AN ANALYSIS INTO THE FACTORS MILITATING AGAINST EFFECTIVE UPTAKE OF MALE CIRCUMCISION AMONG THE 15-35 YEARS AGE GROUP IN GWERU DISTRICT

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A DISSERTATION SUBMITTED TO THE DEPARTMENT OF SOCIAL WORK, BINDURA UNIVERSITY OF SCIENCE EDUCATION IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE BACHELOR OF SOCIAL WORK HONOURS DEGREE.

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DECLARATION

I, Lyndon V Nyika, hereby declare that the work herein presented is my own research which was conducted under the supervision of Dr Nyoni at Bindura University of Science Education. Except the works of other people which have been duly acknowledged, this research has never been presented to the university or anywhere else for a degree.

Signed…… Date……

Lyndon V Nyika

(Student)

This work has been submitted for examination with my approval in partial fulfilment of Bachelor of Science Honours Degree in Social Work.

Signed…….. Date……..

Dr Nyoni

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APPROVAL FORM

Bindura University of Science Education

The undersigned certify that they have supervised the student, Lyndon V Nyika's dissertation entailed**:** An analysis into factors militating against effective uptake of male medical circumcision among the 15-35 years age group in Gweru District , submitted in partial fulfilment of the requirements of a Bachelor of Science Honours Degree in Social Work.

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CHAIRPERSON **DATE**

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EXTERNAL EXAMINER **DATE**

RELEASE FORM

TITLE OF PROJECT An analysis of the factors militating against the active uptake of male circumcision among the 15-35 age group in Gweru District.

PROGRAMME Bachelor of Science Honours Degree in Social Work

YEAR GRANTED 2015

Permission is hereby granted to the Bindura University

SIGNED **……....**

PERMANENT ADDRESS W520 Amaveni Kwekwe

DATE ……

DEDICATION

I dedicate this study to my Mother Mrs D Chiridza, my siblings Shingirai, Tendai, Sourjon, Tashinga and my love Emilia Samanga. I would not have done it without them and for that I am forever grateful.

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ABSTRACT

The study sought to investigate the factors that militate against the active uptake of male circumcision among the 15-35 age group in Gweru district. The target population were male clients in the district. The study sought to explore the barriers, myths and misconceptions that inhibit men from accessing male circumcision services. The research used employed phenomenology research design in collecting the data. Focus group discussions were conducted at Thornhill Airbase and Gweru CBD.50 male clients were interviewed in the in-depth interviews and three key informants were also interviewed because they had knowledge about the subject. The data was collected up to a point of saturation from the whole population. The study showed the factors that impede men from undertaking male circumcision included; fear of pain, stigma and discrimination attached to the procedure, the disposal of the foreskin of the foreskin and culture. The study recommends that alternative circumcision methods be like Prepex be employed and, awareness campaigns to dispel myths and misconceptions be done, spousal, parent-child communication and intra-family communication on VMMC were suggested as a way of encouraging men to take up circumcision.

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ACRONYMS

AIDS- Acquired Immune Deficiency Syndrome

FGDs- Focus Group Discussions

HIV – Human Immune Virus

IDIs- In depth interviews

KIs – Key Informants

MC- Male Circumcision

PSI- Population Services International

RCT- Randomised Controlled Trials

VMMC- Voluntary Medical Male Circumcision

CHAPTER ONE

1.0 Introduction

This research study sought to analyze the factors militating against effective uptake of male medical circumcision among the 15-35 years age group in the Gweru District of Midlands Province of Zimbabwe. The background to the study, statement of the problem, purpose of the study, objectives of the study and research questions, assumptions and limitations are explored in this chapter.

1.1 Background to the Problem

Zimbabwe has recorded a very low uptake of the voluntary medical male circumcision (VMMC) and the country is failing to meet targets set every year, according to the Ministry of Health and Child Care (2013). For some people, circumcision is a religious ritual and to others it can be a matter of family tradition, personal hygiene or preventive healthcare. To others, circumcision amounts to causing bodily harm.

Commented [ln1]: What was the target

The coordinator of Population Services International (PSI) Zimbabwe, was recently on record confirming that the country could save up to about $2,3 billion channeled towards HIV and Aids-related complications if the circumcision process is properly rolled out. The Population Services International (PSI), has also on its record, 18 000 Midlands province men targeted for male medical circumcision this year alone, in a bid to reduce HIV infections. Male circumcision has been a major topic around the world given the benefits unearthed by researchers. According to Sidibe, (2012) three random controlled trials have consistently shown that male circumcision is 60 percent effective in reducing HIV incidence. The trials were done at Orange Farm in South Africa (semi-urban) Rakai, Uganda (rural) and Kisumu, Kenya (urban). World Health Organisation (WHO) and

UNAIDS guidelines recommend male circumcision for HIV prevention in generalized epidemic settings where HIV prevalence is high and circumcision is low. However, AVERT, (2013) noted that while discussion has centered on the potential 60 percent protection of males against HIV, it has spectacularly failed to articulate how females can also benefit from the circumcision of their counterparts. Population Services International is on record as saying that women derive numerous benefits from male circumcision.

According to Kreiger, (2012) several studies have indicated that male circumcision reduces the incidence of Sexually Transmitted Infections (STIs) such as syphilis, Chancroid, Herpes Simplex Virus 2 (HSV-2), Genital Ulcer Disease (GUD) among men, and bacterial vaginosis, trichomonias and bacterial vaginosis in their female partners. In addition, Earp, (2012) posits that male circumcision is said to eliminate the occurrence of posthitis, phimos and paraphimosis. It also reduces the chances of occurrence of urinary tract infections in infants, balanitis, penile cancer and cervical cancer among female partners. In sub-Saharan Africa the geographical regions where men are more commonly circumcised overlap with areas of lower HIV prevalence. Although other risk factors for heterosexual HIV transmission are similar in sub-Saharan African countries with high levels of Male Circumcision (more than 80%), generally have HIV prevalence levels well below those of countries where circumcision is less common (less than 20%).

In addition to the observational evidence, there is now compelling evidence from research trials that male circumcision is efficacious in reducing sexual transmission of HIV from women to men. WHO,(2012) argued that three randomized controlled trials (RCT) have conclusively demonstrated that circumcised men have a significantly lower risk of becoming infected with HIV.

The results of studies in South Africa, Kenya and Uganda have proved convincingly that male circumcision can reduce sexual transmission of HIV by around 60%.Pinto (2012) asserts that the conclusions from the studies have led to the official adoption of male circumcision by the WHO and UNAIDS as an additional intervention in HIV prevention. For countries with high prevalence and low levels of male circumcision, WHO and UNAIDS recommended to make male circumcision services widely available.

Zimbabwe is experiencing a severe, generalized heterosexually driven HIV epidemic. Within the Zimbabwe National Strategic plan 2010-2015, several HIV prevention strategies have been adopted. USAID, (2009) noted that the focus is on promoting safer sexual behavior as outlined in the National Behavioral Change Strategy (NBCS) and on a package of health sector interventions such as prevention of mother to child transmission of HIV (PMTCT), HIT testing and Counseling (HTC), blood safety and others as outlined in Zimbabwe's Health Sector HIV prevalence has declined significantly over the past decade from 29, 3% (1998) to 15, 6% (2007) according to the National HIV and AIDS Estimates.

The decline was attributed to a combination of mortality and behavior change, particularly reduction in partners and high levels of condom use with casual partners. WHO,(2005) Despite these reductions in risk, heterosexual transmission of HIV remains the main driver of HIV transmissions. Therefore additional changes and new strategies are required to further reduce HIV incidence, hence the choice of this research topic.

1.2 Statement of the Problem

Statistics in Gweru district have revealed that from September 2014 to date the majority of clients for MC were drawn from 9-14 years. This group is largely sexually inactive and yet the target group is the 15-35. Factors that inhibit clients of the target group to access the service have not been explored. Observation has indicated that there are some factors militating against effective uptake of male circumcision among the 15-35 years age group, necessitating the need for case studying Gweru District of the Midlands of Zimbabwe to establish the facts on that phenomenon. The researcher will identify factors which lead to the resistance and the fight against effective uptake of medical male circumcision among the 15-35 years age group. No known research has been done to explore militating against effective uptake of male circumcision among the 15-35 years age group. This study seeks to fill the gaps.

1.3 AIM

The study sought to identify the factors that inhibit male clients to acquire male circumcision especially those in Gweru District.

1.4 Objectives

The objectives of this study were to:

1. Examine factors inhibiting clients of the primary target to come for male medical circumcision
2. To identify the characteristics of the clients who come for male circumcision paying particular attention on their interests.
3. To identify ways through which the numbers for the primary target can be scaled up.

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1.5 Research Questions

In order to address the problem the following research questions were used:

1. What factors inhibit clients of the primary target to come for male medical circumcision?

2. What are the characteristics of the clients who come for male circumcision paying particular attention on their interests?
3. What measures can be put in place to increase the numbers of clients from the primary target?

1.6 Justification of the Study

The research would provide information on the interests of male clients who go for MC and also reveal their characteristics. The research would also unearth some of the reasons that are preventing men from going for MC paying particular attention to those on the primary target. The research would also be used to focus on the numbers and get people's opinions through the use of a in-depth interviews, focus group discussions and key informant interviews. This would then lead to the origination of some strategies which can be adopted to increase the uptake of the services. The research would also be used to assess the impact of the low uptake of the MC services by men reaching ages with the highest incidence of new HIV infections on the HIV prevalence in the district. The study would also be used to explore the myth and misconceptions that are hindering men from being circumcised. The findings from the research would be used to generalize the factors to other districts around the province and other provinces as well. The study also would be useful to explore the interests of the majority of those under the target group to go for MC. In addition the research is essential in gathering facts that can be used to scale-up male circumcision activities towards achieving country targets as well as the 80 percent coverage.

1.7 Significance of the Study

The study would benefit the academics who want to study in the area of public health and add in the existing literature. It also assists students to get research information on the effects and impact of undertaking male medical circumcision on the minimization of the spread of HIV and AIDS in Zimbabwe. The research would provide information on the interests of male clients who go for

MC and also reveal their characteristics, which would incidentally unearth some of the reasons that are preventing men from going for MC paying particular on those on the primary target. The research would also be used to explore the factors militating against active uptake of male circumcision using in-depth interviews, focus group discussions and key informant interviews. This would then lead to the invention of some strategies which can be adopted to increase the uptake of the services. The research would also be used to assess the impact of the low uptake of the MC services by men reaching ages with the highest incidence of new HIV infections on the HIV prevalence in the district.

1.8 Assumptions

- It is assumed that the researcher will get positive response from the interviewees.
- That the research participants will be available
- It is assumed that the respondents will answer truthfully

1.9 Study Limitations

The project data was solely from Gweru District of the Midlands Province, due to paucity of data and scarcity of resources, the student could not acquire data pertaining to factors militating against effective uptake of male medical circumcision among the 15-35 years age group, elsewhere, from other provinces in Zimbabwe.

1.10 Summary

This chapter highlighted: background to the study, statement of the problem, purpose of the study, objectives of the study and research questions, assumptions and limitations. The next chapter, reviews related literature.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Literature review is generally known as the existing knowledge that is given by what others have already published before. Gunter (2010) asserts that literature review is the analysis and evaluation of available material regarding a topic on area inside a firm time period. Another author, Mounton (2011) observed that the purpose of releasing literature is to determine and learn what the chief current or new assumptions around the topic say. Henceforth it is important to revise existing literature to see the gaps that were left from the previous authors.

This chapter, presents a comprehensive review of previous research done and published by other scholars on the factors militating against effective uptake of male medical circumcision. The theoretical framework guiding this research was presented. The chapter also included area of investigation, Risk factor for HIV acquisition, Traditional Practice of Male Medical Circumcision, Knowledge Gaps are established.

2.1 THEORETICAL FRAMEWORK

This research is guided by the Social cognitive theory.

Social Cognitive Theory

It is based on the premise that behaviors, environmental influences, and beliefs are highly interactive and dependent (Kalichman, 2012). The framework identifies three main sources of

influence on people's attitudes which are perceptions, intentions to act and their ability to carry out their intentions. Bandura, (2010) noted that these are personal determinats: behavior and environmental factors. Social cognitive theory is centered on the idea that self-efficacy, self-motivation and knowledge, as well as having the required skills to implement a behavior change will lead to action. While SCT has rational cognitive decision-making at the centre of understanding behavior change, it also provides a framework for consideration of the broader context, including the social, cultural and historical constructs in which individuals find themselves making choices. SCT as a framework for understanding attitudes and perceptions in the context of healthcare has been criticized for its focus on individual cognitive rational decision making as a basis for behavior. This is especially the case for many HIV risk reduction interventions that require consistent choices, even in the face of unanticipated sexual encounters for example condom use where rational cognitive decision making and intentions are often not key determinants of behavior (Kelly 2010). Ogden, (2010) argued that other theories of reasoned action have been similarly criticized on conceptual and theoretical grounds, but have been successfully defended based on theoretical grounds. In terms of the present study, SCT provides a useful framework for exploring those factors driving or inhibiting the uptake of VMMC for adolescents, particularly through understanding the influence of individual factors and the community in which they live, including social cultural and environmental factors. The theory is relevant in factoring out reasons that inhibit men to be circumcised. The decision to be circumcised is influenced by the perceptions and attitudes of the individual, interpersonal influences and broader community and societal norms. Thus the perceptions and attitudes expressed by participants may not necessarily indicate personal experiences of the procedure, but certainly an indication of factors that may influence their decision of their peers to be circumcised at some point in the future.

2.2 Identify factors inhibiting clients of the primary target to come for male medical circumcision

Individual-level barriers were found to include fears of the procedure itself and the pain (including post-operative) associated with circumcision, and a low perception of HIV risk. According to Lukobo and Bailey (2010) social barriers included stigma associated with HIV testing, pressures to engage in sex during the healing process and family disapproval of the procedure. In the Zimbabwean context there is also evidence of male clients of the target group who are afraid of acquiring the service because of pain and the waiting period after the procedure. Mavhu et al, (2011) noted that individual fears about the VMMC procedure were identified as a prominent barrier to undergoing circumcision. From the findings it can be noted that the reasons for not getting circumcised can be the same locally and regionally. The thrust of this study is to discover factors inhibiting men in Gweru district. Scott, (2005) argues that some of those who were circumcised reported adverse events such as bleeding, stitches coming out and excessive pain, especially during erections. This has also been the case in Zimbabwe where there has been a lot of misconceptions pertaining adverse events. Mavhu et al. (2011) postulates that whilst the majority of participants were well informed about the extent to which circumcision reduces risk and increase sexual health, some pointed out there is still a problem with misinformation. So the lack of information may probably be the factor militating against male circumcision which will be unearthed. Hatzold, (2014) homologates that the barriers and facilitators influencing the uptake of VMMC presented here given an indication of the knowledge, knowledge, attitudes and perceptions of adolescents within this context together with their peers, partners and family, as well as other societal mediating factors such as the influence of cultural norms, gender relations and issues regarding masculinity.

Chigondo (2014) noted that historically, male circumcision has been associated with religious practice and ethnic identity. She further argued that among the ancient Egyptians circumcision was a sign of fertility and godly sacrifice. Against this background it has been difficult to convince men to go for male circumcision. Chigondo (2014) postulated that some Christian churches in South Africa oppose the practice, viewing it as a pagan ritual, while others, including the Nomiya church in Kenya, require circumcision for membership. Considering that most of the population in Zimbabwe is Christian it is very difficult to convince male clients who have the same beliefs.

Moyo, Mhloyi, Chevo and Rusinga (2015) posits that the derogatory language used to refer to a circumcised penis was noted as another factor contributing to men's negative attitudes towards circumcision. Respondents reported that they were not comfortable with the nouns that emphasize the unnecessary exposure of the penis. Such nouns they noted, include *shondo, shorira, mugarandakamenya and nzvonyo.* Moyo et al (2015) noted that the aforementioned nouns in a way suggest the circumcised man's sexual aggression and high libido. They further noted that others would refer to the circumcised penis as *mubviswadhuku, '*the unveiled', a term which further suggests a disgraceful exposure of the penis. From this findings there is need to educate those carrying out demand creation to desist from using derogatory terms and discourage there use to motivate clients. Chigondo (2014) noted that there was stigma attached to male circumcision, one circumcised men stated that soon after being circumcised some men wanted to see his reproductive organ and they called him all sorts of names. Chigondo (2014) concluded that such stigma can potentially reduce demand for male circumcision.

2.3 To identify ways through which the numbers for the primary target can be scaled up.

The joint report from AVAC, National Empowerment of People living with HIV/AIDS in Kenya, Sonke Gender Justice Network and Uganda Network of AIDS Service Organisation (2013) outlined ways through which Male Circumcision Can be scaled up. For MC to be scaled up there is need for the leaders to be committed, they should provide, vocal, visible and consistent support. The regional leadership also has to be committed by embracing the goal of 80% coverage in priority countries as soon as possible and promote accountability. These bodies include the South African Development Community, the East African Community and the African Union. The report argues that in order for MC to gain impetus VMMC should become visible and should be promoted through global forum as the 2012 international AIDS conference, periodic reviews of progress by the UN. The civil society in priority countries also have a role in scaling up VMMC. However, leaders in many countries have showed little or no commitment in the scaling up of VMMC in priority countries. Africa has been engaged in conflict for the past decade, so the regional bodies have been confined to conflict resolution at the expense of promoting health for example scaling up VMMC. In addition the civil society in many African countries are not given the autonomy to perfom their duties as they wish to.

The other way that VMMC can be scaled is through country implementation. According to the report from AVAC, National Empowerment of People living with HIV/AIDS in Kenya, Sonke Gender Justice Network and Uganda Network of AIDS Service Organization (2013), all the priority countries is supposed to have a timeline driven operational plan for VMMC scale up. The plan is essential in sourcing funds, mobilize resources and to align activities with regional and international activities. Brooks et al (2010) argued that It is a country's mandate to establish and publicize the annual targets for VMMC; the targets should set in line with meeting the 80 per cent coverage. According to the report diverse, adaptable delivery strategies should be pursued reaching

the international target. The priority countries should adopt a comprehensive policy framework to accelerate progress reaching the percent coverage. These policies should provide for task shifting and task sharing, infection control and waste management and strategic configuration of clinic states and surgical teams to promote efficiency. There has not any development with regards to this strategies for example in Zimbabwe there is no policy which seeks to promote VMMC scaling up. In the light of these and other challenges this research will help technocrats to come up with policies that seek to promote the scaling up of VMMC.

There is also need to intensify demand creation activities in order for priority countries to reach the 80 percent coverage. According to the report from AVAC, National Empowerment of People living with HIV/AIDS in Kenya, Sonke Gender Justice Network and Uganda Network of AIDS Service Organization national governments (2013), critical sites, community leaders, instituitional agencies and donours should join forces in the formulation and implementation of operational research to inform demand creation activities. The report argued that such research should investigate the reasons why men come or do not come for VMMC. In addition there should be a budget that is adequate and it should be regarded as an important component. Furthermore, demand generation should focus on reaching key stakeholders that includes men in their 20s and 30s, women and girls and community leaders, these groups should be engaged as partners in communication and education.

2.4 To identify the characteristics of the clients who come for male circumcision paying particular attention on their interests.

Several studies conducted in the sub-Saharan region highlight the fact that even though personal hygiene and protection from STIs/HIV are major reasons for accepting VMMC sexual reasons may play an influential role in acceptability of the procedure. Westercamp and Bailey (2010)

observed that How circumcision is perceived to influence sexual drive, sexual performance, and sexual pleasure for the man himself or for his partners is likely to influence decision making around MC. According to Westercamp and Bailey (2006), most studies assessed three factors associated with sexual activity based on circumcision status (i.e. circumcised or uncircumcised), namely sexual performance, sexual pleasure for men and sexual pleasure for women and found these factors to be a significant reason for circumcision preference both by men and women.

A study in South Africa by Scott et al. (2010) found that sexual reasons for circumcising may be more influential than other reasons, noting that men were 8 times more likely to accept male circumcision if they believed that circumcised men enjoyed sex more, and 6 times more likely to accept circumcision if they believed women enjoyed sex more with circumcised men. The South African study also found that older men were more likely to be motivated to circumcise in order to give a woman sexual pleasure. A study in rural Uganda by Wilcken, Miiro-Nakayima, Hizaamu, Keli, and Balaba-Byansi (2010) found that enhanced sexual pleasure was considered a reason to get circumcised significantly more often by uncircumcised than circumcised men (18.9% versus 2.4%). Further, men considered enhanced sexual pleasure twice as often a reason to circumcise than females (4.8% versus 9.2%). In one study (Mattson et al., 2005) in neighbouring Kenya, acceptability was at 60% among men and 68% among women.

Further, in the same study Mattson and colleagues concluded that the strongest predictor of circumcision preference among men and women even after controlling for education employment, beliefs about circumcision status and disease, was related to the perception that women enjoy sex more with circumcised men because they have more feeling in their penises, enjoy sex more, and confer more pleasure to their partners (2005). In another study (Obure, Nyambedha, Oindo, & Kodero, 2010) in Kenya among non-circumcising Luos, a contrary view was that a circumcised

penis loses sensitivity which was perceived as a good thing because it prolonged sex before ejaculation, thus rendering greater satisfaction to women. Circumcised men are perceived by both men and women as having the ability to sustain sexual activity, giving more satisfaction to their female partners.

Plotkin, Kuver, Curran, Mziray, Prince, and Mahler, (2011) found somewhat mixed results with perceptions varying in the same non-circumcising region of Iringa region of Tanzania, both among men and women. Half the women in the study felt that sex with an uncircumcised man is painful during sex (what they referred to as "pinching"), and hence the preference for a circumcised man. Some men in the study thought that the procedure would reduce sexual sensation while, others thought such men climaxed earlier and yet still others felt that circumcised men took longer to climax which they thought was good for the woman. In Malawi, men and women also perceived a circumcised man as having less penile sensitivity and taking longer to ejaculate, and deriving more pleasure for himself and for his partner (Ngalande et al., 2011).

2.5 Traditional Practice of Male Medical Circumcision

In Zimbabwe, circumcision is traditionally practiced in only a few small populations such as the Tonga and is reportedly rare among the dominant Shona ethnic group. In one research project performed in Zimbabwe, as part of a larger survey of men interviewed at Harare beer halls in April–August of 2000, the researchers included measures on self-reported prevalence of circumcision, knowledge of health benefits or risks associated with circumcision, and willingness to undergo adult circumcision. Studies have shown that 62% of adult males in Africa are circumcised (Drain et al, 2011). He noted that virtually all Muslim adult males are circumcised there are a few minority Christian and animist groups that observe the practice for example Nomiya Church. According to Bailey (2010) in east and southern Africa there is a portion of mainly Bantu-

speaking groups that do not traditionally practice MC, and these areas are those with the highest HIV prevalence. Evidence suggest that all Bantu speaking groups practiced MC as a rite of passage to manhood, but at various points over the last three hudred years the practice dropped by some, mainly lacustrine, Bantu (Caldwell and Caldwell 2010). In Kenya, almost all ethnic groups traditionally practice MC. Those that do not include some peoples spilling over the Ugandan border for example Teso and Chapadola and Turkana and Luo. According to the KDHS (2012) HIV prevalence in Nyanza is the highest of any area of Kenya. Kisimu is the provincial capital of Nyanza and one of the three sites where RCTs of MC are underway. For many, circumcision is part of a prolonged ritual involving many others in the family and community, and the procedure is performed in public by a traditional surgeon who has no formal training (Bailey 2010). Under these conditions, the procedure is often painful- indeed it is an essential part of the ceremony that the boy experience pain in order to become a man. For others, circumcision is done privately by a medical doctor in a clinical setting with minimal recognition by others and pain is minimized. Mayatula and Mavundla (2013) noted that others undergo procedure in a clinic, but participate in all other ceremonial rites.

Accounts of serious complications or adverse events after adolescent and adult circumcision in traditional settings in African are legion. Bailey (2010) posit that every circumcision season there are articles in national and local newspapers depicting in words and pictures cases of advanced infection, severe loss of blood, mutilation, and even deaths due to events attributable to MC. This shows that traditional MC is not safe as compared to the clinical procedure. In interviews with clinicians who have practiced in Uganda, Kenya, Tanzania, Zimbabwe, Malawi and South Africa, every person interviewed had at least one personal experience with a case of a youth coming to hospital with advanced infection, hemorrhage, lacerations, meatal ulcers and stenosis, necrosis and

even amputation. Kapila and Williams (2013) postulates that MC is relatively simple and safe procedure when perfomed in a clinical setting under antiseptic conditions by trained professionals. Bailey (2010) noted that the incidence of complications after clinical circumcision is unknown because they are overlooked or underreported. Bleeding is the most frequent complication and is seen in less than 0.1% of infant circumcisions. Infection is the second common complication, but these cases are often very minor and generally result in local redness or inflammation.

2.6 CASE STUDIES

Auvert, B. et al (2011) reports that in the mid-2000s, male circumcision was found to reduce the female-to-male sexual transmission of HIV by 60 percent. As a result, since 2007, the World Health Organisation (WHO) and UNAIDS have recommended voluntary medical male circumcision (VMMC) as a key component of HIV prevention in countries with high HIV prevalence and low levels of male circumcision. Stover, (2011) argues that to date, 14 countries in Southern and Eastern Africa have initiated programmes to expand the provision of male circumcision in Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland and Tanzania, WHO (2012).WHO recommendations for the implementation of VMMC for HIV prevention.

PLOS Collections (2014) asserts that a massive public health intervention launched in 2009, called for 80 percent coverage of male circumcision by 2016 (20.8 million). It was estimated that performing this number of circumcisions would cost $1.5 billion but would lead to savings of $16.5 billion by 2025 due to averted treatment and care costs. It is thought that 80 percent VMMC coverage would prevent up to 3.4 million new HIV infections, WHO (2012).

WHO and UNAIDS recommend VMMC programmes in countries where it will have the greatest public health benefit. These include countries with a high HIV prevalence among the general population (over 15 percent) and where the vast majority of men are not circumcised (80 percent). VMMC is also recommended in countries where HIV prevalence is between 3 and 15 percent among the general population where HIV transmission occurs primarily via heterosexual transmission, (WHO &UNAIDS 2010).

UNAIDS and WHO, advise that the greatest public health benefit would result from prioritizing circumcision for young males (between 12-30 years of age).

Njeuhmeli Emmanuel.et al (2014) highlighted in his studies, the benefits of prioritizing male circumcision among adolescents rather than adults, as:

- in many places, it is more acceptable both culturally and socially for adolescents to be circumcised than adults
- if performed before becoming sexually active, the benefits of VMMC are long term for both the individual and wider public health
- if VMMC occurs before an individual starts engaging in sexual relationships there are fewer concerns about sexual abstinence and it allows enough time for the wound to heal.

In 2010, UNAIDS emphasised the need to reach older men in order to achieve the 80 percent coverage target and to maximise the population-wide prevention benefits of VMMC. The circumcision of newborn babies has also been put forward as a longer-term strategy to combating the HIV epidemic. (Binagwaho, A. et al, 2010).

Njeuhmeli Emmanuel.et al (2014), further inform that it is projected that circumcising 80 percent of all uncircumcised men in countries with high HIV prevalence and low male circumcision by 2015 would avert one in 5 HIV infections by 2025 and have long-term benefits for both men and women. While VMMC programmes have grown dramatically, particularly in the last few years, it is unlikely this goal will be reached.

A number of suggestions have been made in order to accelerate and maximise the impact of VMMC, including: Red AIDS ribbon on paper bills. Kikaya, V. et al (2014) suggests promotion of VMMC as cost-effective in order to secure more funding from donors, WHO (2010) advocated allowing VMMC to be performed by nurses and other healthcare workers (task shifting).

Plotkin, M. et al (2013) observed that VMMC uptake is low among men aged over 25, then suggested that programmes need to prioritise sub-populations (e.g. by age, geography etc.) in order to maximise a programmes impact and efficiency. Sgaier, et al (2014) suggested that studies need to explore the role of technologies in order to make circumcision more attractive to men.Male circumcision is one of the oldest and most common surgical procedures worldwide. It is not only undertaken for medical reasons but also religious, cultural and social ones. (UNAIDS, 2010).

WHO & UNAIDS (2011) suggests that, male circumcision is normal practice in many communities. However, many cultures have no tradition of male circumcision, and some are strongly opposed to it. As a result, acceptance varies greatly across the world. In addition, some men will have personal reasons for rejecting circumcision, even if their culture allows it.

The WHO (2012), asserts that unlike other HIV prevention methods, male circumcision requires medical intervention. To carry out the procedure safely requires the right level of training and

resources. Poorly performed male circumcision can lead to serious bleeding and damage to the penis. Moreover, if tools are not sterilised properly before each use they can spread HIV.

Khumalo-Sakutukwa et al. (2013), concluded that, because newly circumcised men have to wait a few weeks for their wounds to heal before having sex, in the intervening period, HIV-positive men can pass HIV on to their female partners.MaleCircumcision.Org (2014), highlights that male circumcision is a one-off procedure therefore unlike antiretroviral treatment, has no on-going costs. Once a man has undergone the procedure, he will benefit from the preventive effect for the rest of his life.

Naledi et al (2011) postulates that South Africa (SA) is regarded as one of the economic powerhouses of Africa and spends about 8.6% of gross domestic product (GDP) on health. However, SA does not have the health outcomes that would be expected from such investment, and some countries that spend less of their GDP on health have better health outcomes. SA's poor showing has been attributed to the rapid escalation of HIV and AIDS and tuberculosis together with a weak primary health care (PHC) system.

2.6.1South Africa

Accourding to Njeuhmeli, E. et al (2011),in 2010, South Africa launched a nationwide VMMC programme that aimed to reach 4.3 million HIV-negative men by 2016 (80 percent coverage). By April 2011, 150,000 VMMCs had been conducted, with one new HIV infection averted for every 5 operations. More recently, the scaling up of VMMC services in South Africa has been associated with a reduction in the quality of services including the readiness of facilities and the actual quality of the surgical care provided. (Rech, D. et al, 2014). According to RHRU (2010) despite South

Africa's high levels of HIV and AIDS awareness, there continues to be an estimated 1500 new HIV infections per day. Traditionally, South Africa has relied on an ameliorative paradigm of HIV prevention, whereby emphasis was placed on behaviour change, prevention and palliative care (Butler 2010). Strategically, this stance has relied on the Abstain, Be faithful and **C**ondomise (ABC) approach as the mainstay of HIV prevention (Abdool Karim, 2012). In more recent times, South Africa has pursued a combination of structural, biomedical and behavioural approaches when dealing with the prevention and treatment of HIV and AIDS (SANAC, 2011). On the biomedical front this has included the use of ART for both treatment and prevention, male and female condoms, and most relevantly the introduction of medical male circumcision (VMMC). Colvin (2010) noted that in 2010, South Africa instituted an aggressive roll-out of a national Medical Male Circumcision (VMMC) program with the goal of reaching 80% of HIV negative men aged 15-49 (approximately 4.3 million men) by 2015. As of June 2011, almost 238 000 circumcisions had been conducted. The guidance from the UN recommends at least 5 million circumcisions would be required in South Africa as a prevention strategy to impact on new HIV infections. The South African RCT was conducted in the semi-urban area of Orange Farm; a township located within the Gauteng province. According to the Nelson Mandela/HSRC study of HIV/AIDS, HIV prevalence data gathered from women between the ages of 15 and 49 indicated that Gauteng has the highest HIV prevalence rate in the country (HSRC, 2010). Research also indicates that women are more at risk to HIV infection than men; additionally, peak levels of vulnerability differed amongst men and women.

South Africa's first programme created to translate the WHO/UNAIDS guidelines on VMMC into real life was the Bophelo Pele (Health First) project (Lissouba *et al.* 2010). The project was initiated in 2008 in the township of Orange Farm within the province of Gauteng, the same area

utilised by the preceding RCT. The project sought to determine the feasibility of VMMC implementation within low income communities characterised by low circumcision rates and high HIV prevalence. By offering free VMMC services to all male residents over the age of 15, the project could determine whether VMMC could be rolled out effectively and at scale in rural areas. Other key functions of the project involved, community mobilization and outreach, as well as communication approaches aimed at both men and women incorporating broader HIV prevention strategies and promoting sexual health (Lissouba *et al.* 2010: 1). As of November 2009, the number of men that had undergone VMMC was 14011, demonstrating an average of 740 men being circumcised per month. The study concluded that VMMC "roll-out adapted to African low-income settings is feasible and can be implemented quickly and safely according to international guidelines" (Lissouba *et al.* 2010).

UNAIDS, 2011) Furthermore, during 2010 over 130 000 medical circumcision were conducted across 143 sites, effectively validating VMMC's potential to be rolled out at scale.

2.6.1.1Cultural Considerations for VMMC in South Africa

All over the world male circumcision has its roots deep in the structure of society. Far from being a simple technical act, even when performed in medical settings, it is a practice which carries with it a whole host of social meanings (Aggleton, 2010)

The practice of circumcision within South Africa has long been viewed by various cultural groups as a momentous occasion for young boys who are marking their transition into manhood (Ewing *et al.* 2011). Historically, the initiation of young men into 'manhood' by way of circumcision has been practiced by the Tswana, Northern Sotho, Southern Sotho, Pedi, Xhosa, Ndebele and Shangaan cultures of South Africa (Ewing *et al.* 2011). The Zulu culture however, abolished the

practice of traditional circumcision in the 19th century under the rule of King Shaka Zulu (Ewing *et al.* 2011). In 2010 however, the Zulu King, his majesty Goodwill Zwelethini, was lauded for his decision to officially revive the practice of circumcision within the Zulu culture. The King's declaration was based on the preventative benefit of VMMC against HIV as evidenced in the three RCTs, and was hoped to enhance the uptake of the procedure amongst Zulu men.

In 2009, prior to the announcement by the King, only 26 358 men were medically circumcised in KwaZulu-Natal. In 2010, following the King's statement, this number increased to 70 914 and in 2011, 83 690 men decided to get medically circumcised.

(JHHESA et al. 2012)

It is important to note that there may be a difference between medical male circumcision and traditional forms of circumcision. In more traditional or ritual forms of 'circumcision', the procedure itself can in some cases entail only an incision or partial removal of the foreskin, as opposed to VMMC where the entire prepuce (foreskin) is removed. In addition to the physical act of circumcision itself, the traditional initiation process also involves passing on cultural traditions and social norms associated with the transition into manhood.

It has been argued that SA's national VMMC campaign cannot be detached from these cultural practices an argument no doubt raising an assortment of contentious issues for policymakers as well as custodians of the respective cultures alike (Ewing *et al.* 2011).

Ritual cutting of the foreskin in several cultural communities is central to the process of transition to manhood. Different rituals are described as circumcision but not all equate to the medical definition of VMMC for HIV risk reduction evidenced by the RCTs. Some practices may provide similar risk reduction to VMMC but this has not been shown and the way some ritual cutting is carried out may even heighten risk for HIV infection. (Ewing et al. 2011)

The above excerpt is taken from recently conducted research by the AIDS Foundation of South Africa's Culture and Health Programme (CHP), and provides valuable insight into some of the implications traditional circumcision may have on VMMC and risk compensation. One of the focal points driving the research was to understand how traditionally circumcised boys perceived their own risk of HIV infection subsequent to undergoing the ritual. Using focus groups, community surveys and key informant interviews, the CHP were able to assess a number of variables pertaining to risk behaviour and perceptions of traditionally circumcised boys.

2.6.2 Kenya

Kenya launched its VMMC for HIV prevention programme in 2008. It aimed to conduct 860,000 circumcisions by July 2013 (80 percent coverage). Between 2008 and 2013, the number of annual operations conducted increased dramatically from 8000 to 190,000,(UNGASS, 2014)The vast majority of these operations were conducted in Nyanza province (80 percent) where nearly half of all uncircumcised men in Kenya live. (Galbraith, et al, 2014). The Babukusu are the largest ethnic unit of the Baluyia nation, comprising 17% of the Baluyia population or about 600 000 people. Male circumcision is virtually universal among the Babukusu. Bailey (2010) highlighted that most young men are circumcised by a traditional surgeon, but increasingly families are turning to western-stlye medical practitioners for the procedure.

2.7 Knowledge Gap.

In this dissertation, various works written by various authors and scholars were looked at and comparisons, analysis and appraisals made, to come up with the knowledge gap that had to be researched on in order to make a worthwhile contribution to the current body of knowledge. None of the authors whose work was reviewed in this research, have dealt with factors militating against

effective uptake of male circumcision among the 15-35 years age group, in Gweru District of the Midlands Province of Zimbabwe

2.8 Summary

This chapter, dealt with a comprehensive review of previous research done and published by other scholars on the factors militating against effective uptake of male medical circumcision among the 15-35 years age group. The chapter also ` included area of investigation, Risk factor for HIV acquisition, Traditional Practice of Male Medical Circumcision, Knowledge Gap and summary. The next chapter, presents the methodology undertaken to understand factors militating against active uptake of circumcision.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0INTRODUCTION

This chapter presents the methodology employed to investigate factors militating against active uptake of male circumcision. This chapter discusses in detail the methodology that was used to conduct the research. The research design, population of the study, the sampling techniques, sources of data, data collection methods, research instruments and ethical considerations are discussed at length in this chapter.

3.1RESEARCH DESIGN

Research design is the master plan specifying the methods and procedures for collecting and analysing the needed information, it is the blue print for fulfilling research objectives and

answering the research questions, (Creswell 2014). Research design is a detailed outline of how an investigation will take place this include how data will be collected and what instruments will be used, (Mathew and Ross, 2010). The phenomenology design was employed in the research, it deals mainly with subjective assessment of attitudes, opinions and behaviors, (David and Sutton, 2011). Creswell, (2014) defines phenomenology as a design of inquiry coming from philosophy and psychology in which the researcher describes the lived experiences of individuals about a phenomenon as described by participants. He argues that this design has strong philosophical underpinnings and typically involves conducting interviews. Phenomenology best suits this research because it tolerates the clients' explanations on how they view the factors militating against active uptake of male circumcision.

3.2POPULATION OF THE STUDY

David and Sutton (2011) postulate that a population is basically every possible case that could be included in the study. The study examined the factors militating against the active uptake of male circumcision among the target group hence the population of study will be all male clients between the age of 15-35 in Gweru District. According to the ZDHS,(2012) the total number of males in the district is 1 745. The target group for this research were male clients in Gweru District.

3.3 SAMPLE AND SAMPLING PROCEDURES

Sample is a subset of a population (David and Sutton, 2011).Since the population was large a sample which was a representative group was drawn from the population. Sampling is the process of selecting a suitable sample for the purpose of determining characteristics or parameters of the whole population, (Fabregues, 2011). The research will use one sampling technique in selecting participants for the research, the sampling technique used was a non-probability sampling technique called the snowballing sampling technique.

Snowballing is a sociometric technique generally used to study a small group (Bharati,2011). Snowballing sampling enabled the research to identify a small group of men which in turn identified their friends who for some reasons were afraid to undergo the procedure. It is like the snowball go on increasing its size when rolling in an ice field. For instance it may be difficult to identify participants for this type of research but one person is identified he can tell the names of his friends. The sample selection is based entirely on the opinion of the researcher of who the most appropriate respondents are to be selected. It is more representative and has the ability to generalize over a large population (Bailey, 2010). Purposive sampling was used in selecting the Key Informants. Creswell,(2014) defines purposive sampling as a research in which the inquirer selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study. David and Sutton, (2011) noted that in purposive sampling units are selected according to the researcher's own knowledge and opinion about which one they think will be appropriate to the topic area. They will provide information on male circumcision and its benefits. There is no specific sample the data will be collected until the findings reach a point of saturation.

3.4 SOURCES OF DATA

This research used primary and secondary data. Cook (2011) defined primary data as the information gathered directly from the respondents and participants. The primary data was collected through the Focus Group Discussions, In Depth Interviews and key informant interviews. Secondary data is that which is found by another researcher that you then use yourself (Cook, 2011) .Qualitative secondary sources could be newspapers, and journals. This data constitutes the literature review.

3.4 RESEARCH INSTRUMENTS

Research instruments are the tools that the researcher will use to collect data from the participants, (Mill, 2013).This research employed the Focus Group Discussions, In-Depth Interviews and Key Informant Interviews guides.

3.5 DATA COLLECTION METHODS

The study will use Focus group discussions, In-Depth interviews and Key informant Interviews in collecting data.

3.5.1 FOCUS GROUP DISCUSSIONS (F.G.Ds)

According to Matthews and Ross (2010) FGDs are a form of group interviewing the group is usually small ranges from 5-13 people, it is led by the interviewer. FGDs are a qualitative data collection method which enabled the research to get an understanding on the perceptions of male clients on male circumcision and factors that hinder active uptake. The FGDs will enable the researcher to understand the views and opinions of male clients. During the FGDs the research will gather more information at once as the respondents will be gathered at one place. The research will understand and analyze concurrently the various views of male clients as they will discuss the issue together. During the FGDs male clients will freely express their views on male circumcision and everyone will have the opportunity to say out their opinions. The contribution of one member in the FGDs stimulated others to participate enabling the researcher to get more information. Kingston (2011) argues that FGDS allows the participants to actively participate and discuss lively their views on the topic. Male clients in Gweru District will express freely and will lively participate in the FGDs discussing their perceptions on factors that militate against male circumcision and sharing their ideas with others in the group. Nonetheless FGDs might be a bit

problematic since some do not actively participate because they may be afraid of being judged by their fellow colleagues in the group and their views might be manipulated by others in the group. This loop hole will be hopefully covered by the in depth interviews.

3.5.2 IN-DEPTH INTERVIEWS (I.D.Is)

In depth interviews are one on one interviews that allow participants to talk about the topic in their own way and it is a direct communication between two people, (Matthews and Ross, 2010). In depth interviews were deemed appropriate in obtaining data from male clients as the researcher will sit and discuss at length with the respondent. The participants were freely expressing their views on male circumcision. The in depth interviews enabled the participants to share their views without bias from other participants their responses will not manipulated by anyone. Unlike in FGDs where some may not actively participate in the discussion and others being influence by others, the research will be able to gather high quality information from the in depth interviews.

The in depth interviews were found to be flexible and the respondents were not influenced by others like in FGDs hence they will express their views on factors militating against active uptake of male circumcision. With the open-ended questions and the interviewer probing researcher will get to know more about the perceptions of individual male clients as they will freely express their own line of arguments. Oppenheim, (2012) noted that interviews have a higher response rate, they offer the opportunity to correct misunderstandings and to carry out observations and ratings while controlling for incompleteness and for answering sequence, and interviews can often succeed with respondents who have reading or language difficulties. But interviews are expensive and time consuming to conduct and to process, there are always the risk of interviewer bias, and interviews are usually too expensive to reach a widely dispersed sample. The research however will use the short possible time available and will use available resources but will however come up with

results that are feasible, valid and which can be generalized. Interviews will also be used to fill the loopholes left by FDGs

3.5.3 KEY INFORMANTS INTERVIEWS (KIIs)

Key informants are technical, well informed, observant, reflective members of the community of interest who know much about the culture and are both able and willing to share their knowledge (Bernard, 2012). They will provide information on male circumcision and its benefits .This one on one interviews with the experts in the medical field will enable the researcher to gather rich information on male circumcision as the participants had first-hand information. The researcher will be able to get information on male circumcision and some barriers to male circumcision from the nurses and doctors. The key informants will provide rich information for they have the knowledge that is required in the study area. The key informants may provide information that is biased and might not be a true reflection of the data available, however the research will also use information from FDGs and IDIs.

3.6ETHICAL CONSIDERATIONS

Ethics are codes of conduct guiding research; they promote proper guidance, effective treatment, accurate evaluation and fair decision making standards in research. Cresswell, (2014) notes that researchers need to protect their research participants: develop a trust with them; promote the integrity of research; guard against misconduct and impropriety that might reflect on their organizations or institutions and cope with new, challenging problems. Respondents will be debriefed at every stage of the research process. The researcher will explain the purpose of the study, the merits and demerits of participating in the research study to the respondents. The researcher will seek informed consent from the participants; informed consent means that research

subjects have the right to know what they are being researched on and the nature of the research and to know that they can withdraw at any time, (Ryen, 2012).

Participants were informed verbally about the research and it also assured them on the issue of confidentiality. As a way of ensuring confidentiality the research will not ask for students' names or any personal information. Research participants will not be coerced to continue with the research thus they had the right to withdraw at any stage of the research process.

3.7CHAPTER SUMMARY

This chapter described how the research was carried out and how data was collected. It explained the research design, sampling techniques, the population ways of obtaining data and a sample of interview questions. The methods of data collection used were explored. The next chapter presents data and discuss the research findings.

CHAPTER FOUR: PRESENTATIONAND DISCUSSION OF RESEARCH

FINDINGS

4.0 INTRODUCTION

This chapter presents empirical findings from data gathered through interviews undertaken in exploring and understanding factors militating against active uptake of male circumcision among the 15-35 age group. Based on the data gathering techniques the research questions were:

- What are the characteristics of the clients who come for male circumcision and their interests in undertaking MC?
- What factors inhibit clients of the primary target to come for male medical circumcision?
- What measures can be put in place to increase the numbers of clients from the primary target?

4.1 DEMOGRAPHIC PROFILE OF RESPONDENTS

The demographic characteristics of respondents undertaking MC were explored. The results are summarised in Table 1 below

Table 1-Demographic information

VARIABLE		FREQUENCY
EDUCATION	SECONDARY	15
	TERTIARY	28
	TOTAL	43
MARITAL STATUS	MARRIED	18

	NOT MARRIED	35
	TOTAL	53
EMPLOYMENT STATUS	EMPLOYED	8
	NOT EMPLOYED	4
	IGA	6
	TOTAL	18
KI: SEX	FEMALES	3
	TOTAL	3
AGE	25-30	1
	30-35	2
	TOTAL	3
RELIGION	CHRISTIANITY	50
	ATR	3
	TOTAL	53

50 male respondents were interviewed 10 were circumcised and 40 were not. Three key informants who were female nurse counsellors were also interviewed. The ages of the respondents ranged from 15-35 years. 15 respondents were in the 15-20 age group while, 18 were in the age range 20-25 years, 10 males were in the 25-30 age group. 2 key informants (females) were in the 25-30 years age range and 1 female key informant was in the 30-35 years, 7 males were in the 30-

35 group. The age group with the least number of respondents is the 30-35 years. 5 respondents in the 15-20 age group reported that they were circumcised 3 were in the 20-25 age range while 2 were from 30-35 age groups respectively. From the findings the uptake of male circumcision was higher in lower age groups (15-20) compared to other ages. This could be attributed to popular attitudes that male circumcision is for the young people.

Eighteen respondents said that there they were married, 2 of the respondents reported that they were circumcised and this was attributed to the influence of their spouses. This shows how married people view MC as a program that belongs to the young generation. This could be also attributed to spousal influence as some women are afraid if their husbands are circumcised they would not enjoy sex.

Eight of them were employed four were not and six are involved in income generating activities. Of the 16 only 2 were circumcised this shows that people are afraid to lose their jobs because of MC and this explains the low uptake in the target group.

Fifteen of the respondents are in secondary and twenty eight are in tertiary education. Out of 43 respondents only 8 were circumcised which clearly shows the correlation of education and MC, educated people it can be noted are the ones who spread the myths and misconceptions and are not easy to convince.

Six spouses of the respondents are employed, ten are not and two are involved in income generating activities. It was reported that of the 2 that were circumcised their wives were employed which shows that if wives are employed men can go for MC because they will be sharing the burden with their spouses. In cases where husbands are breadwinners there is a low uptake of MC because of fear of job security.

Of the fifty three, fifty were Christians and three were of the African traditional religion the key informants included. 8 Christians were circumcised using the surgical method and 2 went through the traditional method of male circumcision. The community is dominated by Christians and regardless of the myths surrounding MC and Christianity the number of Christians undergoing circumcision is considerably high.

4.2.1THE DEFINITION OF MALE CIRCUMCISION

The respondents were asked what they understood to be MC. Most of the respondents defined male circumcision as the surgical removal of the foreskin that covers the head of the penis. However some who were of the traditional perspective argued including surgical in the definition rules out those who practice for religious and traditional purposes who does not go through the surgical method. One respondent in the FDGs argued that:

"*ko zvino tikati surgical ko vaya vanoita zvekunochekera musango vasingaite zvekuenda kuchipatara toti havasi kuchechedzwa here?" (*"what about those who practice the traditional method who does not go through the surgical method can we say they are not doing male circumcision"(Respondent 32). This view would point that MC was not really a new strategy

One key informant defined MC as: "the complete removal of the foreskin that covers the penis and it is done surgically or using Prepex"

A respondent from the IDIs noted that MC "is the removal of the foreskin for HIV preventative reasons, sexual interests and culture and religion for example Johanne Marange males, Judaism. Most of the definitions were in line with scholarly definitions that male circumcision is the surgical removal of the intact foreskin of the human penis. Intact foreskin is one of the risk factors for HIV transmission from infected women to men (Wabwire-Mangen et al. 2010). It is imperative to note

that some scholars shared the same thoughts with the respondents that male circumcision is also done for religious and traditional purposes. Circumcision is undertaken worldwide for religious, cultural,and social as well as medical reasons (Government of Uganda MOH 2010)

The respondents in Gweru district exude a better understanding of male circumcision. Most of them were able to define male circumcision and outline the benefits of male circumcision to both men and women. Much of what they said was support by scholarly definition which showed that the program is being marketed in the district using different media. One respondent highlighted that "*i heard about the program on the radio when they were talking about the new method called Prepex"* the majority of the respondents either heard about the program through the radio, television and the newspaper some of them got the information from the clinic. It is clear that men in Gweru have a better understanding of the program, they is need to change attitudes as one key informant pointed out, "they know about the program however there is need to change their attitudes if they are to come in their numbers" . The respondents managed to outline the benefits of male circumcision including the four major benefits and others which were linked to sexual pleasure. They were not in consensus with the benefits of male circumcision to women, for they could not solely take the blame for causing cervical cancer. One respondent in the FGDs argued that, "men can not be blamed for the spread of cervical cancer they are other causes of cancer which does not involve men" this clearly show that for some reasons me are adamant about being circumcised. One key informant highlighted that there is great need to provide health education to the men so that they appreciate the fact that they contribute immensely to the spread of cervical cancer. The key informant noted that, "men should be taught on the causes, effects and prevention of cervical cancer and the role they play in the transmission of the disease, only then will they be able to think about male circumcision"

4.2.2 THE BENEFITS OF MALE CIRCUMCISION TO MEN

The benefits of male circumcision have been highlighted in several adverts promoting MC. Respondents were what the benefits of MC were. Most of the respondents strongly believed that Male Circumcision does come with an array of benefits which include protection from HIV/AIDS by 60 per cent, prevention from STIs and cervical cancer in women. From the FGDs, the respondents put forth that being circumcised will generally keep the private organ smart and also protects against penal cancer. Most of the respondents indicated that being circumcised actually improves sexual pleasure. The key informants noted that MC reduce the risk of urinary tract infections in childhood, reduce risk of ulcerative sexually transmitted diseases in adult hood, prevention of Balanitis and phimosis. One school going respondent highlighted that:

> "*munhu akachecheudzwa ane mikana mishoma yekutapurirwa zvirwere zvepabonde uye anenge ane mukana mushoma wekubatwa nedenda reHIV/AIDS* " ("when one is circumcised they have fewer chances of contracting STDs and they also have fewer chances of being infected with HIV/AIDS") (Respondent 17)

Furthermore one Key informant who is a nurse at the Thornhill Hospital echoed the same sentiments that: "MC prevents the contraction of STIs such as Balanitis and posthitis and it offers a 60 percent protection against HIV/AIDS" (respondent 32)

In addition another Key informant highlighted that:"Male circumcision helps improve hygiene and it prevents against phimosis which is the inability to retract the foreskin and paraphimosis which is the inability to return the retracted foreskin to its original location"(Respondent 28). Much of the benefits that were found in IDIs, FDGs and KIIs conform to several schools of thought. Randomized clinical trials, conducted in sub-Saharan Africa; Uganda; Kenya and South Africa,

showed that male circumcision protects against HIV as well as reduces the incidence of other sexually transmitted infections (STIs), including genital ulcers, human papilloma virus (HPV), and chlamydia in female partners of men.(Kibira, Nansubuga and Tumwesigye 2013). These benefits prompted WHO/UNAIDS to recommend the adoption of male circumcision as part of the comprehensive strategy to reduce heterosexually-acquired HIV infection in countries with high HIV prevalence and low levels of male circumcision.

4.2.3 THE BENEFITS TO WOMEN AND THEIR PERCEPTION

The benefits of male circumcision to women were explored; from the FGDs, IDIs and KIIs brought varying responses on the benefits of MC to women were highlighted. Most respondents agreed that Male circumcision prevents women from contracting cervical cancer which is mainly caused by Human Papyloma Virus (HPV). One participant in the IDIs highlighted that: "*kuchechecheudzwa kunodzivirira gomarara remuromo wechibereko chaamai*." (circumcision prevents the transmission of cervical cancer in women) (Respondent 23). Most respondents agreed that the virus is contracted through sexual intercourse and the major mode of transmission is an uncircumcised penis. One key informant postulated that "HPV is highly found in the foreskin and strives where there is darkness and moisture so there is greater need for men to be circumcised." (Respondent 34) Another Key informant went statistical when she said "research has shown that 4 women are dying of cervical cancer on a daily basis which shows the impact of the diseases hence men need to be circumcised"(Respondent 28). Some respondents in the FGDs also highlighted that MC is beneficial to women in that it increases sexual pleasure by prolonging the act. However they were arguments that most women are against MC in that it reduces the sensitivity of the male organ. One respondent in the FGDs echoed that " most women does not allow their husbands to be circumcised because they think that when men are circumcised they become less sensitive"

4.3 BARRIERS TO MC

The barriers to MC were highlighted and were presented as follows:

4.3.1 RELIGION

Most respondents also highlighted that religion is another impediment to the active uptake of male circumcision. Male circumcision is associated with Islam. Christians consider it to be a pagan practice. To them it is a forbidden practice hence it has militating against the uptake male circumcision in Gweru. One responded echoed that *"kuchechi kwedu isu hatibvumidzwi kuchecheudzwa hazvisi pazvinhu zvatinotenda mazviri"* (we are not are allowed to be circumcised at our it against our doctrine). (Respondent 24)

On religion it was evident that most men in Gweru district still view male circumcision from a religious perspective and cast a blind eye on the health perspective. Many men, as noted in the findings still believe that by getting circumcised they are sacrificing their beliefs for someone else's. Circumcision, many believed is for those that do it for the purpose of their religion and should not be performed in non circumcising communities. Several schools of thought argued that religion has been used as an excuse for not getting circumcised especially among the adults.

4.3.2 CULTURE

Culture is another barrier that was brought during FGDs. There are some cultures that practice male circumcision in Gweru for example the Moslems. So most respondents believed the program belongs to those that already practice the program and undergoing the procedure is equal to losing their cultural identity. One key informant confirmed that "it is difficult to convince this non circumcising community for they believe that the program is for those who already practice it and undergoing the procedure its equal to accepting some else's culture." (Responsent 32). Other respondents in the FGDs believed that Male circumcision, from time immemorial male

circumcision was done as a cultural practice. He highlighted that "*zvekuchecheudzwa zvagara zvichingoitwa nevaremba nevamwewo vanoita zvekuchecheudza kare saka ini handingatori chitendero chevamwe vanhu*" (male circumcision has been practiced by the cultural sects of the "Varemba" and others so i cannot partake in someone else's culture) (Respondent 33) .Chigondo (2014) noted that historically, male circumcision has been associated with religious practice and ethnic identity. She further argued that among the ancient Egyptians circumcision was a sign of fertility and godly sacrifice. Against this background it has been difficult to convince men to go for male circumcision. Chigondo (2014) postulated that some Christian churches in South Africa oppose the practice, viewing it as a pagan ritual, while others, including the Nomiya church in Kenya, require circumcision for membership. Considering that most of the population in Zimbabwe is Christian it is very difficult to convince male clients who have the same beliefs.

4.3.3 DEROGATORY LANGUAGE

Derogatory language was cited as one of factors that inhibit men from acquiring male circumcision services. Respondents in the FGDs noted that being circumcised comes with different names that demotivate men from going through the procedure. One respondent highlighted that:

"*kana munhu achecheudzwa mamwe mazita acho anotaurwa anonyadzisa zvekuti vazhinji vanotoregera izvozvo, unonzwa zvichinzi ane shondo*." (some of the names that are used to refer to those who are circumcised are derogatory in nature for example shona names such as shondo) (Respondent 29).

In the IDIs the issue of using derogatory language was also mentioned, many do not want to go for circumcision because the names that are used to refer to them. One respondent of the 15-19 age group reiterated that the nouns that are used when calling people who are circumcised. The

respondent noted that, "*mazita acho anoshandiswa ndiwo anonyadzisa unonzwa uchinzi une shorira kana kuti mugarandakamenywa.*" (names that are used when calling that are circumcised plays a role in the decision that one makes such nouns include shorira, *mugarandakamenywa)*(Respondent 17). The findings from the interviews and focus group discussion concurred with Moyo, Mhloyi, Chevo and Rusinga (2015)' findings who posits that the derogatory language used to refer to a circumcised penis was noted as another factor contributing to men's negative attitudes towards circumcision. Respondents reported that they were not comfortable with the nouns that emphasize the unnecessary exposure of the penis. Such nouns they noted, include *shondo, shorira, mugarandakamenya and nzvonyo.* Moyo et al (2015) noted that the aforementioned nouns in a way suggest the circumcised man's sexual aggression and high libido. They further noted that others would refer to the circumcised penis as *mubviswadhuku,* 'the unveiled', a term which further suggests a disgraceful exposure of the penis. From this findings there is need to educate those carrying out demand creation to desist from using derogatory terms and discourage there use to motivate clients. Chigondo (2014) noted that there was stigma attached to male circumcision, one circumcised men stated that soon after being circumcised some men wanted to see his reproductive organ and they called him all sorts of names. Chigondo (2014) concluded that such stigma can potentially reduce demand for male circumcision.

4.3.4 FEAR OF PAIN

Fear of pain is another barrier that was outlined by most respondents both school going and married clients. The key informants at the hospital reported that most men are afraid of pain since most of them change their minds at the hospital after they had gone group and individual counselling. One key informant echoed that "most men are afraid of pain from the anaesthetic injection, the removal of the bandage and the salting period which i think has been a barrier to male circumcision in

Gweru" (Respondent 28). One participant from the IDIs asked for the barriers to male circumcision he just said "*zvinorwadza*" (it's painful) (Respondent 15). There was consensus in FGDs that MC is a painful procedure. The issue of pain was also reported in a study that was carried out in Uganda. USAID (2010), noted that the fear of pain arose from the thinking that 'male circumcision is a major and painful surgical process, moreover on the most private bodily organ. From these findings it is imperative to provide information that is realistic about the expected amount of pain and how it can be managed. Muhangi (2010) further noted that the perceived extent of pain as reflected by some respondents seems to reflect an exaggeration of the amount of pain involved in male circumcision.

Pain is a pertinent issue that inhibit men from accessing male circumcision services for many believe that it is a painful process because it involves injections, forceps and the salt process. Men from age 15-35 were all in agreement that it is a painful, they proposed that friendly methods be initiated which probably can change their minds with regards to male circumcision. Some scholars believe that pain as a barrier is prevalent in almost all parts of the country and the region as a whole. The respondents proposed that male circumcision be provided at birth so that the pain will not be felt. The key informants confirmed that men are afraid to get circumcised especially those of the target group.

4.3.5 RECOVERY PERIOD

Another barrier which was a subject of discussion was the recovery period limiting sex life, work, and fun. Most respondents expressed great concern on the period that they have to abstain from sex. One respondent from the IDIs highlighted that "*nguva yacho yekupora ndiyo yakawandisa, mavhiki matanhatu? Unowana mukadzi aenda."* (the healing period is just too long, six weeks? You will find your gone) (Respond 35). One participant in the FGDs even noted that the wives at

times are the ones who are not comfortable with healing period citing that it is too long. He said that " *vakadzi ndivo vanotorambidza varume vavo kunochecheudzwa nekuti nguva yacho yakarebesa"* (wives in some cases are the ones who does not permit their husbands to be circumcised because of the long healing period) (Respondent 28). The key informants noted that besides limiting sex life, men are also afraid that they will not be able to go to work and have fun. The key informant stressed that: "men are afraid to access the male circumcision services because they think that they won't be able to go to work and have fun, they also feel that the healing period is long for it limits their sex life" . the findings from the study concurred with the findings from Uganda. Muhangi (2010) noted that perceptions of a long period required to heal after circumcision is another factor that was found to have implications for men's decisions to go for VMMC. One respondent from the study highlighted that during the period of healing, wives could easily engage in extramarital affairs. Muhangi (2010) postulates that the healing period was also conceptualized in terms of length of the time one may be forced to keep off work as already mentioned in the previous sub-section. So the healing period proved to be a barrier that is prevelant in the whole region however with the introduction of Prepex, issues that are work related will hopefully be addressed.

. Scholars argued that it is one of the major barrier especially among married men. During interviews men asked if it was possible to reduce the number of days as some reiterated that they cannot go for a week without sex. Some even argued that their wives forbid them to be circumcised because of the waiting period. From the findings it was made clear by most respondents that the waiting period is just too long and that it has negatively impacted on the numbers in the district.

4.3.6 HIV TESTING

Most respondents agreed that another barrier to male circumcision is that men do not want to test for HIV/AIDS. The key informants also confirmed that a large number of men do not want to be tested for HIV before they could be circumcised. One key informant highlighted that:

"*varume havadi kuongororwa ropa vasati vachecheudzwa, izvozvo zvinodzivisa varume nevakomana kuti vasachecheudzwe*" (most men does not want to be tested before they could be circumcised and this has inhibited many boys and men from being circumcised) (Respondent 32). One participant seems to agree with the key informant when he stressed that: "male circumcision is a good program but I think you should just carry out the procedure without testing people" (Respondent 27).

In the FGDs respondents noted that testing people before for they could be circumcised is a barrier since most men are not prepared to be tested. In another study that was carried out results of the same nature were also found. Moyo et al (2014) noted that compulsory HIV testing prior to VMMC was another barrier, respondents reported that the required HIV testing was a nerve- wracking experience, often imbued in fear. So because of the HIV-related stigma and discrimination result in multiple levels of fear.

4.3.7 CONSENT PROCESS

Another barrier highlighted was the issue of consent for those below the age of 18. Clients in FGDs who were below the age of consent expressed interest in going to for circumcision but because they could not sign their forms they could not do so. The issue was explicitly discussed in IDIs also as clients below the age of 18 found themselves in a position where they could not make decisions on their own. One respondent in the IDIs one respondent highlighted that:

"*ini kuchecheudzwa ndenge ndichida asi vabereki ndivo vanoramba kusigna maform vachiti unozosangana nedambudziko saka hapana zvandozokwanisawo kuita."* (i like to go for circumcision but my parents refuse to sign my consent form citing that i will encounter complications so i am left with nothing to do) (Respondent 15). In the FGDs the issue was raised among the age group 15-19 as respondents wanted to clarity on the consent process. Another respondent highlighted that :

"*hapana zvinokwanisa kuitwa here kuti tizviendere vabereki vasingazivi nekuti kazhinji kacho topedzisira tazvisignira maforms acho nekuti vabereki vanoramba*" (there anything that we can do so that we acquire the services without the knowledge of the parents because most of the times we sign our forms because the parents will not let us go) (Respondent 17).

The key informants noted that there is need to provide information to the parents about the program because when it comes to consent the clients are found wanting as they cannot sign their forms. The key informants cited the issue as a major challenge in demand creation as most parents lack information. One key informant noted that:

"The issue of signing consent forms for those below the age of consent has been a major drawback. The children want to get circumcised but the parents will not sign their forms, as a result children of this age group sign their own forms or assign friends to do it for them. Usually in these situations there are a number of adverse events since the children will be hiding their wounds from their parents" (Respondent 34). To minimize adverse there is need to provide sufficient information to the parents so that they allow their children to go for circumcision and help in managing their wounds.

In clients under the age of consent highlighted that one they are at the receiving end as they not able to go male circumcision without the consent of the parent or guardian. Many of them showed interest in the program and were willing to undergo the procedure but because they can not make decisions on their own they cant access the service. Key informants cited this as one of the challenges that they encounter when carrying out demand creation, one key informant alluded to the fact that, "most clients below the age of 18 a keen to be circumcised but because they cannot sign their consent forms they are not able to acquire the services. In most cases children end up signing their own forms or use their friends to do it for them." This usually results in adverse events as children will be hiding their condition to their parents. This has contributed negatively to the numbers in the district. In cases where there have been adverse events, it has resulted in conflicts with parents demanding their children's foreskins.

From the barriers it can be noted that there is need to provide clients with truthful information and to intensify demand creation activities in the district. There is need to convince clients that male circumcision is safe simple and smart. Clients also need to understand that male circumcision is not done for religious reasons but is also for health reasons so that the numbers in the district. Demand creation should also include parents for they play a pivotal role in allowing their children to go for male circumcision and it also minimizes conflicts. Parents need to understand the benefits of male circumcision and also some risks involved so that when they sign the forms they know what they are doing it for. The demand creation team should include a nurse counsellor so that he may explain the procedure to the client.

4.4 MYTHS AND MISCONCEPTIONS WERE HIGHLIGHTED AS BARRIERS TO MC

Myths and misconceptions about MC were highlighted which bar men from accessing male circumcision services. The key informants also reiterated some crucial misconceptions that deter

men from coming for male circumcision. In the FGDs, they argued that there is need to demystify all the myths and misconceptions if the numbers for the target group is to increase.

4.4.1 FORESKIN DISPOSAL

One factor which was discussed in the In-depth interviews, Focus group discussions and Key informants was the disposal of the foreskin. Most respondents demanded to know where there skins are put after they have been circumcised amid revelations that they are used to make relish and that they were used for satanic purposes. One key informant highlighted that:

"one of the most prevalent myth is the disposal of the foreskin, many believe that there foreskins are used for other purposes other than being incinerated for instance there is a general consensus that the foreskins are used to make "*makanyanisi*" so it is very difficult to convince people in this area to undergo male circumcision if they are not given an opportunity to see their skins being incinerated." (Respondent 34)

In the FGDs many also hold the same belief that the skins are used for other purposes, one respondent was in agreement with the key informant:

"*makanda edu kana achekwa anoiswepi? Nekuti kazhinji kazhinji tonzwa zvichinzi makanda edu anogadziriswa makanyanisi"* (where do our skins go after circumcision? Because many times we hear that they are used to produce makanyanisi) (Respondent 22).

In the IDIs similar issues were discussed but some respondents raised other petinent issues. One participant sought clarity on:

"*takambonzwa kuti pane gonyeti rakambobatwa mukawanikwa mune makanda, aiendepi*" (we have heard that there was once a truck which was caught at the border post and it was found that

it had foreskins inside, where were they going?) (Respondent 19). This is similar to what Chikutsa and Maharaj (2015) that there is a belief that there are stories that circulate in the community about foreskins that are sold at exorbitant prices and exported to South Africa.

So most respondents believed that their foreskins are used to make someone affluent. One participant in the IDIs also posed a question that, " how far true it is that the foreskins are used for satanic purposes hence making some people rich at our own expense?" (Respondent 18)

Moyo et al (2015) noted in their study that myths and misconceptions arising from cultural beliefs in withcraft negatively impacted on men's attitudes towards circumcision. Respondents in the study highlighted that they cannot leave any part of their flesh, let alone of a penis, in the hands of aliens. They alluded to the fact that they understand that some of these foreskins are being transported to Europe to flourish businesses for the white people. This has hampered the progress towards achieving the targets set in the district.

There is need to educate the people about the disposal of the foreskins and make it clear to them that it is governed by the Human Tissues act. Most men are sceptical that their skins will be used for ritual purposes and other purposes. The key informants noted that many clients want to see their foreskins being burnt only then will they accept to circumcised. They also believe that the foreskins are used for satanic purposes like acquiring wealth so there is great need to change people's attitudes with regards to male circumcision.

4.4.2AFFECTS SEXUAL PLEASURE

Another misconception was that male circumcision reduces sexual pleasure since the sensitive part (foreskin) of the penis is removed. There was general agreement however that being circumcised prolongs sex. The key informants also stressed on the issue that men in Gweru district of the target

population are afraid to access the services because they fear that the sensitive part of the penis would be removed. One key informant posits that :

"many clients are afraid to undergo male circumcision because they believe that if they are circumcised they wont be able to have a many rounds as they would want since the sensitive part of the skin will be removed" (Respondent 28)

In the FGDs it was really a burning issue as most respondents were quick to mention about it. One participant in the FGDs stressed that:

"*chinoita kuti varume vakawanda vasaende kunochecheudzwa inyaya yekuti vanotya kunobviswa kanonaka. Kunyange zvazvo zvichiita kuti bonde ritore nguva yakati rebei asi hazvisi nyore kuti izosimuka zvakare nekuti panenge pasina ganda" (*what inhibits men from undergoing MC is that they are afraid to lose the sensitive part of their organs. Although it prolongs sex it is difficult for it to erect again without the foreskin) (Respondent 23). Moyo et al (2015) postulated that stigma and humiliation came out as additional factors which contributed to men's negative attitudes towards male circumcision. Plotkin, Kuver, Curran, Mziray, Prince and Mahler (2011) in their study in Tanzania also found mixed results, some men in the study thought that the procedure would sexual sensation while, others thought such men climaxed earlier and yet still others felt that circumcised men took longer to climax which they thought was good for the woman. Ngalande et al (2012) posits that in Malawi men and women also perceived a circumcised man as having less penile sensitivity and taking longer to ejaculate and deriving more pleasure for himself and and for his partner. These findings are in contrary with Chigondo (2014) who posits that 75% of the respondents in her study confirmed that circumcised men enjoy sex more than non-circumcised men. These respondents denied that male circumcision reduces sexual pleasure and confirmed that

they are actually having more fun than before. This view concurs with findings from a study by Bailey (2010) in Kenya were it was seen that women enjoyed sex more with their circumcised men than before, and this was a strong predictor of preference to be circumcised. It can be concluded that the respondent's attitudes have to be changed because studies elsewhere has shown that male circumcision increase pleasure. Albert et al., (2011) further noted that in Uganda, respondents in a study there also perceived circumcision as increasing men's sex drive and women's pleasure, something that was viewed as an important benefit by many. Given this background it is important to dispel these misconceptions in order to increase the number of those who are circumcised in Gweru district.

4.4.3 FEAR OF DEATH

Fear of death was highlighted and most of the respondents in the FGDs agreed that Male circumcision leads to death and that many men are afraid to be circumcised. They expressed concern at the number of deaths that were recorded in neighbouring countries like South Africa that were as a result of male circumcision. The IDIs produced more or less the same myths that MC can lead to death. One respondent in the FGDs highlighted that:

"*chikonzero chinoita kuti vanhu vasaenda kunochecheudzwa ndechekuti vanototya kufa nekuti vakanzwa kuti zvinouraya sezvakamboitika kuSouth Africa"* (one reason that deter men to be circumcised is that they are afraid to die because they heard that it claimed lives in South Africa) (Respondent 26). The myth was discussed with almost all respondents in In-depth interviews they also referred to the South African deaths. One school going participant stressed that:

"*ini hangu ndichiri kuda kurarama nekuti ndakangonzwa kuti zvinouraya kana vabereki vanotondirambidza nenyaya iyoyo. Ndakangonzwawo kuti kuSouth vanhu vakafa vakawanda saka*

uuuhm ini hangu handidi" (as for myself i still want to enjoy life, because i heard that it causes death and even so my parents won't allow to go because they also heard that it can claim someone's life. I also heard that a considerable number died down south so uuhm i will not go) (Respondent 19). The key informants even confirmed that many think that male circumcision is deadly and it has really been difficult to convince them that it is simple safe and smart. The key informant highlighted:

"many men have heard through the radio and seen newspapers about the South Africans who died while going through the procedure, this has cultivated a culture of fear for they are now convinced that it can lead to death. It has also been very difficult to convince them to come for male circumcision" (Respondent 34)

They argued that there is need to convince people by providing statistics if they are any about the people who have lost their lives. Most respondents believed that in Zimbabwe they are some people who died due to male circumcision but somehow the information is not published to protect the Ministry and the implementing partners. One participant in the FGDs highlighted that:

"muno muZimbabwe vatoriko vakafa asi hazvingoburitswi chete" (here in Zimbabwe there are some who died but its only that it is not recorded and published).(Respondent 21)

Male clients need to be conscientised on issues surrounding death and male circumcision. One key informant explicitly highlighted that since the inception of the program in 2009 there is no death record to date. The key informant noted that, "since the program started in 2009 not even one death has been recorded around the country and this is the information that the clients need to be fed with" however most respondents believed that such information is not always revealed to the

public. Against this background it is imperative to avail statistics to the people periodically so that the clients are convinced that it does not result in death.

4.4.4 MC AND THE REDUCTION OF THE SIZE OF THE PENIS

All the respondents in the FGDs reported that that Male Circumcision reduces the size of the penis. They think that once one is circumcised the man hood of one is reduced and the idea is shared among all ages. They argued that they have heard people who were circumcised complaining about the sizes of their penis and this has contributed to men not acquiring the services. Most respondents strongly believed that for men to satisfy their wives sexually they should posses large and long man hood. One respondent in the FGDs echoed that:

"*vazhinji vanongoti kana wachecheudzwa nhengo yako inodzoka kuita diki nekudaro hauzogutsi amai nekudaro panove nekunetsana pakati pamai nababa mumba yemukati" (*many people say that when you are circumcised your male organ shrinks as a result you won't be able to satisfy your wife which eventually results in bedroom conflicts) (Respondent 32).

The in-depth interviews produced the same results with most respondents agreeing that when men are circumcised their man hood becomes small. A respondent from the IDIs seems to agree with many respondents when he reiterated that:

"most people say that when one is circumcised it affects the size of one's penis, it becomes small that i wont be able to enjoy sex when i get married which will probably negatively impact my marriage life" (Respondent 22)

The misconception seems to have taken root that many are refusing to undergo male circumcision that even the medical personal confirmed that many are afraid that if they are circumcised their organs shrink. One key informant highlighted that " many are sceptical of the procedure because

they believe that when one is circumcised their penis become small that they cannot function properly. It is further exacerbated by the fact that women also seems to subscribe to the notion that when men are circumcised they are bound to have small organs. So women also immensely contribute to the refusal of men to be circumcised."

The findings were supported by other studies that were carried out in Tanzania and South Africa, perceptions about loss of penile sensitivity, reduction in penis size, decreased ability to satisfy women, excessive sexual desire and increased promiscuity were documented as reasons for not wanting to be circumcised (Bailey et al., (2012), Rain-Taljaard et al., (2010). However, on the contrary a study by Population Services international/Society for Family Health Zambia (2011) found that men perceived circumcised men to enjoy better, longer sex, due to the penis becoming harder and bigger. In another study of 195 male university students in Zambia, majority of them perceived circumcised males as having a natural condom, including the perception that they had enhanced sexual performance (Sanjobo, Mbalwe and Chikungu 2010). It being a myth there is need therefore to provide truthful information on the subject in question.

It is evident from the findings that clients believe that there is a correlation between being circumcised and the size of the penis. Clients however need to be educated that there is no relationship between the two, being circumcised does not affect the size of one's penis. Many respondents think that when they are circumcised they are subject to have small organs that will not work efficiently when they are married.

The low uptake of male circumcision in Gweru district can be attributed to a number of myths and misconceptions that was alluded to in the findings. Most of the misconceptions are baseless, but

they contributed to the numbers of people who are circumcised in the district. There is great need to demystify the myths and conceptions so that the clients will come to access the services.

Those involved in demand creation need to educated people about the myths and misconceptions and provide reliable information. In order to boost numbers in the province there is great need to demystify these and other myths and misconceptions so that more clients will be keen to acquire male circumcision services. The key informants highlighted that there great need for those involved in demand generation to provide information that addresses these issues if the numbers in the district are to increase. One key informant stressed that, "the implementing partners in demand creation need to devise strategies that address these myths and misconceptions if the numbers in Gweru are to increase"

4.5 THE VIEWS OF THE RESPONDENTS ON THE NEW METHOD OF MALE CIRCUMCISION

The introduction of a new method of male circumcision (Prepex) seems to have scaled up the numbers in the province but from the IDIs, FGDs and IDIs there were mixed reactions on the issue. Most respondents in the focus groups believed that Prepex could address issues like pain and the salt process however the waiting period was still a bone of contention as most respondents felt that is even longer than the surgical one. One respondent in the FGDs argued that: *"nzira itsva yakanaka manje nekuti hapana zvekuchekana nezvekunyika musalt, plus method iyi manje inogona kuti tiendewo nekuti haa zvekurwadziwa hazviiti. But chikunetsa manje inyaya yenguva yekuti unenge usingaiti zvepabonde ndiyo yati rebei."* (the new method is the best because it does not involve the forceps and the salt process, in addition the method might convince us to go for circumcision

because i cannot withstand pain) (Respondent 26). But what is still an issue is the waiting period before one can have his conjugal rights.

Another participant who goes to work seems to be fascinated with the new method for it allows him to go to work without any difficulties. The respondent gratefully expressed that:

"*iyi method yakapenga nekuti ndokwanisa kuenda kubasa uye hazvinditadzise kuita mamwe mabasa epamba, kufamba ndofamba zvirinyore*" (this method is the best i can go to work and do other household chores and i can walk with ease) (Respondent 20).

The key informants confirmed that there are some improvements in terms of numbers that are coming for the device. The key informants highlighted that many men of the target group are now accessing the services and they prefer Prepex to forcep guided method. They however noted that there is more that needs to be done if the program is to attract more clients particularly on removal. One key informant highlighted that: "Prepex has indeed helped in boosting the numbers in Gweru district because clients come demanding for the method, it's unfortunate that it starts at 18 years because even those below 18 prefer Prepex to forceps guided. However, there is need to devise mechanisms that reduces pain at removal because it is going to change the perception of many clients about the program" (Respondent 28)

There was a general consensus from both the IDIs, FGDs and KIs that Prepex is the best method if numbers in the district are to increase. However there is need to refine the program especially on removal so that pain reduced.

From the findings it was noted that Prepex is preferred more to forceps guided method hence there is need to intensify demand creation. Most respondents especially those who go to work and those involved in income generating activities recommended Prepex because it allows them to go to

work with the ring on. Those who were disadvantaged however were those below the age of eighteen for they could not be allowed to be circumcised by Prepex. It can be noted that these has had a negative bearing on the number of people who are circumcised in the district as they will wait until the age of 18. The key informants also are of the view that if Prepex demand creation is intensified the numbers in the district will increase. One key informant highlighted that, "it is my firm conviction that if Prepex demand creation is intensified the numbers in the district will be boosted because people have showed interest in the program but however they do not have enough information". Most clients in the FGDs noted that there is need to provide truthful information about the program so that men will be able to acquire the services.

4.6 CHARACTERISTICTS AND INTEREST OF THOSE WHO COME FOR MC

The key informants highlighted on several characteristics and interests of those who come for male circumcision. They were frank to point out that some undergo the procedure because they have understood because they would have understood the program, its benefits to them and to women. One key informant was quick to point that :

"*vamwe vanouya vachitoda kuchecheudzwa nekuti vanenge vanzwisisa kukosha kwazvo kwavari pamwe chete nemadzimai avo*" (some come because they have understood the program especially its benefits to them and their wives) (Respondent 32). The key informant further noted that some of the benefits that persuade include being smart and its effects as a preventative measure against HIV/AIDS.

Another key informant highlighted that most clients are interested in the sexual benefits that are as a result of being circumcised. The key informant posits that:

"most men are lured by the sexual benefits that come with male circumcision for instance men would want to last long in bed and satisfy their wives. Men believe that when you are circumcised it prolongs sex, enlarges the penis and satisfies women" (Respondent 34) much influence it was noted, come from wives as they would to benefit from men's circumcision.

The key informants also argued that children below the age of 15 are persuaded by small things such as getting a ride or peer pressure. One key informant noted that:

*"vana vazhinji vanenge hakusi kuti vanenge vanzwisisa chirongwa asi vazhinji vavo vanenge vachida kungokwira mota kana kuti vanenge vangotevera vamwe vavo nekuti dzimwe nguva vanoti vasvika vanenge vakuramba" (*it does not mean many of them would have understood the program but they want a ride or they would have followed their friends because many a times they refuse to go through the procedure) (Respondnet 34).

Several studies have been carried out to find out the interests of those who come for male circumcision and some of the findings are in agreement with the findings in Gweru district. In their study Freidland et al (2011) found that young people and adults seemed to downplay the protective effect of VMMC because of its partial protection. Circumcision preference according to them was meant to improve their sexual prowess or increase their partners' sexual pleasure, to prevent premature ejaculation and to cure painful sex. A study in Tanzania found perceptions that confirm the importance of enhanced sexual performance and sexual pleasure for the man and the woman, as being motivating factors for getting circumcised (Nnko et al .,2010). Another study by Rain-Taljaard et al., (2010) in South Africa found beliefs about sexual performance with VMMC perceived to enhance sexual performance enlarge the penis and make the penis more appealing to women. This perception was also prevelant in another study in Malawi (Pierotti and Thornton

2012). From the studies and the findings in Gweru it can be noted that the interest of men of acquiring the male circumcision are almost the same that they want to improve their sexual ordeals. However studies elsewhere seems to be in contradiction with the findings, in the United Kingdom, Masood et al,. (2011) found 17% of circumcised men were unsatisfied because they experienced loss of penile sensitivity (18%) and 33% experienced premature ejaculation. A study by Kigozi et al. (2012) found no difference in self-reported sexual satisfaction and function among men in a randomised trial of male circumcision in Uganda where one half of men received circumcision in Uganda where one half of men received circumcision immediately while the other half was delayed for 24 months. In light of these studies there is need to educate people about the benefits of male circumcision especially with regards to male circumcision.

4.7 CHAPTER SUMMARY

This chapter has presented and discussed the research findings that were gathered during the data collection process. In depth interviews, focus group discussions and key informant interviews were used to gather information on the knowledge of male circumcision, the barriers, myths and misconceptions on male circumcision. The findings were presented in a thematic way. The next chapter presents a summary of findings conclusions and recommendations.

CHAPTER FIVE:SUMMARY,CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter presents a summary of major findings, provides the major conclusions that were drawn from this research and recommendations. The summary highlights the main points of the study whilst the conclusion reveals the main findings and the inferences that the researcher made these findings. The chapter is concluded by recommendations to various stakeholders and future researchers.

5.1 SUMMARY OF FINDINGS

The aim of the research was to get an understanding on the factors that inhibit men from accessing male circumcision services in the district. The objectives of the study were to Identify factors inhibiting clients of the primary target to come for male medical circumcision, to identify ways through which the numbers for the primary target can be scaled up and to identify the

characteristics of the clients who come for male circumcision paying particular attention on their interests. A total number of fifty clients participated in the study and three key informants. The theory underpinning this research was the Social cognitive theory. It is based on the premise that behaviours, environmental influences, and beliefs are highly interactive and dependent. The framework identifies three main sources of influence on people's attitudes which are perceptions, intentions to act and their ability to carry out their intentions

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The findings of the study indicated that clients in the district are deterred by many barriers and myths and misconceptions. Fear of pain and fear of death pose a great threat in man acquiring MC services and this has impacted negatively impacted on the numbers in the district. Other issues of concern that inhibit men to undergo for male circumcision are derogatory language, disposal of the foreskin, culture, reduction of the penis among others. As a result it has been very difficult to convince men of the primary target to go for male circumcision. The study also indicated how Prepex can be harnessed and improves the outputs in the district as many clients showed interest.

5.2 CONCLUSIONS

These conclusions are presented basing on the results from the previous chapter.

5.2.1 DEFINITION OF MALE CIRCUMCISION

The participants showed that they have enough information about MC for they were able to define it. Much information was accessed through the media that is adverts in the newspapers, radio and television. Some acquired the information through outreach teams, the hospital and other stakeholders like National AIDS Council. Some participants opted to define male circumcision from the traditional perspective but retaining the same meaning.

5.2.2 BENEFITS OF MALE CIRCUMCISION TO BOTH MEN AND WOMEN

The participants managed to outline the benefits of male circumcision to both men and women. Most clients highlighted that MC reduces the risk of contracting HIV by 60%, it's done for hygiene purposes, prevents against penile cancer in males and cervical cancer in females. The respondents exude a greater deal of information about the program. Regardless of the rich information that participants possessed they were a lot of barriers that were explored.

5.2.3 BARRIERS, MYTHS AND CONCEPTION TO MALE CIRCUMCISION

They were several barriers that were explored in the findings which militate against the active uptake of male circumcision. These included : fear of pain, fear of death, disposal of the foreskin, derogatory language that is linked with being circumcised, in those under the age of consent they cited as the major factor that bar them from acquiring the services, fear of being tested for HIV/AIDS and many more. There is great need to provide information to dispel these myths and misconceptions in order to increase the numbers in the district.

5.2.4 INTERESTS OF THOSE WHO COME FOR MALE CIRCUMCISION

The interests of those who come for male circumcision were explored in the study. The findings reviewed that there are several reasons that convince men to be circumcised. Respondents noted that some come so as to get the benefits that come with MC for both males and females. Most participants highlighted that males especially those who are married want to enjoy sexual benefits that are attributed to MC such as the fact that it prolongs sex, and makes sex enjoyable. The findings showed that females also benefit sexually from the circumcised husband; this was outlined as the major factor that attracts clients for MC.

5.2.5 ON THE NEW METHOD OF PREPEX

Most participants showed keen interest on going for male circumcision using the new method. Some of the reasons that made Prepex a preference was the fact that it does not involve forceps, there is no blood as compared to the forcep guided and that there is no salt healing process. Respondents highlighted that the procedure should be made available from the age of 15.

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5.3RECOMMENDATIONS

5.3.1 There is great need to intensify Prepex demand creation in the district.

Prepex should be available in all the clinics and outreach sites. Nurse counsellors should also be trained on Prepex because it was noted only one nurse is capable of placing the device. The implementing partners should provide so that nurses and demand creation teams will be trained on the new method. There is need to provide truthful information about the program in order to market it and to improve its acceptability.

5.3.2 Awareness Campaigns

Awareness campaigns should be conducted in order to dispel the myths that are held by many people with regards to male circumcision so as to improve the numbers. Adverts on television, radio and newspaper should be intensified and should provide information that answer and dispel myths and misconceptions.

5.3.3 The recruitment of more staff to carry out male circumcision.

Training of more staff will enable the scaling up of male circumcision as it will be carried out in every clinic. The nurses should be trained to insert Prepex devices in all clinics so as to scale up

the numbers in the district. Workshops should be on going so as to respond to changing environments.

5.3.4 Disseminate information

Disseminate information that VMMC for health reasons has no cultural boundaries and its benefits should be enjoyed by anyone. Emphasis should be made on that getting circumcised does not necessarily mean changing one's culture.

5.3.5 The healing period

Give information about the normal or expected healing period; about the recommended period of abstinence from sex; about need to confirm with a health worker before resuming sex; and about how soon one may resume work. Emphasize that return to work after circumcision can be in very few days. There is also need to clarify on the healing period for Prepex and the dangers involved if one attempts to remove the device.

5.3.6 Give risk effects that can be incurred

Give information that the risk of side effects is minimal if MC is carried out by qualified medical personnel in approved settings.

5.3.7 Promote spousal, parent-child communication and intra-family communication on VMMC

5.4CHAPTER SUMMARY

This chapter summarized and gave conclusions together with the suggested recommendations of what can be done pertaining the whole research. The factors militating against the active uptake of male circumcision were highlighted. The suggested recommendations include, awareness campaigns should be conducted in order to dispel the myths that are held by many people with

regards to male circumcision so as to improve the numbers, Give information that the risk of side effects is minimal if MC is carried out by qualified medical personnel in approved settings and Promote spousal, parent-child communication and intra-family communication on VMMC.

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APPENDICES

APPENDIX 1: CONSENT FORM

General Information

My name is Lyndon V Nyika, I am a student at the Bindura University of Science Education (BUSE). In partial fulfillment of the requirements for the Bachelor of Social Work Honours Degree, I am carrying out a study entitled *" Factors militating against effective uptake of male medical circumcision among the 15-35 years age group in the Gweru District of Midlands Province of Zimbabwe"* I am interested in investigating the subject area because of the limited number of clients of this age group who have accessed the services. I have identified you as a potential stakeholder I am therefore asking for voluntary participation. The information obtained is purely for academic purposes and will be treated with confidentiality.

Biographic Information

AGE:

SEX:

MARITAL STATUS:

OCCUPATION:

Section B: Terms and Conditions of Participation

Participation is based on the following terms and conditions:

1. Participation is voluntary and participants will not be coerced to participate.
2. Participants are free to seek clarification in issues that they do not understand.
3. Research proceedings will be recorded in writing and anonymity will be guaranteed by not including names and use of pseudonyms.
4. All information obtained will remain confidential and the research is purely for academic purposes.
5. Participants are free to withdraw from the research at any time.

I …… *(Use initials only)* have read and fully understood the conditions of participation in a research study carried out for the Bindura University of Science Education.

Signature (Participant)……. Witness……..

Signature (Researcher)……. Witness……..

APPENDIX 2: INTERVIEW GUIDE FOR MALE CLIENTS NOT UNDERGOING MALE CIRCUMCISION

a) Introduction

My name is Lyndon V Nyika and I am a student at Bindura University of Science Education (BUSE). In partial fulfillment of the requirements for the Bachelor of Social Work Honours Degree, I am carrying out a study entitled *"Factors militating against effective uptake of male medical circumcision among the 15-35 years age group in the Gweru District of Midlands Province of Zimbabwe*." I am interested in investigating the subject area because of the limited number of clients of this age group who have accessed the services. I hope information obtained will be useful in programming. The information obtained is purely for academic purposes and will be treated with confidentiality.

b) Demographic Characteristics

1. Age 15-20---------- 20-25---------- 25-30---------- 30-35----------

2. Level of education primary--------- secondary-------- tertiary----------

3. Marital status Married---------- Never married---------- divorced---------- widowed----------

4. Employment status employed-------- not employed------ involved in an IGA---

5. Employment status of spouse if married employed---------- not employed---------

Involved in an IGA---------

6. Religion traditional-------- Christianity--------- other----------

7. Do you have any other children/ grandchildren? Yes--------- No-----

8. How many are they and how old are they? ----------

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c) Factors

1. Can you explain your general understanding of male circumcision?
2. Are you circumcised?
3. Can you explain the benefits of male circumcision?
4. How does your spouse benefit from male circumcision?
5. How do women view male circumcision?
6. Can you explain some of the barriers to male circumcision?
7. What are some of the myths and misconceptions that have inhibited men to be circumcised?
8. How do members of your community treat you when you are circumcised?
9. How does culture affect the uptake of male circumcision?
10. How does male circumcision relate to HIV/AIDS?
11. How many methods of Male Circumcision do you know?
12. Which method do you think should be used for your age group?

Increasing Uptake Strategies

1. What can be done to improve the uptake of male circumcision?

2. What is the general perception of Prepex?

3. How can women be involved in encouraging men to go for circumcision?

4. How can those who do cultural male circumcision be engaged?

5. Is there need to have more outreach sites to increase uptake?

APPENDIX 3 :KEY INFORMANT INTERVIEW GUIDE

Introduction

My name is Lyndon V Nyika, I am a student at the Bindura University of Science Education (BUSE). In partial fulfillment of the requirements for the Bachelor of Social Work Honours Degree, I am carrying out a study entitled *"factors militating against effective uptake of male medical circumcision among the 15-35 years age group in the Gweru District of Midlands Province of Zimbab*we*"* I am interested in investigating the subject area because of the limited number of clients of this age group who have accessed the services. I am therefore asking for voluntary participation. I hope information obtained will be useful in programming. The information obtained is purely for academic purposes and will be treated with confidentiality.

Biographic Information

AGE: **SEX:**

TYPE OF ORGANISATION:

WORK OF THE ORGANISATION:

ROLE IN THE ORGANISATION:

MARITAL STATUS:

OCCUPATION:

1. What are the characteristics of the clients who undergo Male Circumcision?
2. What are the interests of those who come for male circumcision?
3. What is the role of your institution in encouraging males of this age group to be circumcised?
4. What challenges are you encountering in mobilizing men to undergo the procedure?

5. What are some of the myths that are encountered in Male Circumcision?
6. What are the misconceptions that have affected the uptake of male circumcision?
7. In your opinion, what are the strategies that can be put in place to improve the uptake of male circumcision?
8. What is the impact of the low uptake on the prevalence rate of HIV/AIDS in the district?
9. In your opinion, what are the factors that are inhibiting men of this age group to be circumcised?
10. Do you have any other issue that warrants discussion?

APPENDIX 4 : FOCUS GROUP DISCUSSION GUIDE

Introduction

My name is Lyndon V Nyika, I am a student at the Bindura University of Science Education (BUSE). In partial fulfillment of the requirements for the Bachelor of Social Work Honours Degree, I am carrying out a study entitled *"Factors militating against effective uptake of male medical circumcision among the 15-35 years age group in the Gweru District of Midlands Province of Zimbabwe"* I am interested in investigating the subject area because of the limited number of clients of this age group who have accessed the services. I am therefore asking for voluntary participation. I hope information obtained will be useful in programming. The information obtained is purely for academic purposes and will be treated with confidentiality.

Participants Demographic Details

1. Number of participants----------

2. Participants Age range----------

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3. Marital status----------

4. Education Level----------

5. Employment Status----------

Questions to be discussed

1. What is your understanding of male circumcision?

2. What are the benefits of male circumcision?

4. What are some of the myths about Male Circumcision?

5. What are the some of misconceptions that you have heard about Voluntary medical male circumcision?

6. What is the relationship between male circumcision and HIV/AIDS?

7. How can male clients be convinced to undergo male circumcision?

8. Do you know the procedures that are offered at the hospital? If Yes can you distinguish between the two?

9. What are some of the barriers to male circumcision?