

Making Medical Male Circumcision Work for Women

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

Namibia 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.

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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.

NAMIBIA

JENNIFER GATSI – NAMIBIA WOMEN'S HEALTH NETWORK

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KEY FINDINGS

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

1. BACKGROUND AND OVERVIEW

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

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

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

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

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

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

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

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

2. METHODOLOGY

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

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

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

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

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

3. RESEARCH FINDINGS

KNOWLEDGE AROUND MMC FOR HIV PREVENTION

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

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

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

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

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

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

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

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

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

3. Questionnaire, No 3

4. Questionnaire, No 7

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

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

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

COMMUNITY PREPAREDNESS

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

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

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

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

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

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

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

“For STI prevention and hygiene.”¹⁰

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

5. Questionnaire, No 7

6. Questionnaire, No 8

7. Questionnaire, No 10

8. Questionnaire, No 7

9. Questionnaire, No 7

10. Questionnaire, No 10

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

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

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

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

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

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

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

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

PERCEPTION OF IMPACT

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

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

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

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

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

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

CURRENT HIV PREVENTION METHODS

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

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

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

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

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

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

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

GENDER-BASED VIOLENCE AND MMC

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

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

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

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

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

19. Focus Group Discussion

20. Focus Group Discussion

21. Focus Group Discussion, Question 6

22. Focus Group Discussion, Question 6

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

ADDITIONAL SERVICES AND NEEDS

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

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

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

4. DISCUSSION

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

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

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

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5. RECOMMENDATIONS

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

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

NAMIBIA SURVEY RESULTS

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

AVAC

www.avac.org

ATHENA Network

www.athenanetwork.org

AIDS Legal Network

www.aln.org.za

Health Rights Action Group

www.hag.or.ug

Mama's Club

clubmamas@yahoo.co.uk

Namibia Women's Health Network

www.nwhn.wordpress.com

Swaziland for Positive Living

www.swapol.net

Women Fighting AIDS in Kenya

www.wofak.or.ke



SWAPOL member interviewing a women in Sigwe.