OF MEDICAL MALE CIRCUMCISION AND TRADITIONAL MALE CIRCUMCISION

Many women participating in the research indicated that they have heard about MMC for HIV prevention. However, when discussed further, responses also indicated some level of confusion between MMC and traditional circumcision whose practices can vary and have not been evaluated for HIV prevention benefits.

RECOMMENDATIONS

- Governments, implementers and advocates must distinguish clearly between traditional and medical male circumcision in all program literature, communications and counselling in regions where traditional male circumcision is practiced.

5. DISCUSSION

Looking across all five-country reports, AVAC and ATHENA recognize that MMC is a promising intervention for HIV prevention. There are also essential steps needed to increase women's involvement and understanding of the strategy. These steps are critical to ensuring that the risks and benefits of MMC are understood and that the strategy is adopted as one of, and not a replacement for, the full range of prevention tools.

Women interviewed in communities, including women living with HIV, raise serious concerns about the impact that the partially effective intervention might have on risk compensation (increased numbers of partners for men and decreased use of condoms by men), sexual negotiation, GBV, stigma, FGM, and resource allocation away from comprehensive HIV prevention, particularly from women-controlled and -initiated prevention tools.

The women interviewed by and participating in the WHIPT teams also voice additional concerns around abstinence until wound healing post-surgery. Data suggest that HIV-positive men who are circumcised and resume sex prior to complete wound healing have an increased risk of transmitting HIV to their female partners compared to uncircumcised HIV-positive men.³ Circumcised partners may or may not know their HIV status because testing is recommended but not required for surgery.

The myths and misunderstandings identified by the WHIPT teams, such as a perception that MMC is directly protective for women, underscore the urgent need for adequate education campaigns on MMC. Campaigns should particularly address the impact that this intervention could have on women and emphasize the partial protection from HIV infection MMC provides for men and its non-protection for women. Further, immediate steps must be taken to understand and address the conflation of MMC with FGM as well as the perception that MMC as an HIV prevention strategy could fuel stigma and discrimination against women living with HIV. Additionally, steps need to be taken to distinguish MMC and traditional male circumcision—which may or may not offer the protection afforded to males by MMC.

All five-country chapters express a need for increased access to, and availability of, women-initiated HIV prevention options. The WHIPT findings underscore the importance of monitoring resources devoted to MMC to ensure that they are not diverted from HIV prevention programs and research for women. The teams also stress the need for all HIV prevention programs, including those offering MMC, to provide comprehensive prevention services and interventions that directly address women's needs and reduce women's risk of HIV. This includes MMC counseling incorporating men's sexual health and gender sensitivity training. Such services should be integrated into new MMC programs and also developed in their own right. Finally, the WHIPT team findings underscore the need to increase women's participation in all aspects of MMC policy and program development so that these policies and programs address women's concerns in operationalizing the rollout of safe MMC.

6. NEXT STEPS FOR WHIPT ADVOCACY

Over the next year, WHIPT teams will execute advocacy plans based on their findings. Actions include:

- Leading national launches of WHIPT's comprehensive report of findings and key recommendations
- Linking women's organizations and networks to WHO MMC country delegations
- Working with MMC implementers on women-specific MMC communications materials
- Ensuring implementers include gender indicators in MMC rollout monitoring and evaluation efforts
- Developing a collaborative research literacy curriculum aimed at women in affected communities
- Monitoring resources allocated to MMC
- Further investigating the conflation of MMC and FGM and how an increase in FGM may be mitigated
- Investigating the benefits and disadvantages of infant male circumcision

3. MJ Mawer, et al. Circumcision in HIV-infected men and its effect on HIV transmission to female partners in Rakai, Uganda: a randomised controlled trial, *The Lancet*, July 2009.

KENYA

CAROLE ODADA – WOMEN FIGHTING AIDS IN KENYA

KEY FINDINGS

- Most of the respondents are aware of medical male circumcision (MMC) for HIV prevention. Awareness levels vary among districts according to stage of implementation.
- Women are overwhelmingly supportive of introducing MMC, but a large percentage of them erroneously believe MMC will directly protect them from HIV.
- There was an emerging sense that MMC fuels female circumcision (female genital mutilation—FGM), with the interpretation that “a ‘cut’ is the same for men and women.”
- Women feel MMC may further stigmatize them as vectors of disease if men’s misperceptions that they are HIV-free after MMC persist.
- Women report that some circumcised men have either continued or adopted risky behaviors.

1. BACKGROUND

Kenya is a multicultural country containing 43 ethnic groups. Traditional circumcision is embraced by various faiths in Kenya such as Islam, Nomiya and Christianity. Out of all the ethnic groups, five do not practice traditional male circumcision as part of their culture. These tribes are concentrated in the Nyanza district in Western Kenya, where the country’s highest HIV prevalence exists.

The government of Kenya launched its national policy on voluntary medical male circumcision (MMC) for HIV prevention in 2008 in the Nyanza district. At the onset of the project, the Luo Council of Elders from Nyanza rejected the policy on the grounds that it did not appear voluntary. Hence the Ministry of Health and a technical taskforce renamed the policy “guidelines”.

In step with the guidelines, Kenya developed a national strategic plan for the rollout of MMC, which was launched in January 2010. A communication strategy is in its final stages, and the training curriculum on MMC is in development. In the MMC national strategic plan it is stated that a training curriculum will be developed and shared with all the stakeholders and that trainings will be conducted with the supervision of the Nyanza Reproductive Health Society.

2. METHODOLOGY

The Kenya WHIPT team¹ chose to pursue research in three distinct settings in Kenya to capture the diversity of traditional circumcision practices, and the potential implications for women that the scale-up would present. Research sites included Kisumu, in Nyanza province, where one of the three randomized clinical trials took place yielding the groundbreaking MMC efficacy results and where it is currently being rolled out; the Kuria district, where male and female circumcision (female genital mutilation—FGM) are practiced as rites of passage; and Mombasa, where male circumcision is practiced at infancy because of Islamic influences, and therefore the women would not be familiar with the practice of MMC.

The data were obtained using questionnaires. The interviewers were women who had been trained on basic facts on voluntary MMC and data collection. The interviewees were mostly women living with HIV and affected with AIDS, drawn from WOFAK's membership except in Kuria, where WOFAK has no branch but collaborated with other women's networks. Interviewers administered a total of 200 questionnaires. Additionally, a total of nine focus groups met.

3. RESEARCH FINDINGS

KNOWLEDGE AROUND MMC

Sixty-five percent of the 200 respondents had heard of MMC, and only 35 percent had not. Specifically, the data show that the urban Kisumu women were the most knowledgeable around MMC, followed by the rural Kisumu women, while Kuria and Mombasa populations were the least knowledgeable. Knowledge correlated with the nearness to the rollout zones, which are concentrated in Kisumu. The nearer the women lived to MMC rollout in urban Kisumu, the more knowledgeable they were about issues of MMC, such as comprehension around partial efficacy.

Fifty-six percent of the respondents had heard about MMC on the radio, and 44 percent had seen posters at government health facilities. None had seen messages on billboards. Of those who had heard about it, 91 percent of the respondents said it lowers the spread of HIV transmission, while nine percent said it was for hygiene. These responses show that what the respondents had heard is in line with the goal of national MMC communications. However, as many as 77 percent were not aware of the need for men to abstain from sex for up to six weeks after circumcision. The same percentage of women reported knowing that MMC does not provide 100-percent protection.

BENEFITS OF SERVICES TO WOMEN

Seventy-eight percent of women surveyed said MMC would prevent women from acquiring HIV. Those who thought they were directly protected falsely assumed that if the man is protected they are equally protected. The literal understanding about MMC as a preventative measure is that "medically circumcised men won't be infected anymore".

1. Carol Odada and Jane Mcochudho

COMMUNITY PREPAREDNESS

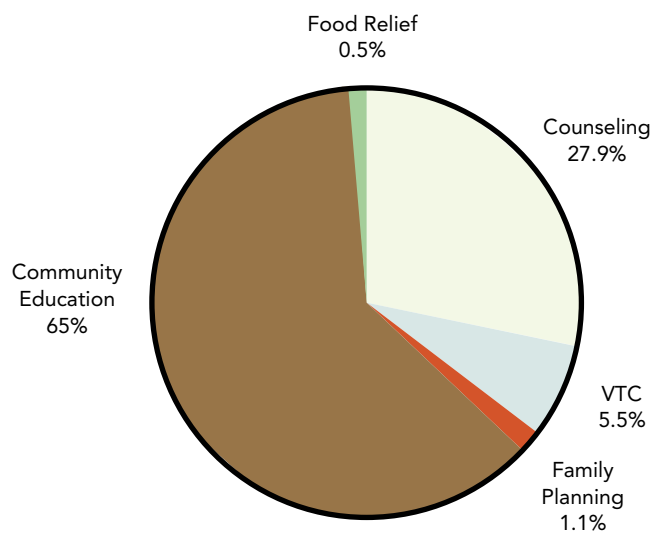
Eighty-five percent of the women said there was a need to introduce MMC in the community, especially respondents from Kisumu, where it is not traditionally practiced. The majority of those who saw no need were from Kuria, where traditional circumcision is practiced, and they did not see the difference between traditional and medical circumcision. Women from the Kuria and Mombasa districts, where traditional circumcision is already practiced as a rite of passage or at infancy, assume a lot of knowledge around male circumcision and are not as open to adopting new behaviors or learning more. Seventy-five percent of the women believe that the men would access MMC if it were available.

CURRENT HIV PREVENTION METHODS

The overwhelming majority of women said they do not feel comfortable negotiating condom use with sexual partners.

Women supporting MMC said they would like to see several other services accompanying MMC. These include safe-sex counseling, voluntary counseling and testing (VCT), family planning, community education on MMC and food relief.

Women want accompanying services



Of the women respondents, 73 percent believed that MMC was negatively changing perceptions of sexual risk.

“Men are already not using condoms for they feel they are well protected by the MMC, for they feel without MMC and their risky behaviors they did not contract HIV and hence feel like overly protected with MMC.”

The 27 percent who felt that MMC was changing ideas of risk for the better, explained that their spouses were going for routine HIV testing and keeping stock of their own condoms for personal use.

DECISION MAKING

On who makes decisions on whether men should go for MMC, 95 percent said men, while 5 percent said women. The numbers clearly show that men are the primary decision makers. Eighty-two percent of the women, however, want to be involved in decision making around MMC.

Of the respondents, 65 percent said they would take their infants for MMC.

PERCEPTIONS OF GENDER-BASED VIOLENCE AND MMC

Ninety percent of the respondents said gender-based violence (GBV) is a problem, while the remaining 10 percent went further to explain that GBV was seen as part of the culture, e.g., wife beating, mistreating girls. Perceptions of GBV and MMC were clearly articulated in the one-on-one interviews. For example,

“MMC is bringing more beatings to women in their houses for [because] MMC fuels mistrust during the healing period. That is when they are abstaining and they suspect their wives are cheating on them.”

Women also felt that blame for HIV would be further feminized by the uptake of MMC, fueling even more stigma and discrimination.

“The women will be left with the greater baggage of care and stigma as they will be seen as the vectors since men will be assumed to be AIDS free. This could cost them their families and even homes.”

PERCEPTIONS AROUND MMC AND FEMALE GENITAL MUTILATION (FGM)

A total of three percent of the respondents said that FGM would protect girls from HIV. A considerable number of women from the Kuria district, where FGM is practiced, perceived that the government was discriminating against them because FGM is outlawed, while MMC is being promoted. At an opinion shapers' meeting in Kuria, an elderly woman who circumcises girls said:

“At last the government has consented to the ‘female circumcision’ in prevention of HIV and AIDS.”

“A cut is a cut and they are all for the same purpose.”

“A cut for FGM has helped them lower prevalence compared to Luo Nyanza (Kisumu) for the FGM suppresses the sexual urge of the woman encouraging faithfulness and delayed sexual debut.” (Paraphrased)

Of the respondents, 20 percent believed that MMC would increase the rates of FGM. From the one-on-one interviews with women 20–32 years of age, one reported:

“My cousins who had been cheated that they had been circumcised—had to face the knife for the new idea that came up that FGM reduces HIV infection risks by some percentage.”

WOMEN’S FREQUENTLY ASKED QUESTIONS DURING INTERVIEWS AND FOCUS GROUPS:

- Does voluntary MMC reduce HIV infection rates in women too?
- How long is the healing period?
- Why is the government partially rolling it out?
- Does MMC affect men’s libido?
- What are the exact reduction rates of HIV infections due to MMC?
- Will women be further stigmatized as carriers of HIV?
- Will MMC add to women’s work load?
- Is female circumcision (FGM) an HIV prevention?
- Is circumcising at a young age as effective as at an older age?
- Is a vaccine an attainable goal?

4. DISCUSSION

Prior to the successful rollout of MMC planned for the Teso and Turkana districts and the eventuality of a national rollout, a number of structural issues need to be addressed.

BENEFITS OF SERVICES TO WOMEN

Women’s involvement in ongoing policy and program development around MMC is disproportionately low although it does exist. Women are, however, engaged on a personal level with their male partners as caregivers, making it imperative that women be informed about the basic facts of MMC, resulting in enhanced emotional and physical care as well as proper safety behaviors. For example, messaging must be made clear that women might eventually, indirectly have lower risk of HIV infection once a critical mass of men in the population is circumcised but until then, they are not protected.

DECISION MAKING

Women’s willingness to be involved in MMC might also suggest that MMC would be successfully integrated into maternal and child health programs.

PERCEPTIONS OF GENDER-BASED VIOLENCE AND MMC

The myth that circumcised men cannot acquire HIV needs to be broadly dispelled. Unless this issue is addressed, women will suffer further stigma and discrimination as vectors of HIV. And, dangerously, circumcised men may be falsely assumed to remain HIV-negative.

Because findings show that MMC can “fuel mistrust during the healing period”, men must be mandated to receive counseling around post-surgery behavior, including the avoidance of GBV. The surgery is an opportune time to deliver this counseling along with other sexual health education because it is likely one of the few encounters men will have with health services.

PERCEPTIONS AROUND MMC AND FGM

Before rollout begins in districts where FGM is practiced, implementation of broad educational campaigns differentiating it from MMC must take place. Furthermore, these campaigns can be used as an opportunity to advocate the end of FGM.

COMMUNITY PREPAREDNESS: TRADITIONAL CIRCUMCISION AND MMC

There is a need to target communities practicing traditional male circumcision because a lot of the circumcision practices do not conform to safety and efficacy standards for MMC for HIV prevention. It is important to distinguish between MMC and traditional male circumcision. There is a clear issue here regarding telling elders who have been traditionally circumcised that their traditional practices may not have, in fact, afforded them the partial protection against HIV that modern MMC practices may provide.

5. RECOMMENDATIONS

- Women advocates should lead MMC campaign efforts to actualize and own its uptake to safeguard against its liabilities for women.
- Advocates and implementers must inform communities (women and men) of advantages and disadvantages of MMC:
 - MMC does not provide direct protection against HIV in women
 - Abstinence is necessary during wound-healing
 - MMC is not to be conflated with FGM
 - MMC is not to be equated with traditional male circumcision
- The National AIDS Control Council should include MMC in the Community-Based Programme Activity Reporting (COBPAP) to monitor MMC's impact on women and track resources.
 - Civil society advocates should advocate gender indicators in the monitoring and evaluation of MMC and also track resources to ensure funding is not diverted from prevention for women.
- The National AIDS Control Council should mandate that all MMC outreach materials and messaging dispel the myth that MMC is equated with FGM for HIV prevention.
 - Civil society organizations should advocate dialogue sessions with opinion leaders of communities that practice FGM, so as to persuade them to abandon the practice altogether.
 - Community members should dialogue among themselves regarding the pros and cons of female circumcision (FGM) and male circumcision.
- The Ministry of Health should consider the integration of MMC for infants into the maternal and child health facilities, given the long-term benefits as well as the safe and inexpensive nature of the procedure.

NEXT STEPS

- Report launch: *Making Medical Male Circumcision Work for Women in Kenya*.
- Link with advocacy groups to inform and mobilize civil society through the MMC Consortium.
- Develop messaging materials for communities and media.
- Liaise with Ministry of Health and UNAIDS to help guide MMC implementation through the MMC Consortium.
- Work with implementers, such as Nyanza Reproductive Health Society and government health facilities, to ensure the monitoring of MMC's impact on women is in place.
- Investigate Female Genital Mutilation/MMC conflation, particularly in the southern part of Nyanza Kuria and Kisii where the practice is a rite of passage.

KENYA SURVEY RESULTS

	Kenya
Total interviews	200
Have heard about MMC for HIV prevention	65%
Have heard about MMC via billboards and radio	--
There are advantages of MMC for HIV prevention	77%
Are aware that ...	
there is a need for condom use after MMC	16%
MMC does not provide 100% protection from HIV risk	88%
men need to abstain from sex for six weeks after MMC	23%
MMC for HIV prevention can be introduced into community	85%
Men would get circumcised	75%
Would support MMC in community	90%
MMC protects women from HIV	78%
MMC is changing ideas about HIV risk	78%
Women talk about MMC for HIV prevention with their sexual partners	44%
Women are involved in decision-making around men getting circumcised for HIV prevention	5%
Women want to be involved in this decision	82%
Would circumcise own infant boy	65%
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	0%
comfortable	2%
fairly comfortable	3%
sometimes comfortable	45%
not at all comfortable	50%
Use condoms with partner(s) now	37%
Gender-based violence is a problem in community	90%
MMC for HIV prevention would impact gender-based violence in community	66%
Female genital mutilation could protect girls from HIV infection	3%
Promoting MMC may promote FGM among girls and women in community	20%

NAMIBIA

JENNIFER GATSI – NAMIBIA WOMEN’S HEALTH NETWORK

JOHANNA KEHLER – AIDS LEGAL NETWORK

KEY FINDINGS

- Women would support MMC as a solution to protect men from STIs and HIV, but acceptance was dependent on the provision of sufficient information on medical male circumcision (MMC).
- Among the women, there is some level of confusion between traditional and medical male circumcision, as well as a general lack of information about MMC for HIV prevention.
- Women’s perceptions of, engagement with and support of MMC is dependent on their positioning as mothers and/or sexual partners.
- Women were concerned that MMC would place more blame on them for HIV infection and that it would decrease women’s ability to negotiate for safer sex practices, indicating that women would be at increased risk for harm.

1. BACKGROUND AND OVERVIEW

As part of preparing for the introduction and rollout of MMC for HIV prevention at a national level, Namibia carried out a situation assessment in 2008. The assessment approach was an adaptation of the WHO Male Circumcision Situation Analysis Toolkit and consisted of five phases aimed at developing an MMC strategy, including a review of existing literature and research on male circumcision, as well as a mapping exercise of existing services. The outcome of the 2008 situation assessment informed the development of the male circumcision policy and action plan for Namibia.

Following the assessment, Namibia developed the Draft Policy on Safe Male Circumcision for HIV Prevention in September 2008. A revised draft policy is now available and guiding three of Namibia’s currently operational pilot sites, although formal scale-up has not yet started. Areas of MMC program design and implementation covered in the policy document include target groups to be circumcised and anticipated public health impact; human resources and training requirements for service providers; the integration of MMC services into existing health services; safety and quality assurance; communication and advocacy; culture and traditional circumcisers; and human rights, ethics and legal issues. Underlying these policy areas is the understanding that an institutional framework will be in place to provide oversight to MMC for HIV prevention policy and programming, namely, the Ministry of Health and Social Services (MOHSS) Male Circumcision Task Force, as well as that a monitoring and evaluation framework and adequate funding will be available.

The policy further states that since the MOHSS leads the health sector HIV and AIDS response, it shall also lead the implementation of the MMC policy. Specifically, the MOHSS shall focus on:

- Provision of technical guidance and support on MMC services;
- Provision of MMC services through the public health system;
- Coordination of the provision of safe male circumcision by all partners, including those in the public, non-governmental organizations (NGO), and private sectors; and
- Documentation of best practices through regular monitoring and evaluation of MMC services and programs.¹

Under the leadership of the MOHSS, the Male Circumcision Task Force shall further be responsible for the coordination and oversight of the technical guidance to strengthen the preparedness of the country to scale up MMC. The policy also states that the Male Circumcision Task Force shall be comprised of representatives of health service providers, policy makers, people living with HIV and partners in the health sector, traditional sector, media and civil society.

However, at the time of drafting the policy document, stakeholders involved were primarily representing Namibian government structures, global agencies and research institutions, with little participation from civil society, community members and people living with HIV. Stakeholders participating in the consultations and drafting process included:

- Ministry of Regional and Local Government, HIV Unit;
- MoHSS: Directorate of Special Programmes, Response Monitoring and Evaluation;
- MoHSS: Directorate of Special Programmes, Health Division;
- NawaLife;
- Centers for Disease Control (CDC);
- United States Agency for International Development (USAID);
- Intrahealth;
- I-Tech;
- University Research Corporation (URC);
- Joint United Nations Programme on HIV/AIDS (UNAIDS); and
- World Health Organisation (WHO).

Namibia Women's Health Network was unaware of any consultation that had taken place with civil society prior to January 2010. The failure to ensure broad consultations with all stakeholders, including civil society, is likely to impact the extent to which civil society will support and comprehend the introduction and rollout of MMC.

2. METHODOLOGY

Namibia Women's Health Network (NWHN) conducted documentation on women's knowledge of MMC for HIV prevention with two groups of women and ten individual women. The two groups were from different locations in Katutura. One group consisted of 30 participants, and the other 45 participants, with an age range of 15–65 years old. The ten individuals were from urban and rural settings of the Khomas Region. One of the groups represented a community that practices traditional male circumcision (Ombili location), and the other group represented a community not practicing traditional male circumcision (Havana location). The ten individual

1. Draft Policy on Safe Male Circumcision for HIV Prevention, 2008. Ministry of Health and Social Services, Republic of Namibia.

interview respondents were from practicing and non-practicing traditional male circumcision communities. The data collection took place from November 2009 to January 2010.

The documentation process, using participatory methodologies, focused on women's knowledge on and preparedness for MMC for HIV prevention. In each of the assessments, questionnaires and focus group discussion guides were used.

Research participants were identified from NWHN's existing structures of support groups as well as from areas in which it has existing programs on gender-based violence (GBV).

3. RESEARCH FINDINGS

KNOWLEDGE AROUND MMC FOR HIV PREVENTION

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

Most of the women participating in the research indicated that they had heard about MMC for HIV prevention. However, when discussed further, responses also indicated confusion between traditional and medical male circumcision, as well as a general lack of information about MMC for HIV prevention.

The focus group discussion in the Ombili Location clearly reflected this confusion and general lack of information. All the participants in this group supported traditional male circumcision, explaining that it protects women from getting sexually transmitted infections (STIs), and indicated that they will support MMC for the same reason, as a protection from getting STIs. There was a lot of debate among participants as to whether MMC is a prevention tool for HIV, as some were arguing that their men are also getting infected with HIV, even though they are circumcised traditionally. The group seemed cautious to fully support MMC for HIV prevention, but conceded that in their experiences traditional male circumcision has worked before in protecting from STIs.

When asked what they had heard about MMC for HIV prevention, most respondents made reference to "low risk of infection".

*"If a man is circumcised that risk of infection is low."*²

*"When they are cut, the foreskin is gone and takes away any disease."*³

*"What I heard about it is that it is done to men and it is very healthy...if one is circumcised, he will not get STIs and will be clean on the penis."*⁴

The lack of clear information and factual knowledge about MMC for HIV prevention was also highlighted when respondents were asked whether they believed that women would be protected from HIV by MMC. Half of the

2. Crone, Tyler, Cebile Dlamini, Feuer, Cindra, Kehler, Johanna. "Impressions of Medical Male Circumcision Questionnaire," No 6, Windhoek, Namibia 2010

3. Questionnaire, No 3

4. Questionnaire, No 7

interview respondents believed that women would be protected by MMC, and half did not. Explaining their response, women stated:

“One can still become infected with the virus, if the male partner is circumcised.”⁵

“The male who is circumcised will not infect me, because it’s a prevention method.”⁶

COMMUNITY PREPAREDNESS

In order to assess respondents’ perception of community preparedness and support for the introduction and rollout of MMC for HIV prevention, the assessment tool included several questions to measure the perceived levels of support amongst community and amongst men. The tool also assessed whether or not and why respondents would support MMC for HIV prevention.

An indication that the community was questioning how the rollout of MMC would be implemented arose in focus group discussions. Questions were raised around guidelines for MMC and organizing the rollout, as well as who in the population would receive priority and whom the focus would be on in respect of factors such as age and marital status.

The need for sufficient community-specific education and information on MMC, including how it would be resourced, was evident in both the group discussions and individual interviews. Participants also expressed the need to extend the focus of MMC more broadly and not solely at HIV prevention.

“We need proper messaging. We do not want a repeat of the first AIDS messaging, which was damaging and caused stigma, discrimination and gender-based violence.”⁷

“I don’t think most people know the advantages that come from being circumcised and are not aware of circumcision.”⁸

Respondents noted that they could support MMC as a solution to protect men from STIs and HIV infection, but had concerns that funding would be diverted from female condom distribution and felt strongly that support and engagement with partners around MMC was dependent on sufficient information on MMC. One of the discussion groups suggested that MMC could be described as an HIV prevention tool for STIs and for hygienic purposes, thus exploring how to broaden the focus on MMC beyond HIV prevention.

“Yes, I think if they get the correct information and understand that it is good for health reasons, they will go for it.”⁹

“For STI prevention and hygiene.”¹⁰

Challenges with regards to concerns about, as well as confusion between, traditional versus medical circumcision arose in discussions and interviews, with older women particularly in the groups displaying insight and knowledge on traditional circumcision practices and expressing concerns that such practices needed to be preserved. It was noted that culture and beliefs might influence how MMC is perceived, especially in communities where traditional male circumcision takes place.

5. Questionnaire, No 7

6. Questionnaire, No 8

7. Questionnaire, No 10

8. Questionnaire, No 7

9. Questionnaire, No 7

10. Questionnaire, No 10

“It can be introduced because in some culture it is a cultural belief and can help.”¹¹

“Those traditionally practising [will say] yes and those not practising traditionally will not as it will be a new concept and might be seen as losing manhood.”¹²

Women’s perceptions of, engagement with and support of, MMC is dependent on their positioning as mothers and/or sexual partners, and thus points to the need for messages around MMC to address this.

“Because I am a mother of boys, I would like to protect them by any means.”¹³

“Women need to be educated on MMC, so as to encourage men to stick to guidelines and also for women to protect themselves.”¹⁴

There was also evidence of some level of misconception within women’s support for MMC with one respondent noting that:

“I will feel safe knowing that I am having sex with someone who is circumcised.”¹⁵

Overall, within the group discussions, there was support for the introduction of MMC in that it was seen to have an HIV prevention effect.

PERCEPTION OF IMPACT

Measuring the perceived impact of introducing MMC for HIV prevention, respondents were asked if they believed that women would be protected from HIV transmission, as well as whether respondents thought that MMC is changing ideas about HIV risks.

Respondents were concerned that the introduction of MMC for HIV prevention would lead to an increase in risk-behavior from men, with a decrease in condom use and an increase in male promiscuity. One respondent noted that MMC could be effective as an HIV prevention strategy, if it is accompanied by health education and counselling around safer sex. Another expressed concern that a lack of factual information regarding MMC could lead to increased risks of HIV transmission.

“Yes, because the government offers counselling and health education how to behave and use condoms.”¹⁶

“For those that don’t have all the correct information on male circumcision will take it the wrong way.”¹⁷

Some hope was expressed that this prevention strategy could change people’s attitudes around assigning blame or responsibility for HIV infection. However, participants also noted that this would take time. **The overriding concern was that it would place more blame on women for HIV infection and that it would decrease women’s ability to negotiate for safer sex practices, indicating that women would be at increased risk of exposure to HIV and other STIs.**

11. Questionnaire, No 6
12. Questionnaire, No 10
13. Questionnaire, No 3
14. Questionnaire, No 10
15. Questionnaire, No 7
16. Questionnaire, No 1
17. Questionnaire, No 7

CURRENT HIV PREVENTION METHODS

Linking the realities and challenges of existing HIV prevention options to levels of preparedness and support for the introduction and rollout of MMC for HIV prevention, respondents were asked about HIV prevention options currently used and available.

Within the focus group discussions, the emphasis was more on abstinence and delaying sex, with less mention of female and male condoms, as compared to the individual interviews. The discussions highlighted a lack of information and knowledge on HIV prevention methods, as well as women's concerns about and barriers to asking for prevention methods to be used. Further discussion revealed participants' concerns that abstinence and/or delaying sex are not "real" HIV prevention options for women.

*"With a partner, to abstain means divorce."*¹⁸

*"As for delaying, that one is only working for the youth."*¹⁹

Condom use was described as inconsistent, and respondents noted that they do not feel comfortable asking their partner to use a male or female condom; that they were not allowed to talk about sex with their partners; and that requesting condom use would be interpreted as mistrust. Most respondents noted that they did have access to female condoms. However, some noted they did not and that only male condoms were to be seen at the clinic. One respondent who has tried promoting the female condom to other women spoke about women walking away from her saying:

*"No, we don't want your AIDS things."*²⁰

Although some respondents noted they could access female condoms, the above quote indicates levels of difficulty by women themselves in accepting and using HIV prevention methods.

GENDER-BASED VIOLENCE AND MMC

The assessment tool included questions designed to assess respondents' perceptions of existing levels of gender-based violence (GBV) in their communities, as well as perceived impact of MMC on GBV.

"There is too much." This was the immediate response from one of the group discussions that highlighted women's understanding of existing high levels of GBV within their community. The respondents noted that they did perceive that MMC could lead to increased levels of physical violence and verbal abuse, with men believing they are fully protected from HIV and other STIs, and women having less ability to negotiate safer sex.

*"It could be that a man after circumcision says they are not enjoying sex, he may say, It's you, I don't enjoy you."*²¹

*"Women will not be able to negotiate safe sex because their partner may think he is immune in some way."*²²

18. Gatsi, Jennifer. "Impressions of Medical Male Circumcision Focus Group Discussion" Windhoek, Namibia 2010

19. Focus Group Discussion

20. Focus Group Discussion

21. Focus Group Discussion, Question 6

22. Focus Group Discussion, Question 6

The existing challenges and threats of violence women face were highlighted through discussions on men being promiscuous and only using condoms with their mistresses. If a wife refused to engage in sexual intercourse because she suspected promiscuity, then her husband often responded with violence or divorce.

ADDITIONAL SERVICES AND NEEDS

In order to assess women's perceptions and needs, respondents were asked to indicate what additional services they thought would be essential for the introduction and rollout of MMC for HIV prevention, as well as for reducing the risks of HIV transmission.

The respondents were very clear about the need for HIV testing, counselling and education of men about condom use, as well as an understanding of the need for six weeks of abstaining from sex post-operation. Some respondents called for "compulsory testing" and that "compulsory condom use" should be enforced on men. Education and counselling of women to empower them was seen as a need, as was peer education around safer sex practices. Respondents also pointed to the need for diverse community messaging that could encourage males to circumcise and still use condoms.

*"Counselling: including all the necessary information on how to do it, how to behave after, advantages and all the benefits."*²³

4. DISCUSSION

The study clearly indicated the lack of knowledge about MMC for HIV prevention, as well as some degree of misinformation about the effects of MMC for HIV prevention. Respondents also felt strongly that MMC should be introduced not as an HIV prevention method but for hygienic purposes.

Given the existence of traditional male circumcision practices in Namibia, the study further revealed a lack of understanding of the differences between MMC and traditional circumcision practices, including the potential effect of either male circumcision practice on HIV prevention.

The study also clearly highlighted women's concerns about the impact of MMC for HIV prevention on their own risk of exposure to HIV due to men's increased risk-behavior; women's decreased ability to negotiate condom use; and the potential increase in GBV. And finally, respondents expressed their concerns that the rollout of MMC for HIV prevention programs will have a negative impact on funds and resources allocated to women's HIV prevention methods.

23. Questionnaire, No 5

5. RECOMMENDATIONS

In light of these findings, the study recommends the following:

- Policy makers and implementers need to ensure that MMC communication strategies and messaging are clear, factual and not misleading.
- Government needs to work closely with civil society organizations representing communities, and especially people living with HIV, to ensure their meaningful involvement in needs assessment, program design and program implementation.
- Women also need to be part of MMC program design and implementation to ensure that they are not negatively affected by the rollout of MMC for HIV prevention.
- Government needs to ensure broad consultative processes with, and active involvement of, traditional male circumcisers, to ensure that the introduction of MMC for HIV prevention is not seen as a threat to traditional practices.
- Resources and funds allocated for MMC for HIV prevention programs should match funds allocated for female prevention methods and programs, such as female condoms and microbicide research and implementation.

NAMIBIA SURVEY RESULTS

	Namibia
Total interviews	10
Have heard about MMC for HIV prevention	80%
Have heard about MMC via billboards and radio	--
There are advantages of MMC for HIV prevention	90%
Are aware that ...	
there is a need for condom use after MMC	60%
MMC does not provide 100% protection from HIV risk	90%
men need to abstain from sex for six weeks after MMC	80%
MMC for HIV prevention can be introduced into community	100%
Men would get circumcised	90%
Would support MMC in community	100%
MMC protects women from HIV	33%
MMC is changing ideas about HIV risk	80%
Women talk about MMC for HIV prevention with their sexual partners	40%
Women are involved in decision-making around men getting circumcised for HIV prevention	60%
Women want to be involved in this decision	89%
Would circumcise own infant boy	--
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	10%
comfortable	0%
fairly comfortable	20%
sometimes comfortable	30%
not at all comfortable	40%
Use condoms with partner(s) now	60%
Gender-based violence is a problem in community	100%
MMC for HIV prevention would impact gender-based violence in community	50%
Female genital mutilation could protect girls from HIV infection	44%
Promoting MMC may promote FGM among girls and women in community	--

SOUTH AFRICA¹

JOHANNA KEHLER – AIDS LEGAL NETWORK

KEY FINDINGS

- There is general support by women for MMC to be introduced into communities. However, this support is contingent upon women having their needs and concerns addressed in the broader HIV prevention agenda.
- Women identify concerns about their inability to negotiate condom use and that MMC will lead to an increase in risk behaviour among men.
- Women identify concerns that MMC will contribute to gender-based violence, including an increase in stigma and blame being directed toward women with regards to HIV infection.
- Women call for increased access to, and availability of, women-controlled HIV prevention strategies in conjunction with MMC rollout, such as the female condom.
- Women from Eastern Cape, where there is a tradition of circumcision, largely responded to the introduction of MMC in their roles as mothers; those from KwaZulu Natal, a largely non-circumcising community, were more focused on the impact of MMC on their sexual health and rights.
- For women to access and act on information related to MMC and HIV, the information needs to be tailored for women. Also, the socio-cultural context and the realities of women, particularly in traditional male circumcising communities, need to be taken into account.

1. POLICY FRAMEWORK AND CONSIDERATIONS: THE SOUTH AFRICAN CONTEXT

South Africa has the world's largest population of people living with HIV, and it has been estimated that about a third of men in South Africa are circumcised.² The practice of traditional and/or religious circumcision is not fully regulated by the state, hence this estimation is based primarily on the percentage of indigenous communities that are traditionally circumcising, as well as the Muslim and Jewish communities.

A newspaper article dated December 4, 2009³ reported that South Africa's National AIDS Council (SANAC) had, as early as 2007, raised the possibility of providing medical male circumcision (MMC) services in South Africa but faced a lack of political support. In 2008, civil society engaged with the issue, and SANAC showed more support and a stronger voice regarding the introduction and rollout of MMC services for HIV prevention.

1. This is an excerpt from the South Africa country report. Kehler, J. & Arnott, J. 2010. *Medical Male Circumcision for HIV Prevention: Are women ready?* Cape Town: South Africa. AIDS Legal Network. Available for download at www.avac.org/WHIPT

2. http://www.malecircumcision.org/publications/documents/South_Africa_MC_case_study_May_2008_002.pdf

3. <http://www.plusnews.org/report.aspx?ReportId=87315>

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

An update on the male circumcision policy process in South Africa, dated July 2009,⁴ stated that the National Strategic Plan (NSP) for HIV and AIDS would incorporate MMC under prevention strategies towards reducing sexual transmission of HIV. This update on the policy development process included a recognition that any policy on MMC should expressly recognize that this is not a stand-alone intervention but forms part of a comprehensive HIV prevention program and that MMC programs must promote safer sex practices, the correct and consistent use of male and female condoms, and sexual and gender equality and must ensure access to appropriate HIV testing and counselling services. It was also noted that MMC programs needed to be gender sensitive, focusing on women as partners and mothers, and explain advantages of MMC for HIV prevention to women.

As of February 2010, the Department of Health has produced a draft set of Implementation Guidelines, and is conducting a feasibility and costing analysis. The *male circumcision policy for HIV prevention in South Africa* to provide a framework for policy makers and implementers is in the process of finalization.

2. METHODOLOGY

STUDY SAMPLE AND PROCESS

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

During the data collection phase, the AIDS Legal Network (ALN) worked in partnership with community-based organizations,⁵ primarily positive women's groups and networks, in both provinces. In KwaZulu Natal, the data were collected in partnership with women from the National Association of People Living with HIV and AIDS (NAPWA), and in the Eastern Cape with women from Her Rights Initiative (HRI), the iBhayi Positive Living Centre and Ikhala Trust.

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

4. <http://www.slideshare.net/NicoPaul/male-circumcision-research-into-policy-final-s-a-h-a-r-a-dec-09-2009>

5. The ALN has ongoing working relationships with the identified organizations in the provinces.

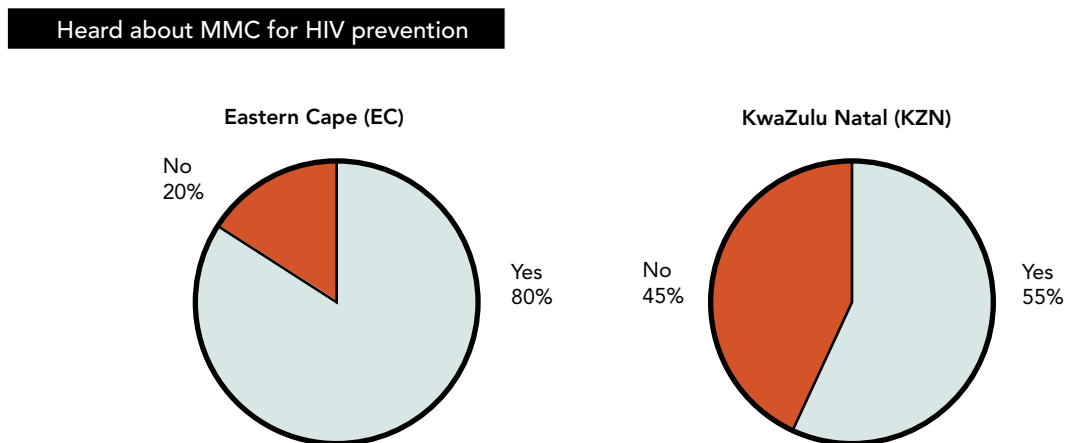
3. RESEARCH FINDINGS

SOCIO-DEMOGRAPHIC BACKGROUND OF RESPONDENTS

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

KNOWLEDGE ABOUT MEDICAL MALE CIRCUMCISION FOR HIV PREVENTION

Asked whether they had heard about MMC for HIV prevention, 67 percent (97) of the total sample said “yes” and 33 percent (48) said “no”.⁶ A markedly higher percentage of women in the EC (55, 80%) indicated that they had heard about MMC for HIV prevention, than in KZN (42, 55%).



Of the total sample, 41 respondents specified that they have heard that MMC reduces the risk of HIV and other STIs, with 57 percent of the KZN and 32 percent of the EC sample making reference to that effect. There was also reference made to the belief that MMC was a “cure” for HIV; one respondent from the EC noted “that it’s safe when it comes to HIV”.⁷

Respondents were further asked how and from whom they had heard about MMC for HIV prevention. In both areas, the radio was by far the significant medium of communication, and both areas had not seen any billboards. In KZN, more than half (13) had heard about MMC through the radio, followed by the community (8).

In the EC, respondents had heard about MMC for HIV prevention equally through the radio (5) as at the hospital/clinic. One respondent from the EC said she saw it on TV, but:

“I didn’t pay much attention as my husband doesn’t want us to listen when things are on about circumcision.”⁸

The quote above arguably highlights some of the socio-cultural tensions around male circumcision, and the exclusion of women from gaining access to information. As traditional male circumcision is a “sacred” and “secret” male institution, women who want to access health and HIV information related to male circumcision practices face many barriers, including the control of women’s information-seeking through watching TV. Thus,

6. Only respondents who had heard of MMC for HIV prevention continued with the questionnaire.

7. EC, January 21, 2010, No 32

8. EC, January 21, 2010, No 38

for women to access and act on information related to MMC and HIV, the information needs to be tailored for women and take into account the socio-cultural context and the realities of women in traditional male circumcising communities.

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

Moreover, when asked whether they are aware that men need to abstain from sex for six weeks after the “surgery”, 35 percent said “no”. Similarly, given the increased risk of HIV transmission before complete wound healing, this percentage indicates both a lack of adequate factual information about MMC and the need for focused awareness and education campaigns for women.

Discussion

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

The data also seem to suggest that “hearing” about MMC for HIV prevention does not necessarily translate into having “factual knowledge” about MMC, such as that MMC is only partially protective against HIV risk, the need for condom use after MMC, and the need to abstain from sex during the period of wound healing. Thus, the data arguably confirm the need for education and awareness raising about MMC for HIV prevention prior to the rollout of MMC programs, as well as highlighting the shortcomings of current information and messaging about the benefits of MMC for HIV prevention.

PERCEPTION OF ADVANTAGES AND DISADVANTAGES OF MMC FOR HIV PREVENTION

To further assess knowledge and perception of MMC for HIV prevention, respondents were asked whether they thought there are advantages and/or disadvantages. Of the 92 respondents⁹ who completed the question, the majority (66, 72%) indicated that there were advantages of MMC for HIV prevention, and 26 (28%) did not see any advantage.

Eastern Cape

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

The second-highest response code for advantages of MMC for HIV prevention was related to the prevention and protection from STIs and HIV infection, since “once the foreskin is cut, there are few chances of STIs.”¹⁰

At this stage of the questionnaire, common misconceptions also emerged in that some respondents noted the advantages of MMC as reducing HIV completely, as “no foreskin means there is no HIV threat”.¹¹

9. The response rate for this question was 92 percent of the total sample.

10. EC, January 21, 2010, No 6

11. EC, January 22, 2010, No 3

The data seem to suggest, especially in the EC sample, that some respondents approached this question as mothers and not necessarily as sexual partners, emphasizing the advantage that MMC would limit the number of “boys dying in the bush”. While this stated advantage of MMC does not correlate with MMC for HIV prevention, it arguably highlights that women’s expressed support for MMC may not necessarily be linked to its benefits for HIV prevention, but instead to the desire to increase the “safety” of traditional male circumcision practices.

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

KwaZulu Natal

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

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

“It is good for men, not for women, because it is only men who are protected from HIV and STIs. As for me, no I am not protected.”¹²

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

“Men are prioritized, and women will be blamed for HIV, as it happened before.”¹³

Discussion

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

COMMUNITY PREPAREDNESS AND SUPPORT FOR MMC FOR HIV PREVENTION

Asked whether respondents believed that MMC for HIV prevention could be introduced into their community, the majority (70%, 65) agreed and 28 (30%) disagreed. The response rate showed marked differences between the two samples, in that a much higher percentage of respondents in the EC (80%) thought that MMC for HIV prevention could be introduced to their community, as compared to 55 percent of respondents in the KZN sample.

Eastern Cape

Elaborating as to why respondents thought that MMC for HIV prevention could be introduced into their community, the majority of responses (18) in the EC sample clustered around the need to engage and involve women, as well as community, on issues of education and awareness-raising regarding MMC. Respondents also

12. KZN, December 17, 2009, No 17

13. KZN, December 18, 2009, No 9

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

“It will also give a chance for our boys to learn about the risk of HIV infection, as they will be educated.”¹⁴

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

“They will misunderstand; they will think that you can’t be HIV when you are circumcised.”¹⁵

KwaZulu Natal

In KZN, 55 percent (21) of respondents agreed that MMC for HIV prevention could be introduced into their community. Four (4) respondents noted a similar assumption as respondents in EC that introducing MMC as an HIV prevention option would lead to men wanting to be circumcised in order to not have to use condoms.

“Because men don’t want to be protected and use condoms.”¹⁶

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

“We need more information and workshops on MMC.”¹⁷

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

Discussion

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

The data also suggest high levels of perceived support amongst men, as well as individual support, for the introduction and rollout of MMC as an HIV prevention strategy.¹⁸ The data, however, also indicate that support for the introduction of MMC for HIV prevention is qualified by the need for women’s greater involvement in MMC for HIV prevention discussions and decisions as well as the noticeable tensions between traditional and medical male circumcision practices.

PERCEPTION OF IMPACT

To measure the perceived impact of introducing MMC for HIV prevention, respondents were asked if they believed that MMC would protect women from HIV transmission, and whether they thought that MMC is changing ideas about HIV risks.

14. EC, January 21, 2010, No 25

15. EC, January 21, 2010, No 36

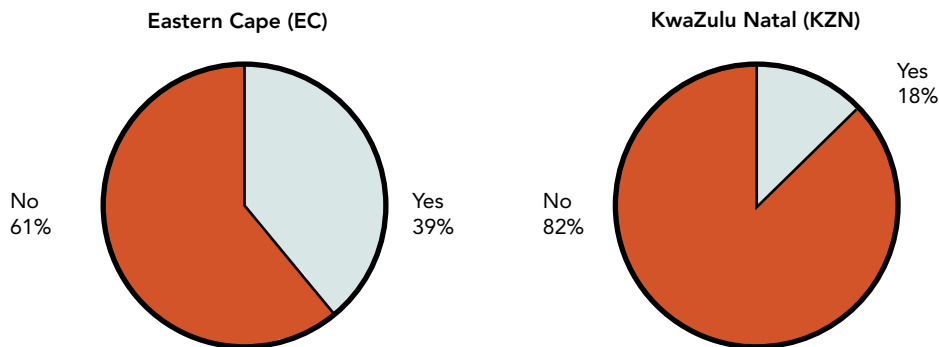
16. KZN, December 18, 2009, No 1

17. KZN, December 17, 2009, No 17

18. More information about this issue can be found in the full report: Kehler, J. & Arnott, J. 2010. *Medical Male Circumcision for HIV Prevention: Are women ready?*. Cape Town: South Africa. AIDS Legal Network.

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

Women are protected from HIV by MMC



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

Respondents also mentioned different hopes, as well as concerns, relating to the potential of MMC to change existing ideas and beliefs about HIV risks, ranging from the hope that information and education for men during MMC would decrease men’s risk behaviors and increase condom use, to the fear that men always blame women for HIV infections and that this would not change with the introduction of MMC. Reference was also made to the risk that men may perceive MMC as a “license” for unprotected sex.¹⁹

“Men will always blame women, as they will think they cannot be infected.”²⁰

“People will think there is a cure, the invisible condom, and will never change behaviour.”²¹

Discussion

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

WOMEN’S INVOLVEMENT

When asked if women are talking with their partners about MMC for HIV prevention, the majority (71%, 65²²) said ‘no’ and less than a third of respondents (29%, 26) indicated that women are talking about it with their partners.

19. Although the majority of comments indicate respondents’ disbelief in MMC changing ideas about HIV risks, the quantitative data do not necessarily support this, with 54 percent of respondents saying “yes” and 46 percent saying “no”.

20. EC, January 27, 2010, No 56

21. KZN, December 23, 2009, No 30

22. The overall response rate for this question was 94 percent.

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

In order to assess women’s actual and desired involvement in the decision-making processes about MMC for HIV prevention, respondents were asked whether women are involved, as well as whether women would want to be involved, in this decision. Of all respondents, 29 percent (26)²³ indicated that women are involved, and 75 percent (70)²⁴ indicated that women would want to be involved, a marked difference.

Whilst the data suggest a greater current, as well as desired, involvement of women in decisions about male circumcision in the EC sample, women in the Eastern Cape are somewhat involved in traditional male circumcision processes and thus relate differently to questions of women’s involvement in male circumcision. As mentioned above, respondents from the EC sample are more likely to respond in their role as mothers, as compared to engaging with questions of MMC as sexual partners.

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

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

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

“Women need to be a part of taking this important decision, education and after care.”²⁵

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

HIV PREVENTION OPTIONS

Levels of preparedness and support for the introduction and rollout of MMC for HIV prevention is arguably closely linked to existing HIV prevention options and challenges. Asked to identify HIV prevention options available currently, 71 percent (69) of the total sample mentioned condoms, with 43 (78%) responses in the EC sample and 23 (55%) responses in KZN to this effect. Although this high response rate referring to condoms as an HIV prevention option is noteworthy, only 3 respondents (KZN) made specific reference to female condoms—arguably indicating a lack of female condom availability and access.

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

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

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

25. KZN, December 23, 2009, No 29

“For me there is nothing available for now, there is nothing available for women, nothing.”²⁶

In order to assess perception of women’s “ability” to negotiate condom use, respondents were asked to indicate how comfortable they thought women are in negotiating condom use on a five-point scale, ranging from “not at all” (1) to “very much” (5). Of the 92 (95%)²⁷ respondents who completed the ratings, 37 percent (34) indicated that women are “not at all” comfortable, while 22 percent (20) believed that women are “very much” comfortable. Seventeen percent (16) indicated that women are “somewhat” comfortable. There were also significant differences between the two samples, in that more than twice as many respondents in KZN (54%, 20) thought that women are “not at all” comfortable, as compared to EC respondents (25%, 14).

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

“Because women are not making decisions in their relationships.”²⁸

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

“So that we can be prevented from infections.”²⁹

Assessing condom use further, respondents were asked whether they are currently using condoms with their partners,³⁰ and what they thought their partners would say if asked to use a condom after being circumcised (open-ended question). More than half of the respondents (56%, 54) were very clear that they could not insist on using a condom, and 24 respondents (25%) said that their partners would or “might” (4, 4%) agree to do so.

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

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

“He won’t allow it, he’ll tell me that he’s circumcised and should I be infected that will mean that I got it from other men.”³¹ (21–29 yrs)

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

“No, since we women let men take control of sex.”³² (21–29 yrs)

- Men believing they are fully protected through circumcision

“He will say what is the use, I am already circumcised.”³³ (21–29 yrs)

26. KZN, December 23, 2009, No 30

27. The response rate was 100 percent in EC and 88 percent in KZN.

28. KZN, December 18, 2009, No 1

29. EC, January 22, 2010, No 2

30. Based on the fact that 19 percent of respondents declined to answer this question, combined with the challenges of self-reported condom use data, a decision was taken not to analyze these responses.

31. KZN, December 14, 2009, No 69

32. EC, January 22, 2010, No 21

33. KZN, December 16, 2009, No 60

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

“We will get into a fight, because now they have the wrong information that circumcision prevents HIV.”³⁴ (50–64 yrs)

Discussion

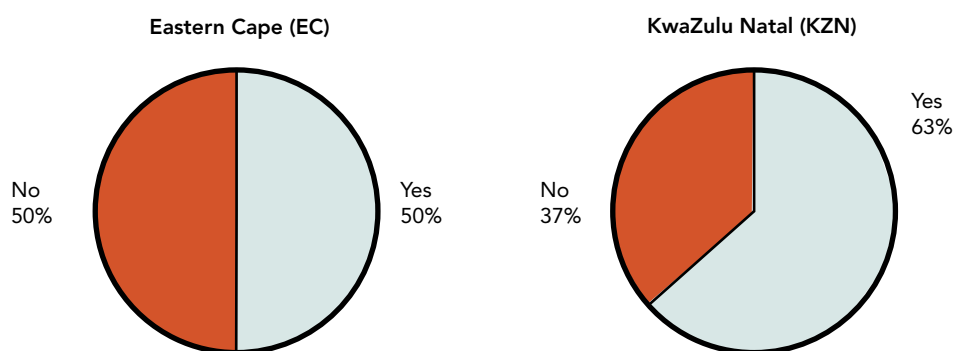
The data suggest that currently available HIV prevention options, such as female and male condoms, provide limited benefit to women in a societal context of gendered inequalities and power imbalances. The data also confirm that most women are not in the position to negotiate condom use and thus, women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

GENDER-BASED VIOLENCE AND MMC FOR HIV PREVENTION

When asked whether GBV is a “problem” in their community, 63 percent (54) said “yes” and 37 percent (32) said “no”.³⁵ However, the two samples differ, in that 83 percent (30) of KZN respondents said “yes”, while 48 percent in the EC sample said “yes”.

Respondents were also asked whether and how they thought that MMC for HIV prevention would affect GBV.³⁶ In total, 55 percent of respondents (44) felt that MMC for HIV prevention would affect GBV in their communities, and 45 percent (36) did not. Corresponding to the higher percentage of respondents who thought GBV is a problem in their community, 63 percent of KZN respondents further believed that MMC would affect GBV.

MMC will have an impact on



Responses explaining how MMC for HIV prevention would affect GBV in their community referred to men refusing to use condoms (EC), women being blamed for any infections, and women being forced into unprotected sex (KZN).

34. KZN, December 17, 2009, No 14

35. The overall response rate for this question was 87 percent (91% EC and 86% KZN).

36. The overall response rate for this question was 82 percent (87% EC and 76% KZN).

Discussion

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

FOCUS GROUP DISCUSSIONS

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

KwaZulu Natal

In one of the KZN focus group discussions,³⁷ participants explored how difficult it was to negotiate safer sex with their partners, primarily focusing on risk behaviors in men as well as concerns that MMC would essentially be a risk factor for women and women will be blamed for HIV.

“It can be introduced, but not as a prevention method, because as a Zulu woman you know how stereotyped Zulu men are? He won't allow us to use a condom when we are having sex, because he will say he is protected because he has removed the foreskin, which means we are both protected.”³⁸

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

“It is males who will always claim that they are circumcised and cannot contract HIV. They will force female partners to have sex without a condom. If they refuse they will beat them or dump them, to be on the safe side, you have to agree on submission.”³⁹

Eastern Cape

The focus group discussions in the Eastern Cape⁴⁰ clearly confirmed and re-emphasized the numerous challenges of introducing MMC in communities that practice male circumcision as the rite to manhood, and also identified some of the socio-cultural barriers.

“I don't want my child to be circumcised medically forgive me, he must use his forefathers' ways. I accept that he must be protected against diseases, but I don't accept medical circumcision.”⁴¹

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

37. KZN Focus Group Discussion in KwaMakhuta on January 13, 2010. Participants were 25–30 years old.

38. KZN Focus Group Discussion, January 13, 2010.

39. KZN Focus Group Discussion, January 13, 2010.

40. Focus group discussions in the Eastern Cape were facilitated on January 27, 2010 in Port Elizabeth and on January 29, 2010 in New Brighton.

41. EC Focus Group Discussion, January 29, 2010.

“The only thing I think is to improve the way the old or traditional way, they should improve the way of doing it by involving the medical doctors, because this is culture and culture is culture.”⁴²

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

“People must be given information; although there are few people who would accept medical male circumcision maybe it will only be accepted by women.”⁴³

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

“Women are affected, if something goes wrong men are never around; it is up to a mother to make means to amend the situation.”⁴⁴

Discussion

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

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

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

4. CONCLUSION

In summary, the data highlight a need to develop strategies that will engage women in all aspects of MMC as an HIV prevention strategy to ensure that women’s needs, concerns and HIV risks and vulnerabilities are ad-

42. EC Focus Group Discussion, January 27, 2010.

43. EC Focus Group Discussion, January 27, 2010.

44. EC Focus Group Discussion, January 29, 2010.

dressed. Moreover, there seems to be a general lack of knowledge, and some level of embedded misconceptions, about MMC for HIV prevention amongst women in the study.

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

Concerns about women's lack of involvement in decisions about male circumcision, as well as its impact, are arguably also reflected in the expressed desires of women to be actively involved in discussions and decision-making processes on MMC for HIV prevention. Although the perceived need and reasons for women's involvement may differ, the data strongly suggest that women's involvement in all aspects of MMC for HIV prevention is essential, so as to adequately respond to women's concerns and needs and to ensure that women's HIV risks and vulnerabilities are addressed with this new HIV prevention strategy.

The data arguably also suggest a link involving women's recognized lack of power to negotiate condom use, expressed concerns about the impact of MMC on risk behavior in men, and perception of an increased risk of GBV following the introduction of MMC for HIV prevention.

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

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

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

5. RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

SOUTH AFRICA SURVEY RESULTS

	South Africa
Total interviews	145
Have heard about MMC for HIV prevention	67%
Have heard about MMC via billboards and radio	--
There are advantages of MMC for HIV prevention	72%
Are aware that ...	
there is a need for condom use after MMC	83%
MMC does not provide 100% protection from HIV risk	82%
men need to abstain from sex for six weeks after MMC	65%
MMC for HIV prevention can be introduced into community	70%
Men would get circumcised	69%
Would support MMC in community	87%
MMC protects women from HIV	31%
MMC is changing ideas about HIV risk	46%
Women talk about MMC for HIV prevention with their sexual partners	29%
Women are involved in decision-making around men getting circumcised for HIV prevention	29%
Women want to be involved in this decision	75%
Would circumcise own infant boy	--
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	22%
comfortable	6%
fairly comfortable	17%
sometimes comfortable	17%
not at all comfortable	37%
Use condoms with partner(s) now	72%
Gender-based violence is a problem in community	63%
MMC for HIV prevention would impact gender-based violence in community	55%
Female genital mutilation could protect girls from HIV infection	12%
Promoting MMC may promote FGM among girls and women in community	--

SWAZILAND

CEBILE DLAMINI – SWAZILAND FOR POSITIVE LIVING (SWAPOL)

SIPHIWE HLOPHE – SWAPOL

GCEBILE NDLOVU – SWAPOL

KWASHIE KUDIABOR – ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

KEY FINDINGS

- A majority of the women surveyed have heard about MMC and believe that it is protective for men against HIV, would support it and want to be involved in the process.
- An estimated half of the women surveyed believe that MMC will protect them from HIV.
- A majority of the women are concerned that some men would feel that MMC provides 100-percent protection and would therefore be sexually riskier than before becoming circumcised.
- Only half the women knew that men needed to abstain from sex for six weeks post-surgery.
- There is a perception that women are not targeted in current MMC messaging.
- Some of the current places of MMC implementation are stand-alone clinics for men and fail to integrate MMC delivery with sexual and reproductive health services for either men or women.

1. BACKGROUND

Swaziland is a southern African country with a low level of male circumcision given that traditional “cutting” is not practiced. However, studies conducted in 2006 by the Family Life Association in Swaziland (FLAS), a non-governmental organization providing sexual and reproductive health services, showed a high level of acceptability of MMC among men, with 87 percent surveyed willing to undergo circumcision for protection against HIV.

The FLAS 2006 study further estimated the unit cost for a comprehensive package of MMC services in Swaziland at R376.00 (about \$50), which includes surgical costs (78.6%); communications (14.5%); testing (3.6%); and pre- and post-operative counseling (3.3%). In preliminary analyses, this package of services has been shown to be cost-effective when compared to other prevention interventions, particularly because MMC is a one-off procedure that does not have to be funded over time.

In December 2009, the Government of the Kingdom of Swaziland adopted policy, strategy and an implementation plan on Safe Male Circumcision for HIV Prevention. The previous Prime Minister, Absalom Themba Dlamini, and the current Prime Minister, Sibusiso Dlamini, are strong supporters of MMC, and there is a dedicated MMC coordinator in place in the Ministry of Health.

Through Swaziland's National Emergency Response Council on HIV and AIDS (NERCHA), Jhpiego, Population Services International and UNICEF, doctors and nurses have been trained to perform MMC. A total of six government sites have been identified as pilot projects for the country's Accelerated Saturated Initiative, with some currently active.

POLICY GOAL, OBJECTIVES AND CONTEXT

The objectives of the MMC policy are to create an enabling environment for the scale-up of well coordinated MMC services; increase the number of health facilities providing safe male circumcision services in both the urban and rural parts of Swaziland; and increase the number of HIV-negative men aged 15–24 years accessing MMC services. This age group may benefit the most from services, as they are collectively and currently at greatest risk of HIV infection based upon epidemiologic data.¹ They either are already sexually active or will become sexually active soon.

The policy addresses a number of aspects such as targeting the populations that will result in the most public health impact; training cadres of healthcare workers to provide MMC services; the type of facilities where MMC services shall be provided; integration of MMC with other health services; costing; quality assurance; communications including messaging around MMC's partial efficacy; human rights, ethics and legal issues; and socio-cultural considerations. Although the policy calls for monitoring and evaluation, it does not include gender indicators that would determine whether women are benefiting, being harmed or not being affected at all.

2. METHODOLOGY

Quantitative research methods involving questionnaires were used to get the impression of MMC among the women interviewed. The qualitative method involved the use of focus group discussions to explore issues underpinning MMC in the community. The population consisted of predominantly HIV-positive women with a mean age of 41 who were purposely selected from rural and peri-urban communities in the Manzini and Hhohho regions, where MMC had not yet been implemented. Overall, 73 women participated in the one-on-one interviews in the ten communities, whereas four focus group discussions were held in four communities.

LIMITATIONS OF THE STUDY

A potential limitation resulting from the focus group discussions is that some women were not comfortable to fully express their views in fear of judgment.

It would have been beneficial for the study to find out the experiences of women whose husbands had undergone the MMC, to facilitate comparisons with experiences of women in the rural communities whose husbands have not yet undergone the MMC. This was not possible, as the study team was not able to get clearance from the MMC clinic due to confidentiality issues.

1. Strategy and Implementation Plan for Scaling up Safe Male Circumcision for HIV Prevention in Swaziland, 2009–2013. Swaziland Male Circumcision Task Force.

3. RESEARCH FINDINGS

KNOWLEDGE LEVEL OF WOMEN AROUND MMC

Of the 73 women interviewed, about 88 percent (64/73) had previously heard about MMC. The women who heard about it responded that MMC prevents HIV in men, improves penile hygiene, and reduces transmission of sexually transmitted infections (STIs) by removing the foreskin of the penis. Some also mentioned they heard “it is done in the mountain”, referring to it as a foreign culture—not in Swaziland. A majority of the women reported they heard about MMC on the radio or from individuals in the community. However, no mention was made of street billboards as a source of information.

MMC CHANGING IDEAS ABOUT MEN’S RISK

Of the 64 respondents who said they had heard about MMC, 92 percent (59/64) were aware of the advantages of MMC for HIV prevention. Most of the women explained further that MMC prevents STIs, including HIV in men.

When asked if they were aware that there is need for consistent condom use after MMC, only 61 percent (39/64) said “yes”. This same percentage of respondents were aware that MMC does not provide 100-percent protection. Only 52 percent (33/64) agreed that men need to abstain from sex for six weeks after MMC.

A high proportion of the women—91 percent—felt that MMC could be successfully introduced into the community. The women further explained that introducing MMC in the community would improve access to other comprehensive sexual and reproductive health services. This would increase awareness and knowledge among both men and women in the communities, especially if women would be involved from the beginning. A further 72 percent (46/64) of the women thought men would utilize the MMC services when introduced. Almost 89 percent (56/64) of the women themselves said they will support it.

“Men are cheaters and MMC can help to reduce STIs including HIV.”

Fifty-three percent (34/64) of respondents believed that MMC would protect them from acquiring HIV from their partners. It is not clear, however, whether the women thought it would provide direct or indirect protection over time.

Nearly 63 percent (40/64) of the women thought that MMC would change ideas about HIV in the community.

“Men would think they are 100 percent protected and they will continue to have sex without condoms with multiple partners putting me as wife at risk of getting HIV.”

There’s a fear that men would increase their sexual risk-taking behaviors because they feel more or completely protected by MMC. This fear was expressed by 55% (22/40) of the women who think MMC would change ideas about HIV in the community.

Only 47 percent (30/64) of the women affirmed they talk about MMC with their partners. However, 86 percent (55/64) of the women were willing to be involved in the decision-making process to support their male partners during the healing process and to discuss circumcising their male children.

CURRENT HIV PREVENTION METHODS IN USE

Fifty-two percent (33/64) of the women reported they are not comfortable asking their male partners to use male or female condoms, as men are the sexual decision-makers. Only 33 percent (21/64) of the women self-reported that they are currently and consistently using condoms. This number may be higher than other cohorts in Swaziland, given that the women surveyed were assumed to be predominantly HIV-positive. Also, self-reporting may induce the women to want to give a socially acceptable answer although it may be inaccurate.

The women who are currently not using condoms affirmed that their male partners would refuse to use condoms even when circumcised because they'll falsely believe that they are 100-percent protected.

“My partner does not want to use condoms even now. Nothing will make him to change his mind to use it. Men are difficult to convince.”

PERCEPTION AROUND GENDER-BASED VIOLENCE (GBV) AND MMC

About 61% of the women said MMC would negatively impact gender-based violence (GBV), since men would refuse to use condoms after being circumcised. Condom negotiation would be even more difficult after MMC, given its current challenges, the women reported.

“We were asked to use condoms and now circumcision. We are confused. Men are refusing to use condoms and we are not in the position to defend or negotiate for safe sex.”

4. DISCUSSION

Clinics that offer and promote MMC are situated in the urban setting. This is a huge challenge, as many of the rural and peri-urban communities still lack information on and access to MMC when and where it will eventually be rolled out through mobile clinics. Lack of education before this scale-up was a gap identified by the research.

Section 3.7 of the Government of the Kingdom of Swaziland's MMC Policy calls for women and girls to be involved in decision-making, meaning included or targeted when developing messages for MMC. SWAPOL has become more involved in these processes through the WHIPT project, but seemingly from this survey, more women need to be included.

There are concerns about the range of services provided in the context of MMC programs. Programs that have a strict focus on MMC in absence of comprehensive sexual and reproductive health services miss the opportunity to engage men around sex, sexuality and family planning and to transform sexual and gender norms. It is critical that MMC be offered as part of a package of services and interventions for the man himself, and where possible, his sexual partners.

In general, women are willing to support the MMC program, but they lack an understanding of how they can be involved. Communication messages are targeting only men. This may be a reflection of the cultural view that

women in Swaziland are considered minors. There is a specific need to rollout MMC in clinics catering to both men and women's sexual health, and a need to develop balanced messages—targeting both men and women about the benefits and risks of MMC. Explicitly informing communities that MMC does not provide direct protection against HIV in women is crucial to the successful scale-up of the intervention. There is also the general need to address gender inequity throughout Swaziland.

5. RECOMMENDATIONS

- Swaziland's HIV/AIDS policy makers along with implementers and civil society advocates must address gender implications of MMC in the current policy by identifying, messaging and monitoring for potentially harmful outcomes of promoting MMC, such as increased behavior risks and sexual violence against women.
- Advocates and implementers must inform communities that MMC does not provide direct protection against HIV in women.
- Policy makers, implementers and advocates must support MMC literacy campaigns in the rural and urban communities with correct information about the benefits and risks of MMC.
- Implementers must provide MMC services that are integrated into comprehensive sexual and reproductive health services such as HIV testing and counseling, prevention of mother-to-child transmission (PMTCT), family planning and post-natal care, and other HIV services for both men and women.

NEXT STEPS

- Report launch: *Making Medical Male Circumcision Work for Women in Swaziland*.
- Link with civil society groups to inform and mobilize civil society around MMC.
- Develop messaging materials for communities and media.
- Liaise with Ministry of Health and UNAIDS to help guide MMC implementation.
- Work with implementers, such as Population Services International and the Family Life Association of Swaziland, to ensure the monitoring of MMC's impact on women is in place.

SWAPOL's Cebile Dlamini interviewing an urban woman in the district of Nkambeni for her opinion on the rollout of MMC.



SWAZILAND SURVEY RESULTS

	Swaziland
Total interviews	73
Have heard about MMC for HIV prevention	88%
Have heard about MMC via billboards and radio	--
There are advantages of MMC for HIV prevention	92%
Are aware that ...	
there is a need for condom use after MMC	61%
MMC does not provide 100% protection from HIV risk	61%
men need to abstain from sex for six weeks after MMC	52%
MMC for HIV prevention can be introduced into community	91%
Men would get circumcised	72%
Would support MMC in community	89%
MMC protects women from HIV	53%
MMC is changing ideas about HIV risk	63%
Women talk about MMC for HIV prevention with their sexual partners	47%
Women are involved in decision-making around men getting circumcised for HIV prevention	23%
Women want to be involved in this decision	86%
Would circumcise own infant boy	--
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	--
comfortable	--
fairly comfortable	--
sometimes comfortable	--
not at all comfortable	52%
Use condoms with partner(s) now	33%
Gender-based violence is a problem in community	--
MMC for HIV prevention would impact gender-based violence in community	61%
Female genital mutilation could protect girls from HIV infection	--
Promoting MMC may promote FGM among girls and women in community	--

UGANDA

MILLY KATANA

ALLEN KUTEESA – HEALTH RIGHTS ACTION GROUP

MARION NATUKUNDA – MAMA'S CLUB

KEY FINDINGS

- Women are aware of traditional/religious male circumcision and medical male circumcision (MMC) but lack factual knowledge.
- Women are slightly more in favor of supporting the rollout of MMC than not, because it is economical and hygienic and reduces HIV.
- Rollout would need massive sensitization and could feasibly be taken up by communities that practice traditional male circumcision.
- MMC is thought by some to be a “new” justification for female circumcision (female genital mutilation), potentially increasing its rates in areas where FGM is practiced.

1. BACKGROUND

Uganda saw a significant reduction in adult HIV prevalence, from a peak of 18 percent in 1992 to the current 5.4 percent among adults and 0.7 percent among children according to the UNAIDS. However, attention has been drawn to Uganda’s recent reversal in its prevention success.¹ The stagnated rates are partially attributed to the decline in practice of self-protective behavior among the populations. This has posed critical challenges to the national response. As a result, scaling up prevention of new infections and re-thinking prevention campaigns to develop relevant, suitable and timely interventions is very high on the agenda of the National Strategic Plan (NSP) of Uganda. However, Uganda’s Prime Minister has shown limited leadership to date in medical male circumcision (MMC) programming.

As the epidemic matures, the populations most severely affected have shifted from young unmarried individuals to older married or formerly married individuals. Women aged 30–34 years and men aged 40–44 years have the highest rates of infection. Also, women are infected more than men across all age brackets.²

Traditional male circumcision is widely practiced for religious and traditional reasons, often within the first two weeks after birth or at the beginning of adolescence as a rite of passage into adulthood. It is now performed to reduce the risk of contracting HIV and other sexually transmitted infections (STIs). Male circumcision (MC) rates overall in Uganda are at around 25 percent.

1. Epidemiological Fact Sheet on HIV and AIDS, Uganda 2008, <http://www.unaids.org/en/CountryResponses/Countries/uganda.asp>, Nov 2010

2. National HIV & AIDS Strategic Plan 2007/8–2011/12: Moving Towards Universal Access.

MMC for HIV prevention has received endorsements by the Uganda Ministry of Health as a method that reduces the risk of HIV transmission when used with other preventive methods. A National Task Force on MMC and a National Focal Person for MMC have been put in place. MMC became part of the policy dialogue in Uganda in 2009. As a result, a policy was launched in September 2010. Formal scale-up was slated to begin in June of this year, but nationwide training of health workers and strategy development are still not in place.

Below is the general understanding of “male circumcision” in Uganda based on interviews with key stakeholders and community representatives.

- MC is the removal of foreskin from the male genital organ.
- MC is done in the community, mosques and hospitals.
- MC is thought by some to increase sexual sensitivity, while others say it reduces male sexual sensitivity.
- MC is transition to manhood in the cultural context.
- MC is seen as a sign of bravery.
- MC is perceived to be an HIV prevention strategy.
- MC puts a burden on women as caretakers for those who have been circumcised.
- There is a lack of women’s involvement in MC, i.e., male partners seldom consult their female partners on MC.
- The above poses a risk of women engaging men in sex before they are completely healed, due to lack of knowledge on abstinence for six weeks.
- MC costs between \$10 and \$200.
- MC is done only for religious and cultural purposes, i.e., practiced by Moslems and the Bagisu tribe in the eastern region of Uganda.
- MC is sometimes equated with FGM.

2. METHODOLOGY

TOOLS

The questionnaires used for community research were jointly developed by WHIPT teams from South Africa, Namibia and Swaziland, reviewed by the Uganda country team and tailored to the Ugandan context. They were then adapted and translated into two local languages: Luganda and Sabin.

DATA COLLECTION

A set of three data collection tools was used. These included one quantitative survey targeting women; one key informant guide targeting district and national level officials; and a focus group discussion guide targeting women at community levels. A team of six data collectors and four staff members from Human Rights Action Group (HAG) and Mama’s Club were trained in these instruments for the data collection exercise.

Sixty-three women were administered the questionnaire from Kampala District of the Central Region, and Kapchorwa District of the Eastern part of Uganda. These regions were purposely selected to represent dissimilar communities. Kampala is a cosmopolitan city with both rural and urban characteristics, and with cultural and

religious diversity. Kapchorwa is a rural district and was selected because traditional circumcision for both men and women, for FGM, has been practiced for years. A qualitative analysis of key informants and six focus group discussions informed the outcomes.

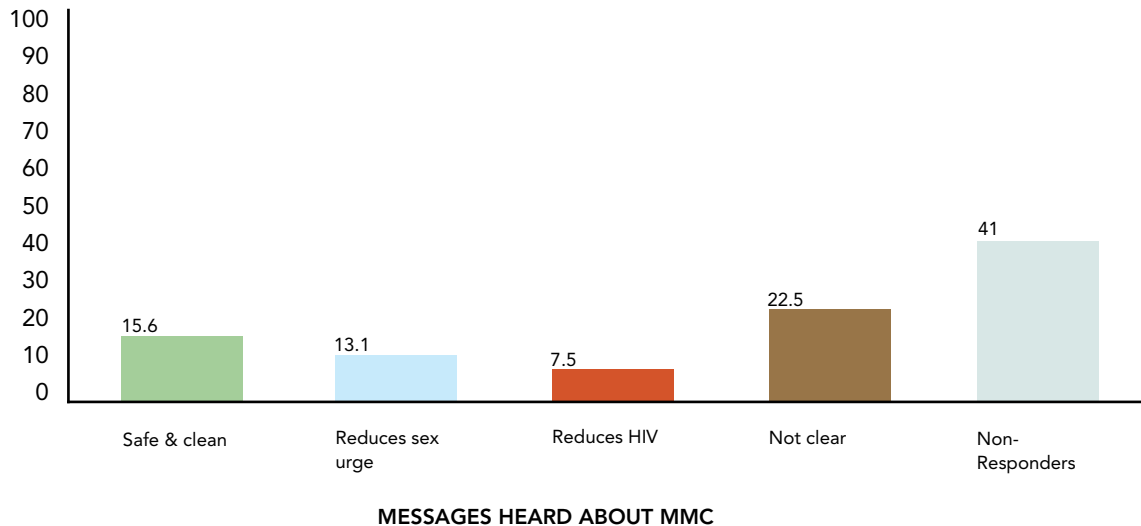
3. RESEARCH FINDINGS

MMC KNOWLEDGE LEVEL AND MESSAGING

Out of a total of 66 respondents, 98.5 percent indicated they had heard about MMC. Knowledge about MMC was a qualification for completion of the questionnaire by answering subsequent questions.

Respondents reported receiving a range of messages about MMC. Overall, 15.6 percent of respondents reported hearing that MMC is “safe and clean”, 13.1 percent that it “reduces sex urge”, 7.5 percent that it “reduces HIV”, and 22.5 percent said the messages were not clear. The rest of the respondents (41 percent) never gave a concrete response, as some indicated that the questionnaire was not clearly understood.

Percent distribution of messages heard about MMC



SOURCE OF INFORMATION ABOUT MMC

When the respondents were asked the sources of the above messages, 16.4 percent said they heard messages from HIV counselors; 23.1 percent from the church; 18.1 percent from Moslem friends; 17.0 percent from the media (newspapers, radios); 9.7 percent from peer groups; and 6.4 percent from the general community.

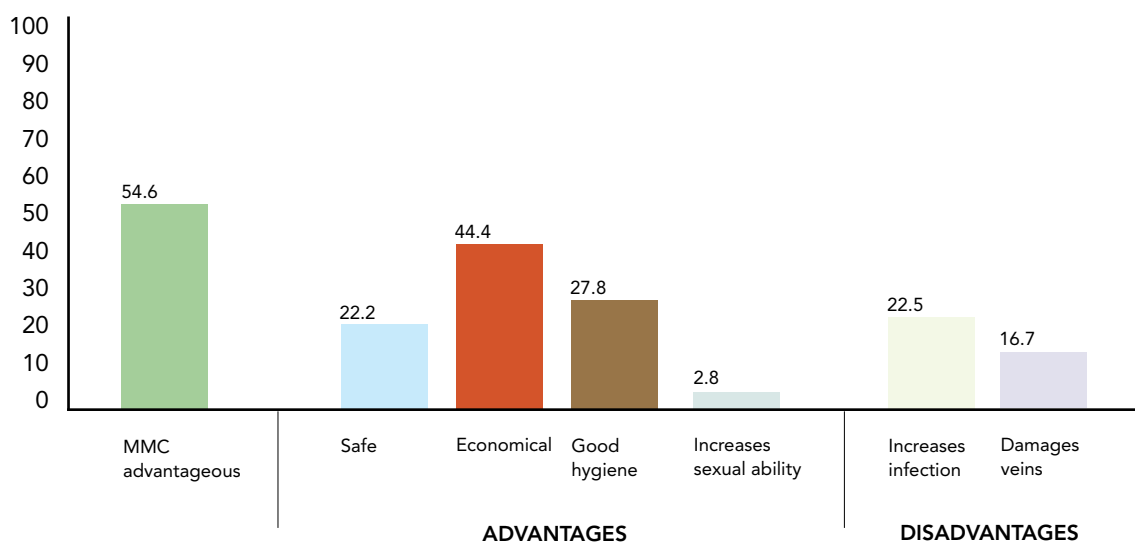
LOCAL ADVERTISEMENT MESSAGES

Nearly half (47.0 percent) of respondents reported they had heard about MMC and HIV on the radio or had seen the information on billboards. Messaging displayed on these billboards read “Reduce HIV with MMC”; “MMC is clean and hygienic”. One of the respondents reported billboard messages promoting MMC over traditional MC—unless traditional circumcisers are trained to carry out the surgery safely and effectively according to MMC guidelines.

MMC CHANGING IDEAS

Slightly over half (54.6 percent) of respondents indicated that MMC had advantages to HIV prevention—72.2 percent of respondents from Kapchorwa district compared to only 33.3 percent from Kampala. A number of advantages were cited: 22.2 percent of the respondents indicated that it is “safe”; 44.4 percent that it is “economical” (traditional MC being expensive because it is accompanied by a ceremony whose cost is mainly met by the women as mothers, who are responsible for hosting and feeding the celebrants); 27.8 percent that it is “good hygiene”; and 2.8 percent that it increases “sexual ability”. Two major disadvantages were reported: 30 percent of the respondents said MMC increases HIV infection, while 16.7 percent reported that it damages the veins.

Percent distribution of advantages and disadvantages of MMC



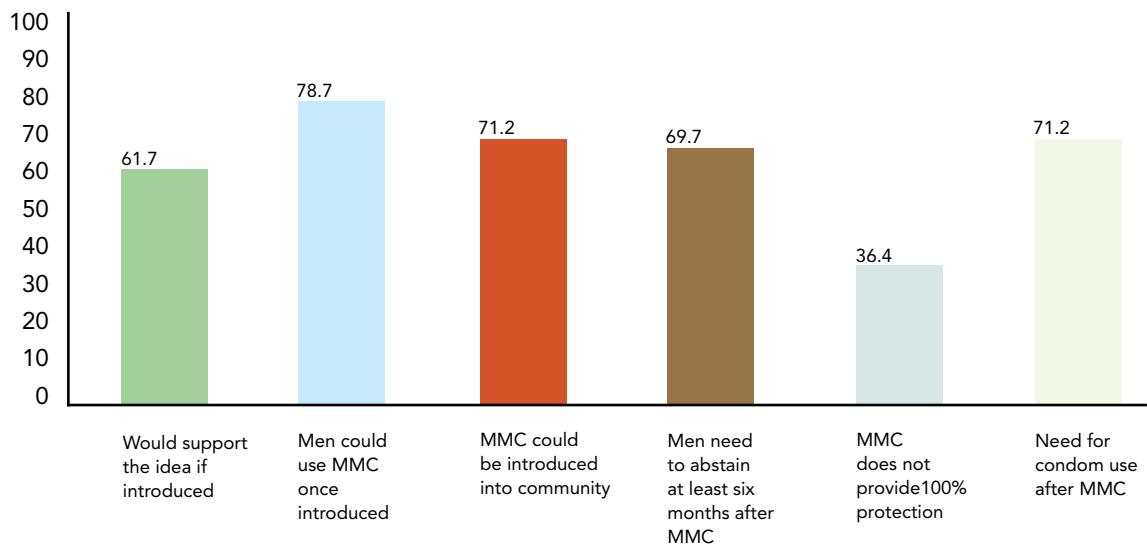
Of the respondents, 71 percent said that there is a need for condom use even after MMC (86.7 percent for Kampala and 58.3 percent for Kapchorwa). Nearly four in ten (36.4 percent) respondents said that MMC does not provide 100-percent protection against HIV, and 69.7 percent said that men need to abstain from sex at least six weeks after MMC.

On introducing MMC into respective communities, 71.2 percent of the women thought it could be done (76.7 percent for Kampala and 66.7 percent for Kapchorwa). Respondents said that MMC could be promoted as

part of the cultural practice in areas where men have to be traditionally circumcised. Some said MMC surgery would be easy to treat, and that for it to be successful there needs to be mass sensitization in the respective communities. Furthermore, 61.7 percent of respondents said they themselves would support the idea in their communities for reasons of safety and cleanliness (12.8 percent); lower HIV infection rates (41.1 percent); and cultural familiarity (20.6 percent).

Of those who said MMC could be introduced, 78.7 percent said they thought men would seek MMC services once introduced (91.3 percent for Kampala and 66.7 percent for Kapchorwa). The reasons given for men to welcome the idea mirrored the women’s reasons for supporting it: cultural respect (20.9 percent); increase in cleanliness (19.2 percent); and a decrease in HIV infection rates (19.2 percent). Again, the respondents underscored the need for mass sensitization if men were to use it.

Percent distribution of attitudes about MMC



CURRENT HIV PREVENTION METHODS AVAILABLE

Respondents were asked which HIV prevention methods were currently available in their communities. Nearly a quarter (24.2 percent) of respondents indicated the use of the ABC model (abstinence, be faithful, use condoms); 23.4 percent indicated use of prevention of mother-to-child transmission (PMTCT); 27.5 percent indicated HIV voluntary counseling and testing (VCT). In addition to these proven prevention strategies, 8.1% of women reported using “the withdraw” method to reduce HIV risk.

ADDITIONAL PREVENTION SERVICES NEEDED

Respondents were asked to indicate additional services that should be provided with MMC. Fifteen percent of respondents indicated that there is need for MMC literacy; 27.3 percent indicated HIV testing services and 15.8 percent indicated medical care, while 33.1 percent said there was need for MMC to be championed by govern-

ment and implemented through established health structures for more acceptability by the communities. Other desired HIV prevention services specified for rollout alongside MMC were sensitization on condom use (28.7 percent); free HIV counseling and testing services (41.1 percent); and promotion of abstinence (16.1 percent).

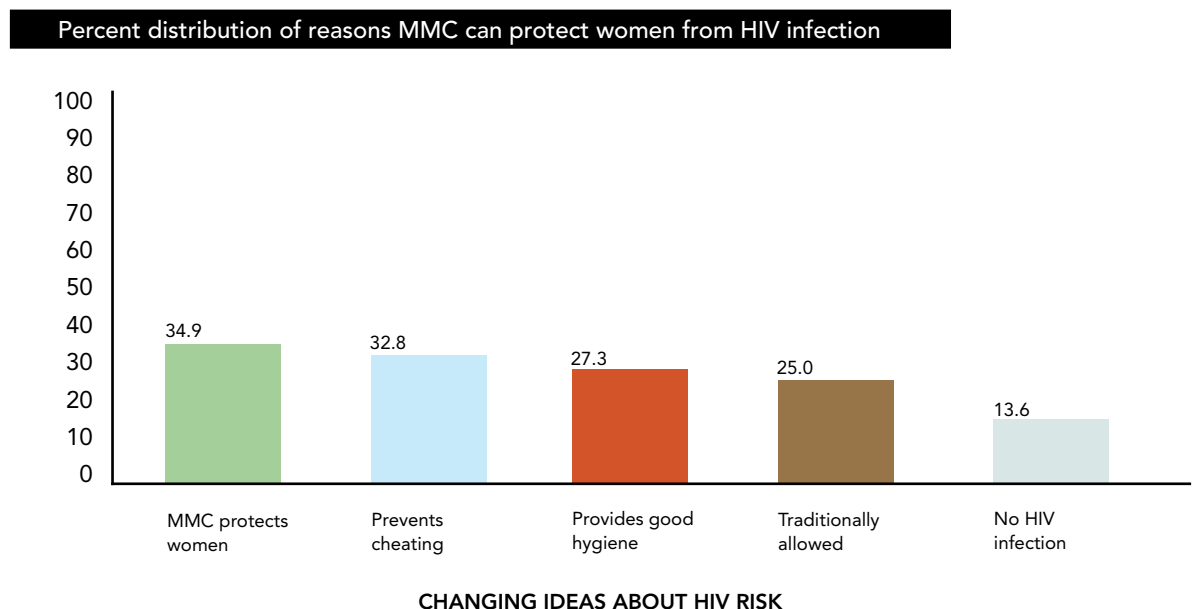
BENEFITS OF MMC SERVICES TO WOMEN

Of the respondents, 35 percent thought that they would be directly protected from HIV through MMC (33.3 percent for Kampala and 36.1 percent for Kapchorwa). Respondents gave reasons why they thought so:

“MMC prevents cheating because it reduces sexual urge.”

“MMC provides good hygiene; it is traditionally allowed.”

“It leads to no HIV infection.”



Of the respondents, 50 percent thought that MMC is changing ideas about HIV risk. Respondents cited reasons that included that MMC is safe (26.7 percent); mass sensitization about MMC (25.0 percent); and promotion of condom use (18.1 percent). However, 17.5 percent said MMC has had no impact on HIV infection.

DECISION MAKING

Of the respondents, 65.2 percent said that women would be involved in decision making for MMC (63.3 percent for Kampala and 66.7 percent for Kapchorwa). Forty-two percent of the respondents said that women would want to be involved in decision-making because they don't like condom use. However, respondents said

some of the women do not want to be involved since they have limited capacity (8.9 percent); they are not well-informed (1.7 percent); MMC is not clear (21.1 percent); or they wanted to avoid gender-based violence (GBV) (38.3 percent).

Respondents reported that making a decision about men getting circumcised for HIV prevention depends on a number of factors: traditional leadership (28.1 percent); cultural factors (18.9 percent); man's own decision (16.7 percent); religious factors (15.9 percent); and peers (4.5 percent).

Almost one-third of the respondents said they would circumcise their infant boys if MMC were protective against HIV (33.3 percent for Kampala and 27.8 percent for Kapchorwa).

Just a quarter of respondents said they were currently using condoms with their respective partners (30.0 percent for Kampala and 22.2 percent for Kapchorwa). Only 6 percent said they were comfortable asking their male partners to use a male or female condom (13.4 percent for Kampala and 0.0 percent for Kapchorwa). Respondents perceived a number of reactions from their partners if they insisted on using a condom after MMC: suspicion that women were not being faithful and further GBV if men do not understand partial efficacy.

PERCEPTIONS AROUND MMC AND GBV

Of the respondents, 44 percent thought that GBV was a problem in their communities. Thirty-eight percent of respondents thought MMC would lead to increased GBV in their communities (23.3 percent for Kampala and 50.0 percent for Kapchorwa). Twenty-two percent of respondents said MMC would improve marital sex; 20.9 percent said it would lead to low HIV risk and low GBV; and 7.2 percent said it would bring respect for men.

PERCEPTIONS AROUND MMC AND FGM

Three in every ten (32 percent) respondents thought that FGM could protect girls from HIV infection (16.7 percent for Kampala and 44.4 percent for Kapchorwa). Thirty percent of respondents thought that promoting MMC for HIV prevention would also promote FGM by some people who may misunderstand this new prevention technology.

QUESTIONS AND ISSUES ARISING

Respondents were asked to identify what should be priorities, visions and needs for reducing women, family and community risks for HIV. Thirty-one percent of respondents indicated a need to emphasize ABC; 28.3 percent reported establishment of positive-living clubs; 10.6 percent said there is need for one to be open about sero-status; 8.6 percent indicated a need for the media to educate the community about MMC; and 1.7 percent indicated the need to circumcise male infants.

Regarding MMC, respondents had a number of questions: Is it free of charge? (18.1 percent) What are the side effects of MMC? (16.4 percent); Should HIV-positive men undergo MMC? (15.0 percent); Is MMC by force? (14.2 percent); What is the age limit for MMC? (5.8 percent); Does MMC protect women in discordant relationships?

4. DISCUSSION

MMC KNOWLEDGE LEVEL

Awareness in Kampala and Kapchorwa about MC is very high because traditionally it is a rite of passage. However, knowledge around MMC for HIV prevention is limited due to its being a new intervention that still needs to be appreciated by communities.

Survey participants pointed out some of the most common communication messages about MMC. These include “MMC reduces HIV infection” and “MMC is safe and clean”. Groups promoting MMC have used different ways to disseminate information. Counselors have been equipped with full information on MMC to pass on to people, especially those who come for their services. The media has been used to air MMC issues. Through the media, peers and the general community have been able to access information about MMC, which has been given out to other peers and friends in the process.

Awareness of MMC is now increasing through outside advertisements (use of billboards) with messages urging the community to reduce HIV through MMC and addressing some hygiene and safety concerns. At the same time, brochures have been produced informing the public about MMC. Information, education and communication material on MMC is available but does not include messaging around women’s safety and MMC.

The majority of respondents pointed out that MMC is advantageous. However, there are still concerns that it could increase infection in both men and women and supposedly damage veins around the penis. It is likely that the introduction of MMC will be supported in most communities, possibly due to sexually active couples’ not enjoying condom use.

According to the respondents, ABC for the sexually active partners, PMTCT for children and testing before getting involved in sexual intercourse are the primary HIV prevention services available almost in the whole of Uganda. There is need for continuous promotion of these services and in particular the need to promote correct and consistent use of condoms alongside MMC sensitization.

Women hold different perceptions and myths about MMC as far as HIV prevention is concerned. There is a belief that MMC will protect women from HIV simply because men will no longer cheat. It is therefore important to address these myths and bring facts about MMC with evidence-based information to our communities.

GENDER-BASED VIOLENCE

Although women want to be involved in decision-making surrounding their husbands’ MMC, not all are involved in the process. This is because some women have limited capacity to influence their spouse; others are not informed of their rights; others are unsure about MMC; and others fear that their involvement could instigate GBV. In the process of getting involved in sexual decision-making, women have been frustrated and emotionally and physically hurt.

GBV cannot be ignored if MMC is to succeed in Uganda. The success of MMC among men will depend on the kind of relationship existing within couples and on whether MMC is rolled out with sensitivity to women’s safety

issues, such as abstinence before wound-healing and men's avoidance of increased risk behavior. Although the majority of community members foresee a positive impact in their communities, a few members caution about a negative impact.

FEMALE GENITAL MUTILATION (FGM)

There is a dangerous confusion around MMC and FGM, especially in Kapchorwa district. The Government of Uganda has outlawed FGM, but it is secretly done at night among some rural communities of Kapchorwa. **Respondents said that promotion of MMC is likely to increase FGM.** Community members still lack a clear understanding of the ultimate purpose of MMC and therefore think, **"FGM is for female as MMC is to male" as far as HIV prevention is concerned.** Male and female circumcision are both cultural practices, so the feeling of the respondents was that promoting one would imply approval of the other. The respondents felt that there is need for HIV prevention approaches that are directly linked to and benefit women, not merely looking at strategies where women's health is dependent on men. In other words, MMC is thought to be a "new" justification for FGM.

OUTSTANDING QUESTIONS AND RESEARCH

Other issues that need clarification before MMC is fully implemented include the age limit for MMC, side effects, the costs involved, and whether an HIV-positive man can benefit from MMC and reduce the risk of passing infections to his female sexual partners.

5. CONCLUSION AND RECOMMENDATIONS

From the documentation, it is clear that women are aware of traditional/religious male circumcision but have little knowledge of MMC and its benefits to them. On the same note, women are not empowered in decision-making around MMC—with either their spouses or their infants. Policy makers should consider the social and gender implications of MMC in the community, if it is to be appreciated and beneficial to both men and women.

MMC acceptability and use in communities revolves around promotion, advocacy and sensitization efforts undertaken by the government, implementers and advocates.

- Government and advocates must provide increased sensitization of women, with enough clear information about MMC before the community is prepared for its uptake.
- Government, advocates and community leaders need to address the myths and bring facts about MMC with evidence-based information to communities.
- Government and implementers must develop an MMC package that will integrate sexual and reproductive health with gender equity and empower women to get involved in decision-making, especially on condom use.
- Implementers must impart knowledge and skills in decision-making regarding the circumcision of their male infants.

- Community advocates should be involved in mass campaigns and sensitization about MMC as a method of HIV prevention and its benefits and challenges for women.
- Implementers and advocates must emphasize MMC as a complementary HIV prevention method rather than a stand-alone method.
- The media should give out clear and correct messages about MMC.
- All MMC outreach materials and messaging should dispel the myth that MMC is equated with FGM for HIV prevention.
- Civil society organizations should agitate for dialogue sessions with opinion leaders of communities who are practicing FGM, for consideration of eliminating the practice.

NEXT STEPS

- Report launch: *Making Medical Male Circumcision Work for Women in Uganda*.
- Link with HEPS-Uganda to inform and mobilize civil society around MMC.
- Develop messaging materials for communities and media.
- Liaise with Ministry of Health and UNAIDS to help guide MMC implementation.
- Work with health service providers at the district level, to ensure the monitoring of MMC's impact on women is in place.
- Investigate Female Genital Mutilation/MMC conflation.
- Work with cultural leaders to change traditional attitudes toward the role of women in promoting safe male circumcision.

UGANDA SURVEY RESULTS

	Uganda
Total interviews	66
Have heard about MMC for HIV prevention	98.5%
Have heard about MMC via billboards and radio	47%
There are advantages of MMC for HIV prevention	54%
Are aware that ...	
there is a need for condom use after MMC	71%
MMC does not provide 100% protection from HIV risk	36%
men need to abstain from sex for six weeks after MMC	67%
MMC for HIV prevention can be introduced into community	71%
Men would get circumcised	79%
Would support MMC in community	62%
MMC protects women from HIV	35%
MMC is changing ideas about HIV risk	50%
Women talk about MMC for HIV prevention with their sexual partners	42%
Women are involved in decision-making around men getting circumcised for HIV prevention	65%
Women want to be involved in this decision	42%
Would circumcise own infant boy	30%
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	0%
comfortable	3%
fairly comfortable	3%
sometimes comfortable	35%
not at all comfortable	46%
Use condoms with partner(s) now	26%
Gender-based violence is a problem in community	44%
MMC for HIV prevention would impact gender-based violence in community	38%
Female genital mutilation could protect girls from HIV infection	32%
Promoting MMC may promote FGM among girls and women in community	30%

AVAC

www.avac.org

ATHENA Network

www.athenanetwork.org

AIDS Legal Network

www.aln.org.za

Health Rights Action Group

www.hag.or.ug

Mama's Club

clubmamas@yahoo.co.uk

Namibia Women's Health Network

www.nwhn.wordpress.com

Swaziland for Positive Living

www.swapol.net

Women Fighting AIDS in Kenya

www.wofak.or.ke



SWAPOL member interviewing a women in Sigwe.