

Making Medical Male Circumcision Work for Women

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

Uganda 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.

UGANDA

MILLY KATANA

ALLEN KUTEESA – HEALTH RIGHTS ACTION GROUP

MARION NATUKUNDA – MAMA'S CLUB

KEY FINDINGS

- Women are aware of traditional/religious male circumcision and medical male circumcision (MMC) but lack factual knowledge.
- Women are slightly more in favor of supporting the rollout of MMC than not, because it is economical and hygienic and reduces HIV.
- Rollout would need massive sensitization and could feasibly be taken up by communities that practice traditional male circumcision.
- MMC is thought by some to be a “new” justification for female circumcision (female genital mutilation), potentially increasing its rates in areas where FGM is practiced.

1. BACKGROUND

Uganda saw a significant reduction in adult HIV prevalence, from a peak of 18 percent in 1992 to the current 5.4 percent among adults and 0.7 percent among children according to the UNAIDS. However, attention has been drawn to Uganda's recent reversal in its prevention success.¹ The stagnated rates are partially attributed to the decline in practice of self-protective behavior among the populations. This has posed critical challenges to the national response. As a result, scaling up prevention of new infections and re-thinking prevention campaigns to develop relevant, suitable and timely interventions is very high on the agenda of the National Strategic Plan (NSP) of Uganda. However, Uganda's Prime Minister has shown limited leadership to date in medical male circumcision (MMC) programming.

As the epidemic matures, the populations most severely affected have shifted from young unmarried individuals to older married or formerly married individuals. Women aged 30–34 years and men aged 40–44 years have the highest rates of infection. Also, women are infected more than men across all age brackets.²

Traditional male circumcision is widely practiced for religious and traditional reasons, often within the first two weeks after birth or at the beginning of adolescence as a rite of passage into adulthood. It is now performed to reduce the risk of contracting HIV and other sexually transmitted infections (STIs). Male circumcision (MC) rates overall in Uganda are at around 25 percent.

1. Epidemiological Fact Sheet on HIV and AIDS, Uganda 2008, <http://www.unaids.org/en/CountryResponses/Countries/uganda.asp>, Nov 2010

2. National HIV & AIDS Strategic Plan 2007/8–2011/12: Moving Towards Universal Access.

MMC for HIV prevention has received endorsements by the Uganda Ministry of Health as a method that reduces the risk of HIV transmission when used with other preventive methods. A National Task Force on MMC and a National Focal Person for MMC have been put in place. MMC became part of the policy dialogue in Uganda in 2009. As a result, a policy was launched in September 2010. Formal scale-up was slated to begin in June of this year, but nationwide training of health workers and strategy development are still not in place.

Below is the general understanding of “male circumcision” in Uganda based on interviews with key stakeholders and community representatives.

- MC is the removal of foreskin from the male genital organ.
- MC is done in the community, mosques and hospitals.
- MC is thought by some to increase sexual sensitivity, while others say it reduces male sexual sensitivity.
- MC is transition to manhood in the cultural context.
- MC is seen as a sign of bravery.
- MC is perceived to be an HIV prevention strategy.
- MC puts a burden on women as caretakers for those who have been circumcised.
- There is a lack of women’s involvement in MC, i.e., male partners seldom consult their female partners on MC.
- The above poses a risk of women engaging men in sex before they are completely healed, due to lack of knowledge on abstinence for six weeks.
- MC costs between \$10 and \$200.
- MC is done only for religious and cultural purposes, i.e., practiced by Moslems and the Bagisu tribe in the eastern region of Uganda.
- MC is sometimes equated with FGM.

2. METHODOLOGY

TOOLS

The questionnaires used for community research were jointly developed by WHIPT teams from South Africa, Namibia and Swaziland, reviewed by the Uganda country team and tailored to the Ugandan context. They were then adapted and translated into two local languages: Luganda and Sabin.

DATA COLLECTION

A set of three data collection tools was used. These included one quantitative survey targeting women; one key informant guide targeting district and national level officials; and a focus group discussion guide targeting women at community levels. A team of six data collectors and four staff members from Human Rights Action Group (HAG) and Mama’s Club were trained in these instruments for the data collection exercise.

Sixty-three women were administered the questionnaire from Kampala District of the Central Region, and Kapchorwa District of the Eastern part of Uganda. These regions were purposely selected to represent dissimilar communities. Kampala is a cosmopolitan city with both rural and urban characteristics, and with cultural and

religious diversity. Kapchorwa is a rural district and was selected because traditional circumcision for both men and women, for FGM, has been practiced for years. A qualitative analysis of key informants and six focus group discussions informed the outcomes.

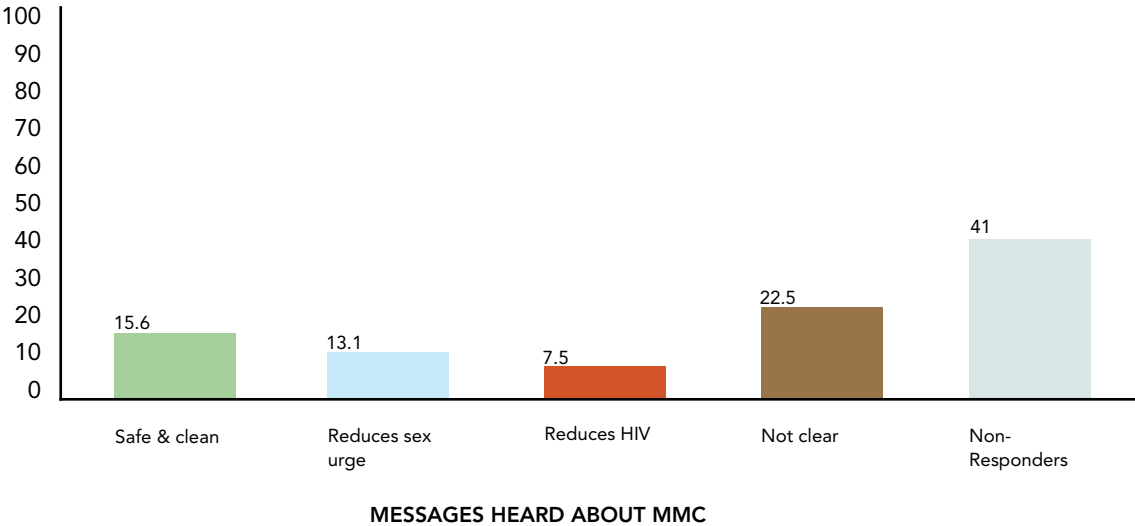
3. RESEARCH FINDINGS

MMC KNOWLEDGE LEVEL AND MESSAGING

Out of a total of 66 respondents, 98.5 percent indicated they had heard about MMC. Knowledge about MMC was a qualification for completion of the questionnaire by answering subsequent questions.

Respondents reported receiving a range of messages about MMC. Overall, 15.6 percent of respondents reported hearing that MMC is “safe and clean”, 13.1 percent that it “reduces sex urge”, 7.5 percent that it “reduces HIV”, and 22.5 percent said the messages were not clear. The rest of the respondents (41 percent) never gave a concrete response, as some indicated that the questionnaire was not clearly understood.

Percent distribution of messages heard about MMC



SOURCE OF INFORMATION ABOUT MMC

When the respondents were asked the sources of the above messages, 16.4 percent said they heard messages from HIV counselors; 23.1 percent from the church; 18.1 percent from Moslem friends; 17.0 percent from the media (newspapers, radios); 9.7 percent from peer groups; and 6.4 percent from the general community.

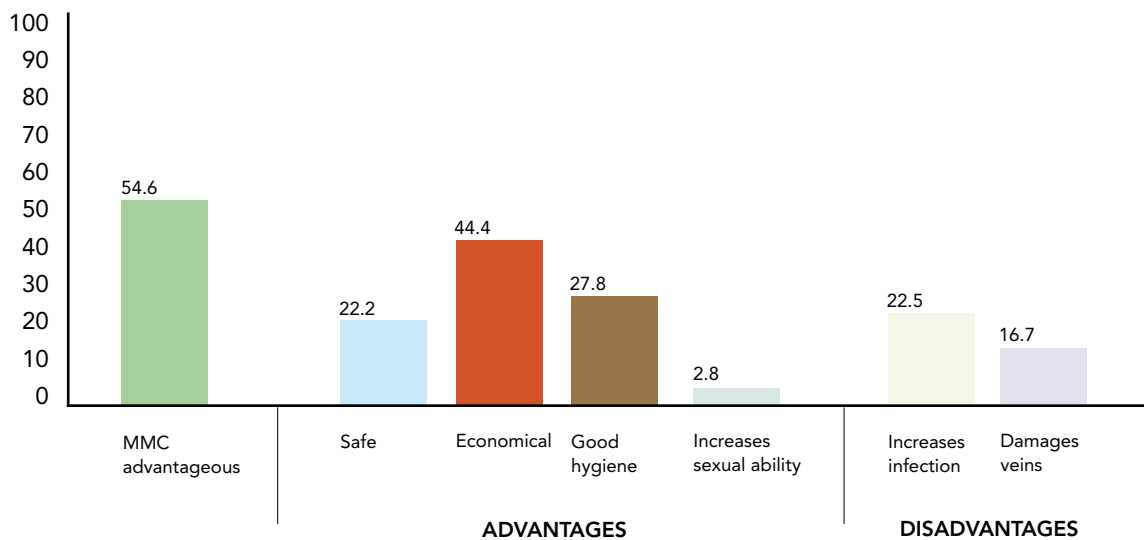
LOCAL ADVERTISEMENT MESSAGES

Nearly half (47.0 percent) of respondents reported they had heard about MMC and HIV on the radio or had seen the information on billboards. Messaging displayed on these billboards read “Reduce HIV with MMC”; “MMC is clean and hygienic”. One of the respondents reported billboard messages promoting MMC over traditional MC—unless traditional circumcisers are trained to carry out the surgery safely and effectively according to MMC guidelines.

MMC CHANGING IDEAS

Slightly over half (54.6 percent) of respondents indicated that MMC had advantages to HIV prevention—72.2 percent of respondents from Kapchorwa district compared to only 33.3 percent from Kampala. A number of advantages were cited: 22.2 percent of the respondents indicated that it is “safe”; 44.4 percent that it is “economical” (traditional MC being expensive because it is accompanied by a ceremony whose cost is mainly met by the women as mothers, who are responsible for hosting and feeding the celebrants); 27.8 percent that it is “good hygiene”; and 2.8 percent that it increases “sexual ability”. Two major disadvantages were reported: 30 percent of the respondents said MMC increases HIV infection, while 16.7 percent reported that it damages the veins.

Percent distribution of advantages and disadvantages of MMC



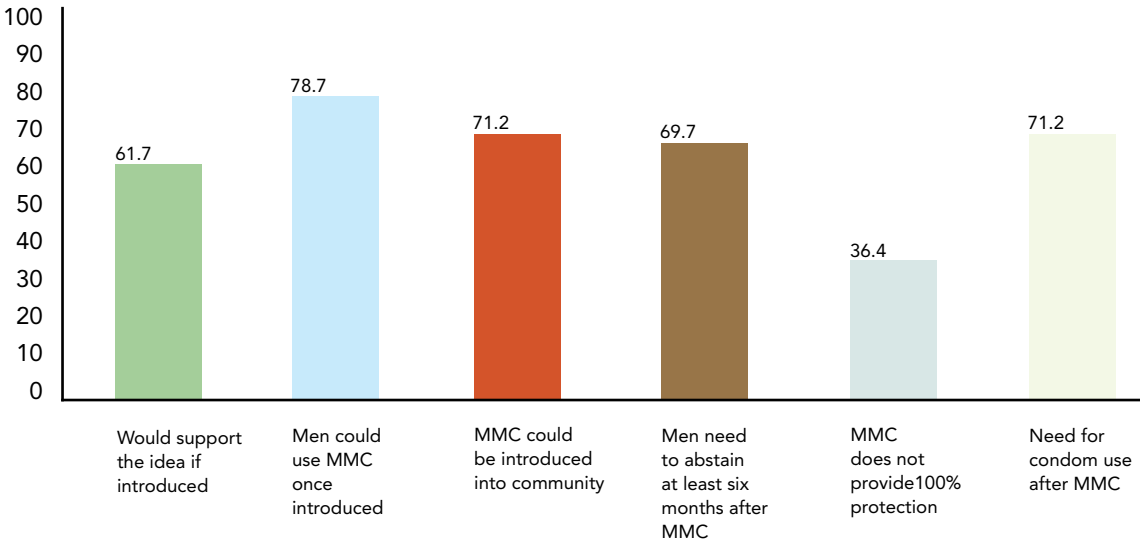
Of the respondents, 71 percent said that there is a need for condom use even after MMC (86.7 percent for Kampala and 58.3 percent for Kapchorwa). Nearly four in ten (36.4 percent) respondents said that MMC does not provide 100-percent protection against HIV, and 69.7 percent said that men need to abstain from sex at least six weeks after MMC.

On introducing MMC into respective communities, 71.2 percent of the women thought it could be done (76.7 percent for Kampala and 66.7 percent for Kapchorwa). Respondents said that MMC could be promoted as

part of the cultural practice in areas where men have to be traditionally circumcised. Some said MMC surgery would be easy to treat, and that for it to be successful there needs to be mass sensitization in the respective communities. Furthermore, 61.7 percent of respondents said they themselves would support the idea in their communities for reasons of safety and cleanliness (12.8 percent); lower HIV infection rates (41.1 percent); and cultural familiarity (20.6 percent).

Of those who said MMC could be introduced, 78.7 percent said they thought men would seek MMC services once introduced (91.3 percent for Kampala and 66.7 percent for Kapchorwa). The reasons given for men to welcome the idea mirrored the women’s reasons for supporting it: cultural respect (20.9 percent); increase in cleanliness (19.2 percent); and a decrease in HIV infection rates (19.2 percent). Again, the respondents underscored the need for mass sensitization if men were to use it.

Percent distribution of attitudes about MMC



CURRENT HIV PREVENTION METHODS AVAILABLE

Respondents were asked which HIV prevention methods were currently available in their communities. Nearly a quarter (24.2 percent) of respondents indicated the use of the ABC model (abstinence, be faithful, use condoms); 23.4 percent indicated use of prevention of mother-to-child transmission (PMTCT); 27.5 percent indicated HIV voluntary counseling and testing (VCT). In addition to these proven prevention strategies, 8.1% of women reported using “the withdraw” method to reduce HIV risk.

ADDITIONAL PREVENTION SERVICES NEEDED

Respondents were asked to indicate additional services that should be provided with MMC. Fifteen percent of respondents indicated that there is need for MMC literacy; 27.3 percent indicated HIV testing services and 15.8 percent indicated medical care, while 33.1 percent said there was need for MMC to be championed by govern-

ment and implemented through established health structures for more acceptability by the communities. Other desired HIV prevention services specified for rollout alongside MMC were sensitization on condom use (28.7 percent); free HIV counseling and testing services (41.1 percent); and promotion of abstinence (16.1 percent).

BENEFITS OF MMC SERVICES TO WOMEN

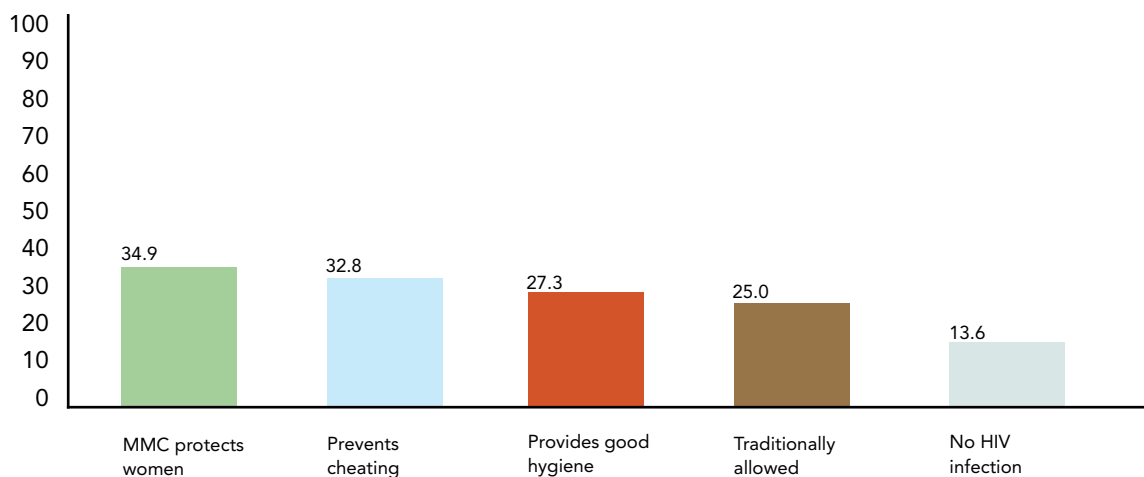
Of the respondents, 35 percent thought that they would be directly protected from HIV through MMC (33.3 percent for Kampala and 36.1 percent for Kapchorwa). Respondents gave reasons why they thought so:

“MMC prevents cheating because it reduces sexual urge.”

“MMC provides good hygiene; it is traditionally allowed.”

“It leads to no HIV infection.”

Percent distribution of reasons MMC can protect women from HIV infection



CHANGING IDEAS ABOUT HIV RISK

Of the respondents, 50 percent thought that MMC is changing ideas about HIV risk. Respondents cited reasons that included that MMC is safe (26.7 percent); mass sensitization about MMC (25.0 percent); and promotion of condom use (18.1 percent). However, 17.5 percent said MMC has had no impact on HIV infection.

DECISION MAKING

Of the respondents, 65.2 percent said that women would be involved in decision making for MMC (63.3 percent for Kampala and 66.7 percent for Kapchorwa). Forty-two percent of the respondents said that women would want to be involved in decision-making because they don't like condom use. However, respondents said

some of the women do not want to be involved since they have limited capacity (8.9 percent); they are not well-informed (1.7 percent); MMC is not clear (21.1 percent); or they wanted to avoid gender-based violence (GBV) (38.3 percent).

Respondents reported that making a decision about men getting circumcised for HIV prevention depends on a number of factors: traditional leadership (28.1 percent); cultural factors (18.9 percent); man's own decision (16.7 percent); religious factors (15.9 percent); and peers (4.5 percent).

Almost one-third of the respondents said they would circumcise their infant boys if MMC were protective against HIV (33.3 percent for Kampala and 27.8 percent for Kapchorwa).

Just a quarter of respondents said they were currently using condoms with their respective partners (30.0 percent for Kampala and 22.2 percent for Kapchorwa). Only 6 percent said they were comfortable asking their male partners to use a male or female condom (13.4 percent for Kampala and 0.0 percent for Kapchorwa). Respondents perceived a number of reactions from their partners if they insisted on using a condom after MMC: suspicion that women were not being faithful and further GBV if men do not understand partial efficacy.

PERCEPTIONS AROUND MMC AND GBV

Of the respondents, 44 percent thought that GBV was a problem in their communities. Thirty-eight percent of respondents thought MMC would lead to increased GBV in their communities (23.3 percent for Kampala and 50.0 percent for Kapchorwa). Twenty-two percent of respondents said MMC would improve marital sex; 20.9 percent said it would lead to low HIV risk and low GBV; and 7.2 percent said it would bring respect for men.

PERCEPTIONS AROUND MMC AND FGM

Three in every ten (32 percent) respondents thought that FGM could protect girls from HIV infection (16.7 percent for Kampala and 44.4 percent for Kapchorwa). Thirty percent of respondents thought that promoting MMC for HIV prevention would also promote FGM by some people who may misunderstand this new prevention technology.

QUESTIONS AND ISSUES ARISING

Respondents were asked to identify what should be priorities, visions and needs for reducing women, family and community risks for HIV. Thirty-one percent of respondents indicated a need to emphasize ABC; 28.3 percent reported establishment of positive-living clubs; 10.6 percent said there is need for one to be open about sero-status; 8.6 percent indicated a need for the media to educate the community about MMC; and 1.7 percent indicated the need to circumcise male infants.

Regarding MMC, respondents had a number of questions: Is it free of charge? (18.1 percent) What are the side effects of MMC? (16.4 percent); Should HIV-positive men undergo MMC? (15.0 percent); Is MMC by force? (14.2 percent); What is the age limit for MMC? (5.8 percent); Does MMC protect women in discordant relationships?

4. DISCUSSION

MMC KNOWLEDGE LEVEL

Awareness in Kampala and Kapchorwa about MC is very high because traditionally it is a rite of passage. However, knowledge around MMC for HIV prevention is limited due to its being a new intervention that still needs to be appreciated by communities.

Survey participants pointed out some of the most common communication messages about MMC. These include “MMC reduces HIV infection” and “MMC is safe and clean”. Groups promoting MMC have used different ways to disseminate information. Counselors have been equipped with full information on MMC to pass on to people, especially those who come for their services. The media has been used to air MMC issues. Through the media, peers and the general community have been able to access information about MMC, which has been given out to other peers and friends in the process.

Awareness of MMC is now increasing through outside advertisements (use of billboards) with messages urging the community to reduce HIV through MMC and addressing some hygiene and safety concerns. At the same time, brochures have been produced informing the public about MMC. Information, education and communication material on MMC is available but does not include messaging around women’s safety and MMC.

The majority of respondents pointed out that MMC is advantageous. However, there are still concerns that it could increase infection in both men and women and supposedly damage veins around the penis. It is likely that the introduction of MMC will be supported in most communities, possibly due to sexually active couples’ not enjoying condom use.

According to the respondents, ABC for the sexually active partners, PMTCT for children and testing before getting involved in sexual intercourse are the primary HIV prevention services available almost in the whole of Uganda. There is need for continuous promotion of these services and in particular the need to promote correct and consistent use of condoms alongside MMC sensitization.

Women hold different perceptions and myths about MMC as far as HIV prevention is concerned. There is a belief that MMC will protect women from HIV simply because men will no longer cheat. It is therefore important to address these myths and bring facts about MMC with evidence-based information to our communities.

GENDER-BASED VIOLENCE

Although women want to be involved in decision-making surrounding their husbands’ MMC, not all are involved in the process. This is because some women have limited capacity to influence their spouse; others are not informed of their rights; others are unsure about MMC; and others fear that their involvement could instigate GBV. In the process of getting involved in sexual decision-making, women have been frustrated and emotionally and physically hurt.

GBV cannot be ignored if MMC is to succeed in Uganda. The success of MMC among men will depend on the kind of relationship existing within couples and on whether MMC is rolled out with sensitivity to women’s safety

issues, such as abstinence before wound-healing and men's avoidance of increased risk behavior. Although the majority of community members foresee a positive impact in their communities, a few members caution about a negative impact.

FEMALE GENITAL MUTILATION (FGM)

There is a dangerous confusion around MMC and FGM, especially in Kapchorwa district. The Government of Uganda has outlawed FGM, but it is secretly done at night among some rural communities of Kapchorwa. **Respondents said that promotion of MMC is likely to increase FGM.** Community members still lack a clear understanding of the ultimate purpose of MMC and therefore think, **"FGM is for female as MMC is to male" as far as HIV prevention is concerned.** Male and female circumcision are both cultural practices, so the feeling of the respondents was that promoting one would imply approval of the other. The respondents felt that there is need for HIV prevention approaches that are directly linked to and benefit women, not merely looking at strategies where women's health is dependent on men. In other words, MMC is thought to be a "new" justification for FGM.

OUTSTANDING QUESTIONS AND RESEARCH

Other issues that need clarification before MMC is fully implemented include the age limit for MMC, side effects, the costs involved, and whether an HIV-positive man can benefit from MMC and reduce the risk of passing infections to his female sexual partners.

5. CONCLUSION AND RECOMMENDATIONS

From the documentation, it is clear that women are aware of traditional/religious male circumcision but have little knowledge of MMC and its benefits to them. On the same note, women are not empowered in decision-making around MMC—with either their spouses or their infants. Policy makers should consider the social and gender implications of MMC in the community, if it is to be appreciated and beneficial to both men and women.

MMC acceptability and use in communities revolves around promotion, advocacy and sensitization efforts undertaken by the government, implementers and advocates.

- Government and advocates must provide increased sensitization of women, with enough clear information about MMC before the community is prepared for its uptake.
- Government, advocates and community leaders need to address the myths and bring facts about MMC with evidence-based information to communities.
- Government and implementers must develop an MMC package that will integrate sexual and reproductive health with gender equity and empower women to get involved in decision-making, especially on condom use.
- Implementers must impart knowledge and skills in decision-making regarding the circumcision of their male infants.

- Community advocates should be involved in mass campaigns and sensitization about MMC as a method of HIV prevention and its benefits and challenges for women.
- Implementers and advocates must emphasize MMC as a complementary HIV prevention method rather than a stand-alone method.
- The media should give out clear and correct messages about MMC.
- All MMC outreach materials and messaging should dispel the myth that MMC is equated with FGM for HIV prevention.
- Civil society organizations should agitate for dialogue sessions with opinion leaders of communities who are practicing FGM, for consideration of eliminating the practice.

NEXT STEPS

- Report launch: *Making Medical Male Circumcision Work for Women in Uganda*.
- Link with HEPS-Uganda to inform and mobilize civil society around MMC.
- Develop messaging materials for communities and media.
- Liaise with Ministry of Health and UNAIDS to help guide MMC implementation.
- Work with health service providers at the district level, to ensure the monitoring of MMC's impact on women is in place.
- Investigate Female Genital Mutilation/MMC conflation.
- Work with cultural leaders to change traditional attitudes toward the role of women in promoting safe male circumcision.

UGANDA SURVEY RESULTS

	Uganda
Total interviews	66
Have heard about MMC for HIV prevention	98.5%
Have heard about MMC via billboards and radio	47%
There are advantages of MMC for HIV prevention	54%
Are aware that ...	
there is a need for condom use after MMC	71%
MMC does not provide 100% protection from HIV risk	36%
men need to abstain from sex for six weeks after MMC	67%
MMC for HIV prevention can be introduced into community	71%
Men would get circumcised	79%
Would support MMC in community	62%
MMC protects women from HIV	35%
MMC is changing ideas about HIV risk	50%
Women talk about MMC for HIV prevention with their sexual partners	42%
Women are involved in decision-making around men getting circumcised for HIV prevention	65%
Women want to be involved in this decision	42%
Would circumcise own infant boy	30%
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	0%
comfortable	3%
fairly comfortable	3%
sometimes comfortable	35%
not at all comfortable	46%
Use condoms with partner(s) now	26%
Gender-based violence is a problem in community	44%
MMC for HIV prevention would impact gender-based violence in community	38%
Female genital mutilation could protect girls from HIV infection	32%
Promoting MMC may promote FGM among girls and women in community	30%

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.