

Making Medical Male Circumcision Work for Women

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

Swaziland 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.

SWAZILAND

CEBILE DLAMINI – SWAZILAND FOR POSITIVE LIVING (SWAPOL)

SIPHIWE HLOPHE – SWAPOL

GCEBILE NDLOVU – SWAPOL

KWASHIE KUDIABOR – ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

KEY FINDINGS

- A majority of the women surveyed have heard about MMC and believe that it is protective for men against HIV, would support it and want to be involved in the process.
- An estimated half of the women surveyed believe that MMC will protect them from HIV.
- A majority of the women are concerned that some men would feel that MMC provides 100-percent protection and would therefore be sexually riskier than before becoming circumcised.
- Only half the women knew that men needed to abstain from sex for six weeks post-surgery.
- There is a perception that women are not targeted in current MMC messaging.
- Some of the current places of MMC implementation are stand-alone clinics for men and fail to integrate MMC delivery with sexual and reproductive health services for either men or women.

1. BACKGROUND

Swaziland is a southern African country with a low level of male circumcision given that traditional “cutting” is not practiced. However, studies conducted in 2006 by the Family Life Association in Swaziland (FLAS), a non-governmental organization providing sexual and reproductive health services, showed a high level of acceptability of MMC among men, with 87 percent surveyed willing to undergo circumcision for protection against HIV.

The FLAS 2006 study further estimated the unit cost for a comprehensive package of MMC services in Swaziland at R376.00 (about \$50), which includes surgical costs (78.6%); communications (14.5%); testing (3.6%); and pre- and post-operative counseling (3.3%). In preliminary analyses, this package of services has been shown to be cost-effective when compared to other prevention interventions, particularly because MMC is a one-off procedure that does not have to be funded over time.

In December 2009, the Government of the Kingdom of Swaziland adopted policy, strategy and an implementation plan on Safe Male Circumcision for HIV Prevention. The previous Prime Minister, Absalom Themba Dlamini, and the current Prime Minister, Sibusiso Dlamini, are strong supporters of MMC, and there is a dedicated MMC coordinator in place in the Ministry of Health.

Through Swaziland's National Emergency Response Council on HIV and AIDS (NERCHA), Jhpiego, Population Services International and UNICEF, doctors and nurses have been trained to perform MMC. A total of six government sites have been identified as pilot projects for the country's Accelerated Saturated Initiative, with some currently active.

POLICY GOAL, OBJECTIVES AND CONTEXT

The objectives of the MMC policy are to create an enabling environment for the scale-up of well coordinated MMC services; increase the number of health facilities providing safe male circumcision services in both the urban and rural parts of Swaziland; and increase the number of HIV-negative men aged 15–24 years accessing MMC services. This age group may benefit the most from services, as they are collectively and currently at greatest risk of HIV infection based upon epidemiologic data.¹ They either are already sexually active or will become sexually active soon.

The policy addresses a number of aspects such as targeting the populations that will result in the most public health impact; training cadres of healthcare workers to provide MMC services; the type of facilities where MMC services shall be provided; integration of MMC with other health services; costing; quality assurance; communications including messaging around MMC's partial efficacy; human rights, ethics and legal issues; and socio-cultural considerations. Although the policy calls for monitoring and evaluation, it does not include gender indicators that would determine whether women are benefiting, being harmed or not being affected at all.

2. METHODOLOGY

Quantitative research methods involving questionnaires were used to get the impression of MMC among the women interviewed. The qualitative method involved the use of focus group discussions to explore issues underpinning MMC in the community. The population consisted of predominantly HIV-positive women with a mean age of 41 who were purposely selected from rural and peri-urban communities in the Manzini and Hhohho regions, where MMC had not yet been implemented. Overall, 73 women participated in the one-on-one interviews in the ten communities, whereas four focus group discussions were held in four communities.

LIMITATIONS OF THE STUDY

A potential limitation resulting from the focus group discussions is that some women were not comfortable to fully express their views in fear of judgment.

It would have been beneficial for the study to find out the experiences of women whose husbands had undergone the MMC, to facilitate comparisons with experiences of women in the rural communities whose husbands have not yet undergone the MMC. This was not possible, as the study team was not able to get clearance from the MMC clinic due to confidentiality issues.

1. Strategy and Implementation Plan for Scaling up Safe Male Circumcision for HIV Prevention in Swaziland, 2009–2013. Swaziland Male Circumcision Task Force.

3. RESEARCH FINDINGS

KNOWLEDGE LEVEL OF WOMEN AROUND MMC

Of the 73 women interviewed, about 88 percent (64/73) had previously heard about MMC. The women who heard about it responded that MMC prevents HIV in men, improves penile hygiene, and reduces transmission of sexually transmitted infections (STIs) by removing the foreskin of the penis. Some also mentioned they heard “it is done in the mountain”, referring to it as a foreign culture—not in Swaziland. A majority of the women reported they heard about MMC on the radio or from individuals in the community. However, no mention was made of street billboards as a source of information.

MMC CHANGING IDEAS ABOUT MEN’S RISK

Of the 64 respondents who said they had heard about MMC, 92 percent (59/64) were aware of the advantages of MMC for HIV prevention. Most of the women explained further that MMC prevents STIs, including HIV in men.

When asked if they were aware that there is need for consistent condom use after MMC, only 61 percent (39/64) said “yes”. This same percentage of respondents were aware that MMC does not provide 100-percent protection. Only 52 percent (33/64) agreed that men need to abstain from sex for six weeks after MMC.

A high proportion of the women—91 percent—felt that MMC could be successfully introduced into the community. The women further explained that introducing MMC in the community would improve access to other comprehensive sexual and reproductive health services. This would increase awareness and knowledge among both men and women in the communities, especially if women would be involved from the beginning. A further 72 percent (46/64) of the women thought men would utilize the MMC services when introduced. Almost 89 percent (56/64) of the women themselves said they will support it.

“Men are cheaters and MMC can help to reduce STIs including HIV.”

Fifty-three percent (34/64) of respondents believed that MMC would protect them from acquiring HIV from their partners. It is not clear, however, whether the women thought it would provide direct or indirect protection over time.

Nearly 63 percent (40/64) of the women thought that MMC would change ideas about HIV in the community.

“Men would think they are 100 percent protected and they will continue to have sex without condoms with multiple partners putting me as wife at risk of getting HIV.”

There’s a fear that men would increase their sexual risk-taking behaviors because they feel more or completely protected by MMC. This fear was expressed by 55% (22/40) of the women who think MMC would change ideas about HIV in the community.

Only 47 percent (30/64) of the women affirmed they talk about MMC with their partners. However, 86 percent (55/64) of the women were willing to be involved in the decision-making process to support their male partners during the healing process and to discuss circumcising their male children.

CURRENT HIV PREVENTION METHODS IN USE

Fifty-two percent (33/64) of the women reported they are not comfortable asking their male partners to use male or female condoms, as men are the sexual decision-makers. Only 33 percent (21/64) of the women self-reported that they are currently and consistently using condoms. This number may be higher than other cohorts in Swaziland, given that the women surveyed were assumed to be predominantly HIV-positive. Also, self-reporting may induce the women to want to give a socially acceptable answer although it may be inaccurate.

The women who are currently not using condoms affirmed that their male partners would refuse to use condoms even when circumcised because they'll falsely believe that they are 100-percent protected.

“My partner does not want to use condoms even now. Nothing will make him to change his mind to use it. Men are difficult to convince.”

PERCEPTION AROUND GENDER-BASED VIOLENCE (GBV) AND MMC

About 61% of the women said MMC would negatively impact gender-based violence (GBV), since men would refuse to use condoms after being circumcised. Condom negotiation would be even more difficult after MMC, given its current challenges, the women reported.

“We were asked to use condoms and now circumcision. We are confused. Men are refusing to use condoms and we are not in the position to defend or negotiate for safe sex.”

4. DISCUSSION

Clinics that offer and promote MMC are situated in the urban setting. This is a huge challenge, as many of the rural and peri-urban communities still lack information on and access to MMC when and where it will eventually be rolled out through mobile clinics. Lack of education before this scale-up was a gap identified by the research.

Section 3.7 of the Government of the Kingdom of Swaziland's MMC Policy calls for women and girls to be involved in decision-making, meaning included or targeted when developing messages for MMC. SWAPOL has become more involved in these processes through the WHIPT project, but seemingly from this survey, more women need to be included.

There are concerns about the range of services provided in the context of MMC programs. Programs that have a strict focus on MMC in absence of comprehensive sexual and reproductive health services miss the opportunity to engage men around sex, sexuality and family planning and to transform sexual and gender norms. It is critical that MMC be offered as part of a package of services and interventions for the man himself, and where possible, his sexual partners.

In general, women are willing to support the MMC program, but they lack an understanding of how they can be involved. Communication messages are targeting only men. This may be a reflection of the cultural view that

women in Swaziland are considered minors. There is a specific need to rollout MMC in clinics catering to both men and women's sexual health, and a need to develop balanced messages—targeting both men and women about the benefits and risks of MMC. Explicitly informing communities that MMC does not provide direct protection against HIV in women is crucial to the successful scale-up of the intervention. There is also the general need to address gender inequity throughout Swaziland.

5. RECOMMENDATIONS

- Swaziland's HIV/AIDS policy makers along with implementers and civil society advocates must address gender implications of MMC in the current policy by identifying, messaging and monitoring for potentially harmful outcomes of promoting MMC, such as increased behavior risks and sexual violence against women.
- Advocates and implementers must inform communities that MMC does not provide direct protection against HIV in women.
- Policy makers, implementers and advocates must support MMC literacy campaigns in the rural and urban communities with correct information about the benefits and risks of MMC.
- Implementers must provide MMC services that are integrated into comprehensive sexual and reproductive health services such as HIV testing and counseling, prevention of mother-to-child transmission (PMTCT), family planning and post-natal care, and other HIV services for both men and women.

NEXT STEPS

- Report launch: *Making Medical Male Circumcision Work for Women in Swaziland*.
- Link with civil society groups 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 implementers, such as Population Services International and the Family Life Association of Swaziland, to ensure the monitoring of MMC's impact on women is in place.

SWAPOL's Cebile Dlamini interviewing an urban woman in the district of Nkambeni for her opinion on the rollout of MMC.



SWAZILAND SURVEY RESULTS

	Swaziland
Total interviews	73
Have heard about MMC for HIV prevention	88%
Have heard about MMC via billboards and radio	--
There are advantages of MMC for HIV prevention	92%
Are aware that ...	
there is a need for condom use after MMC	61%
MMC does not provide 100% protection from HIV risk	61%
men need to abstain from sex for six weeks after MMC	52%
MMC for HIV prevention can be introduced into community	91%
Men would get circumcised	72%
Would support MMC in community	89%
MMC protects women from HIV	53%
MMC is changing ideas about HIV risk	63%
Women talk about MMC for HIV prevention with their sexual partners	47%
Women are involved in decision-making around men getting circumcised for HIV prevention	23%
Women want to be involved in this decision	86%
Would circumcise own infant boy	--
Women's comfort in asking their male partners to use a male or female condom after circumcision:	
very comfortable	--
comfortable	--
fairly comfortable	--
sometimes comfortable	--
not at all comfortable	52%
Use condoms with partner(s) now	33%
Gender-based violence is a problem in community	--
MMC for HIV prevention would impact gender-based violence in community	61%
Female genital mutilation could protect girls from HIV infection	--
Promoting MMC may promote FGM among girls and women in community	--

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Swaziland for Positive Living

www.swapol.net

Women Fighting AIDS in Kenya

www.wofak.or.ke



SWAPOL member interviewing a women in Sigwe.