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Understanding and Addressing Socio-Cultural Barriers to Medical Male Circumcision in Traditionally Non-Circumcising Rural Communities in Sub-Saharan Africa

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Abstract

Given the success of recent clinical trials establishing the safety and efficacy of adult medical male circumcision in Africa, attention has now shifted to barriers and facilitators to programmatic implementation in traditionally non-circumcising communities. In this study, we attempted to develop a fuller understanding of the role of cultural issues in the acceptance of adult circumcision. We conducted four focus group discussions with 28 participants in Mutoko in Zimbabwe, and 33 participants in Vulindlela, in KwaZulu-Natal, South Africa, as well as 19 key informant interviews in both settings. We found the concept of male circumcision to be an alien practice, particularly as expressed in the context of local languages. Cultural barriers included local concepts of ethnicity, social groups, masculinity, and sexuality. On the other hand, we found that concerns about the impact of HIV on communities resulted in willingness to consider adult male circumcision as an option if it would result in lowering the local burden of the epidemic. Adult medical male circumcision promotional messages that create a synergy between understandings of both traditional and medical circumcision will be more successful in these communities.

Keywords

HIV; male circumcision; barriers; cultural identity; sexuality

Introduction

Three randomised controlled clinical trials in Africa confirmed the benefits of medical male circumcision (MMC) in reducing the risk of HIV infection in heterosexual men (Avert, et al 2005, Bailey, et al 2007, Gray et al 2007). Given the strength of the MMC trial results, WHO/UNAIDS (UNAIDS 2007) recommended male circumcision as an HIV prevention strategy, particularly in countries with generalised heterosexual HIV epidemics, high HIV prevalence and low MMC rates. Mathematical modelling of MMC in 11 African countries

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shows that achieving 80% coverage of male circumcision in the 15–49 year old age group could avert almost 3.36 million HIV infections by 2025; highlighting the importance of expanding male circumcision services (Londish and Murray 2008, Njeuhmeli et al 2011).

By the end of 2010, only 2.7% of the approximately 20 million MCs needed for the estimated impact (WHO/UNAIDS 2011) had been conducted. Rates of circumcision need to be increased in order to maximise the number of averted HIV infections. Influencing men to undergo medical circumcision in settings where circumcision has not historically been practised is currently one of the most important challenges facing MMC practitioners in southern African countries.

Acceptability of Medical Male Circumcision

Studies indicate that culture, religion and age influence the acceptability of medical male circumcision (Kebaabetswe et al 2003, Scott, Weiss and Viljoen 2005, Tsela and Halperin 2006). A review of thirteen acceptability studies conducted in nine sub-Saharan African countries that do not traditionally circumcise, including Zimbabwe and amongst ethnic groups in South Africa that do not traditionally practice circumcision, found that the median proportion of uncircumcised men willing to be circumcised was 65%. Sixty nine percent of women favoured circumcision for their partners, and 71% of men and 81% of women were willing to circumcise their sons if the procedure was safe, affordable, and protective against HIV (Westercamp and Bailey 2007). Acceptability across the nine countries was found to be quite consistent.

Studies in Zimbabwe, Zambia, Malawi and Tanzania showed age-specific preferences for circumcision, indicating that younger men were more likely to express a desire to be circumcised (Ngalande et al 2006, Halperin, Fritz and McFarland 2005, Lukobo and Bailey 2007).

Studies conducted in South Africa identified several barriers to uptake of medical male circumcision, including the fear of pain and adverse events from the circumcision procedure, culture, religion, age, and cost (Westercamp et al, 2012). A study in rural KwaZulu-Natal revealed that while older men did not consider medical male circumcision to be beneficial to their community, younger men wanted the service to be available (Scott, Weiss and Viljoen, 2005). The study reports that women would choose to have their partners and/or sons circumcised if the procedure would reduce STI risk but some did not feel empowered to demand their partners be circumcised. Factors that would facilitate the adoption of medical male circumcision by Zulu men varied. For younger men, these included hygiene, protection from STIs, reduced pain during sex, and sexual satisfaction. The hygiene aspect of medical circumcision appears to be a widespread perceived benefit of the procedure that has been observed in other settings in Africa (Tarimo et al, 2012). Similar findings have emerged in other African countries as well amongst rural and urban populations (Francis, et al, 2012). Older men also mentioned their desire to give their female partners sexual pleasure.

Culture and religion

Because circumcision carries great cultural import in most societies, WHO/UNAIDS (2007) recommended that the socio-cultural context of traditional male circumcision should inform how medical male circumcision programming is promoted. The meanings and associations people attach to circumcision should be considered when designing circumcision programmes, as these will act as the filter through which medical male circumcision promotion will be received (Sithole et al 2009). For instance, how will communities respond to medical male circumcision promotion when circumcision, or the lack of it, is a mark of citizenship, religious or cultural affiliation, or a sign of “otherness” that signals exclusion,

marginalisation or oppression? (Dowsett and Couch 2007). Additionally, it is important to understand the meanings attached to traditional forms of circumcision.

Earlier studies found that some ethnic groups in which circumcision is not commonly practised disapprove of circumcision by using derogatory terms for a circumcised man or a man with a congenitally shortened prepuce (Bailey, Muga et al, 2002). In ethnically homogenous areas, circumcision could lead to rejection by local women and serve as a barrier to marriage (Bailey, Muga et al, 2002, Lukobo and Bailey, 2007). Seventy percent of Xhosa initiates practicing traditional circumcision expressed fear that they would be stigmatised if they did not complete the traditional circumcision procedure, emphasizing the need to understand local practices before implementing programmes (Peltzer and Kanta, 2009).

Since the medical male circumcision trial results, several sub-Saharan African countries have developed ambitious national rollout plans. Despite high levels of reported acceptability of medical male circumcision in both traditional and non-traditional circumcising communities (Westercamp and Bailey, 2007), few countries have achieved substantial scale-up of circumcision services. Thus far, implementation discussions have focused on top-down issues of health services capacity, including quantitative assessments of the number of trained health professionals, suitable health centres, costs and user fees. Country progress reports on the scale-up of circumcision do not highlight the importance of bottom-up consultation in communities which has been shown to increase willingness to accept medical circumcision if it is endorsed by traditional leaders (Sigler, Mbwambo and DiClemente, 2012).

In this paper, we argue that understanding the local context and meanings of circumcision are a crucial and overlooked aspect of the implementation of the medical male circumcision intervention in sub-Saharan Africa. We conducted a study to examine cultural perceptions of medical male circumcision in traditionally non-circumcising rural communities in South Africa and Zimbabwe in an effort to unpack the idea of “culture” and elicit participants’ personal and collective reflections on the interplay of local practices on health, HIV, circumcision, and gender. We explore how local communities filter information on medical male circumcision into its most locally salient parts and consider how these conceptions and attitudes towards circumcision could influence uptake of medical male circumcision as a public health intervention.

Methods

Study Setting

This study was conducted in Mutoko, a rural district in the Mashonaland East province of Zimbabwe and in Vulindlela, a rural district in the KwaZulu-Natal province of South Africa.

In Zimbabwe, a traditionally non-circumcising country with a population of approximately 12 million and an estimated HIV prevalence rate of 14% in the 15 to 49 age group (WHO/UNAIDS, 2011), approximately 10% of men are circumcised. Small sub-populations of the two predominant Shona and Ndebele-speaking groups circumcise either for religious or cultural reasons. The Chewa tribal group of Malawi origin, and Muslims who are predominantly in urban Harare circumcise for religious reasons and some small tribal groups, such as the Tonga, the Shangani, the Venda, and the Fengu/Xhosa circumcise for cultural reasons.

In South Africa, a country with one of the highest HIV prevalence rates in the world, HIV infection rates vary between provinces. HIV rates for antenatal clinic attendees range from

30.2% in the Western Cape Province to 39.5% in the KwaZulu-Natal province (SA Department of Health, 2010). Traditional male circumcision is predominantly practiced among the Xhosa and Basotho tribes while the Zulu tribe in the KwaZulu-Natal Province (KZN) has no recent history of the practice. Traditional circumcision was practiced among the Zulu up until the 19th century when the legendary King Shaka is reported as having prohibited it because it deprived him of young warriors for months at a time (Kaiser Daily Global Health Policy Report, 2009). Medical circumcision is now endorsed by the current Zulu King and political leadership in KwaZulu-Natal, however, this support needs to be on-going for it to have a significant change on men's attitudes towards circumcision and impact on masculine identity.

Study Sample

A total of 80 individual participants aged 18 years and older were recruited as a sub-sample from communities participating in NIMH Project Accept HPTN 043 - a Community-Based Voluntary Counselling and Testing (CBVCT) trial (Khumalo-Sakutukwa et al 2008). A purposive sampling methodology was used to recruit participants for both key informant interviews (KII) and focus group discussions (FGD) from eight (8) communities participating in the Project Accept intervention. We conducted in-depth interviews with nineteen (19) key informants from traditional, political, religious and health care sectors and community volunteers in both settings. Participants were between 19 and 65 years old.

A total of sixty-one (61) individuals participated in eight (8) gender- and age-segregated FGDs, four FGDs per study site

Participants were segregated by age and gender in order to determine if there were any differences in their perceptions of male circumcision. Both FGD and key informant participants were representative of the communities in Vulindlela and Mutoko as they were recruited from diverse backgrounds and age range. Younger participants were mostly unemployed school leavers, older participants were mostly self-employed as farmers or engaged in income generating projects within their communities. Fewer participants were in formal employment, such as, health care providers and pastors. All participants had achieved a minimum level of basic literacy.

Data Collection

Each FGD was approximately two hours long whilst the KII lasted approximately one hour. We obtained individual participant consent to audio record FGDs and KII.

Project Accept staff trained in qualitative methods of inquiry conducted all interviews and FGDs and provided guidance to investigators on the selection of potential participants. Participants at the Mutoko site belonged to a sub-group of the Shona ethnic group and those from the Vulindlela site were of Zulu origins. The FGDs and KII were conducted in local languages. Due to the sensitive nature of the topic, same gender facilitators and interviewers led discussions.

Ethical Considerations

This study was approved by the University of California, San Francisco, Committee on Human Research (UCSF CHR); the University of the Witwatersrand, Human Research Ethics Committee (Medical), South Africa; and the Medical Research Council of Zimbabwe (MRCZ). Written informed consent was obtained from each participant with assurances for confidentiality.

Data analysis

Interviews were transcribed, translated into English and entered into Atlas.ti software for coding and analysis. The analysis was conducted in two phases. In the first phase, investigators from both sites jointly developed a codebook for data analysis. In the second phase, each site independently carried out interpretive analysis of coded themes. Investigators identified key themes that explained the presence of contextual patterns relating to participants' understandings and perceptions of traditional and medical circumcision. This process facilitated the identification and interpretation of findings from both sites that are discussed below.

Results

In both sites, knowledge and perceptions of traditional circumcision were important filters through which perceptions of medical circumcision were formed and discussed. In both Mutoko and Vulindlela, traditional male circumcision was an alien practice, and hence there was limited knowledge of actual circumcision practices. Nonetheless, participants in both communities expressed strong and frequently negative feelings about the significance of male circumcision for gender and cultural identity. In both communities, traditional practices or "partial circumcision" provided an additional filter for understanding information about medical circumcision. In the following sections, we present our findings regarding traditional, partial, and medical male circumcision, and how the conversations fed into a dialogue about how male circumcision interventions could be promoted in communities.

Traditional Male Circumcision

Mutoko participants did not have a local term to refer to traditional circumcision. During the first focus group discussions, researchers used the term *kudzingiswa* (a term used in the bible to refer to religious circumcision). Mutoko participants were aware of very few men in the community who were circumcised and regarded them as "outsiders," either from outside Mutoko district or from other countries, such as Malawi and Mozambique.

"Here in Mutoko, there is no such thing. I think people are borrowing the practice from other people in Harare where people of different tribes live together."
(Susan*, FGD, 18–25 years)

* All participant names are pseudonyms to protect the identity of participants

Similarly, Vulindlela participants viewed male circumcision (known as *ukusoka*) as part of the cultural identity of the neighbouring Xhosa and Basotho ethnic groups. Their knowledge of *ukusoka* was derived from their social interactions with individuals from these groups, including intermarriage between Zulu women and Xhosa and Basotho men, but emphasized that it was not a Zulu practice.

"Zulus do not circumcise ... no, it is the Xhosas whom we used to tell ourselves that they circumcise... we say it is the Xhosa tradition... that is why we do not have the knowledge that circumcision is important to us because we know that it is not our tradition." (Sipho, KII, 25 or older)

Women's understandings of traditional male circumcision were generally more limited than men's. In Mutoko, a lack of social interaction with circumcised men seemed to account for the unfamiliarity with circumcision. An older female key informant, who was also a traditional healer explained,

“I just heard about it, I have never come across anyone (who has been circumcised). They said they remove the foreskin, I do not know how they do it but I understand it helps to prevent disease.” (Chipo, KII, 25 or older)

Younger women in Mutoko with limited knowledge of male anatomy had difficulty grasping the concept of male circumcision, could not differentiate between castration and circumcision, and had trouble understanding which part of the penis was the foreskin. They expressed some frustration and confusion during the group discussions:

“Yes we are not happy about it (interviewer’s questions). With me I feel you should explain further so that we can have a clear understanding, when a person is said to have removed the foreskin, where do you find the foreskin? I am a bit confused, where do we find this foreskin? Where does it come from?” (Shuvai, FGD, 18–24 years)

These young women also implied that circumcised men without a foreskin were not capable of producing sperm during ejaculation. A participant expressed conflicting understandings when she stated:

“That’s where sperm also comes out (foreskin) when you have sexual intercourse? I really do not have any idea where sperm comes from.” (Memory, FGD, 18–24 years).

The majority of participants from both study sites expressed negative perceptions of traditional male circumcision. Mutoko participants largely relied on rumours and had very strong negative perceptions of circumcision as it related to male sexuality. Because of their limited exposure to circumcised men, Mutoko men believed that circumcised men were born without a foreskin, which they considered abnormal; that circumcised men were ridiculed by other men; and that being circumcised was the same as being physically castrated.

Both older and younger men associated circumcision with the shame of being emasculated and perceived manhood as being determined by either the absence or presence of the foreskin. Circumcised men were perceived as “half a man” emasculated by the loss of the foreskin. As a result, most men indicated that they would be afraid to be seen without a foreskin and would be afraid to bathe in the river with other men. A young man in a FGD who disclosed to the group that he was circumcised believed that other men perceived him as being “halved,” and joked with his counterparts about the negative effects of circumcision on sexual performance:

“[A]s for us who have been circumcised, we think those uncircumcised are far much better (sexual performers) than us who are halved.” (Laughter) (John, FGD, 18–24 years)

Mutoko male participants used terms they considered derogatory and stigmatizing to circumcised men. Older men referred to a penis without a foreskin as *nzvonzo*, while younger men referred to it as a *red head* and a *small head*. A young man highlighted the stigma attached to circumcision when he said:

“I would say I heard of those with red heads, those small heads. Small heads are those (penis) who would have been circumcised.” (Joshua, FGD, 18–24 years)

Older males in focus groups also concurred with the stigma attached to circumcision. A 50-year-old male explained that:

“Our penis is supposed to be closed when we are born but if someone is born without the foreskin then we call it *nzvonzo* because the penis will be open so we used to say the person is abnormal.” (Taurai, FGD, 25 or older)

Another older male highlighted the stigma attached to the loss of a foreskin:

“the issue of *nzvonyo*, we used to hear about it when we were very young and I also saw some people who were like that, so I used to ask them why they look different from others when we were taking a bath together. We used to feel pity for them so one of them told us that this was done so that no diseases can get inside the penis.” (David, FGD, over 25).

Despite their unfamiliarity with traditional male circumcision, Mutoko men expressed some concerns about potential complications. A young man in a focus group discussion drew some nervous laughter from other participants when he expressed his fear of getting deformed during the circumcision procedure as he equated male circumcision to castrating the penis:

“Is it not that if one is urinating, eventually one would stop urinating and the genital will close thereafter? I personally think that the head of the penis will completely be cut off.” [Laughter from the group]. “You might be deformed in the process (of the circumcision procedure).” (Tawanda, FGD, 18–24 years)

In contrast to the rumour and lack of information that permeated Mutoko discussions of traditional circumcision, men in Vulindlela were informed about circumcision largely through negative reports in the South African national media about traditional circumcision practices and complications in the Eastern Cape province among Xhosa communities. Their dialogues were more concerned with the health risks and pain during the circumcision procedure; the risk of infections after the procedure; and the incidence of young Xhosa men reported to be dying in the mountains from traditional circumcision:

“... we (in the community) are afraid...fear is what is our problem ... we are just afraid to go and get circumcised we are telling ourselves that there amongst the Xhosas, people are dying... we hear that people are dying when they are undergoing circumcision.” (Mbongeni, KII, 18–24 years)

‘Partial’ Circumcision

Despite negative perceptions of traditional male circumcision, both Mutoko and Vulindlela participants spoke positively and with more familiarity about a traditional practice in their communities, which they referred to as ‘partial’ circumcision. The procedure involved cutting off tissue from under the foreskin or penis glans to enhance its movement during sexual intercourse. Participants explained that this practice was referred to as *kuvhura nzvonyo* (opening the penis head) in Mutoko, and *ukugweda* in Vulindlela.

Older female participants from Mutoko described *kuvhura nzvonyo* as being performed by mothers or female care-givers on male infants during bathing. It involved pushing the penile foreskin back and forth and did not involve cutting off any part of the foreskin. However, a young man from Mutoko described *kuvhura nzvonyo* as a form of self-circumcision that was more common in the past:

“There are some people who circumcise on their own, they usually take some thread from the tail (of a cow) and thread it on the needle. They take cow’s tail; its hair and they take a needle and they pierce (Inaudible). It is called *nzvonyo* (penis head) Now days it is very rare, rarely.” (Tapiwa, FGD 18–24 years)

Vulindlela participants described *ukugweda* as being performed by young men on each other while herding cattle in the bush. They stated that adult men sanctioned the practice as part of adolescent sexual initiation. Participants described “partial circumcision” practices in a positive light and highlighted multiple benefits of *kuvhura nzvonyo* and *ukugweda* related to

sexual performance. It was believed that these practices minimised bleeding and pain during adolescent sexual debut, particularly if their female partner was also a virgin:

“I also heard it when I was at school. It is from schoolmates, boys would form a group whereby such issues were discussed. It was said that the boy would not have any problem when he grows older, especially when he sleeps with a girl who is still a virgin even if when he sleeps with a girl it won't be a problem he won't bleed.” (Thulani, FGD, 18–24 years).

A Vulindlela participant explained how *ukugweda* enhanced male sexual potency and penile erection, but also had negative consequences:

“There is one main reason for it (ukugweda) to break this little vein underneath... it (penis) goes in and pricks straight on this thing, the real clitoris of a woman... it's a real danger you can definitely impregnate someone easily, faster” (Bongani, KII, 18–24 years)

Medical Male Circumcision

At the time of the study, Vulindlela participants had become aware of the trials on medical male circumcision, particularly since one of the sites was located in South Africa, while those from Mutoko site had no knowledge of the studies, due to the absence of electronic and print media in Mutoko. Therefore, in Mutoko, most participants' knowledge about the medical male circumcision trials came from synopses provided by the study staff during the conversations, whereas men and women from the Vulindlela site were able to reference to extensive media reports on the benefits of medical circumcision for HIV prevention.

Participants from both study sites perceived medical male circumcision with mixed feelings, particularly male participants. Because the majority of men in Mutoko were not familiar with circumcision and were not even aware that male circumcision services were available at local private mission hospitals, they had very little to say about the procedure. Upon being informed of its potential benefits by the study interviewers, Mutoko participants expressed willingness to accept medical male circumcision if the procedure would prevent them from getting HIV. One key informant said he would support the promotion of circumcision if it mitigated the HIV pandemic in his community:

“this AIDS disease it will make them (other traditional leaders) to accept it (medical circumcision). If we see that circumcision is improving the quality of life by prolonging life then we need to accept it. We cannot condemn it.”(Benjamin, KII, 25 and older)

Another participant advanced the opinion that extensive and open promotion of medical male circumcision as an HIV prevention intervention could enhance the acceptability of the programme in their community.

“I feel it is a good programme since some of our group members are already saying they were circumcised but since it was done secretly very few people knew about it. We can now see the advantages of circumcision. It was something done secretly even in the hospital they do not talk about it yet they know about it. If awareness is created people will be free to accept.” (Gift, FGD, 18–24 years)

Vulindlela men were especially articulate about their ambivalence towards medical circumcision. Vulindlela men acknowledged that there were health and sexual benefits to MMC, however, they were concerned about potential local barriers to accessing circumcision services, the perceived lack of technical expertise to conduct circumcision procedures at the local hospital and the health risks associated with the procedure.

Men in Vulindlela strongly believed that medical circumcision, just like traditional circumcision, had more to do with the social identity of Xhosa and Basotho men, and that for Zulus only *ukugweda* was appropriate.

“Just the Zulus you see when you are just going around talking about this thing (medical circumcision) they do not want to accept it especially because they are saying it is not their tradition...it’s the tradition for Xhosas. Most of the time the Zulus they do this thing, the Zulus do what we call *ukugweda* they cut this vein.” (Thokozani, FGD, 25 or over)

As with traditional circumcision, fear of death from the medical circumcision procedure was cited as a major potential barrier to getting circumcised. However, Vulindlela participants did perceive that medical circumcision was less risky than traditional circumcision. One man noted that:

“at the hospitals you just have never heard that he went to be circumcised and he died.” (Bheki, FGD, 25 or over).

However, Vulindlela participants worried that clinicians performing circumcision at the local hospital probably lacked technical expertise because they were of Zulu origin and believed that only Xhosa medical doctors could perform safe circumcision because circumcision was part of their culture.

“Yes just here at Edendale hospital and in other hospitals you just hear them sometimes saying we will make an appointment with the doctor on your behalf, the doctor who will come to do that job it’s a doctor who will come from the Xhosa region...because they are trained to remove the (fore)skin they are also removing the skin professionally...” (Lungisani, FGD, 25 or over)

Participants also expressed concerns about complications from the medical circumcision procedure. Some men felt more vulnerable to complications than Xhosa men whom they perceived as having more traditional circumcision resources and would know where to go for advice if they experienced complications from the procedure.

“You then have to look at the fact that according to the Zulus you go to the doctor. For Xhosas, there are people from there, who know how to do this thing (TMC), isn’t it? They do not have to visit so and so and go from here to there. In that case you can say that the Xhosas know that if a person is faced with a situation like this they know what they give him.... because they are the ones who know how it (circumcision) should be done”. (Bonginkosi, FGD, 18–24 years)

Despite these concerns, men in Vulindlela understood there were potential health and hygiene benefits to MMC. Younger men were particularly keen to learn more about these health benefits. They hoped that the removal of the foreskin and improved hygiene could offer some protection against disease, including HIV, because they believed that the foreskin retained semen and sperm, which led to infections:

“I can say that during intercourse when meeting with a woman when I ejaculate the penis will cease to be erect. The foreskin will then take the ejaculated fluids and keep them underneath the foreskin. Thus when you see sperms beneath the foreskin I think the foreskin makes you contract more of the HIV virus.” (Thabo, FGD, 18–24 years)

A young man from Vulindlela site emphasised the importance of penile hygiene in reducing disease:

“According to me what we know about circumcision is that we should keep ourselves clean all the time you see...and I think that where there is heat a disease

also hides... I think that circumcision will help in that even if that disease comes for you it will not be kept inside (the foreskin). It is not going to find warmth you see.” (Sakhile, FGD, 18–24 years)

Younger men in Vulindlela who had heard about medical circumcision and HIV prevention in the media expressed favourable views of circumcision and its promotion as an HIV prevention intervention:

“We have seen it on TV they have told us that from modern days so far eh people who are circumcised...if you compare with those who are not circumcised...the chances of getting HIV/AIDS they are few on them...you see so it means it’s a public interest issue.” (Mzamo, KII, 18–24 years)

Distinct from its HIV prevention potential, medical male circumcision was associated with enhanced sexual pleasure, particularly by older men from the Vulindlela site. Older males perceived medical circumcision as having the capacity to make sex more enjoyable because the female partner would know that a circumcised man was free of disease.

“As I explained earlier on that if they are circumcised it is because they want to be pleasurable maybe to a woman some of them then know that there are diseases here...if you remove the foreskin... you do not get those diseases.” (Siyabonga, KII, 25 years or over)

Female participants from both study sites had more circumscribed knowledge about medical male circumcision procedures than men. Mutoko women in particular exhibited a general lack of understanding of the concept of male circumcision. These women had difficulty understanding how circumcision could prevent a man from getting disease:

“If a person is circumcised he can get the disease, but if he is not, he won’t get it, how can he get it?” (Tatenda, FGD, 18–24 years)

They also made no connection between circumcision and sexuality:

“When you are having sexual intercourse, the foreskin has nothing to do with the act.” (Shupi, FGD, 18–24 years).

However, Vulindlela women appeared more informed than women in Mutoko, and they were less ambivalent about the procedure than Vulindlela men, perceiving many more benefits from medical male circumcision than disadvantages. These women spoke at length about medical male circumcision’s potential benefits to male sexual potency and penile hygiene. Younger women based their positive perceptions on their sexual experiences with traditionally circumcised Xhosa and Sotho men. They assumed that circumcised men were more sexually potent because they experienced painless ejaculation during sexual intercourse. They also believed that uncircumcised men experienced pain on ejaculation because the foreskin tightly closed the tip of the penis and prevented sperm from reaching the Fallopian tubes.

“Okay I can say during the sexual intercourse...the foreskin.... I do not know what closes it then but they say it closes... and they say he also feel pain...the time he withdraws (ejaculates)). I do not know what happens then maybe he will feel the time he was withdrawing (ejaculating)) and sperms will end up not getting to the fallopian tubes” (Buhle, FGD, 18–24 years)

Younger women believed that the penis grew in size after medical circumcision and that a circumcised man had a ‘cleaner’ penis than an uncircumcised man. One young woman in an FGD said:

“they say no my penis is too small I want it to grow ((They all laugh)). Yes I suppose it grows after circumcision” (Thobi, FGD, 18–24 years)

Those who perceived circumcised men as being clean advocated MMC for Zulu men because, in their words:

“Zulu men are always dirty,” (Khanyo, FGD, 18–24 years).

Curiously, unlike their male counterparts, young women believed that medical male circumcision was less safe than traditional circumcision and that men experienced increased bleeding after it.

“They now circumcise at the hospitals and the doctor will cut that thing but he feels pain more than the ones that went to the mountain (for traditional circumcision)... he will feel pain for two weeks after that he can't wear a trouser maybe if you still have a grandmother you will take your granny's pinafore (They all laugh). You wear a pinafore because you can't wear something you see that is tight like a trouser and the underwear's... When you put a trouser on it hurts.” (Zenhlanhla, FGD, 18–24 years)

Discussion

Our findings suggest that in South Africa and Zimbabwe, medical male circumcision national policies and programmes are being pushed forward without the importance of local needs being adequately addressed in scale-up activities. These local needs are in the form of information, health services access, and local interaction and debate about what cultural and gender beliefs are influencing the rollout of medical male circumcision in unprepared and uninformed communities (Brooks, Etzel, Klosinski, et al, 2010). Rather than exploring the idea of “culture as barrier”, our analysis focused on how local cultures in Vulindlela and Mutoko filtered information on medical male circumcision.

As such, different patterns of discussions on both traditional and medical circumcision emerged. Our findings indicate that, even though participants from both sites recognised the benefits of medical male circumcision, there were important socio-cultural factors that made an impact on how it was perceived. Interestingly, while some of these perceptions varied from positive to negative viewpoints of traditional, partial, and medical circumcision, there was a strong sense of ambivalence about medical circumcision, affected by age, gender and viewpoints on its potential to protect against HIV infection.

For male participants, social and cultural identity played a major role in their perceptions of medical male circumcision, which influenced their decisions on whether or not they would adopt the intervention. Participants from Mutoko, who had more limited knowledge of the practice of both traditional and medical circumcision and tended to perceive circumcision negatively, did not express any real cultural prohibitions on circumcision. They based their negative perceptions of the practice with local association of circumcision as an “outsiders” practice, one indicating lower social status or status as a foreigner. This is congruent with findings from studies by Dowsett and Couch (2007). Mutoko participants also equated circumcision with masculinity, ascribing stigma and shame to circumcised men as being emasculated because they did not have a foreskin.

Male Vulindlela participants highlighted local conversations about the impact of both traditional and medical circumcision on local concepts of Zulu ethnicity, manhood, and masculinity. In particular, male and female participants felt that circumcision could improve sexuality and sexual pleasure, being further enhanced by revelations of other forms of penile procedures known as ‘partial’ circumcision (*ukugweda*).

Vulindlela participants appeared to have a better understanding of circumcision, with more issues being raised with traditional than medical circumcision due to information

surrounding the problems experienced by groups in South Africa that traditionally circumcise, particularly the reports of circumcision-linked morbidity and mortality in the Eastern Cape Province (Dyonana, 2003, Meel, 2005). However, there was an interesting dissonance in that whilst Vulindlela participants who were Zulu and equated traditional circumcision with being foreign to their culture and dangerous, they expressed preference for a Xhosa doctor to perform a medical circumcision for them. They assumed Xhosa physicians would have more expertise as they practiced circumcision traditionally – this response contrasted with the negative perceptions they previously attached to traditional circumcision. Vulindlela participants were also more aware of the HIV preventive effects of medical male circumcision and showed willingness to adopt medical circumcision if they could be assured of safety and reduced pain during and after the procedure.

The fact that in Mutoko, women perform *kuvhura nzvonyo* indicates the important role women play in influencing male perceptions of sexual hygiene and sexuality. These findings make it imperative to involve women in medical male circumcision discussion and promotional campaigns. Medical circumcision education could build on the women's understandings of *kuvhura nzvonyo* as one way of enhancing penile hygiene and thus promoting sexual health. Programme planners should be encouraged to explore these various distinctions of penile procedures performed by different social groups, to understand the purposes these procedures serve and how these strategies could be used to highlight the health benefits of medical male circumcision.

Vulindlela female participants can also facilitate the promotion and acceptance of medical male circumcision by being encouraged to talk with their partners about their preferences for circumcised men, and how it could benefit them in their relationship. All women could benefit from more sexual reproduction education to enhance their knowledge of the male anatomy so they can appreciate the health benefits of medical male circumcision. This highlights that medical male circumcision promotional messages should be appropriate to the educational understandings of the target population groups and foster greater discussion between men and women regarding sexual health and sexual preferences. One of the strongest research findings suggest that the cultural divide between men and women needs to be addressed and mutual understandings of male and female health is desperately needed in communities.

Our findings suggest that medical male circumcision policy planners in Zimbabwe and South Africa should investigate adolescent and neonatal medical circumcision. We show that older men, particularly from Mutoko would prefer medical male circumcision promotion to target younger men whom they perceived as more sexually active and at higher risk for HIV infection.

Older men indicated that they would be reluctant to defer sexual contact during the healing period post circumcision highlighting the need for more education about the long-term benefits of medical circumcision and the need to abstain during the healing period. Greater consideration should be taken of the socio-cultural context and information needs of target groups when mobilizing and disseminating materials for medical male circumcision. Formative research prior to implementation of medical male circumcision programmes could better clarify the factors that influence health decisions.

These findings highlight the importance for medical male circumcision programme planners to understand the local context and meanings of circumcision when implementing male circumcision as an HIV prevention intervention. As indicated, the hypothetical “acceptability” of medical male circumcision in traditionally non-circumcising communities was established prior to the publication of the male circumcision trial results. However, this

study, which was conducted after the successful trials, highlights the numerous factors that influence acceptability of programme implementation, particularly when people have specific cultural knowledge and beliefs about what circumcision involves or equate medical with traditional circumcision.

Messages promoting medical male circumcision will need to be carefully tailored to be socially and culturally sensitive, with a focus on minimizing local barriers, including pre-existing stigma and discrimination associated with circumcision. Our results indicate that the development of male circumcision promotional messages that address locally held beliefs and cultural norms around medical circumcision, and also attempt to normalise circumcision, may be challenging in communities with no history or negative perceptions of traditional or medical circumcision. Our findings show that members of these communities are willing to engage in dialogue about potential benefits of medical male circumcision but require serious education about the procedure. Understanding the content of these local discussions will offer programme planners the opportunity to build on positive perceptions of medical male circumcision, break down negative perceptions of the procedure and build locally responsive mobilisation activities that promote medical circumcision. This approach will aid the scale-up of medical male circumcision and maximise its potential to significantly impact on HIV infection.

Limitations

Our study has several limitations. Study recruitment took place in two communities already engaged in an intensive community level HIV prevention intervention. Our purposive sampling strategy in these communities resulted in a sample that may have been more knowledgeable and engaged with the topics of traditional and medical circumcision than would be average for rural communities. Given the nature of our ethnographic methods, the specific local issues identified in each community may not be typical of rural communities in Zimbabwe and South Africa more generally. Nonetheless, our methodology did facilitate the identification of local dialogues about medical male circumcision, a process that would be useful to replicate in other similar traditionally non-circumcising communities.

Conclusion

In promoting medical male circumcision as a public health strategy for HIV prevention, medical circumcision programme developers must consider how best to create a synergy between understandings of both traditional and medical circumcision. Large-scale circumcision programmes need first to interact with the local knowledge systems present in communities in order to develop culturally responsive programmes that address the perceptions and value systems that people place on circumcision and their health. Medical circumcision initiatives need to include both women and men and should encourage greater knowledge about ones' body, ones' sexual health and as well as that of the opposite gender. Social mobilisation and evaluation is critical to successful medical male circumcision campaigns as well as continual assessment of local knowledge, perceptions and attitudes towards circumcision. This is essential in order to develop programmes that will accommodate the presence or absence of the social history of male circumcision in their respective communities.

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Table 1

Key Informants Number per site and Occupation/Background

Site	Occupation and / or Background								Total
	Traditional Healers	Health Care Providers	Politicians	Traditional Leaders	Religious Leaders	Community Volunteers	Youth		
Vulindlela	1	2	2	1	1	2	1	10	
Mutoko	1	2	1	1	2	1	1	9	
Total	2	4	3	2	3	3	2	19	

Table 2

FGD Participant Numbers per Site and Gender

Sites	Young Men 18–24 years	Older Men 25 yrs & older	Young Women 18–24 years	Older Women 25 yrs & older	Total
Vulindlela	8	8	5	7	28
Muroko	8	9	8	8	33
Total	16	17	13	15	61