VOLUNTARY MEDICAL MALE CIRCUMCISION

FOR BETTER HEALTH

(VMMC)

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PREFACE

Dr. SILAS GACHANJA KINYEKI.

Dr. Kinyeki is a Multi-Discipline Scholar who combines several areas of learning from different academic backgrounds. This includes Business Management and Administration, Procurement and Supplies Management, Human Resources Management, Marketing Management, Training and Management Development, Project Management and Development Economics, as well as Community Development.

Dr. Kinyeki is Fellow of the Institute of Management Specialists, A fellow of the Institute of Professional Financial Managers and A member of the Kenya Institute of Management. He is also a member of the Rotary club of Makeni (Sierra Leone) –District 9100. He is a chief Editor of the Journal of Multi-Discipline Scientific Research and an Editor and Peer Reviewer of the (APREPAU) journals. He received his undergraduate degree from United States International University (USIU-A) African Campus Nairobi, Kenya, MBA from Irish University Business School and a PhD from South California University. Dr.Kinyeki has contributed several articles to international journals and has also published more than ten books in Economics, Management, Social Sciences, Marketing and Project Management.

He is currently An Associate Professor in Management studies and Economics at DMI –St. Eugene University, Lusaka. He was prior to this a Senior Lecturer at University of Makeni, St. Joseph College Management And Technology, Yoni Campus in Sierra Leone. He was also prior to this, Dean of Academic Affairs, and HOD for Post graduate Department at the University of Makeni as well as Senior Exams officer.

Dr. Kinyeki is now publishing two very good books namely, The Rewards and Benefits Management, (A case study of Compensation Management in Developing countries versus Developed Nations) and Challenges of Economic Growth and Poverty in Developing Countries – ( A case study of Root causes of Poverty and inadequate growth in poor countries-A case Africa).

Dr. Silas G. Kinyeki became interested in reviewing, editing and publishing this thesis into a book for future reading of younger generations and the benefit of the wider community that needs to be sensitized on the health benefits of getting circumcised as one way of fighting HIV/AIDS scourge in developing countries and the whole world.

You can read some of Dr. Kinyeki’s books in Research, Science and Technology publishers at http://www.rstpublishers.com/ and http://books.rstpublishers.com/
About the book:

This is his tenth book on a series of diversified subject areas ranging from ‘management, economics, Human rights and good governance, business management and administration, Human resource management, Procurement and supply management, as well as project management’.

The other books which you can browse Dr. Silas G. Kinyeki’s website and read them are:

1. Development Economics and Project Management in Developing Countries.
3. Procurement, Tendering and Contracts Administration in Developing Countries.
7. (VMMC)-Voluntary Medical Male Circumcision for Better Health.

According to Dr. Kamoto Mbewe -(Zambia-The Post daily of 1st August 2012), Voluntary Medical Male circumcision can reduce female to male sexual transmission of HIV by 60 per cent. The Technical Director of JHPIEGO, Dr. Joseph Nikisi also said that circumcising 80 per cent of HIV negative men between the ages of 15 and 49 in Zambia would avert an estimated number of 330,000 new infections saving about US $ 1.2 billion by 2025. Dr. Mbewe added and said that Zambia intended to circumcise about 198,511 negative men by end of 2012. He said that only 32,000 men have been circumcised by now. He added and said that there is a need to spread the information on male circumcision among the primary and secondary target groups and also speak out against the myths and misconceptions about the male circumcision.

Dr. Nikisi said that the foreskin increases the risk of HIV because the thinly “keratinised mucosal” layer of the inner foreskin is susceptible to minor trauma and abrasion which could facilitate entry of pathogens. The area under the foreskin is warm, has moist environment, and is suitable for pathogen replication.

A multi-country study of foreskin according to Dr. Nikisi found that the human papilloma Virus (HPV) infection was lower on circumcised men, and that cervical cancer rates were higher in the female partners of uncircumcised men. The male circumcision
national co-ordinator, Dr. Daniel Makawa (Zambia), said that male circumcision does not cause male impotence or erectile dysfunction. He added and said that people should also know that male circumcision does not prevent pregnancy and it does not provide 100 per cent HIV infection protection. Male circumcision does not cure HIV and does not protect women from HIV.

ACKNOWLEDGEMENTS:

Acknowledgement is made to a number of people who have contributed quite a lot of materials for the publication of this 2012 book on VMMC and especially to the list of the names on the references that in one way or the other helped to make this book a reality. It is because there is no monopoly of knowledge that scholars are able to spread their tentacles to all areas of knowledge in order to share ideas and knowledge.

May the Almighty God bless all those who contribute into the areas of sharing knowledge and educates others in order for them to also share knowledge to others as an extension of learning.

FOLLOW THE LIGHT AND GET ENLIGHTENED. BE CIRCUMCISED TODAY FOR YOUR BETTER HEALTH. (GENESIS CHAPTER 17:10)

The research has looked at various culture and traditions that either believe or do not believe in circumcision based on their traditions, beliefs or for health reasons with specific cases touching on Zambia, Kenya, Malawi and even South Africa.

Circumcision in different parts of the world is done on basis of different reasons ranging from cultural traditions and beliefs and up to health factors. It is done for health factors in developed countries whereas it is done for traditions and cultural factors in many of the developing countries.

Time has come and enlightenment has shown through research the dire need of circumcision due to health reasons and especially to the reduction of transmission of HIV by 60 per cent. It is therefore no longer an issue of traditions, culture or beliefs, but a matter of
necessity for health reasons. A change in this perspective is therefore necessary for all communities as soon as possible.

The author is a senior lecturer and member of the faculty of Commerce and management at the DMI-ST Eugenen University, Lusaka, Zambia. He is therefore making a passionate appeal to all people through this book to consider their status and take the necessary action immediately.

**Dedication**

This book is dedicated to those who see the light of the day and hence accept change because if they do not change, the change will change them by force. Male circumcision has a long historical background going to the times of the Old Testament. This research work was done together with (Agnes) who deserves a pat on the back for a job very well done. Secondly is to thank a Mr. Arun who is a lecturer for social work at DMI-St-Eugene University, Lusaka, Zambia.

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CHAPTER 1

INTRODUCTION

Male circumcision (MC) is associated with various cultural factors, including religious sacrifice, rites of passage into adulthood, and the promotion of hygiene. The distribution of circumcision and initiation rites throughout Africa, and the frequent resemblance between details of ceremonial procedure in areas thousands of miles apart, indicate that the circumcision ritual has an old tradition behind it and in its present form is the result of a long process of development.

The earliest documentary evidence for circumcision is from ancient Egypt. Genesis (17:11) places the origin of the rite among the Jews in the age of Abraham, who lived around 2000 B.C. According to Genesis, God told Abraham to circumcise himself, his households and his slaves as an everlasting covenant in their flesh. Those who were not circumcised were to be cut off from their people, Genesis 17:10-14. However, the origination of male circumcision is not known with certainty.

It has been suggested that the custom of circumcision gave advantages to tribes that practiced it and thus led to its spread. Theories about male circumcision are conflicting, but it is important to note that the only point of agreement among proponents of the various theories is that promoting good health had nothing to do with it.

In clinical settings, it is normally done as a quick outpatient procedure using local anaesthesia. Not until recently, MC has been thought as only related to culture and religion where some tribes could carry it and others could not carry it out, notably, the tribes (Luvale and Lunda) from the North Western and Eastern provinces of Zambia (for example, the ‘Mukanda’ ceremony), and the Muslim and Jewish people among others. In several countries, prevalence of non-religious circumcision has undergone rapid increases and decreases, reflecting cultural mixing and changing perceptions of health and sexual benefits.

Presently, MC practices in Africa are varied. Whereas men in Muslim countries are circumcised, as in North Africa or a large part of West Africa, in other societies the prevalence of MC depends on other cultural factors, such as changes that occurred under
colonization. In countries such as Cameroon and the Democratic Republic of Congo, which are predominately non-Muslim, most men are circumcised. In Kenya, where only a minority of men are Muslims, men in all tribes except the Luo practice Male Circumcision.

The first paper suggesting a protective effect of MC against HIV infection was published in 1986. Since then, many observational studies have been published, some of which have observed that most men living in East and southern Africa, the regions with the highest prevalence of HIV are not circumcised.

A majority of these observational studies are cross-sectional, and a minority are prospective. A systematic review and meta-analysis found that in sub-Saharan Africa MC is associated with a significantly reduced risk of HIV infection among men, with an adjusted relative risk of 0.42 (95% CI: 0.34%–0.54%).

All of these studies were based on observational data and, in the absence of experimental studies, a causal relationship between MC and protection against HIV infection could not be determined. Direct experimental evidence is needed to establish this relationship and, should a protective effect of MC be proven, to convince public health policy makers of the role of MC in reducing the spread of HIV.

In sub-Saharan Africa, where most studies have been done, male circumcision is statistically associated with a reduced rate of HIV infection. Male circumcision may thus be seen as a potential new intervention for reducing HIV incidence, and there is anecdotal evidence of an increased demand for male circumcision in some communities as a result of increased concern about HIV/AIDS.

Globally, approximately 25% of men are circumcised for religious, cultural, medical, or parental choice reasons (Moses et. al., 1998). Among the Jewish people, male circumcision continues to be almost universally practiced. Male infants are traditionally circumcised. Jewish people refer to their holy book (the Torah) for justification.

The covenant was made between Abraham and God, the outward sign of which was circumcision for all Jewish males: ‘this is my covenant, which ye shall keep, between you and me and thy seed after thee: every male among you shall be circumcised,’ (Genesis 17: 10). Therefore, for these people religion is seen as a major factor influencing the decision to
accept circumcision and not necessarily HIV prevention. Today this perception is changing. The main reason for this is the link between male circumcision and the prevention of HIV and sexually transmitted diseases (STDs).

This has taken circumcision out of its cultural and religious setting and placed it in a more clinical context, thereby opening the practice up to a wider audience. Health activists, human rights advocates, researchers, and policy makers, however, emphasize that MC is only partially effective against HIV and other sexually transmitted infections (STIs), and that HIV-positive men who are circumcised can still transmit HIV to a sexual partner.

Therefore, UNAIDS and other organizations have emphasized promotion of MC in combination with other risk reduction methods, such as consistent condom use, partner reduction, delayed onset of sexual initiation, and HIV counselling and testing (CT). UNAIDS recommends a human rights-based approach to introducing and expanding MC services to ensure that procedures are carried out safely, with sound informed consent, and without discrimination (UNAIDS 2008).

**MEANING; OBJECTIVES AND CHARACTERISTICS OF THE PHENOMENA**

Male Circumcision is a surgical removal of the foreskin and can be done as a traditional culture or medical influence. In this regard, we are talking about the medically influenced circumcision, hence, its name being Voluntary Medical Male Circumcision. The oldest circumcision occurred and is documented in the ancient Egypt. Circumcision was common, although not universal among ancient Semitic peoples.

In the aftermath of the conquests of Alexander the Greek didn’t like circumcision of which they regarded a circumcised man to be rated, and this led to the decline in its incidence among many people that had previously practiced. Circumcision hence has rich roots among ethnic groups. It has ancient roots among many peoples and ethnic groups in sub-equatorial Africa and is still performed on adolescent boys to symbolize their transition to warrior status or adulthood.

Circumcision was also adopted by some Semitic peoples living in or around Egypt. Herodotus reported that circumcision is only practiced by Egyptians, Colchians, Ethiopians, Phoenicians, “the Syrians of Palestine and the Syrians who dwell around the rivers Thromdon and Arrhenius, as well as their neighbours the Mac Romans and Macrons.” He also
reports however, that the “Phoenicians when they come to have commerce with the Greeks, cease to follow the Egyptians in this custom and allow the Egyptians in this custom and allow their children to remain uncircumcised.

In Genesis, God told Abraham to circumcise himself, his household and his slaves as an everlasting covenant in their flesh. Those who were uncircumcised were to be “cut off” from their people. In Africa, Male Circumcision is practiced in various parts of the continent and of late, significance/ importance has been attached to the scientific studies that Male circumcision reduces the risk of one getting the deadly HIV virus.

The distribution of circumcised and initiation rites throughout Africa, and the frequent resemblance between details of ceremonial procedure in areas thousands of miles apart, indicate that the circumcision ritual has an old tradition behind it, and in its present form is the result of a long process of development.

In East Africa, Male Circumcision is regarded as a rite of passage to adulthood but is only practiced in some nations or tribes. Among the Kikuyu people of Kenya and the Masai people of Kenya and Tanzania, Male Circumcision has historically been the graduation element of an educational program which targets traditional beliefs, practices, culture, religion and history to youth who were on the verge of becoming fully fledged members of society.

The circumcision ceremony was made public and required a display of courage under the knife in order to maintain the honour and prestige of the young man and his family. The only form of anaesthesia was a bath in the cold morning waters of a river, which tended to numb the senses to a minor degree. The circumcised youths were required to maintain a stoic expression and not to flinch from the pain. After this ceremony, the circumcised youth automatically became members of the warrior team.

In Zambia, Male Circumcision has been practiced with nothing to do with religious beliefs whatsoever. The common tribes practicing Male circumcision being from the North Western part of the country and it was regarded as the rite of passage to adulthood. Of late Male Circumcision in Zambia has been of a national concern and the Ministry of Health has put in measures in making sure that this service impacts every male child by building capacity.

Scientists have indicated that Male Circumcision has the ability to reduce the risk of getting the HIV virus through the exposed hardened glands during the act of sex by 60%. Other benefits of Male Circumcision include the sexual female partner being safe from the risk of
getting cervical cancer throughout hygienically glands that can’t hold the HPV that leads to cancer.

Simple comparison provided first evidence of MC – HIV link

The figure above shows areas where Male circumcision is practised as a culture or tradition and those countries that don’t practise Male Circumcision in relation to HIV prevalence rates.

OBJECTIVES OF THE STUDY

GENERAL OBJECTIVE

The general objective of the whole study is to find out the relationship between Male Circumcision and the effects of HIV/ AIDS infection.

SPECIFIC OBJECTIVE

- To give a general understanding on male circumcision
- To find out the benefits of male circumcision
- To study and relate Male Circumcision and HIV AIDS
To study and find out how the risk of contracting HIV AIDS can be reduced by circumcision

To draw a conclusion and to recommend how best HIV AIDS can be prevented through Male circumcision.

**FACTORS RELATED TO THE PHENOMENA**

Since the inception of Male Circumcision at Society for Family Health in Lusaka, YWCA in 2007, demand has caused the rate of people being circumcised to be at low pace. In this study therefore, we shall be able to see on the attitudes and perceptions of Male Circumcision amongst men of 15-39 years of age.

The study shall also help us determine how males feel in regard to being circumcised. To help the researcher to gather information, she shall issue questionnaires and observe some of the cases coming or being managed at YWCA and Chachacha Male Circumcision Site. Chachacha has a target of performing about 1,000 MC’s monthly and on daily basis is expected to see about 30 clients coming for the MC Service.

It is observed that only 5 clients on an average come to seek MC services and this alone indicates that there is something wrong because Lusaka has a huge population of uncircumcised men. Last month alone, Chachacha site did or performed 635 and YWCA did 465 MC’s against their monthly target of 1,000. One would ask why this could turn out like this when a lot of men and people pass by the gates of Chachacha without really getting concerned or asking about the Male circumcision services offered at this location.

The study therefore shall avail on the awareness of MC in general to the males who opt for it and also those who don’t opt for it. Apart from the awareness, the study will also avail the perception of males towards this important program and service. Out of those males who circumcise, the study shall also avail information on how their life is now as compared to before they were circumcised. This will give us the general understanding on how men feel and value the medical Male Circumcision in our communities.

Partners of the circumcised males will also be questioned or assessed to see on their perceptions and attitudes towards Male Circumcision. This will help the study to do some conclusions on the causes of low numbers at MC sites widely. Generally the clients who
come for Male Circumcision will be given a simple questionnaire before they go into theatre and this will help the study in gathering information that will be relevant to the study.

**MALE CIRCUMCISION IN GENERAL UNDERSTANDING**

Male Circumcision as stated in the introduction part is very uncertain of some issues like, where it really originated or who is supposed to access it. People worldwide have issues surrounding this very service or procedure.

Scientists have been arguing that Male Circumcision protects those circumcised by 60% or less. It is wise to actually use a condom while searching for 100% protection against the transmission of HIV. One would then ask a question of, “Why then circumcise as you will also require another measure of safe sex.”

Young and adults think using a condom is much better since it gives you maximum protection than circumcision. Circumcision is a painful procedure and it’s half paying to be a circumcised man and yet one can still use a condom that doesn’t hurt.

On the other hand, we can see or say that when one is circumcised, the risk of getting or having an STI is reduced. Male Circumcision happens once and remains permanent; one does not need to redo it each time they have sex as opposed to condom use. It is readily available all the time.

Male Circumcision in the 19th century was believed to be necessary for various reasons. According to the Encyclopaedia Britannica, “This surgical operation which is commonly prescribed for purely medical reasons is also an initiation or religious ceremony among Jews and Muslims” now it was primarily a medical procedure and only after that a religious ritual.

The entry explained that in recent years, the medical profession has been responsible for its considerable extension among other than Jewish children for reasons of health. By 1929, the entry is much reduced in size and consists merely of a brief description of the infant and performed chiefly for purposes of cleanliness. In this regard, we want to echo on Neonatal Circumcision. In fact, let me say that there are two types of circumcision;

i. Neonatal Circumcision.

ii. Adult Circumcision (VMMC) Voluntary Medical Male Circumcision.

Let us look at these in more detail.
Neonatal Circumcision

Neonatal Circumcision is the surgical removal of the foreskin of infants at birth or sometime later up to 60 days or 2/12 months old. In the entire world, Neonatal Circumcision is practiced and in some parts of the world, it is compulsory for all new born baby boys.

Historically, Neonatal Circumcision was promoted during late Victorian times in English speaking parts of Canada, Australia, New Zealand, the United States, and the United Kingdom and was widely practiced during the first part of the 20th century in these countries.

However, the practice declined shortly after the Second World War and somewhat later in Canada, Australia and New Zealand. It has been argued that the practice did not spread to other European countries because other considered the arguments for it fallacious. In South Korea, circumcision was largely unknown before the establishment of the United States trusteeship in 1945.

Infant Circumcision has been abandoned in New Zealand and Britain and is now much less common in Australia and Canada. The decline in circumcision in the UK followed the decision by the National Health Services in 1948 not to cover the procedure, following an influential article by Douglas Gardens which claimed that circumcision resulted in the deaths of about 16 children fewer than 5 years each year in the United Kingdom. It has been observed though that Infant Male Circumcision is a practice that has put baby boys and mothers remain unhappy after this choice in the aftermath feelings of this kind of decision.

In this regard I came across a journal or article of a circumcised man. He came to learn of his condition at 18 years when he saw his male counterparts who were uncircumcised. The man could not believe that his own parent (mother) would do or make such a decision without getting concerned of her baby’s feeling or though on issues of pain or depression.

He blames his parents for allowing such a kind of thing to happen to him. In his own words he says “I now understand why I sometimes have difficulty maintaining an erection or achieving orgasm. This isn’t shameful failure of my masculinity. This isn’t evidence of my physical and emotional disinterest in a sexual partner. This isn’t proof of my shortcoming as a man. I’ve learnt this is proof of the operation success. Erectile dysfunction and diminished sexual pleasure are the desired surgical outcomes of circumcision. My operation was a success”.
**ADULT MALE CIRCUMCISION (VMMC)**

This kind of Male Circumcision is done when a person is no longer an infant; one is an adolescent or adult preferably 7-39 years of age.

Clients for VMMC are selected carefully through a process that involves;

- Physical
- Clinical

These clients make an informed decision to come for VMMC; there they are received and counselled for HIV, for possible VCT (Voluntary Counselling and Testing). Thereafter, clients are offered an HIV test. All these stages are made and they consent to every stage by signing a formal written consent.

Unlike the Neonatal Circumcision, VMMC is more human centred because most of these choose to do MC procedure.

In both Male Circumcision types, the World Health Organization and UNAIDS have supported circumcision as a preventive for HIV infections in regions with huge rates of heterosexual transmitted HIV; however, the circumcision solution has several fundamental flaws that undermine its potential for success.

This article by Robert S. Van Howe, Michelle R. Storms indicates and explores in detail the data on which this recommendation is based, the difficulty in translating results from high risk adults in a research setting to the general public; the impact of risk of compensation and how circumcision compares to existing alternatives. It was analyzed that it is concluded that the circumcision solution is a wasteful distraction that takes resources away from more effective, less expensive, less invasive alternative.

By diverting attention away from more effective interventions, circumcision programs will likely increase the number of HIV infections. Most researchers have based their information on the trails done in various places like the Orange Farm in South Africa. The Random Clinical Trials are often presented as proof beyond a reasonable doubt that Male Circumcision prevents HIV infection. These RCT’s are the gold standard of medical experimentation.
Most people have received important information regarding Male Circumcision. When asked why they do opt for this service; most of them indicate that:

i. It protects against some Sexually Transmitted Infections especially HIV.

ii. Helps maintain hygiene.

iii. For peer support. Because all have done it.

iv. Some still say it enhances their sexual pleasure.

MALE CIRCUMCISION IN ZAMBIA

Male Circumcision in this country is highly talked of. Most African countries are now promoting this surgical procedure because of the benefits.

In the North Western part of Zambia, people known as the Luvailes practice Male Circumcision. It is done as a rite of passage to adulthood. People doing this procedure are mostly untrained but they gained their experience through informal training and continued practice.

Most Luvailes were looked down upon due to this fact of being circumcised. Nowadays it is no longer the case. Luvailes are being imitated and admired because all learned people are adopting the practice of Male Circumcision by using qualified personnel to offer the service.

Zambia has a lot of Not for Profit organizations which run programmes in the race to fight against HIV. Male Circumcision is one of such programmes. Society for Family Health being funded by the Bill and Melinda Gates, they are in the forefront in making sure that Male Circumcision programmes go down to the door steps of the people.

Society for Family Health runs in about 5 provinces and has various sites where MC is offered at no fee at all. Chachacha in Lusaka town centre is one of the sites that is dedicated in offering Male Circumcision services to the community. People or staffs doing the MC programme are or medical professionals (Nurses and Clinical Officers) and they are given a two week MC training to enhance their knowledge in the surgical procedure.

University Teaching Hospital was the first one in Zambia to pilot the MC programme. It was approved in 2004 and the staffs then were trained by Jhpiego, a Non-governmental
organization. Clients are booked way back in advance to control the flow as staffing levels are critical in Zambia.

There isn’t much demand for MC in Zambia, as people are struggling to understand the reasons that justify one being circumcised. We have already seen that Male Circumcision is a risk reducer against HIV and this is 60%. Along with being circumcised, you need to protect yourself with a condom to achieve maximum protection. It is this fact that again makes people to think otherwise.

Though MC is a once procedure that one benefits for life, it is very costly as one needs to use condoms for sex since circumcision is not 100% safe. It is said that a condom is far much cheaper than the MC procedure which is so expensive. Most learned men therefore think it is wiser to condomise than being circumcised since it’s expensive to be circumcised with a much lower benefit.

The other issue is the question of how the removal of a foreskin prevents the HIV transmission. This question remains unanswered accurately. Proponents of the circumcised solution have speculated that the interior mucosa of the prepuce is thinner and more prone to tearing. However, mucosa of the inner and outer prepuce is thinner and outer prepuces have been shown to be of the same thickness.

Proponents also speculate that HIV is more likely to be transmitted through the foreskin because it has a high concentration of longer man’s cells which they believe are the entry point for HIV.

Research has shown that longer man’s cells are quiet efficient in repelling HIV and explains why the transmission rate of HIV is one per 1000 unprotected coital acts. The inner foreskin secretes iangein which kills viruses. Langerhan cells also protect against other sexually transmitted infections which may explain why circumcised men are at greater risk of getting an STI. In general, mucosal immunity provides a stronger barrier to infection than the skin.

In addition to this fact, proponents have identified the sub-perpetual space as a harbour for sexually transmitted viruses. Meter analysis assessing the susceptibility to genital infections with herpes simplex virus and human papilloma virus has not shown an association with circumcision status. Unfortunately these speculations have been repeated so often in the medical literature that many physicians and public health officials consider them factual.
There is however no direct scientific evidence to support the hypothesis that the foreskin is a predisposing factor for infection.

On the other hand, Male Circumcision poses as a risk to human nature. Once a man felt that he has been provided with additional protection. It’s like wearing safety belts as a driver or passenger and then he drives carelessly. As a consequence of the increase in high risk behaviour, the number of targeted events (traffic facilities) either remains unchanged or increases. When modelling HIV infections in San Francisco.

Blowe and Mclean found that if an HIV vaccine offered 50% protection, but reduced condom usage or increased other risky behaviours, it would likely result in higher HIV infection rates.

Zambia is among the leading countries in promotion of Male Circumcision. Since its inception in 2007 it been proved by most donors that Zambia is doing and increasing in the numbers in the men accessing the service.

Southern, Eastern, North western, Lusaka, and Copperbelt are the provinces that facilitate Male circumcision services through their partnership with the Society for Family Health. Since 2009 the sites are circumcising about 1000 men.

Zambia creates demand through various approaches, some of these being media, e.g. materials and promotions, use of other circumcised men through demand creation and mobilisation. Though it is really a challenge to convince people for this important service numbers tend to rise to alarming numbers during school holidays. Demand creation therefore is natural during school holidays in every site where male circumcision is provided.
Stopping the bleeding.
Cut blood vessels should be located accurately and tied or transfixed.

1. Using forceps (tweezers), the blood vessel is located.
2. The blood vessel is then held with the forceps and gently pulled up so than an artery forceps can be applied.
3. The artery forceps is then applied, taking the minimum amount of extra tissue.

An MC procedure at one of Zambia’s sites in Lusaka.

**LOCAL STATISTICAL SCENERIO**

In Zambia, Male Circumcision is or, has been practiced by peoples of North Western province- the Luvalenes. It is practiced as a rite of passage from childhood to adulthood. The Luvalenes are the only people who have been known for these Male Circumcision practices. Boys would be grouped together in winter and the experienced traditional practitioners, who are well known in that society, would be ready to perform their ritual which is a cultural related ceremony.

In Luvalene land, circumcised boys are then educated about their responsibilities and duties as an adult member of the community. The precise details of what they are taught are not well known as it is not documented and is frequently considered highly confidential or secret. These ceremonies often involve demonstrations of bravery and manhood to confirm that the initiate is ready and worthy to become an adult member of the community.

The actual cutting of the foreskin, though a pivoted moment in the circumcision ceremony, is a small component of the whole process. The limited data available on the safety of traditional circumcision point to the high rates of complications and adverse events.
Another important difference is how much of the foreskin is removed. Some traditional circumcision involves only a small cut to the foreskin or partial removal. The carefully standardised procedures used in the three randomized controlled trials that demonstrated the protective effect of Male Circumcision left, at most, a few millimetres of the inner aspect of the foreskin. They all removed sufficient foreskin that had the glands remained fully exposed even on a non erectile penis.

Despite these important differences in procedures, there are many ways that clinical and traditional circumcision services can work together amicably. Traditional and Clinician providers can collaborate to improve the safety and acceptability of circumcision, reduce complications, enhance the health education content of civic education and rituals and improve the sexual and reproductive health of men and women while preserving the social cultural importance of the circumcision process.

Some examples of such collaboration include:

- Training traditional providers in anatomy aseptic techniques, control of blood loss and wound closure.
- Ensuring supply of necessary instruments and dressings to reduce complications from circumcision
- Cooperating on the information provided and training given to circumcision initiates to maximize good health outcomes for the participants and their current or future partners and family members
- Ensuring a smooth and rapid transfer to or intervention by, clinical services if a medical complication associated with the circumcision arises.
- Developing models by which clinical and traditional providers can cooperate and share responsibility for the tasks involved in the circumcision process while respecting the different skills that each contributes.
- Understanding more about the cultural and social significance of circumcision performed by traditional providers according to the setting and age of the initiate
USEFULNESS OF THE STUDY IN THE PRESENT SCENARIO

Male circumcision has been a contravention issue in most countries of our continent. The process of foreskin removal has been practiced in Zambia and in many African countries such as D.R Congo, Nigeria, among other nations. Male Circumcision is being promoted by the Zambian Ministry of Health as part of the nations’ comprehensive HIV prevention strategy.

The Zambian Ministry of Health is developing a plan to expand male circumcision services to reach 50% of men and 80% of newborns by 2020, after reviewing the evidence, that male circumcision could play an important role in curbing AIDS as part of a comprehensive HIV prevention programme.

Although the battle over who was the true discoverer of AIDS, a pandemic that continues to ravage mankind from the time it was discovered on June 3, 1981 is not known, the media and medical experts are now looking to other ways of reducing the risks of contracting HIV/AIDS. It has been clinically proved to reduce the risk of getting the deadly HIV and some other Sexually Transmitted Infections in men, including Syphilis, Cancroid, HPV (Human Papilloma Virus).

HPV can cause penile cancer in men and cervical cancer in females or women. It should be emphasized that Male Circumcision does not provide 100% protection, hence, it is important for all circumcised men who are sexually active (after six week healing period is complete) to use condoms correctly and consistently every time they have sex.

People in all circles of life have reactions or perceive the procedure differently or with value attached. The study on the attitudes and perceptions of males towards Male Circumcision will help realise or appreciate alot of issues in regard to the process or procedure. Some of the issues would answer the following:

- Low turn outs of MC clients at our MC Center.
- Links of Male Circumcision to tradition and culture.
- Whether MC is a painful procedure.
- How MC is taken in our community.
- Relationship between MC and the HIV.

The study is an important tool as it will entail and avail the issues surrounding the Male Circumcision procedure itself. A lot other surveys and study took place around the globe.
Notably, South Africa’s Orange farm took a genesis of how Male Circumcision or the evidence on the circumcision and the HIV relationship. Since Male Circumcision is an important tool in the preventive measures of HIV, it is hence important and very cardinal to investigate and gather information on how the people perceive and react towards this important service.

The study is designed to yield detailed information concerning the attitudes and perceptions towards male circumcision among youths. It is realized that despite MC being prioritized as a strategy to reduce the risk of HIV infection, and as important for sexual health and hygiene, little is known of its acceptability, especially in countries where MC is not universally practiced.

By virtue of the results to be obtained, the study aim to serve as a base of information that will render knowledge of factors that hinder successful rollout of MC at the nation level, and ensure informed legislative and policy systems to assist in decision making concerning MC as regards the perceived goals of the nation towards reducing HIV spread and other sexually related diseases. Country level decision makers need information about the socio-cultural and medical determinants of circumcision, as well as risk of the procedure, in the context of comprehensive HIV prevention programming.

**GLOBAL STATISTICAL PHENOMENA**

Global Statistical Phenomena in this case is demanding that we look at the entire world or parts of the world where Male Circumcision has been occurring and how the demand and reaction from people has been.

Male Circumcision has been practiced in most parts of the world, some being:-

- America.
- Africa.
- Australia.

America does mostly Neonatal Circumcision and it is always done by medical professionals at hospitals. Due to the almost universal coverage of circumcision among Muslim and Jewish men, prevalence in the Middle East and North Africa is high, with published data from Egypt, the Islamic Republic of Iran, Morocco and Turkey suggesting that over 95% of males are circumcised in those countries.
In West Africa, where circumcision is common among both non-Muslim and Muslim men, demographic and health surveys (DHS) show a very high prevalence overall (97% in Benin, 96% in Côte d’Ivoire, 95% in Ghana and 90% in Burkina Faso).

There are some variations within the region; for example, circumcision is less common in the Upper West region in Ghana (68%) and among the Lobi in south-west Burkina Faso (28%). Published sources indicate the prevalence of circumcision to be greater than 80% in most of West African countries (Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, the Niger, Nigeria, Senegal, Sierra Leone and Togo).

In other parts of sub-Saharan Africa, ethnicity is a major determinant of circumcision. Overall prevalence is low in Rwanda (9%), Burundi (<20%) and Uganda (25%), and higher in other countries (70% in the United Republic of Tanzania, 84% in Kenya, 92.5% in Ethiopia, 93% in Cameroon and greater than 80% in Chad, the Democratic Republic of the Congo, Djibouti, Eritrea and Somalia).

In contrast, circumcision is less common in southern African countries, with prevalence estimates of around 15% in Botswana and Swaziland, 10% in Zimbabwe, 17% in Zambia, 21% in Malawi and Namibia and 35% in South Africa; the prevalence estimates are higher in Mozambique (60%), Angola (>80%) and Madagascar (98%). Circumcision is highly prevalent in Muslim Asian countries (Bangladesh, Malaysia, Indonesia, and Pakistan) and also in the Republic of Korea and the Philippines.

It is uncommon in other parts of South-East Asia, including the Hong Kong Special Administrative Region, Thailand, Viet Nam, the Lao People’s Democratic Republic, Cambodia, Myanmar, China, Japan and Taiwan, China.

Only 3% of Chinese boys attending a clinic in the Hong Kong Special Administrative Region were circumcised. These circumcisions were performed either for medical reasons, because the doctor recommended it as routine, for familial preference or for the perceived health benefits. The prevalence among a sample of 1145 Taiwanese boys aged 7 to 13 years was 8%.41 A recent study of mothers of infant boys in Mysore, southern India, found that, as expected, prevalence was associated with religion, with 57% of Muslim boys circumcised compared
with 2.5% of non-Muslim boys. The relatively low prevalence of circumcision among the Muslim boys in this study is likely due to the young age of the boys at time of the interview (90% of the Muslim mothers reported that they would typically circumcise their sons at age greater than one year).

Neonatal circumcision became common in English-speaking industrialized countries in the mid-19th century, but is currently widely practiced only in the USA, where currently between 60% and 90% of newborn males are circumcised, depending on the region. Nationally representative studies have shown that the overall prevalence of circumcision among adult men is around 79% in the USA50, 59% in Australia52 and 16% in the United Kingdom. There is little representative data from other European countries, except for Denmark (1.5%) and Slovenia (4.5%), with circumcised men in the latter survey being almost exclusively Muslim or of non-Slovenian origin.

Neonatal Circumcision is looked at as being the preferred and easy. On the other hand, it is very unfair to subject babies to a painful procedure that exposes them to torture and hurt unwillingly. It is discovered that when they grow up they are ignorant of their original anatomy of the manhood. This kind of arrangement makes these circumcised boys to regret later in life. Let us look at this American young man who underwent Neonatal Circumcision.

He says, “I discovered and realized that my experience in sexual matters was not real, my perception- my physical appreciation of normal sexual contact. My sexual perception is radically muted, too. This was done to me by other people. My sexual perception was taken from me. I have a self denial on this matter, this time the denial didn’t just protect my self-image of being fully “normal”.

This time the denial protected me from knowing the people who I have trusted the most, who I loved the most- had betrayed me. The denial guarded me from fully knowing and feeling the painful discovery that I have been hurt badly and forever, in the most intimate and personal part of my life. I was permanently sexually maimed intentionally by the people who claim to love me the most- (my parents).”

This man goes on to say how depressed he was as he knows the whole thing was done to numb his organ and this has affected him so much. On the other hand, Male Circumcision services in the United States of America are more acceptable and they are the order of day.
SUB-SAHARAN AFRICA

In sub-Saharan Africa, where most studies have been done, male circumcision is statistically associated with a reduced rate of HIV infection. Male circumcision may thus be seen as a potential new intervention for reducing HIV incidence, and there is anecdotal evidence of an increased demand for male circumcision in some communities as a result of increased concern about HIV/AIDS. But little is known about the acceptability, feasibility, safety, and cost-effectiveness of male circumcision in different parts of sub-Saharan Africa, especially among currently non-circumcising populations, among whom the introduction of male circumcision has the greatest potential impact.

Research also suggests that the protective effect against HIV infection is most pronounced if the procedure is done before the onset of sexual activity. In many parts of sub-Saharan Africa, circumcision is typically done as part of initiation to manhood rites, at ages ranging from 10 to 20 years or even older.

Botswana Statistics

- Population: 1.8m
- HIV Prevalence: 17.6%
- MC Prevalence: 11.2%

Leadership, partnerships and advocacy

1. Leadership: MOH leading the programme. Dedicated MC coordinator appointed and district and facility level focal persons assigned. Safe MC Reference group is in place for advisory, policy issues; chaired by Director of Department of HIV/AIDS Prevention and Care. Technical working group in place with all partners represented, STI unit is the secretariat. NAC supports resource mobilization.

2. Partnerships: WHO, UNAIDS, ACHAP, CDC/BOTUSA, I-Tech, Jhpiego, PSI. Partners provide financial, human and technical support resources.
3. Advocacy: Former President Festus Mogae is chairperson of NAC and a leading figure in the ‘African champions for HIV prevention initiative’. He led adoption of MC as additional HIV prevention strategy in Botswana. Sensitization of political (Cabinet, MPs) and social leaders, media, civil society organizations, private practitioners, health care providers, medical aid schemes and public done in 2009.

Situation analysis;

Rapid situation analysis of health facilities was conducted by government and partners in 2007. Results informed the development of the national safe male circumcision additional strategy for prevention of HIV/AIDS. In-depth needs assessment of 51 public and private facilities ability to expand and strengthen safe MC services conducted in 2008/9 which informed the development of the national operational plan for scaling up safe male circumcision in Botswana: 2011 – 2015. Situation analysis of traditional healers also conducted.

Policy and regulatory framework;

MC has been incorporated into existing HIV prevention policy and approved by cabinet.

Strategy and operational plan;

Strategy approved by government. Phased scale-up plan to reach MC prevalence rate of 80% among HIV positive males aged 0-49 years old by 2016. Six facilities selected to be strengthened as centres of excellence. DMPPT used to derive costing and impact data. MC included in GFATM application.

Training

Safe MC training curriculum has been developed which includes a video. By April 2010, 90 health workers trained (medical officers and nurses/social workers). Team of master trainers from I-TECH were trained by MOH. Currently decentralized training is being conducted in the centres of excellence. Traditional healers HIV training curriculum has been developed with safe MC.
Quality Assurance;

Quality Assurance framework has been developed, strategy being developed. WHO MC QA guide and toolkit have been adapted and the standards adopted. Team of QA facilitators were trained at a WHO workshop in September 2009. Twenty eight focal persons in centres of excellence trained on QA. External quality assessments conducted at four centres of excellence in February 2010. Internal quality assurance assessments are ongoing.

Service delivery

Scaling up of service delivery started in April 2009 with MC services integrated into existing HIV prevention services. Thirty five public health facilities are performing MC including the six centres of excellence, seven public clinics and a few privates. CDC/ACHAP/WHO supported the MOH to provide mass MC services in July 2009 for initiates in the Kgatleng district. 1321 initiates were counselled and offered HIV testing; 88.5% were tested, 96.2% circumcised, 3.8% excluded with 2% mild to moderate adverse events. All initiates were reviewed 24-48 hrs post-MC.

Service delivery statistics:
MCs done from January 2009 - March 2012= 10 000 plus.

Communication

Communication provides a background, a situation analysis and challenges to male circumcision along with an implementation plan, messages and monitoring and evaluation plan. For example, the radio brief provides background information on male circumcision for mass media outlets; the poster targets subjective norms by modelling a satisfied female whose partner underwent circumcision and encouraging other women to encourage their partners to go for circumcision; and the booklets provide post operative care instructions to clients as well as additional HIV prevention messaging. All these basics highlight the need for adherence to safer sexual behaviour, because male circumcision does not provide 100% protection against HIV.
**Kenya Statistics:**

- Population: 37.5m
- HIV Prevalence: 7% for the country. 15.3% for Nyanza province.
- MC Prevalence: 85% for the country. 40% for Nyanza province

**Leadership, partnerships & advocacy**

1. **Leadership:** MOH continues to provide overall technical leadership. Programme now mainstreamed into MOH annual planning process. A national and provincial task force are operational. Focal MC persons at national and district levels are being enforced. Joint MC inter-ministerial task force are working well.

2. **Partnerships:** The MCC (FHI, University of Illinois at Chicago and Engender Health), Nyanza Reproductive Health Society, Impact Research and Development, MSI, IMC, APHIA (Engender Health, PATH, PSI), UNICEF, PEPFAR, WHO/UNAIDS, Gates continue to be key partners. World Bank is new partner since January 2010.

3. **Advocacy:** Ministry of Medical Services called for continued scale up at recent stakeholder’s meeting. It joined voices from Prime Minister Mr. Raila Odinga who has endorsed the scale up of MC and in 2009 met with the council of Luo elders to promote MC. Situation analysis was completed for Nyanza, Teso, Turkana and Nairobi provinces. Policy & regulatory framework for MC policy is in place.

   It is called ‘National guidance for MC’ to enhance acceptance as some groups felt that a formal policy would suggest a mandate of MC for all men. DMPPT training has been done and data collection is being finalized and the report will be made available soon.

**Strategy and operational plan**

The voluntary male MC strategic plan for next 5 years was published in April 2010; to be posted on MC Clearinghouse. Key target: all provinces to have MC prevalence of 80% by 2013. The target groups are 15-49 year old and newborns. A phased approach to service delivery is underway, with initial programme in Nyanza; Nairobi Province now adding on the activities; preparatory activities in Western Province are all underway.
Training

Training is on going in the efforts to build capacity in the Ministry of Health institutions all over the world. The trainees are selected carefully and these are qualified health personnel in different disciplines.

Quality assurance

A quality improvement team has been established. At the national level the M&E team is in charge of QI/QA in the health sector and MC is integrated in this. WHO MC QA toolkit is being used. Local adaptation is also underway. Quality assurance strategy is in the strategic plan. World Health Organisation supported QI national/provincial training April 2010 and the donors have special programs that give support to all Male circumcision team all over the world.

Service delivery

Service delivery scaled up in Nyanza and started in Nairobi. MC services being offered in prisons. Service delivery statistics: MCs Sept 2008 - April 2010= 110,000. World Bank initiates funding for a pilot service of 5000 MCs in Teso area. Zambia has not remained behind but is among the leading implementers and supporters of Male circumcision programs. It does this through the outreach and static programs.

Monitoring and evaluation (M&E)

M&E framework in place: M&E system and forms to monitor MC uptake and adverse events developed and forms being distributed. M&E indicators developed in line with WHO/PEPFAR

Lesotho Statistics:

- Population: 2m
- HIV Prevalence: 23.2%
- MC Prevalence: 48%
LEADERSHIP, PARTNERSHIPS AND ADVOCACY

- **Leadership:** MOH is leading the programme. MC Task Force with two sub-committees have been created: the Clinical and the Advocacy and Communications Subcommittee. MC Focal person has been identified in the MOH.
- **Partnerships:** PSI, PEPFAR, WHO, UNAIDS, UNICEF, UNFPA.
- **Advocacy:** Extensive advocacy has been done with traditional leaders. Traditional task team on MC formed. Situation analysis Situation analysis in formal health sector has been completed. Final report printed and ready to disseminate.

POLICY AND REGULATORY FRAMEWORK

MC Policy has been approved by Ministry of Health and Social Welfare minister. Policy summarized into a brief, translated in Sesotho and ready to be disseminated. MC scale up will be implemented as part of a comprehensive HIV Health Sector Prevention strategy within the health sector; this policy is also ready for dissemination. Regulations do not allow certain task shifting to nurses.

A review is planned of regulations and processes of task shifting in Lesotho and other countries. Strategy and operational plan Strategy and operational plan approved; awaiting a formal launch. Guidelines on comprehensive HIV prevention service with MC as one component have been elaborated and are now under review. Exploring ways of how to work with traditional providers are of great significance.

Current prevention policies are essentially centred, beyond fidelity and abstinence, on the use of condoms. Individual prevention involves adopting measures that should allow each individual to avoid becoming infected, such as the use of condoms or abstinence if this is acceptable. Because male circumcision does not provide total protection against infection, it cannot be considered as an individual method of prevention. It is a means of reducing risks aimed at lowering the risks of transmission of infection among a population in the same way as reducing the number of partners or providing treatment for infected individuals.

The aim is not to impose a sole method of prevention, one that is 100% reliable, and which, if it is not used all the time, will lose its effectiveness. Male circumcision should therefore form part of a raft of preventative measures, including this means of risk reduction among others.
In countries with high prevalence, male circumcision could benefit the male population where the use of condoms would not be sufficiently widespread.

On the other hand, women cannot benefit directly from this potential advantage. In any case, they do not have to consent to a sexual relationship with a man without using a condom, just because he is circumcised. Male circumcision should form part of a system that offers access to screening and treatment and care for infected individuals, combined with an education and information programme aimed at encouraging changes in sexual behaviour.

**Monitoring and evaluation**

Monitoring and Evaluation framework has not yet been developed. Plans are to be developed for operations research in the health sector. Each country needs to assess their current status, identify gaps, and proceed accordingly. Situation analysis is an essential first element allowing one to determine the current status and map the way forward. Monitoring and Evaluation can provide ongoing information on programmes, usually based on a framework of specific indicators to measure programme performance, outcomes, and impacts over time.

**MALE CIRCUMCISION IN NAMIBIA**

Recent studies in sub-Saharan Africa show that male circumcision can reduce the transmission of HIV/AIDS by 60%. Namibia’s Ministry of Health and Social Services (MOHSS) is exploring how to include this intervention in its HIV/AIDS prevention strategy. The qualitative research reported here assessed the perception of male circumcision among Namibia’s general population and key stakeholders. This study was part of a larger situation assessment of male circumcision in Namibia designed to provide appropriate information for decision-making regarding a national prevention strategy.

**A. Background**

HIV prevalence among pregnant women in Namibia is near 20% (MoHSS 2007), and national HIV prevalence is estimated to be among the highest in the world. Despite significant efforts and funding to slow HIV incidence, the annual number of new infections remains stable.
A renewed focus on prevention is urgently needed to slow these infections. Any HIV prevention strategy requires a diverse mix of evidence-based interventions, and male circumcision is one such intervention that could be effective. Preliminary results from the 2006–2007 Namibia Demographic and Health Survey (NDHS) indicate that 21% of 15–49-year-old men there are circumcised, varying by region from 1% in Ohangwena to 57% in Omaheke.

Other than the NDHS data, little in-depth information is available on male circumcision in Namibia. This rapid situation assessment sought to explain the determinants of male circumcision in different regions, the acceptability of the practice, where male circumcision is practiced, the barriers to access, safety precautions, and whether health facilities could safely respond to greater demand for male circumcision.

B. Historical Context for Male Circumcision in Namibia

The relatively low prevalence of male circumcision in Namibia is related to a number of historical, social, and political factors. The original inhabitants of this area, the Khoi-San people, such as Nama and San people, have not engaged to a significant degree in ritual circumcision as part of their cultural practices.

However, for centuries male circumcision was an integral cultural practice among the Bantu-speaking people here (such as the Herero, Ovambo, and Kavango ethnic groups) who migrated from Central African regions and settled in this part of Africa.

Before the arrival of Europeans, some social developments, such as divine kingship, contributed to the decline of male circumcision in the Ovambo kingdoms, especially among members of the royal families in areas settled by Oshidonga and Oshikwanyama speakers.

2. Before male circumcision was discontinued in these kingdoms, only circumcised men could become kings (Loeb, 1967). Once the concept of divine kingship developed in the Donga and Kwanyama kingdoms, kings could no longer be circumcised because it was taboo for a divine person to lose blood, which was viewed as a bad omen.

During wars, some Ovambo Kings did not want their young men to be unavailable due to rites-of-passage ceremonies such as ritual circumcisions. Furthermore, missionaries opposed
such ceremonies. Although these social, political, and historical factors led to the decline of male circumcision, the legacy of male circumcision among certain privileged members of society endured for a long time.

Also, some kings (e.g., in Kwanyama Kingdom) didn’t easily give into the missionaries’ pressure to abandon the rites of passage ceremonies. Also, the colonialists and missionaries disagreed on the need to end circumcision. Ultimately, the practice of male circumcision ended in the most populated parts of northern Namibia and at present is mainly restricted to smaller ethnic groups, such as the Kavango and Herero communities.

**PREVALENCE OF MALE CIRCUMCISION IN MALAWI**

From the desk review only two nationally representative surveys had looked at prevalence of male circumcision in Malawi prior to the present situation analysis, both conducted in 2004. According to the Malawi Demographic ad Health Survey of 2004, the estimated prevalence of male circumcision amongst men aged 15 to 49 years was 20.7%. Circumcision amongst males was commonest in the southern region at 33.1% followed by the centre (12.2%) and northern region (5%).

From this survey, circumcision was more common in older age groups, 25 years and above where it was about 21% and above compared to the younger age groups, less than 25 years of age where circumcision rates were 18.4% in the 15-19 years age group and 17.1% in the 20-24 years age group.

As indicated in the section on determinants circumcision rates also varied by religion and ethnic group being more common amongst Moslems and amongst the Yao tribe. The results from the two surveys are reproduced in the Table below.
Prevalence of male circumcision by background characteristics according to the MDHS 2004, PNG 2004 survey, and circumcision situation analysis 2009.

<table>
<thead>
<tr>
<th>Background characteristic</th>
<th>Percent circumcised</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MDHS (n = 3114)</td>
</tr>
<tr>
<td></td>
<td>PNG (n = 2052)</td>
</tr>
<tr>
<td></td>
<td>SITAN (N = 3734)</td>
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<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>12-14</td>
<td></td>
</tr>
<tr>
<td>24.2</td>
<td>25.5</td>
</tr>
<tr>
<td>15-19</td>
<td></td>
</tr>
<tr>
<td>20-24</td>
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<td>25-29</td>
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<td>30-34</td>
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<td>35-39</td>
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<td>40-44</td>
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<td>45-49</td>
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<td>&gt;50</td>
<td></td>
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<tr>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>North</td>
<td></td>
</tr>
<tr>
<td>Centre</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td></td>
</tr>
</tbody>
</table>
Similar figures are reported in the PNG survey of 2004 where overall circumcision rates amongst adolescents was found to be 17% with similar regional, religious and ethnic variations as in the MDHS survey.

In the SITAN 2009, circumcision is reported amongst 26.7% of all males sampled which may be an indication of an increase over the 2004 reported prevalence of 20.7%. Age, place of residence and regional trends follow the same patterns reported in 2004 (Table 6). However in the SITAN 2009, the prevalence of circumcision has increased in the centre and southern regions by approximately 8 and 16% respectively while it has remained almost the same in the northern region.

If the current rates are applied to the population religious distribution reported in the 2008 Population and Housing Census, the above rates would translate, based on current population, into 636,347 of the male population aged 18 and above as having been circumcised and just over 5 million not circumcised in Malawi. The lowest number of circumcised males is in the northern region at 45,730 while 205,461 and 370,948 men aged 15 and above are circumcised in the central and southern regions respectively.
(Table 4). Distribution of population circumcised in Malawi by region

<table>
<thead>
<tr>
<th>Religion</th>
<th>% circumcised</th>
<th>Population 18+</th>
<th># religion</th>
<th># circumcised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christians</td>
<td>80</td>
<td>11.6</td>
<td>2,972,335</td>
<td>2,377,868</td>
</tr>
<tr>
<td>Moslems</td>
<td>13</td>
<td>93.3</td>
<td>2,972,335</td>
<td>386,404</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Christians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>96</td>
<td>11.6</td>
<td>378,905</td>
<td>363,749</td>
</tr>
<tr>
<td>Centre</td>
<td>83</td>
<td>11.6</td>
<td>1,271,497</td>
<td>1,055,343</td>
</tr>
<tr>
<td>South</td>
<td>73</td>
<td>11.6</td>
<td>1,321,933</td>
<td>965,011</td>
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<tr>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Muslims</td>
<td></td>
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<td></td>
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<tr>
<td>North</td>
<td>1</td>
<td>93.3</td>
<td>378,905</td>
<td>3,789</td>
</tr>
<tr>
<td>Centre</td>
<td>7</td>
<td>93.3</td>
<td>1,271,497</td>
<td>89,005</td>
</tr>
<tr>
<td>South</td>
<td>21</td>
<td>93.3</td>
<td>1,321,933</td>
<td>277,606</td>
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<td>Totals</td>
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<td>North</td>
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<td>Centre</td>
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<tr>
<td>South</td>
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</tbody>
</table>

1. Religion distribution based on Population and Housing Census 2008
2. % circumcised based on the MDHS 2004
3. Population figures based on 2008 Population and Housing Census results

Overall, the country prevalence as estimated by the present situation analysis is 26.7% compared to 20.9% in DHS2004. The pattern among the regions has remained the same, with more in the southern region (49.6%), followed by the central region with prevalence of 20.2%, and the northern region being the least (4.7%). The Figure below shows an increasing trend in the south and central regions, whereas this has remained constant in the northern region.

District prevalence of male circumcision shows a high prevalence of circumcision in Mangochi (90.2%), Mulanje (51.4%), Blantyre (32.7%) and Nkhotakota (54.6%) while it is reported at less than 10% in the rest of the sampled districts. When the prevalence by ethnic group is applied nationally based on ethnic distribution of the population in Malawi the picture appears as in Figure 5.
As expected high prevalence of male circumcision is observed in the southern followed by the central and northern regions and is mostly concentrated along the Yao and Lomwe dominated districts of the southern region and along the lakeshore districts with high Muslim populations.

As observed above, there has been increase in proportions of males circumcised in the circumcising districts when compared to the levels in 2004 while it has remained largely at the same level in the other districts.

As part of the SITAN 2009 KABP Survey respondents were not only asked about their perceived circumcision status but also given a standard definition of what constitutes male circumcision. Based on the standard definition, the reported circumcision prevalence of 26.6 drops to 23.0 meaning that about 3.6% of the population that those that were circumcised were in fact, probably not circumcised by standard of the World Health Organisation definition.

However no visual inspection was performed as part of the KABP survey. The differences are attenuated mostly amongst the Lomwe tribes of Mulanje where the reported circumcision status of 51.4% drops by almost half to 24.6 when the standard definition was provided to the respondents likely reflecting the practice of circumcision in the district which is not really complete removal of the foreskin but partial circumcision. This is further corroborated in the knowledge section where despite a high circumcision rate reported for the district, correct knowledge of circumcision is low compared to the other high circumcising district of Mangochi.

**Age at which male circumcision is conducted**

Most focus group participants in all categories noted that ethnic groups that circumcise send their children for Male Circumcision between the ages of 9 and 12 year (below 24 years). They said the adolescents are circumcised at this age range because it is the age of the rite of passage from childhood and adulthood in those ethnic groups. During this period, the male children are sent to initiation camps for initiation rites and they are circumcised as part of their rite of passage. They also noted that middle aged (25 -40 yrs) men are circumcised when they would like to marry a Moslem woman or would like to become a Moslem.
Thus “sometimes we hear that a grown up man who has married a Muslim goes for circumcision and they let it.” They also observed that middle aged men nowadays are getting circumcised on hygienic grounds after being advised to do so by medical doctors.

From the sample of 1734 abstracted hospital records as part of the desk review process, 88.6% were circumcised before the age of 18 years while the majority of these were between the ages of 5 and 10 years (69.2%)

DETERMINANTS OF MALE CIRCUMCISION IN MALAWI

Religion

Circumcision has historically been associated with religious practice and in Malawi the practice is common among Muslims. Published evidence from surveys conducted in Malawi report that most respondents had been circumcised for religious reasons. This is corroborated by findings from key informant interviews conducted during the desk review which indicate that male circumcision is an Islamic religious ritual predominantly practiced among Moslems throughout the country.

Key informants reported that it is a religious requirement for all Moslem men to be circumcised and for this reason, they pointed out that almost 100% of Moslem adolescents and men are circumcised. As a religious ritual, they expressed that Moslem men are circumcised as a precondition for joining Islam or being a Moslem man. Almost all the respondents noted that it is predominantly practiced among Moslems throughout the country. They observed that it is a religious requirement for all Moslem men to be circumcised. Thus one respondent said,

“R: Ok, because this issue is more of an Islamic practice, most of the people that are circumcised are Muslims. But for us Christians this practice is still not known, maybe that’s why we are not circumcised.”
Another retorted:

“If one is being circumcised, people would think that one is changing religion from Christianity to Islam especially if they are not told why people get circumcised because circumcision is associated with the Islamic faith. There are more Christians than Muslims here so you can easily know that this one is a Muslim and this one is a Christian if they are circumcised or not”.

Published literature indicates that Muslims practice circumcision as an affirmation of their relationship with God in a practice also called tahera meaning purification, a sentiment reported by Moslem informants in the key informant interviews who explain that circumcision is associated with cleanliness among Moslem men and that those that are not circumcised are seen as unclean.

In fact, our respondents explained that Prophet Muhammad (Peace be upon him) himself was circumcised as a sign of being clean and he urged all true Moslem men to emulate his example. They also explained that circumcision is recognized in the Bible and that all the Prophets in the Old Testament were circumcised including Jesus Christ. One FGD participant said; “Yes it was written in the Bible. God told the Israelites not to be with an uncircumcised person”.

Another participant said; “When we closely look at the word circumcision it’s not that it has just started now, it was there during the days of Jesus and generation of Jesus. It was part of their culture during that time. That is why here many who do circumcision are Muslims; because it was a ritual during the time of Muhammad who founded their religion. That is why they like doing circumcision, but we cannot say it was their laws, but it was just their culture or cultural norms”.

Apart from Muslim faith, other religions practice circumcision as a religious ritual e.g. among the Jewish religions but the practice does not appear to be mandatory among the other religions who mostly take a neutral stance on circumcision. As explained by one Muslim respondent, circumcision is recognized in the Bible and that all the prophets in the Old Testament were circumcised including Jesus Christ. Despite this, apart from Moslems, there are some Christians who also circumcise their children especially those that belong to the Yao tribe as part of their culture.
For example, in Mangochi district it is reported from the KII that 75% of Yao’s who Christians are also circumcised regardless of their religious affiliation. Christian men from other tribes also go through the circumcision process if they want to join Islam. This usually happens when a man is marrying a Moslem woman. On average, it is reported by the key informants that about 5 to 10% of all male circumcisions done per year in the areas where the interviews took place happen because of the above reasons.

In the Malawi Demographic and Health Survey (MDHS) of 2004, circumcision was reported to have been undertaken among 93.3% of the Muslims, 13.9 of Christians, 21.2 % of Seventh day Adventist and Baptist,19.4 of Anglicans, 6.1% of the CCAP and 8.6% of Catholic men aged between 15 and 49 sampled in the survey.

A national survey amongst adolescents conducted in 2004 reports a similar trend with circumcision being commonest amongst Muslim youth (78%) as opposed to only 3% amongst Catholics, 6.3% amongst Protestants, 14.3% amongst Revivalists and 6.1% amongst other religions.

In the KABP survey conducted as part of the male circumcision situation analysis, circumcision was reported to have been undertaken among 96.4% of the Muslims, 13.0 of other Christians, 16.4 % of Seventh day Adventist and Baptist,38.1 of Anglicans, 16.1% of the CCAP and 8.6% of Catholic men (Table 2). When respondents for the KABP survey were asked why male circumcision is carried, the majority (over 85%) irrespective of education status, ethnicity, religion nor age thought male circumcision is done because of religion.

Ethnicity
Apart from religion, ethnicity appears to be the other major determinant of circumcision in Malawi. Information from KII indicated almost all men of the Yao tribe are circumcised. Respondents indicated that male circumcision has been part of Yao culture for centuries and that it has been passed on from one generation to the other among the Yao.

They observed that Arabs who brought Islam to the Yao people found them already practicing Male Circumcision.

Information from key informants and focus group participants from Mangochi, Mulanje and Blantyre indicated that men of the Yao, Lomwe and Mang’anja tribes are circumcised during traditional initiation ceremonies. They indicated that male circumcision has been part of their
cultures for centuries and that it has been passed on from one generation to the other. They also observed that circumcision among the Yao involves complete removal of the foreskin while that of the Lomwe, for example, involves partial removal of the foreskin. The two quotations below highlight this;

“As part of promoting our Lomwe culture, a lot of people go there to practice their culture so they go to Tsimba so as to be circumcised and not to be seen as children”.

“Both Muslims and Lomwes practice circumcision but they are different in the way they use it and their circumcision is different. The Yaos is complete while the Lomwes is partial. The Yao remove the whole foreskin while the Lomwe just cut part of it so as there is bleeding”.

As a cultural practice, male circumcision is a rite of passage for boys. For a boy to become a man in the three tribes, he has to undergo circumcision. As a rite of passage, circumcision is performed during the traditional initiation ceremonies at the initiation camp commonly known as Ndagala among the Yao, Tsimba among the Mang’anja and Thezo/Zoma among the Lomwe.

The participants also noted that traditional male circumcision is not practised among the Chewa, Sena, Tonga, Ngoni, Tumbuka and Lambya. However, they emphasized that men from such tribes undergo circumcision whenever they want to join Islam, marry Muslim women, on medical reasons and upon their personal requests at the hospital.

One of the respondents said, “traditionally… male circumcision is not a part of the custom here in Nkhatabay unlike may be in the Yao culture….. people who come for circumcision either come on personal requests at the hospital or when a patient has a medical indication that requires them to have circumcision but otherwise generally as a custom here in Nkhatabay-Bay amongst the Tonga people circumcision is not part of their culture.”

Another respondent said; “We’ve not talked to a lot of people concerning male circumcision, but what they know in their hearts is that circumcision is for our friends from the southern region, they think those are the ones who get circumcised, but it’s because they don’t know and understand it. Maybe it’s because it has something to do with AIDS that’s why it’s rarely talked about and they consider it to be more of culture and tradition of our friends rather than ones responsibility to protect themselves from the HIV virus”.
Another participant also said; “The problem with circumcision is that it is done by Muslims, so, let the Muslims do it. As for us, we are Chewa and we do what is for us as Chewa, which is how it should be”.

Here the participants were very quick to point out that nowadays there are stories from the media linking male circumcision to the prevention of HIV transmission. As a result of this, there is an increasing demand for male circumcision services in both government and private hospitals. They also observed that most men who are accessing these services are educated ones who have read the literature about the reduced risk of HIV infection among circumcised men.

Respondents, especially from Mangochi also noted that there are some members of other tribes or ethnic groups that undergo circumcision when they would like to join Islam or marry a Moslem woman/Yao woman. In Islam, to which the majority of Yao people belong, uncircumcised men are considered as unclean and they are sometimes stigmatized.

National survey data also indicates this to be the case. For example, among respondents in the 2004 MDHS who reported to have been circumcised, 82.3% belonged to the Yao tribe, 29.8% to the Lomwe tribe, while amongst other tribes the prevalence of circumcision was generally very low, below 7%. Amongst adolescents in the 2004 national survey as part of the Protecting the Next Generation:

Understanding HIV Risk Among the Youth (PNG) Project conducted by the Guttmacher Institute, the majority of circumcised adolescents were from the Yao tribe (63.5%) followed by the Lomwe (15.9%), Mang’anja tribes (9.7%), Chewa (9.0%), Sena (6.3%) and almost none (<1%) amongst the Tumbuka, Tonga, Ngoni and Nkhonde tribes.

This is further corroborated in the 2009 male circumcision situation Analysis which indicates that amongst Yao respondents, 90.3% were circumcised and among the Lomwe, Mang’anja and Chewa respondents the rates were 42.8%, 30.9% and 26.8% respectively whereas in the other tribes the less than 10% of the respondents were circumcised.

In the ethnic groups practicing circumcision, especially amongst the Yao of Mangochi and other parts of Malawi, circumcision is performed as a rite of passage, during the Jando initiation ceremony. During this ceremony, male initiates are circumcised as a sign of manhood and faithfulness to their cultures and this typically happens in and around puberty.
Male circumcisions are also performed on religious grounds. In Islam, male circumcision is considered as a religious ritual for male Moslems.

These circumcisions are either done at Jando or in a mosque. The only difference is that initiates who are circumcised at a mosque are taught the Islamic beliefs while those who go through the Jando ceremony are taught traditional beliefs and social norms. Additionally, male circumcisions are performed on social grounds. Among the Yao, male circumcision is a requirement for marrying a Moslem/Yao woman. Usually, order males (24 years above) who want to marry are the ones who fall under this category. The circumcision is done on demand and it is performed at home.

In these communities, uncircumcised men are considered as unclean among the Yao and they are sometimes stigmatized. However, among the Lomwe and the Mang’anja, such stigmatization is not common. In fact, among the Lomwe and the Mang’anja, uninitiated men are the ones who are stigmatized.

They are called all sorts of names such as wodyera ku nkongo (one who eats with his back) and mlukhu osavinidwa (uninitiated). They are not allowed to visit initiation camps and if they dare to come close, they are caught and initiated against their will. They are also seen as people who are not grown up (they are considered as children by those who are initiated).

However, there are some Lomwe who have stayed with the Yao for a long time and they also circumcise their boys as a custom. As such, both the Yao and Lomwe practice circumcision as part of their cultures. The Lomwe practice circumcision during the Chidototo/Simba traditional initiation ceremony.

The initiates who undergo circumcisions at the Simba go through some sufferings and tough time during the initiation ceremonies and these hardships make them become enduring and persevering people. In addition, instructions about morality and personal hygiene are given to the initiates during the ceremony.

**Social determinants**

**Social desirability**

Male circumcision is also performed because of social or health related reasons. A desire to conform may be a strong determinant for demanding circumcision and this is mentioned as a potential factor especially amongst ethnic groups living amongst the Yao tribe.
earlier especially by respondents in Mangochi, uncircumcised men are stigmatized and thus demand circumcision to conform and respondents indicate that up to about 10% of the circumcisions in places such as Mangochi may be due to this.

Additionally and apart from religious demands, those marrying into Yao communities typically have to undergo circumcision whether or not they join Islam as a religion. Munthali et al., (2006) in a study amongst adolescents in selected districts of Malawi report youth as indicating that they underwent circumcision because they envied peers who had been circumcised and undergone initiation ceremonies. In the same study, another influence to undergo circumcision was the presents that new initiates are given as part of the initiation ceremony.

Most of the participants in the in-depth interviews and focus group discussions stated that they had heard about the association between male circumcision and a reduced risk of HIV infection before they were asked to participate in this particular study. Most of them said that they got this information in the media, workshops and in some literature that has been published about studies that were conducted in some countries in sub-Saharan Africa. Through these sources of information, they were convinced that circumcised men have a reduced chance of contracting or transmitting HIV to their sex partners. One respondent said,

“R: Yea we…..we have read and I have attended …um…some workshops where results of …research done in some parts of Africa had revealed that there was a link between males who are circumcised and the reduction in HIV transmission.”

Another respondent said:

“R: Yeah, I know. In fact I have attended several meetings like I attended one which was hosted by Banja La Mtsogolo and it was discussed that there is an association between the two. The one who was facilitating the workshop said that when a man is circumcised, the foreskin is removed and it leaves the front of the penis to be hard making it difficult to be easily cracked and even if that man sleeps with an infected woman he doesn’t have cuts and because the HIV normally penetrates the blood through an opening on the skin, by a certain percentage, a circumcised man is protected but the protection is I mean not 100%. yeah.”

This particular respondent just like the other respondents noted that male circumcision does not offer 100% protection against HIV infection. In fact, almost all respondents stated that the studies that were done reported that male circumcision could reduce HIV infection by 60%.
When they were asked to explain why they thought this was the case, some respondents attributed the reduced risk of HIV infection to the fact that the foreskins of circumcised men do not retain vaginal fluids after intercourse and that they are so hard (strong) that they do not develop cuts during intercourse as a result of friction.

“In some literature they say that uncircumcised people are pre-disposed to get HIV/AIDS because of the foreskin than those who are circumcised since their foreskins have some evidence of putting some mucus or fluids so once you remove it then the foreskin of the penis it is dry so those fluids which are… they prefer to …their media for HIV/AIDS they cannot survive”.

Another respondent said, “R: Ya currently I could proudly say from my understanding and from the experience that I have had of course we could agree that there is association or relationship between male circumcision and the reduction of risk of HIV/AIDS transmission. Currently I could proudly say there has been ah of course a relationship in the sense that when somebody is circumcised, he has a reduced chance of becoming infected with the virus.

The formation of the skin when it has been exposed and one which has not been exposed are different in texture so having that with a different texture you have a harder texture to the skin that has been circumcised because it has been exposed while the one which is not exposed because it hasn’t been circumcised is a bit stiffer.

So as a result when there is that friction and the cuts have been made it will be difficult for somebody whose skin is hard to have some cuts unlike the one with soft skin the cuts are very easily to be made in such a way if you have cuts that is a direct entry point for HIV unlike a place where you don’t have any cuts. So we are looking at the place where we have soft tissues and hard tissues that’s where the demarcation comes in.”

The respondents also welcomed the idea of introducing male circumcision as one of the prevention strategies against HIV infection. They stated that it was a positive step towards combating the HIV/AIDS pandemic. One respondent felt that male circumcision is better that condom use in the sense that it is done once and does not need to be repeated every time one is having sexual intercourse like the condom.

However, the respondent was skeptical about the 60% reduced risk of HIV infection among circumcised men. She noted that the 60% reduced risk could not be guaranteed for every
circumcised man. She observed that condom use offers almost 99% protection from HIV infection if it is used consistently and effectively unlike the 60% reduced risk of HIV infection offered by male circumcision. Thus “R: Well it’s something positive (laughing) (I: can you explain what you mean?). I mean we can have an additional method that can help prevent HIV transmission.

I know (I: mmh) especially that the intervention is only applied once (I: mmh) as compared to a condom for example that has to be used every time (I: mmh) people have sexual intercourse (I: mmh). So I think it is one of the best ways for circumcised men to prevent themselves from HIV/AIDS.

But the problem of this method is the issue of probability which you can’t guarantee (laughing) I mean the 60% chance cannot guarantee every individual that they will not get HIV infection (laughing) (I:mmh) so if you are giving 60% chance what about one who wears a condom? I know its 99% to 1% if it is used effectively.”

On the same issue of male circumcision, one of the respondents wondered whether male circumcision indeed reduces the chance of HIV infection. Of course he admitted that he had heard rumors that male circumcision reduces the risk of HIV infection but that he did not have the evidence and was skeptical about the reduced risk. He talked about the high death rates of people in areas that are predominantly circumcising as one of the reasons for his skepticism about this issue. He thus said, “Yea I have heard it as a rumour. I will put it in that way. My question has always been how true this rumour is because I still believe, unless proven otherwise that at the moment those who are practicing male circumcision are mostly our colleagues the Muslims. My question which I would put forward to you is that have you gone to Muslim areas and have you been told that they are not dying? Because if you go for instance, to a district like Mangochi which is perceived to be a Muslim area and you are told nobody has never died of HIV/AIDS then this research you are trying to pursue will be seen to be effective because now government will implement it by saying from today onwards let all Malawian males go for circumcision.

So, I doubt about this reduced risk based on death rates in those areas where there are Muslims who undergo male circumcisions. So I have heard about it but I don’t have evidence to that effect. I will just tell you for your information that I had my cousin who
actually passed away and yet he was circumcised when he was 38 years old. So, I have problems with it (male circumcision).

As such, what I will only suggest is that if it is proved that it is effective then I think it should start from childhood. Adults may be but I still believe that there will be some problems because somebody who is 38 or 30 years old to undergo circumcision I don’t know. Yah, so, what I can say at the moment is that I have heard about it but I don’t have the evidence.”

**Socioeconomic status**

Elsewhere, especially in western European countries circumcision has been associated with socioeconomic status. There is a paucity of published data on association between male circumcision and socioeconomic status. The only nationally representative study in Malawi that looked at male circumcision and socioeconomic status is the 2004 MDHS which found no major differences in prevalence of male circumcision by wealth quintile, urban/rural or education status.

**REVIEW OF LITERATURE:**

Male circumcision, the surgical removal of all or part of the foreskin of the penis is one of the oldest and most common surgical procedures worldwide. It is usually practiced for religious, cultural, social and religious reasons. Recently, research evidence has shown that male circumcision has a number of health benefits: including reduced risk in acquisition of urinary tract infections; syphilis; chancroid and the human papilloma virus in circumcised men. Furthermore, it has been established that cervical cancer is 2 to 5.8 times more frequent among women partners of uncircumcised males compared to partners of circumcised males.

The medical necessity for routine male circumcision has emerged as a controversial subject in the recent era. Potential medical benefits of circumcision include a small decrease in the rate of urinary tract infection and penile cancer and decreased risk of acquiring sexually transmitted infections. Currently, little is known on the attitudes and perceptions towards male circumcision among young adults. Moreover, controversy surrounds the procedure and its benefits and risks to health.

Not much has been done to determine the attitudes and perceptions of youths towards acceptability of male circumcision. Apart from grounded evidence that male circumcision reduce susceptibility to HIV infection from women to men, ensures penile hygiene and
fosters several health benefits; how circumcision is perceived to influence sexual drive, sexual performance and sexual pleasure for the man himself and/or his partner is likely to influence positive attitude towards circumcision.

The linkage between male circumcision and HIV infection acquisition has also recently been explored. A 25-year longitudinal study of a birth cohort of New Zealand children concluded that male circumcision may reduce the risk of sexually transmitted infection acquisition and transmission by up to one half, suggesting that there are substantial benefits accruing from routine neonatal circumcision.

More recently, a 60% reduction in HIV acquisition among circumcised men aged 18-24 years was demonstrated in a study from South Africa. Subsequently, two other studies in Kenya and Uganda have demonstrated reduction in risk of HIV acquisition of 53 and 48% respectively among circumcised men.

Since the publication of these results, there has been a great deal of interest in using male circumcision as part of HIV prevention strategies in high HIV prevalence countries where the virus is mainly transmitted heterosexually. In fact, in March 2007, the WHO and UNAIDS recognized male circumcision as an effective intervention for HIV prevention particularly in regions where the incidence of heterosexually acquired HIV infection is high, such as Sub-Saharan Africa. Guidelines have been developed on the practice of safe male circumcision and tools been developed for countries to use when considering scaling up of this intervention.

Malawi is one such country in Sub-Saharan Africa with high HIV prevalence and where the majority of males are not circumcised. However, even though male circumcision is now considered a proven public health intervention, its widespread introduction in countries such as Malawi, where communities either circumcise males using traditional methods or do not circumcise at all, is an issue which requires careful consideration. In light of this, several stakeholders’ consultations have been held in the country to examine the applicability of these research findings to the Malawian context. Among some of the concerns often voiced by some stakeholders is the apparent discrepancy in HIV prevalence in circumcising versus non circumcising communities whereby those districts where male circumcision is traditionally practiced also have quite
high prevalence of HIV. This may be attributable to incompleteness of circumcision as traditionally practiced or confounding. The table below shows results from the MDHS 2004 relating circumcision status and HIV prevalence.

Although the numbers are quite low precluding conclusive statistical inference, a general association is noted with a high prevalence of HIV amongst circumcised males compared to uncircumcised males. However, this association could be due to confounding of HIV status by ethnicity as both a high prevalence of male circumcision and HIV is associated with ethnicity.

In fact, amongst the circumcising ethnic groups, Yao and Lomwe, circumcised males had a lower HIV prevalence than uncircumcised males, 13.4% and 9.5% versus 16.8% and 13.5% respectively. Apart from this it is also reported that ceremonies around ritual circumcision result in high risk sex which promotes HIV transmission hence reducing the already compromised benefits of a traditional circumcision.

### Relationship between circumcision status and ethnicity in the MDHS 2004

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<th>ETHNICITY</th>
<th>Chewa</th>
<th>Tumbuka</th>
<th>Lomwe</th>
<th>Tonga</th>
<th>Yao</th>
<th>Sena</th>
<th>Nkhonde</th>
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The revised STI guidelines of 2008 only obliquely mentions male circumcision in light of its potential as a harmful practice if conducted in traditional settings under unsterile conditions and the attendant practices such as kutchotsa fumbi which increase the risk of sexually transmitted infections including HIV/AIDS.

The tone of existing policies and guidelines is also echoed in the life skills curriculum for primary and secondary schools, where the issue of male circumcision is only addressed in light of its potential as a risk factor for STI and HIV/AIDS but no direct reference is made for its potential for hygiene improvement.
These policies and guidelines were developed at a time when the evidence base for male circumcision’s linkage with HIV/AIDS was not strong enough and may in future be revised. However the general protective effects of male circumcision which have been well known for some time ought to have been addressed earlier and the fact that they were not addressed may point to a potential obstacle to be overcome in any male circumcision programming strategy.

The newly developed HIV prevention strategy for Malawi however acknowledges the potential role of male circumcision in strategic objective 1 of reducing sexual transmission of HIV where it specifically calls for the development of a male circumcision policy, interventions and communication guidelines based on international and local evidence which the present situation analysis is part of.

Male circumcision is not just a medical intervention with public health significance; but, also a cultural practice, which has always had wider social, political, religious and ethical dimensions. The term “Male Circumcision” is translated as kwumbala in Yao language. Kwumbala literally means removal or cutting of the foreskin (kata msumbu). Although it is a neutral word, it can sometimes be used negatively by non-circumcised men in order to insult a person because it associates the person with the cutting of his foreskin. However, when it is used among circumcised men, it is used to respect a person who is circumcised. Among the Lomwe and Mang’anja, they use the term “mdulidwe” which also connotes “cutting” (of the foreskin). Normally, the term mdulidwe is not commonly used among circumcised men.

Instead it is used by uncircumcised men to insult those that are circumcised. A man who is not circumcised is called “wosadulidwa” or “wodyera ku nkhongo”. The term “wosadulidwa” means uncircumcised while “wodyera ku nkhongo” means “one who eats through the back of his head” and it is an insult to an uncircumcised person.

In Malawi the discussions on male circumcision in the media and political circles have seldom dwelled on the critical evidence of its protective benefits for HIV spread and other health benefits. The discussion to date has unfortunately been colored by the religious and cultural connotations surrounding circumcision focusing on the conflict between the school calendar and initiation practices, religion and culture and the occasional conflict between circumcising communities and non circumcising communities.
To adequately address issues of acceptability, accessibility and feasibility of male circumcision, especially among currently non-circumcising populations, among whom the introduction of male circumcision has the greatest potential impact, a situation analysis was proposed. The situation analysis sought to generate relevant data that could be used to inform and guide future initiatives to promote male circumcision as part of a comprehensive HIV prevention strategy in Malawi. The key focus of the situation analysis therefore was to document existing status of male circumcision in Malawi.

The analysis specifically sought to:

- Review and document previous studies conducted on male circumcision in Malawi
- Examine what are the key determinants, of male circumcision in Malawi using existing data sources published and unpublished as well as using additional data collected as part of the analysis
- To determine current rates, service providers and behaviours that determine current and future male circumcision practice in Malawi
- To explore knowledge, attitudes and perceptions of people in Malawi about male circumcision in general and as an HIV prevention strategy.
- To assess the acceptability of introducing male circumcision as an HIV prevention strategy in both circumcising and non-circumcising communities in Malawi.
- To investigate the feasibility of implementing a male circumcision strategy for HIV prevention in Malawi.
- To document the unit costs of providing male circumcision at different health facility levels and estimate costs needed for national uptake and scaling up of male circumcision as a public health intervention.
- To provide recommendations on whether male circumcision should be adopted as one of the strategies for HIV prevention in Malawi.

The National HIV/AIDS council for Zambia (2004: 58) reports that HIV and other STIs are transmitted at a much higher rate in populations where a low proportion of males have been circumcised. In part, the foreskin has a large number of HIV target receptor cells – cells to which the virus can more readily attach itself and gain entry to the body. With circumcision, these receptor cells are removed.
Circumcised men also appear to be less susceptible to abrasions and tearing and less prone to ulcerative STIs, all of which facilitate transmission of the virus. Zambia is in a part of Africa where levels of male circumcision tend to be low (and where HIV prevalence high). Overall, about 85% of adult men are uncircumcised in most countries of eastern and southern Africa. The numbers are comparable in Zambia. A study in Ndola in the late 1990s found that about 93% of male respondents had not been circumcised (CSO, 2003).

Numerous studies have been conducted in several regions regarding male circumcision. A study in Namibia was carried out and similarly assessed perceived benefits and disadvantages, key influences affecting how decisions about circumcision are made, and levels of awareness about how circumcision can prevent the spread of HIV (Hiltebeitel, 2008).

Preliminary findings suggest that participants are well aware of perceptions and attitudes surrounding male circumcision, regardless of whether the practice is prevalent in their region or community.

A majority of focus group participants associated male circumcision with cleanliness, although some viewed it as increasing the risk of insect bites or other physical trauma. Some participants from areas with lower circumcision rates thought that it could lead to disfigurement or death or, if conducted by traditional circumcisers, the spread of HIV.

Participants generally agreed that uncircumcised men are more susceptible to infections, although many were uncertain about whether circumcision offered health outcomes superior to good hygiene practices. Many focus group participants were aware that male circumcision had been shown to reduce the risk of HIV. However, because HIV is transmitted through blood and semen, many participants were uncertain as to how circumcision actually reduces the risk of HIV infection. Some participants said they did not perceive substantial benefits if circumcision did not eliminate the need for condom use.

Hiltebeitel (Ibid.) reports that male circumcision was strongly associated with groups within Namibia who continue what was once a more widespread tradition of multi faceted rite of passage for young men. Participants from areas with lower circumcision rates expressed differing, often strongly held, opinions about whether circumcision was compatible with their cultural or religious beliefs.
Normative pressures were a common topic throughout discussions. Community and family pressures were seen as potentially exerting strong influences, especially in areas where circumcision rates are high. The decision was largely viewed as one that would be made by parents, especially mothers. The attitudes of sexual partners also appeared to have strong potential to influence men’s decisions.

Younger participants were more likely to view the decision as an individual choice. Normative pressure was seen as potentially working against the practice as well, with some participants concerned that it might prove difficult to be among the first in their community to decide on circumcision. Some participants stated that they would be more likely to choose circumcision if it were more widely accepted as a social norm, while among other groups, the practice was viewed as virtually compulsory.

Overall, participants expressed generally positive attitudes towards male circumcision, especially in regard to perceived health benefits. Regardless of the prevalence of the practice in their areas, study participants overwhelmingly supported the idea that the then government of Namibia had a role to play in dissemination of information on the topic of male circumcision. Participants wanted the government to provide clarification on the relationship between circumcision and health, especially with regard to HIV.

In a national survey in South Africa of 1067 men, Peltzer (2007), found that 15 years and older men have been circumcised, the majority (57.2%) had been circumcised traditionally and 42.8% medically. The vast majority of whites (97.8%), Indians (92.8%) and coloureds (87.4%) were circumcised medically, compared to only 21.8% of black Africans.

On the centrally, the Population Studies International (PSI) research study for Zambia (2007) submits that in the modern era individuals view MC as not being dependent on cultural and religious beliefs. Both circumcised and uncircumcised men believe that circumcision is not dependent on an individual’s region or culture. Similarly those from religions that advocate circumcision also echo this view.

Thus circumcision in the modern context is considered to be a matter more of personal choice, independent of one’s religion or culture. Other common determinants of male circumcision are ethnicity, perceived health and sexual benefits and the desire to conform to social norms. There is more to know about the attitudes and perceptions of youths.
A study undertaken in Malawi to investigate knowledge, beliefs and attitudes towards male circumcision reveal that more women than men were willing to accept MC, and to take their sons and to persuade their partners to be circumcised (Ngalande, 2004). To achieve this, separate focus groups with men and women aged 18 to 70 were conducted in eight communities using a semi structured interview guide. Some participants associated MC with Islam, medical problems and better genital hygiene. Ngalande also reports that except for the North, most females preferred circumcised males for a sexual partner.

A review of the 13 studies of acceptability of male circumcision on nine sub Saharan countries showed that median acceptability was 65% among men; nearly 69% of women favored circumcision for their male partners; and 81% of both men and women found circumcision acceptable for their male children (Westercamp and Bailey, 2007).

This showed that the knowledge and experience of parents on MC influenced acceptability on their children. Further, Mattson (2005) submits that some studies found that the most common barriers to acceptability of male circumcision were fear of pain, cultural and religious reasons, cost and concerns about complications and side effects especially if male circumcision was performed in traditional, non-medical settings.

Moreover, the major facilitators of male circumcision acceptability include better penile hygiene, protection from STIs and HIV infection, and the belief that male circumcision improved sexual pleasure. Other participants reported not to circumcise and gave the following reasons: religious, no knowledge about circumcision, belief that the procedure as dangerous, other for financial reasons. According to UNAIDS (2007a), families of higher social economic status and educational level, or living in urban areas are more likely to express positive attitudes towards circumcision.

A study carried out in India investigated the acceptability of male circumcision among Indian women (Madhivanan et al., 2008). This was a cross sectional survey conducted among a convenience sample of 795 women attending a reproductive health clinic in Mysore, India. Madhivanan reports that among the participants, the majority of women were Hindus (78%), 18% were Muslims and 4% were Christians.

After women were informed about the risks and benefits of male circumcision, a majority of women with uncircumcised children (n=564, 81%) said they would definitely have their children circumcised if the procedure were offered in a safe hospital setting, free of charge,
and a smaller number (n=50, 7%) said they probably consider the procedure. Only seven women (1%) said that they would definitely not consider MC and 63 (9%) were unsure. With these results, the study found MC to be highly acceptable among females.

Based on the literature review, most studies undertaken on MC show that a larger number of youths have positive attitudes concerning MC and that only a few view circumcision as not beneficial, especially that MC does not provide full protection against HIV and that its introduction does not eliminate the use of condoms among sexual partners.

Other participants generally agree that MC result to lower risk of HIV infection with others expressing uncertainty about whether MC offer health outcomes significantly superior to hygiene and how circumcision actually reduces the risk of HIV infection for the reason that HIV is transmitted through blood and semen. However, the above studies suggest that youths are aware of the benefits of MC and that some prefer circumcised to uncircumcised male partners. The above studies considered both males and females, the majority of whom were married.
CHAPTER 2

RESEARCH METHODOLOGY

INTRODUCTION

Methodology is generally a guideline system for solving a problem, with specific components such as phases, tasks, methods, techniques and tools. The selection of the research method is crucial for what conclusions you can make about a phenomenon. It affects what you can say about the cause and factors influencing the phenomenon. It is also important to choose a research method which is within the limits of what the researcher can do. Time, money, feasibility, ethics and availability to measure the phenomenon correctly are examples of issues constraining the research.

The chapter describes the methodology that was used as a guiding principal throughout this study. The research design, scope, sample size, data collection method, as well as the statistical analysis are discussed below. Owing to sensitivity of the subject under study, protection of human subjects and ethical considerations is included.

Our analysis uses a simple, parsimonious model to evaluate the potential impact of MC, and further empirical research is needed to support more detailed models. However, this analysis would show that MC could avert high HIV infection rates and save millions of lives in sub-Saharan Africa over the next twenty years. Especially in southern Africa (Zambia) this could go some way to meeting the 2001 United Nations General Assembly Special Session on AIDS targets, the Millennium Development Goals, and the objectives set by bilateral donors.

FOMULATION OF THE RESEARCH PROBLEM

Male circumcision has become a very interesting topic in the entire world today. Issues that link any kind of information are welcome in the vain to try and gather more data on the VMMC services. In this study the researcher decided to critically look at the link between male circumcision and the HIV infection.

As we know MC is the surgical removal of the foreskin of a man. The foreskin through researches and surveys has proved a influence the penetration of the HIV virus into the blood stream of an un-circumcised man. This is because the inner skin of the pennies bruises easily during coitus.
The diagram above indicates how the foreskin facilitates HIV entry.

**PILOT STUDY**

A pilot study is a mini study conducted before doing the actual main study. A few information was gathered in Lusaka to see how people relate MC and HIV. This study was done within Lusaka before the main research.

**NEED AND IMPACT OF THE STUDY:**

The study is mainly on the comparison or relationship between HIV and Male circumcision. As said in the general introduction Male circumcision has been researched that the foreskin harbours what are known as target cells; these cells make it possible for the HIV virus to be deposited in another person.
Also the inner skin of the male circumcision is very soft and bruises easily. During sexual intercourse there is a lot of bruising causing the weakness of the inner skin, this allows HIV to penetrate the same skin.

Male circumcision is the surgical removal of the foreskin. When the foreskin is removed the glans penis will be exposed to the outside and it will be keratinised. This will make it hard for easy bruising thereby protecting the circumcised people. This study will avail on issues that indicate the relationship between Male circumcision and HIV.

**OBJECTIVES OF THE STUDY:**

The study aims at finding outcomes and answers to some questions that have been lingering in peoples’ minds. Some these objectives are;

- To find out whether Male circumcision is related to the HIV infection.
- To find out the acceptability of male circumcision of in the community.
- The accessibility of male circumcision in our community.
- Who should access Male circumcision.

**STUDY DESIGN**

Most investigations of HIV infection as it relates to circumcision status are observational and cross-sectional. Although cohort studies are available, such as the HIV infection in men studies, most of the reported data as they apply to circumcision status are derived from baseline analysis rather than follow-up of participants over time.

The study used non-experimental design under which a descriptive study was employed for the purpose of permitting the description and analysis of male circumcision in relation to HIV AIDS prevention. Many scientific disciplines, especially social science and psychology, use this method to obtain a general overview of the subject. A fundamental element of descriptive reporting is a clear, specific and measurable definition of the disease or condition in question. Therefore, this study used descriptive study design for simplicity of analysis of the findings.
SAMPLING PROCEDURE AND SAMPLE SIZE

In this study non-probability sampling was used where purposive sampling was employed to target clients who came for circumcision for convenience’s sake. Probability sampling utilises some form of random selection to ensure that our study population is given an equal chance of being selected to be part of the research. Thus this factor was partially ignored as subjects were selected for convenience’s sake as the population/individuals studied were based on the judgement of the researcher.

Purposive sampling targets a particular group of people. When the desired population for the study is rare or very difficult to locate and recruit for a study, purposive sampling may be the only option. Our study is characterised by a hard to find group of circumcised men to draw our conclusions for HIV prevention. Thus purposive sampling will be a convenient method to capture the target study population and achieve our research mission.

DATA COLLECTION METHOD

A structured questionnaire with both closed and open ended questions were used, to provide the respondents with a possibility to express oneself freely without being restricted to proposed responses by the researcher. The underlying assumption is that respondents are free to answer the questions in the questionnaire at own convenience and honesty.

The aim of this approach is to ensure that each interview is presented with exactly the same the same questions in the same order. This ensures that the answers can be reliably aggregated and that comparisons can be made with confidence between sample subgroups or between different survey periods.

DATA ANALYSIS AND PROCESSING

Descriptive statistics was used to analyse and interpret the responses that were obtained in the questionnaires. In order to do this, the use of statistical software was necessary. Therefore, Statistical Package for the Social Sciences (SPSS) and MS-EXCEL was used to undertake the computational process in order to present data in different media such as frequency tables and graphs for easy of interpretations of findings.
Descriptive statistics provide simple summaries about the sample and the measures. Together with simple graphics analysis they form the basis of quantitative analysis of data. It helps us simplify large amounts of data in a sensible way.

**ETHICAL CONSIDERATIONS**

Keeping in mind that circumcision is embedded in a much more sensitive approach and that the individuals involved belong to different religious groups, cultural and ethnic traditions, the information obtained was treated with the highest confidentiality deserved. No individual risked harm due to disclosure of their private information as a result of their participation in this research.

The data acquired will be used for academic purposes only at DMI St. Eugine University. This is in an attempt to avoid humiliation and stigmatization of any of the research subjects involved in this study. Participants in this research will be voluntary and therefore subjects will have to give their informed consent to participate in the research.

**SCOPE OF THE STUDY**

The study focuses on the relationship between male circumcision and HIV AIDS. It is not so different from previous studies that may have been undertaken by different researchers. It builds on previous research findings and aims to fill in the gaps in order to establish an informed population in the area of male circumcision. The study seeks to establish how male circumcision is related to HIV AIDS in terms of how male circumcision can reduce the risk of contracting HIV.

**RESEARCH LIMITATIONS**

The limitations of this study are common to those of this nature and scale. The research subjects concerned may have been involved in several studies of this nature and thus express unwillingness participating in the study. The sensitive nature of the study may be the reason for non-response and/or even concealment of information in the manner in which responses will be offered by respondents. The research will be more perfect assuming an automatically positive response from the public.
- **Inadequate Finance:** Finances were limited for the researcher to do all the requirements of the research.

- **Inadequate Time:** Time was not enough as the programme demanded to be involved in the actual work and the distribution of questionnaires. The research is to be done in at least 3 months but this was not the case. There was so much to be done in a constrained time frame.

- **Small Sample:** The study sample was also made smaller than should have been appropriate for the purpose of generalization of study findings to other learning institutions. However, lack of funds meant downsizing the sample size for the funds available to be adequate. The study only involved 33 respondents out of about 500 clients estimated to undergo circumcision in a month at a site.

- **Negative or no Response:** Some respondents were not ready to give out information this impacted negatively on the research and concrete conclusion about reality of MC/HIV relation could not be accurately reviewed.
CHAPTER 3

RESEARCH FINDINGS

INTRODUCTION

This chapter presents information obtained from the respondents in the research that was conducted from the month of January to the month of April 2012. The research was concerned with ‘the relationship between Male Circumcision and HIV AIDS.’ On the foregoing, information presented in this chapter includes demographic information of the research on the relationship between male circumcision and HIV AIDS.

Circumcision occurs at a wide range of ages, and neonatal and child male circumcision is routinely practiced in many countries for religious and cultural reasons. There are several advantages of circumcising males at a younger versus older age, including a lower risk of complications, faster healing, and a lower cost. However, some parents may wish to wait for an older age for religious or cultural reasons, or have a preference to wait until the child can give consent for the procedure.

The procedure is undertaken by a range of providers, with the choice of provider depending on family or religious tradition, cost, availability and the perception of service quality. As an engrained religious and cultural practice, paediatric circumcision is likely to continue to be highly prevalent around the world, and is now being considered as a long-term HIV prevention strategy.

This review shows that circumcision complications are rare when conducted by trained and experienced providers with adequate supplies and in hygienic conditions. However, there is a clear need for comprehensive, ongoing training programmes for both medically trained and non-medically trained providers, which should cover all aspects of the procedure and after-care in order to avoid the current unnecessary morbidity associated with the procedure in many settings. There is currently relatively little data comparing risks by different methods, types of provider or age at circumcision, and further prospective studies are needed. A number of new disposable devices for circumcision are available, and further work is needed to evaluate the potential for these to be used in different settings.
In recent years, many articles have appeared in the literature that has examined the relationship between circumcision status and the risk of contracting human immunodeficiency virus (HIV) infection. This page introduces abstracts, full text articles, and other material about this relationship. The materials are indexed in chronological order.

Whether circumcision status plays a role in HIV risk or not, it is important to recognize that HIV can be prevented through several known very effective means, such as condom use, and limiting exposure to multiple partners. Rather than advocating circumcision, given the existing evidence, it would be appropriate to advocate better public health education, so that individuals can make appropriate decisions regarding their own sexual behaviour.

Furthermore, the consideration of circumcision with regard to STD and AIDS prevention does not apply to children. Kept intact from birth, they can weigh the issue for themselves when they are old enough to consent. A vaccine may even be available by the time they reach adulthood!

According to a recent meta-analysis of studies on male circumcision—the removal of all or part of the foreskin of the penis—in sub-Saharan Africa, this procedure may reduce HIV infection risk by approximately 50 percent. Acceptability, feasibility, safety, and cost-effectiveness of male circumcision as a public health intervention need to be explored and better understood if appropriate decisions with regard to the allocation of scarce HIV intervention resources are to be made.

To this end, on February 7-8, 2000, Horizons convened a meeting of leading international researchers to explore programmatic and research implications of the strong association between male circumcision and lower prevalence of HIV infection.

**Male Circumcision: What We Know So Far:**

In sub-Saharan Africa, where most studies have been done, male circumcision is statistically associated with a reduced rate of HIV infection. Male circumcision may thus be seen as a potential new intervention for reducing HIV incidence, and there is anecdotal evidence of an increased demand for male circumcision in some communities as a result of increased concern about HIV/AIDS. But little is known about the acceptability, feasibility, safety, and cost-effectiveness of male circumcision in different parts of sub-Saharan Africa, especially
among currently non-circumcising populations, among whom the introduction of male circumcision has the greatest potential impact. Research also suggests that the protective effect against HIV infection is most pronounced if the procedure is done before the onset of sexual activity. In many parts of sub-Saharan Africa, circumcision is typically done as part of initiation to manhood rites, at ages ranging from 10 to 20 years or even older.

**Next Steps for Research:**
Randomized controlled trials should be conducted to prospectively evaluate the effect of circumcision on HIV transmission. While such studies are expensive and difficult to implement, often involving sensitive ethical issues, they are the only way to adequately address key questions about circumcision. Such studies should include penile hygiene as an independent variable. Little is known about the role of the foreskin in relation to HIV transmission, which needs further study.

Acceptability studies should be done in currently non-circumcising populations. Social and behavioural consequences of introducing male circumcision as an HIV intervention should also be studied. Anecdotal evidence suggests that male circumcision is perceived in some areas as protective against HIV infection, and has even been referred to as the “invisible condom.” Perceptions of protection may lead to increased risk behaviours, including reduced condom use. Thus any male circumcision intervention should include HIV prevention education, counselling and behavioural change interventions, and sustained promotion of condom use.

Researchers should also explore the safety of the procedure in different settings, operational aspects of male circumcision interventions (training, personnel, equipment, cost), issues of informed consent (including parental versus client consent), and public understanding of risks and benefits. Finally, a country-level rapid assessment tool should be developed to prepare for male circumcision programs.
Future Research Directions for Horizons;

The Horizons Program is well placed to address a number of research questions related to male circumcision in its ongoing research portfolio, and to undertake operations research specific to this issue. Participants proposed the following activities for Horizons:

- Integrate assessments of attitudes and beliefs about male circumcision in ongoing studies in circumcising and non-circumcising populations, including the role of circumcision in the gender and sexual socialization of boys.
- Explore the understanding of the benefits of male circumcision among parents, adolescents, and young adults.
- Conduct observational studies of traditional male circumcision practices, including assessments of parent and client understanding of the benefits of male circumcision.
- Include questions on circumcision status in ongoing studies.
- Model the costs and impact of male circumcision in different settings.
- Design longer-term studies on the costs and safety of male circumcision.
- Develop and field-test a rapid assessment tool to assess the feasibility and cost of introducing male circumcision.

As a result of carrying out these research activities, Horizons would contribute to answering the following research questions:

- Whether introducing male circumcision as an HIV intervention in currently non-circumcising populations is feasible, acceptable, and cost-effective.
- What the gender and ethical implications of promoting male circumcision are and how they can be addressed programmatically.
- How best to collaborate with non-clinical (religious and traditional) and clinical providers of circumcision services to implement safe and effective male circumcision interventions (in terms of training, supervision, and support).
- How best to obtain informed consent at different ages.
- How male circumcision should be promoted to enhance acceptability while at the same time avoiding a reduction in preventive behaviour, such as condom use.
- More about the minimum resource package needed to perform male circumcision safely, such as properly equipped facilities and adequately trained staff.
• Using mathematical modelling, what the short- and long-term impact of male circumcision on HIV transmission under different conditions is, at different ages, in different populations, as well as the cost of such interventions.
• What specific criteria program managers should use to prioritize male circumcision among proven HIV prevention strategies.

**Relationship between HIV and Male Circumcision**

Although many participants recognized the role of male circumcision in the prevention of STDs, including HIV, most were unclear or unconvinced. Some misunderstood or disbeliefed how the two are related. Others perceived that circumcision led to an increased risk for HIV.

Although many focus group participants had heard news items on the protective relationship between HIV and male circumcision and could even cite the 60% protective rate, some were either confused or did not believe that the change of HIV transmission was affected by circumcision. This disbelief seemed to involve: the difficulty in distinguishing between the concepts of reduced risk versus no risk, the lack of understanding of the mechanism of transmission, misconceptions regarding the role of bathing, the level of protection condoms provide, and a fatalistic attitude toward prevention in general.

1. **Reduced risk versus no risk:**

Broadcast messages on reduced risk and the relationship between male circumcision and HIV had confused many participants, who seemed to grapple with the distinction between “no risk” and “reduced risk.”

**Understanding the mechanics of transmission:**

Many participants were adamant that male circumcision offered no protection against HIV because transmission occurs through blood and semen, which are unrelated to foreskin. According to older women in Okavango, ‘They need to use condoms because HIV is not found in the foreskin but inside the body. But STDs, like gonorrhoea, are found on the outer part of the skin.’
In several cases, participants distinguished the protective effect of male circumcision from HIV versus other STDs, namely syphilis and gonorrhoea. This is possibly due to the different ways these infections are believed to be transmitted.

2. Bathing

Some participants think the relationship between male circumcision and HIV could be mitigated by bathing. According to a young female from Karas, ‘It is necessary for circumcised men to use condoms, because sometimes you sleep with someone who is infected with STDs.’

However, a young woman from Oshana is of the view that ‘Male circumcision can lower the risk of HIV infection because men don’t like bathing like us women.’ He can go without bathing for two days, even though he sleeps with different women. But because he is circumcised, it can help him not to get infected because the bacteria on his manhood will die when exposed to air, given that the skin is no longer there.

From these excerpts it is clear that some respondents view circumcision as an alternative or addition to bathing. Some participants described an increased benefit of circumcising over bathing in times or locations where water is scarce. An older, uncircumcised man from Khomas discussed the role of cleanliness as a protective strategy and how a lack of water may compromise that strategy:

3. Role of condoms

In addition to the perception that bathing prevented HIV transmission, participants similarly discussed the role of condoms. In general, participants expressed an acceptance of the continued need to use condoms, despite circumcision status. In response to a question about whether circumcised men still need to use condoms as protection from HIV, a young man from Kavango said, “Yes, men who are circumcised will need to use a condom because the disease is carried by semen. Condoms are best.”
According to a young man from Karas, “Basically, whether you are circumcised or not, if you have penetrating sex and are unprotected, you’ll get HIV.” Likewise, a young, circumcised man from Omaheke said, “Whether you are circumcised or not, you can’t not use a condom.” In some cases, the continued need to use condoms furthered disbelief in the relationship between circumcision and HIV prevention. For others, circumcision was seen as an additional strategy for protection, including condom use.

**Problems with condoms:**

In Caprivi alone, some participants said that condoms should not be used at all, citing them as sources of HIV infection and adding that condoms are forbidden by the Bible because they inhibit conception. These participants saw male circumcision as the solution to the HIV/AIDS problem. This belief was related to the fact that circumcision did not interrupt pregnancy and was therefore consistent with religion.

The following comments were made during a discussion with older men in Caprivi when the facilitator asked, What is the relationship between wearing condoms and male circumcision? Some people feel there is no relationship. The condoms are bringing too many deaths to Caprivi they say.

**Fatalism:**

Some participants attached fatalism to HIV infection, stating that it is only bad luck if you get it and that circumcision status makes no difference. AIDS was identified as an unavoidable curse. A male respondent from Caprivi said, “It was important to be circumcised a long time ago, but no longer. Now, even if you are circumcised, AIDS can kill you.”

**Belief that male circumcision increases the risk of HIV:**

When asked about the relationship between HIV and male circumcision, many respondents said that being circumcised increases the risk of infection. This belief appeared to be related to two main reasons: 1) infection that is caused by unsafe circumcising practices (i.e., re-using blades) and 2) that being circumcised leads to increased sexual risk taking (disinhibition) as a result of a sense of being protected. Increased risk from unsafe circumcising practices:
Many participants from areas with lower rates of circumcision reported that male circumcision contributed to HIV infection when it is performed by traditional circumcisers who use one blade for many procedures.

**Disinhibition:**

For many participants, understanding and accepting the relationship between HIV and male circumcision reduced or eliminated the belief in the need for other protective strategies, such as condoms and partner fidelity. This was common among men, although some women suggested feeling less vigilant about the need to protect against disease with circumcised partners. Young women from Oshana discussed the question of how a man’s circumcision status affects his condom use and number of sexual partners:

If a person is circumcised, that doesn’t mean he is free to engage in unsafe sex with anyone. It is not that he won’t get bacteria. Of course he will, especially HIV, which one can get easily. They have to protect themselves like those who are not circumcised.

In addition to the perception that those who are already circumcised may engage in higher-risk behaviours as a result of their belief that they are protected, some uncircumcised participants indicated that they found the option of circumcision compelling precisely because it would mean they would not have to use condoms.

The following quote from an older man from Oshana reflects the complex relationship between lack of knowledge, disinhibition, and bathing with regards to circumcision and STDs: he said, ‘Circumcisions won’t be done because, first, the people from here are scared of such things. Second, they accept [their fate]. Third, they don’t know the reasons why someone should be circumcised. But [Angolans] do: to prevent STDs. I think, if you sleep with a woman without a condom who has an STD and you are not circumcised, you will be infected immediately.

If you’re circumcised, you won’t be infected. . . . In developed countries, there are just a few people that are infected, but here, in Namibia, a lot of people are. In those countries, one person has about 80 women, and he sleeps with them all in one day. But if you have a lot of women and, say, two are infected, you won’t leave without being infected.’
PRESENTATION ANALYSIS AND INTERPRETATIONS OF THE RESPONSES

The tables below represent a statistical overview of all the responses that were provided into the questionnaires by the respondents and these are discussed in detail as we proceed.

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Background characteristics are thought to have an influence on the attitudes and perceptions of individuals towards male circumcision. Among the characteristics captured are; age, religious denomination, residential area and ethnicity of respondents.

Age of an individual in the study group is an important factor. Some researchers may be interested in a particular age group when carrying out their studies. This study, however, is interested in all ages as the subject in question affects all persons. The table below show that majority of the respondents (49%) were aged between 20 and 25 years, followed by 27% for ages between 26 and 30 with a tie of 12% for ages between 15 and 19 and 31 and above.

Table 1.0) Age distribution of respondents

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>20-25</td>
<td>16</td>
<td>49</td>
</tr>
<tr>
<td>26-30</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>31+</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 1.1 indicates respondents’ education level. The table shows that the majority of the respondents attained tertiary education school level, 15 (45%). 36% of the respondents did not indicate their education attainment, 12% attained secondary education and 6% only attained primary education.
Table 1.1) Distribution of respondents by education level

<table>
<thead>
<tr>
<th>Levels</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary education</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Secondary education</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>Non-response</td>
<td>12</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The table below shows the distribution of respondents by occupation. Majority of the respondents (64%) operate in other works not mentioned, 9% are teachers and only one(3%) of the participants is a health personnel while 15% are general workers.

Table 1.2 Occupation of Respondents

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Health personnel</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>General worker</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Others</td>
<td>21</td>
<td>64</td>
</tr>
<tr>
<td>Non-response</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Religious denomination is yet another very important variable because it, in one way or another, influence individual attitudes and perceptions towards circumcision and its relationship to HIV prevention. In Christianity, the bible supported circumcision of all Jewish males. Figure 2.0 shows that most respondents were Christians (97%) and only one (3%) respondent was a Muslim.
Table 1.3) Residence of the respondents

<table>
<thead>
<tr>
<th>Residence</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matero</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Mandevu</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>UNZA</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Nyumba Yanga</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Chilenje</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Rhodespark</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Kabanana</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>John Haward</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Kamwala</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>CBU</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Libala</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Chilanga</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Valley View</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Long Acres</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Mutendere</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Kanyama</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Arakan Baracks</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Non-response</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>91</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>
Residence of the respondents is also an important variable in this study. Where respondents are located actually shows how easy it is for them to access male circumcision services. We are able to tell this through analysis of the distance to the site where they access circumcision services. As shown in table 1.3 above, clients for Chachacha MC site come from surrounding townships except for the one from the Copperbelt University (CBU).

In Zambia male circumcision is considered a cultural practice among the Luvale, Lunda and among other (Muslim) people. It is therefore expected that respondents with such an ethnic background have a positive attitude towards male circumcision. In the same way, marital status of an individual also influences decision on circumcision. Figure 2.1 shows that there were more Nyanja respondents (10) compared to other tribes with Bemba being second out of a total of 33 respondents who participated in this study.

![Figure 2.1) Ethnicity of Respondents](image)
In figure 2.2, more of the respondents were single 25(76%) with only 8(24%) married.

**RESPECTENTS’ AWARENESS ON MALE CIRCUMCISION**

There is a high level of knowledge among respondents and growing awareness among the general public about the benefits of male circumcision for HIV prevention.

**Table 1.4) Awareness of male circumcision**

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ever heard or learnt about Male Circumcision</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33</td>
</tr>
<tr>
<td><strong>Where did you first hear about Male Circumcision</strong></td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td>15</td>
</tr>
<tr>
<td>Radio</td>
<td>7</td>
</tr>
<tr>
<td>Church</td>
<td>1</td>
</tr>
<tr>
<td>Family Member</td>
<td>7</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
</tr>
<tr>
<td>Who should be circumcised</td>
<td>Total</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Newborn baby boys</td>
<td>21</td>
</tr>
<tr>
<td>Adults</td>
<td>5</td>
</tr>
<tr>
<td>School going children</td>
<td>3</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
</tr>
<tr>
<td>Non-response</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

In the table above, it is clearly shown that all respondents are aware about male circumcision. When asked about the first source of information on male circumcision, majority respondents indicated that they got information from their friends. The table also indicates that majority respondents prefer new born babies to be circumcised while others indicated that everyone must be circumcised.

Table 1.5) Are male circumcision services easily accessible in your community

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>18</td>
<td>55</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>39</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>97</strong></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Male circumcision services seem not to be easily accessible as expected, 55% of the respondents agreed that circumcision programs are easily accessible in their community indicating that 45% of the communities have no access to male circumcision.
Table 1.6 shows the source of circumcision programmes for those who admitted easy access to male circumcision. It is expected that the introduction of information desks for male circumcision be implemented in all health centres to increase access to the service, but it seems most likely that few people enquire about male circumcision.

**Table 1.6) Source of MC programmes**

- CBU clinic
- Chachacha MC; DHMT Chawama
- Chilenge clinic, YWCA, Kabwata clinic, Kamwala CLINIC
- Chilenje Clinic
- Chingwele and Matero clinics
- Health Promoters
- Moses Siame; Joshua Ndaba
- UNZA Clinic; YWCA

**BELIEFS, BENEFITS AND ATTITUDES TOWARDS MALE CIRCUMCISION:**

With the possibility that male circumcision could be considered as an additional HIV prevention strategy in most communities of Zambia, it is nevertheless important to realise that male circumcision is generally considered a cultural or religious practice and it is rarely considered a health issue. However, with the perception that male circumcision reduces the risk of HIV and STIs and especially that it is associated with reduced risk of cervical cancer for women, many could now consider it a health issue. In an event to elucidate respondents’ beliefs and attitudes towards male circumcision, respondents were asked to state if they know of any myths about male circumcision.

As shown in table 1.7, majority of respondents (61%) stated that there are no myths about male circumcision while 27% stated that there are some myths.
Table 1.7) Do you think there are some myths about male circumcision?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>61</td>
</tr>
<tr>
<td>Non-response</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>97</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Some of the myths that respondents gave are that those circumcised become less sensitive thus less sexual satisfaction. Others stated that circumcision is painful and takes long to heal. Other myths stated are that: people die due to bleeding; circumcision is only done by certain tribes; the foreskin is cooked and those circumcised eat it. Others cited sexual satisfaction to ladies and prolonged ejaculation as myths.

Table 1.8) Should male circumcision be restricted to certain tribes?

<table>
<thead>
<tr>
<th>Male circumcision be restricted to certain tribes</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

In table 1.8, only one respondent did agree that male circumcision be restricted to certain tribes. The rest of the respondents are of the view that male circumcision should not be restricted to certain tribes. This indicates that whether an individual come from a circumcising or non circumcising tradition, male circumcision must be open to everyone as it is beneficial for health.
Table 1.9) would you advise your brother/friend to undergo male circumcision

<table>
<thead>
<tr>
<th>Would you advise your brother to undergo male circumcision?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32</td>
<td>97</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Would you encourage your friend to undergo male circumcision?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32</td>
<td>97</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

The table above show that 97% of the respondents reported that they would advise their brothers and friends to go for circumcision and only one (3%) would not advise their brother and friend to undergo circumcision. Among the reasons for advising circumcision to their brothers are; reduced risk of HIV infection and penile hygiene including reduced risk of cervical cancer for women.

The preferred age for circumcision varied, but the majority (79%) respondents reported that it must be done between ages 0 and 15.
In table 1.10, results indicate that majority of the respondents (49%) prefer who should access circumcision for ‘others’ (here respondents cited reasons that all men must access circumcision regardless of their status for the benefit of all citizens). All males, everyone else regardless of their status, their should be no limit as to who must access circumcision and the like. 30% prefer circumcision for the singles, 9% for school boys while only 6% prefer circumcision for married men.

**Table 1.10) Who should access Male Circumcision**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singles</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>School boys</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Married men</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>16</td>
<td>49</td>
</tr>
<tr>
<td>Non-response</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

When asked if parents should consent for their sons to be circumcised, majority of the respondents (94%) agreed to this and only 1(3%) mentioned that parents should not consent
for their sons to be circumcised with 3% declining to offer a response, these results are shown in table 1.11 below.

Table 1.11) Should parents consent for their sons to be circumcised?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31</td>
<td>94</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

When asked if all men must undergo an HIV test before circumcision, majority of the respondents (82%) were in support of this view while 15% disagreed on undergoing an HIV test before circumcision.

Table 1.12) Must all men undergo an HIV test before circumcision?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>27</td>
<td>82</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

The table below is a summary of some reasons given by respondents for undergoing an HIV test before circumcision.
### Table 1.13) Reasons for undergoing an HIV test before circumcision

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits becomes real</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>For a person to benefit fully</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>For easy treatment in case of they have a soul</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>For them to be responsible</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>For them to receive special treatment if positive</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Good to know one's status and if positive one has to be put on medication before undergoing circumcision</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>In case they are positive, they will know how to protect their partners and themselves</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>So that you are 100% sure about your health by not having the virus</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>To avoid other transmissible diseases that may interfere the health of staff circumcising clients</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>To give a bit of protection because circumcision is not 100%</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>To know how much health care person needs</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>To know how to treat their wound</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>To know their HIV status</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>To know their HIV status and protect their partners</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>To know their status</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>To know your status</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
In the table below, all respondents suggested that only health professionals should offer male circumcision and only one could not review his/her response.

**Table 1.14) Who should offer male circumcision services**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health professionals</td>
<td>32</td>
<td>97.0</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The percentage of male infants circumcised varies by geographic, by religious affiliation, and to some extent, by socioeconomic classification. The figure below shows that most respondents (70%) are of the view that it is acceptable to circumcise new born babies. 24% are not of this view.

As many may argue, circumcision must be based on personal conviction and the right for own decision be respected. In the modern era, we see that majority of parents especially the literate consent for their sons to be circumcised. Is this not against the rights of an individual to decide on his/her own? The question remains unanswered by many writers and not much has been researched on this issue.

**Figure 2.4) Is it good or acceptable to circumcise new born babies?**
Table 1.15) Is there enough information in your community about male circumcision?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13</td>
<td>39</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>52</td>
</tr>
<tr>
<td>Non-response</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

The table above show that information about male circumcision is not fully disseminated to society. Respondents have reported luck of information in their communities. 52% of respondents have mentioned that their communities receive not enough information about circumcision with 39% reporting having enough information. Only 9% of the respondents concealed information as to whether or not their communities have enough information about male circumcision.

When asked on what should be done to increase access to information on male circumcision, majority of the respondents preferred TV programs (21%). 12% preferred radio programmes and school involvement. Other (33%) respondents preferred all media of information dissemination and others suggested drama and peer education for rural areas as they may not have access to radios and TV programs.
Figure 2.5) what should be done to increase access to information on male circumcision

In figure 2.6 below, majority (76%) of respondents are of the view that male circumcision must be implemented in the Ministry of Health as a policy.

**Figure 2.6) Should male circumcision be implemented in the Ministry of Health as a policy?**

Only 12% of the respondents disagreed to implementing male circumcision as a policy in the Ministry of Health and 12% of the respondents declined from giving their thought.
In order to promote a health economy, many countries have thought to offer male circumcision as a free service. If offered on a fee, it is set at a cost that would accommodate all class of communities. In the table below, majority of the respondents (91%) are of the view that male circumcision should be offered as a free service.

Table 1.16) Do you think male circumcision should be offered as a free service?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30</td>
<td>91</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Non-response</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

Male circumcision is surrounded with numerous misconceptions. While others feel circumcision is a simple procedure, others feel it is not easy and simple at all thus deter them from undergoing the operation. The table below show that majority of the respondents (58%) think male circumcision is an easy procedure 33% feel it is not easy or simple at all. This show that there is need to make more efforts in convincing the male circumcision clients to be on the porcedure of circumcision and how easy and simple it is if done by health professionals.

Table 1.17) Do you think male circumcision is an easy or simple procedure?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>19</td>
<td>58</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Non-response</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>
Male circumcision has been associated with reduced risk of HIV infection. Ever since the initiation of medical male circumcision, research trials have found that circumcision prevented HIV infection levels by up to 60%.

Table 1.18) Does male circumcision protect someone against HIV infection?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16</td>
<td>49</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>39</td>
</tr>
<tr>
<td>Non-response</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>97</td>
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<tr>
<td>Missing</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

The table above show that 49% of the respondents agreed that circumcision protects one against HIV infection. 39% of the respondents did not agree that male circumcision protect one against HIV infection while 9% of the respondents did not provide a response. Statistically speaking, the difference between respondents who are not in support of circumcision reducing HIV infection and those in support is so minimal.

This is not a good sign in an environment where much efforts are placed in an event to promote male circumcision as an HIV reduction strategy. The statistics above show that there is need for intensive information dissemination to communities as regards male circumcision.
Table 1.19) Should the National AIDS Council of Zambia be part and parcel of policy formulation in the MC programs?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Non-response</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

It is important that government bodies with the authority to oversee the problems associated with HIV/AIDS, such as the National AIDS Council of Zambia and the Ministry of Health, be part and parcel of policy formulation in male circumcision programs. As shown in the table above, 94% of the respondents second the involvement of the National AIDS Council of Zambia to play a role in decision making for the fight against HIV infection.

Table 1.20) Should the Ministry of Health be the only policy making organisation in issues of HIV and male circumcision?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>23</td>
</tr>
<tr>
<td>Non-response</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

In the table above, majority of respondents (70%) are not of the view that the Ministry of Health be the only policy making organisation in issues of HIV and male circumcision.
Generally, the differences in numbers or percentages as seen in our analysis above show that the overall results indicate positive attitudes towards male circumcision by respondents and society as a whole. It is overwhelming to note that our communities have positive attitudes and perceptions towards male circumcision as a health measure to curb risk of HIV infection. As shown in figure 2.7 above, 94% of the respondents agree that male circumcision is beneficial, non of the respondents disagreed and only 2(6%) declined to share their thought.
CHAPTER 4

FINDINGS

INTRODUCTION:

In this chapter, a more elaborate and clear picture of the research findings are reviewed to give out the participants’ view about the relationship between MC and HIV. As indicated above male circumcision is the surgical removal of the foreskin which is thought to be a culprit for HIV transmission. Male circumcision has been shown to reduce men’s risk of becoming infected with HIV through heterosexual intercourse by at least 50 – 60% and possibly as much as 70% or more. While male circumcision has been shown to reduce the risk of acquiring HIV significantly, male circumcision does not provide complete protection from HIV infection.

Research Findings

As mentioned earlier, the general of this study is to find out the relationship between male circumcision and HIV. Participants were given questionnaires and the following results were obtained after analysis of the responses;

- There is growing awareness among the general public about the benefits of male circumcision
- Friends are the main source of information concerning male circumcision
- Access to male circumcision services is a major concern in some communities
- There is lack of full information about male circumcision in the communities
- All media instrument be used in dissemination of information to promote male circumcision
- Preferred age for circumcision among the general public is 0 to 15 years
- All men must undergo an HIV test before circumcision
- The general public prefer circumcision to be done by qualified health professions
Male circumcision must be implemented in the health sector as a policy

All men must undergo circumcision regardless of their traditional beliefs for health benefits

- Male circumcision should be offered as a free service and where a charge applies it should not go beyond 5000 Zambian kwacha

- There is still a problem with the general public’s perceptions about male circumcision, while others agree that male circumcision protects one against HIV infection, others argue that it does not because it only provides partial protection and one still need to use a condom even when circumcised thus less beneficial.

Discussion of Findings;

The relationship between male circumcision and HIV is quite significant. There is positive attitude among communities that male circumcision protects one against risk of HIV infection. The situation analysis clearly demonstrates changing perceptions on acceptability of male circumcision if the right information is provided.

Most of the community members are not at present willing to pay for male circumcision and where they are, they can only pay very small price for it. The preferred provider of male circumcision is the formal health sectors and none of the respondents prefer traditional circumcisers. The preferred age for conducting male circumcision is around adolescence (between 0-15 years).

When asked about the first source of information on male circumcision, majority respondents indicated that they got information from their friends. It seems most likely that communities are free to interact among themselves and share ideas regarding male circumcision. This is actually one of the benchmarks of decision making as regards circumcision.

In general, respondents expressed positive attitudes toward male circumcision. This was particularly true for those who were primarily in favour of male circumcision because of the perceived health benefits. Men who were not in favour of circumcision felt “fine with how they are” and did not see any reason to change.

Preference for who should be circumcised varied. However, the majority respondents (64%) preferred circumcision for newborn baby boys. Only 55% of the participants reported that
Male circumcision was easily accessible in their communities. This is not good as it reflects that there is much that needs to be done to increase access to male circumcision among youths.

The preferred age for circumcision varied, but the majority (79%) respondents reported that it must be done between ages 0 and 15. Some respondents seemingly felt not to circumcise those who are too old, but would encourage it for younger boys. This is similar to the findings arrived at in Malawi where most focus group participants in all categories noted that ethnic groups that circumcise send their children for Male Circumcision between the ages of 9 and 12 year (below 24 years). When asked at what age male circumcision is typically done, responses ranged from birth through to adulthood for Namibians.

When asked who should offer male circumcision, all respondents (100%) suggested that only health professionals should offer male circumcision. This is overwhelming as participants showed that their main concerns related to the quality and safety of the procedure to those willing to undergo circumcision. 97% of the respondents reported that they would advise their brothers to go for circumcision and only one (3%) would not advise their brother to undergo circumcision.

Among the reasons for advising circumcision to their brothers are; reduced risk of HIV infection and penile hygiene including reduced risk of cervical cancer for women. Similarly 97% of the respondents reported that they would encourage their friends to go for circumcision.

Respondents were also asked if they perceived some myths about male circumcision. 9% of the respondents declined to give their view. The majority (61%) of the respondents said there are no myths about MC and 27% disagreed having any myths about male circumcision. Among the myths that were highlighted by the participants are that; that circumcision is a painful procedure and the wound takes long to heal. Others stated are that; people die due to bleeding, circumcision is only done by certain tribes, the foreskin is cooked and those circumcised eat it. Others cited sexual satisfaction to ladies and prolonged ejaculation as myths.
When asked if circumcision should be restricted to certain tribes, majority of the respondents (97%) reported that circumcision must not be restricted to certain tribes but be open to everyone who would want to undergo the procedure.

Respondents were also asked if parents should consent for their sons to be circumcised and 94% agreed, 3% disagreed and similarly, 3% did not review their opinion. Participants were also asked if it was acceptable to circumcise newly born babies and only 24% rejected this and 70% agreed that it was acceptable.

On the contrary, this is not the case with some respondents as regards the right of the child to decide on MC. In a study on male circumcision in Namibia, participants felt that it is best to wait until the child is a little older so that their growth is not inhibited and so he can make the decision for himself.

A young woman from Kavango said, “It is better to circumcise a man from eight years old. It is not good to circumcise a baby as it affects the baby’s growth.” A young woman from Oshana said, “It is not good to circumcise a child young because he needs to decide for himself. What if I get him circumcised while young and he blames me when he grows up?”

Respondents also expressed their view on whether or not an HIV test must be done to all males who are to undergo circumcision. 82% were of the view that before circumcision clients must undergo an HIV test, 15% disagreed and 3% also did not respond. Among the proposers of an HIV test before circumcision, the supporting reasons were that; so that you are 100% sure about your health by not having the virus, to avoid other transmissible diseases that may interfere the health of staff circumcising clients.

If the client is HIV positive wounds delay to heal and may bring other problems so a test is necessary to determine how much health care a person needs, to determine if any help could be offered and ascertain successful healing, help if the client is positive, important to know one’s status, to prevent their partners and, to be better informed about one’s health and healing, for a person to benefit fully become responsible.
When asked if there was enough information about male circumcision in their communities, only 39% of the respondents reported having enough information and the majority (52%) reported lack of information about male circumcision and 9% declined from giving a response.

This is not so good especially where the rollout of male circumcision is a priority as lack of information will hinder service delivery for male circumcision. Thus, clients expressed interest in increasing information spread concerning male circumcision and suggested that all forms of media to do this: newspapers, radio programs, TV programs, Internet, posters and billboards, drama and peer education among others.

If male circumcision is to be implemented as a compulsory measure in the health policy, a clear standard service package ought to be defined and service linkages established especially with HIV and STI treatment. Respondents were asked if they would recommend adoption of male circumcision in the health policy as a compulsory measure. 76% were in support of this and only 12% rejected the proposal with 12% declining to express their opinion.

When asked if MC must be offered for free, 91% were of this view, while others preferred a charge for the procedure ranging from 1000 to 5000 Zambian kwacha if MC clients are to pay, only 3% reject free service for male circumcision and 6% declined to respond. Respondents were also asked if male circumcision was beneficial in their society and 94% agreed and 6% of the respondents did not give a response. 58% were of the view that MC was an easy procedure, 33% disagreed and thought circumcision was a painful procedure with a record of 6% non-response and 3% not sure from some respondents.

When asked if male circumcision protects one against HIV infection, 49% of the respondents agreed that circumcision protects one against HIV infection. 39% of the respondents did not agree that male circumcision protect one against HIV infection while 9% of the respondents did not provide a response.

Statistically speaking, the difference between respondents who are not in support of circumcision reducing HIV infection and those in support is so minimal. This is not a good sign in an environment where much efforts are placed in an event to promote male circumcision as an HIV reduction strategy. The statistics above show that there is need for intensive information dissemination to communities as regards male circumcision.
It is important that government bodies with the authority to oversee the problems associated with HIV/AIDS, such as the National AIDS Council of Zambia and the Ministry of Health, be part and parcel of policy formulation in male circumcision programs.

As shown in the table above, 94% of the respondents second the involvement of the National AIDS Council of Zambia to play a role in decision making for the fight against HIV infection. Majority of respondents (70%) are not of the view that the Ministry of Health be the only policy making organisation in issues of HIV and male circumcision.
CONCLUSION

Despite some perceived disadvantages, participants overall endorsed male circumcision, especially relative to health. Their main concerns related to the quality and safety of the procedure, accessibility, the coordination of efforts among providers (medical and traditional), the benefits, and the possible tendency toward dis-inhibition. There was overwhelming support for increased access to information to the public on male circumcision.

Many respondents felt that a clear and comprehensive education program - one that would incorporate local authorities, door-to-door educators, and media sources, such as radio and TV shows among others - would reduce misconceptions about and encourage uptake of male circumcision.

Respondents also expressed a preference for having services provided at hospitals, increasing training, and making circumcision services more available. Some participants expressed a mistrust of traditional circumcisers, while expressing preference for medical health practitioners. As seen in our analysis, majority of the respondents (97%) suggested that only health professionals should offer male circumcision with an insignificant 3% declining to respond. This is overwhelming as participants showed that their main concerns related to the quality and safety of the procedure to those willing to undergo circumcision.

With the possibility that male circumcision could be considered as an additional HIV prevention strategy in most communities of Zambia, 76% were in support that male circumcision must be incorporated in the health policy as a compulsory measure. Some respondents expressed willingness to advice their friends and brothers to undergo circumcision. In the broadest sense, this study aimed to investigate the relationship between male circumcision and HIV.

From the results as analysed in the findings, it is clear that male circumcision is receiving overwhelming recognition and support; many of the participants are in favour of circumcision.
for hygiene and other health benefits such as HIV prevention. There is a high level of knowledge among respondents and growing awareness among the general public about the benefits of male circumcision for HIV prevention.

Ambitious targets have been set for the control of the HIV pandemic. While access to life-saving anti-retroviral therapy (ART) for those infected with HIV is increasing rapidly throughout the world, effective programmes to reduce HIV transmission are still needed, especially in Africa. Many factors influence the risk of acquiring and transmitting HIV, but where measures intended to reduce transmission have been rigorously tested at a population level, the results have been mixed.

However, current prevention policies are essentially centred, beyond fidelity and abstinence, on the use of condoms. Individual prevention involves adopting measures that should allow each individual to avoid becoming infected, such as the use of condoms or abstinence if this is acceptable.

Because male circumcision does not provide total protection against infection, it cannot be considered as an individual method of prevention. It is a means of reducing risks aimed at lowering the risks of transmission of infection among a population in the same way as reducing the number of partners or providing treatment for infected individuals. The aim is not to impose a sole method of prevention, one that is 100% reliable, and which, if it is not used all the time, will lose its effectiveness.

Male circumcision should therefore form part of a raft of preventative measures, including the means of risk reduction among others. In countries with high prevalence, male circumcision could benefit the male population where the use of condoms would not be sufficiently widespread. On the other hand, women cannot benefit directly from this potential advantage.

In any case, they do not have to consent to a sexual relationship with a man without using a condom, just because he is circumcised. Male circumcision should form part of a system that offers access to screening and treatment and care for infected individuals, combined with an education and information programme aimed at encouraging changes in sexual behaviour.
We live in an age of daring, often unwise, sexual freedom, talking openly about all manner of sexual matters. We know about sexually transmitted infections (STIs) which are rapidly increasing, and the threat of HIV and AIDS. We can talk of gay and straight, lesbian, transsexuals and more.

We are used to seeing naked women on television, in magazines and newspapers – but not naked men! Men are very private, both in pictures and talk. They do not talk about the penis, let alone circumcision. Most of men are ignorant. These are strangely taboo subjects in this sexually enlightened age.

**DIFFICULTIES FACED BY THE RESEARCHER:**

The researcher was given enough time to do the research but she underwent a lot of challenges in her vain to do the study. On the collection of data the respondents were so reluctant to give out their concerns as they complained that the questionnaires wasted their time as they were only interested to be circumcised and not to answer questionnaires.

**RECOMMENDATIONS**

Male circumcision provides only partial protection, and therefore should be only one element of a comprehensive HIV prevention package which includes:

- The provision of HIV testing and counseling services
- The promotion of safer sex practices
- The provision of male and female condoms and promotion of their correct and consistent use

For effective provision of male circumcision services in Zambia, the following have to be urgently put in place;
Education

- Widely broadcast information on the health benefits of male circumcision for men and women and the importance of condoms and partner fidelity.
- Tackle myths linked to male circumcision.

Training and services

- Offer training in male circumcision for traditional circumcisers and medical personnel.
- Provide certificates to legitimize traditional circumcisers and prevent circumcision by those unqualified to provide the service.
- Increase the level of collaboration between the medical community and traditional circumcisers
- Increase forums for mutual learning and sharing of expertise and resources.
- Establish centres or mobile facilities for male circumcision.
- Increase integration of male circumcision services into existing health facilities.
- Reduce the costs of male circumcision.

Behaviour change communication

- Communication campaigns for male circumcision should focus on health benefits and include role models for men and women.

References


APPENDICES

STRUCTURED QUESTIONNIARE

The DMI St Eugene University
School of Social Sciences
Department of Social Work
Woodlands, Lusaka.

Questionnaire

TOPIC: THE RELATIONSHIP BETWEEN MALE CIRCUMCISION AND HIV.

INSTRUCTIONS

Please indicate your response by ticking in the correct box or brackets provided.

A. RESPONDENT INFORMATION

1. AGE:
   - [ ] 15-19
   - [ ] 20-25
   - [ ] 26-30
   - [ ] 31 and above

2. Address:

3. Contact Number (OPTIONAL)

4. Education level;

   - Primary School
   - Secondary School
Tertially Education

5. Occupation
☐ Teacher
☐ Health Personnel
☐ General worker
☐ Other…………………………………………………

6. Religion
☐ Christian
☐ Moslem
☐ Hindu
☐ Others……………………………………………………..

7. Marital status
☐ Married
☐ Single
☐ Widower

8. Tribe:
☐ Tonga
☐ Luvale
☐ Nyanja
☐ Bemba
☐ Others…………………………………………………………..

B. RESPONDANT AWARENESS ON MC.

9. Have you ever learnt or heard of Male Circumcision?
10. Where did you first hear about Male Circumcision?

☐ Friend
☐ Radio
☐ Church
☐ Family Member
☐ Others

11. Do you know anywhere else where Male Circumcision is offered as a service?

☐ Yes
☐ No

12. In your own opinion why should be circumcised?

☐ Newborn baby boys
☐ Adults
☐ School going children.

13. Is Male Circumcision programmes easily accessible in your community?

☐ Yes
☐ No

If your answer is Yes, mention them:

C. BELIEFS, BENEFITS AND ATTITUDES TOWARDS MALE CIRCUMCISION.

14. Do you think there are some myths about Male Circumcision?

☐ Yes
☐ No

If your answer is yes, please mention any two myths;

15. Do you think that Male Circumcision should be restricted to certain tribes?

☐ Yes
☐ No
16. Would you advise your brother to undergo Male Circumcision?
   □ Yes
   □ No

17. If your answer is No to question 18 please give reasons;

18. Would you encourage your friend to undergo Male Circumcision?
   □ Yes
   □ No.

18. What age do you think one should be circumcised?
   □ 0-15
   □ 16-20
   □ 21-25
   □ Above 25.

19. Who in your opinion should access Male Circumcision?
   □ Singles
   □ School boys
   □ Married Men
   □ Others.
   Specify: ..........................................................................................................................................................
   ..........................................................................................................................................................
   ..........................................................................................................................................................
   ..........................................................................................................................................................

D. GENERAL KNOWLEDGE

20. In your own opinion should parents consent for their sons to be circumcised?
   □ Yes
   □ No

21. In your own opinion must all men undergo an HIV test before circumcision?
   □ Yes
No

If your answer is Yes kindly give reasons;

22. Who should offer the Male Circumcision service?
□ Health Professionals
□ Traditional Healers
□ Others
Specify……………………………………………………………………………………………………
……………………………………………………..

23. In your own opinion do you think it is good or acceptable to circumcise new born babies?
□ Yes
□ No

24. Do you think there is enough information in your community about Male Circumcision?
□ Yes
□ No

25. What should be done to encourage people access more information on Male Circumcision?
□ Radio Programs
□ TV programs
□ School involvement
□ Church involvement
□ Others
Specify……………………………………………………………………………………………………
……………………………………………………………………………………………………

26. In your own opinion should Male circumcision be implemented in the Ministry of Health as a policy?
□ Yes
□ No
27. Since when did you start thinking about being circumcised?

- [ ] One month ago
- [ ] One year ago
- [ ] One week ago
- [ ] Other

Specify: ........................................................................................................................................
........................................................................................................................................

28. Do you think MC should be offered as a free service?

- [ ] Yes
- [ ] No

If your answer is NO in question number 28 how much should it be? ..........................................................................................................................

29. Is MC beneficial in our society?

- [ ] Yes
- [ ] No

30. In your own opinion do you think Male Circumcision is an easy or simple procedure?

- [ ] Yes
- [ ] No

31. Male circumcision has ever been practiced as a rite of passage in some parts of the world. Do you agree?

- [ ] Yes

Give reasons for your answer ..........................................................................................................................
........................................................................................................................................

32. Does MC protects one against HIV infection?

- [ ] Yes
- [ ] No
33. In your own opinion should the National AIDS Council of Zambia be part and parcel of policy formulation in the MC programs?

☐

☐

34. In your own opinion should Ministry of Health be the only policy making organization in issues of HIV and Male circumcision?

☐

☐

35. In your own opinion, do you think MC has benefits?

☐

☐

END OF QUESTIONNAIRE. THANK YOU FOR YOUR TIME.
## WORK PLAN

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>SPECIFIC ACTIVITY</th>
<th>DESCRIPTION OF ACTIVITY</th>
<th>TIME FRAME</th>
</tr>
</thead>
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<tr>
<td>1.</td>
<td>Review of literature</td>
<td>Collection of secondary data from different libraries and internet</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Development of research proposal.</td>
<td>It consists of the full development of proposal.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Preparation of data collection</td>
<td>Involves the formulation of closed and open ended questionnaires.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Pre-testing and editing</td>
<td>Testing of questions in questionnaires at Chachacha Site.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Field work</td>
<td>Distribution and collection of questionnaires within Chachacha and</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Data Analysis</td>
<td>Cleaning and coding of data.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Finalizing the report</td>
<td>Writing a final report.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Submission of the report</td>
<td>This simply handing in of a final report for assessment.</td>
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</tbody>
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I. Background & Methodology

Society for Family Health/Zambia’s (SFH) strategic plan is based on a careful assessment of internal and external factors related to the future of social marketing in Zambia. During a May 2006 strategic planning workshop, a core team of six managers representing different levels of and departments within the organization updated the organization’s vision in terms of health outcome targets for 2011.1 The core team assessed key challenges relative to the 2011 vision and identified priority activities to expand and strengthen health programs and build organizational and financial foundations. Subsequently, a draft plan was shared with a wider group of SFH staff members and finalized based on their feedback. The Government of Zambia (GRZ), non-governmental organizations, donors, SFH Board and PSI/Washington contributed to the 2006-2011 plan through individual interviews conducted during March and April 2006.

SFH’s 2006-2011 strategic plan draws heavily upon previous organizational development efforts including prior strategic planning exercises, the December 2005 Results Initiative assessment and the April 2006 SFH staff survey. Since SFH’s last strategic planning exercise more than 4 years ago, the organization has expanded health programming, secured new funding, added field offices and restructured the head office, strengthened systems and built capacity by recruiting and training staff members. The 2006-2011 plan builds on these efforts.

II. SFH Identity, Mission and Core Values

Identity

SFH is a registered not-for-profit Zambian trust in conjunction with the Pharmaceutical Society of Zambia. SFH is both a Zambian organization and an affiliate of PSI, an international social marketing organization.

Established in 1992, SFH is one of the largest non-governmental organizations in Zambia with 250 staff members and nine project offices around the country. As of April 2006, SFH markets six products to address HIV/AIDS, malaria, reproductive health and water borne diseases: Maximum condoms, Maximum Scented condoms, Care female condoms, Safeplan oral contraceptives, Mama Safenite insecticide-treated mosquito nets and Clorin home water treatment solution. Since 2002, SFH has developed and promoted the New Start network of
voluntary counselling and testing for HIV (VCT) services including stand-alone VCT centres as well as mobile clinics.

Mission
SFH’s mission is to empower low-income and vulnerable Zambians to lead healthier lives in line with the Government of Zambia’s health priorities. We do this through social marketing: working with both the private and public sectors to promote healthy behavior and to ensure access to quality, affordable health products and services.

Beliefs
SFH’s mission is derived from the following fundamental beliefs:
In the broadest sense, health is the greatest gift. It is a prerequisite for broader socio-economic improvement as articulated through the Millennium Development Goals. All people – regardless of race, ethnicity, tribe, nationality, religion, gender or socio-economic status have the right to full access to information, products and services conducive to leading healthy lives. SFH has the obligation to address health inequities by focusing on the poor and underserved.

Health is a public as well as a private matter. While the state has an obligation to guarantee rights to health, people may seek to realize those rights through individual initiatives in their families and civil society. Commercial techniques, such as marketing, have great potential to contribute to public health.

Core Values
SFH core values are guiding principles and tenets that describe how the organization strives to operate:
Accountability: As employees of a non-profit social organization, we acknowledge an obligation to set and demand the highest standards of accountability cost-consciousness in the use of resources entrusted to us by our supporters and to be role models in this regard.
Professionalism: SFH employees have a professional work ethic: we are honest, dedicated to our mission and accountable for our work. We respect other SFH staff members, our partners and the people we serve. We aspire to be a hard-working, dynamic, proactive and reliable
organization and we base our strategies on evidence and self-criticism for continuous improvement.

Efficiency: We value efficiency and timeliness at every level of our operation. We cultivate nimble, responsive and efficient systems and procedures that enable us to meet and beat deadlines and seamlessly convert ideas and decisions into action.

Innovation: We strive to apply innovative technical, logistical and communications solutions to the preeminent health challenges in Zambia.

Collaboration: We encourage teamwork, communication and participation to maximize the collective efforts of all staff. We embrace opportunities for furthering and enhancing our mission through partnerships with other organizations and community groups.

Cultural Responsibility: We are committed to designing and implementing all program activities in such a way as to maximize health impact while respecting and promoting Zambian culture.