

Making Medical Male Circumcision Work for Women

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

Kenya Country Report

An excerpt from the original five-country report with coverage of Kenya, Namibia, South Africa, Swaziland and Uganda



ABOUT WHIPT

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

ACKNOWLEDGEMENTS

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

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

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

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

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

Photo Credits: Cindra Feuer

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

This report is dedicated to

Lynde Francis

1947–2009

Founder of the first AIDS treatment clinic in Zimbabwe.

Influencer of formative dialogue around women and medical male circumcision.



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

EXECUTIVE SUMMARY

KEY FINDINGS

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

1. BACKGROUND

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

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

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

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

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

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

2. METHODOLOGY

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

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

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

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

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

3. KEY CONSIDERATIONS OF WHIPT SCOPE AND STRUCTURE

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

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

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

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

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

4. SUMMARY OF FINDINGS²

WOMEN'S AWARENESS OF AND INVOLVEMENT IN MMC

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

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

RECOMMENDATIONS

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

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

WOMEN'S SUPPORT FOR THE INTRODUCTION OF MMC

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

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

UNDERSTANDING PROTECTION

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

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

RECOMMENDATIONS

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

IMPLICATIONS FOR SEXUAL DECISION-MAKING AND GENDER-BASED VIOLENCE

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

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

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

RECOMMENDATIONS

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

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

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

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

RECOMMENDATIONS

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

CONFLATION OF MEDICAL MALE CIRCUMCISION AND TRADITIONAL MALE CIRCUMCISION

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

RECOMMENDATIONS

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

5. DISCUSSION

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

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

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

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

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

6. NEXT STEPS FOR WHIPT ADVOCACY

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

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

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

KENYA

CAROLE ODADA – WOMEN FIGHTING AIDS IN KENYA

KEY FINDINGS

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

1. BACKGROUND

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

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

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

2. METHODOLOGY

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

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

3. RESEARCH FINDINGS

KNOWLEDGE AROUND MMC

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

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

BENEFITS OF SERVICES TO WOMEN

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

1. Carol Odada and Jane Mcochudho

COMMUNITY PREPAREDNESS

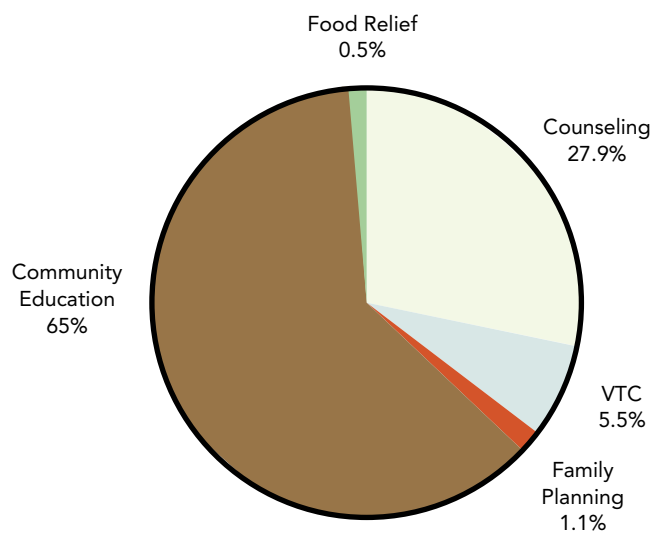
Eighty-five percent of the women said there was a need to introduce MMC in the community, especially respondents from Kisumu, where it is not traditionally practiced. The majority of those who saw no need were from Kuria, where traditional circumcision is practiced, and they did not see the difference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

CURRENT HIV PREVENTION METHODS

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

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

Women want accompanying services



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

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

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

DECISION MAKING

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

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

PERCEPTIONS OF GENDER-BASED VIOLENCE AND MMC

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

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

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

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

PERCEPTIONS AROUND MMC AND FEMALE GENITAL MUTILATION (FGM)

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

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

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

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

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

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

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

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

4. DISCUSSION

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

BENEFITS OF SERVICES TO WOMEN

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

DECISION MAKING

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

PERCEPTIONS OF GENDER-BASED VIOLENCE AND MMC

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

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

PERCEPTIONS AROUND MMC AND FGM

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

COMMUNITY PREPAREDNESS: TRADITIONAL CIRCUMCISION AND MMC

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

5. RECOMMENDATIONS

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

NEXT STEPS

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

KENYA SURVEY RESULTS

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

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www.aln.org.za

Health Rights Action Group

www.hag.or.ug

Mama's Club

clubmamas@yahoo.co.uk

Namibia Women's Health Network

www.nwhn.wordpress.com

Swaziland for Positive Living

www.swapol.net

Women Fighting AIDS in Kenya

www.wofak.or.ke



SWAPOL member interviewing a women in Sigwe.