The perceptions of male students towards circumcision as a strategy in the prevention of HIV / AIDS - a case study of MSU

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Abstract

HIV/AIDS is a debilitating killer disease which hinders sustainable economic development. In an effort to curb HIV infection, the Zimbabwe Minister of Health and Child Welfare in 2009, declared free and voluntary circumcision for males between the ages of 18 to 29 years. However, only 3.75% of the students at MSU were circumcised by June 2012. This research is intended to reveal the perception of these males towards male circumcision as they are considered as most sexually active and exposed to and or at risk to HIV / AIDS infection. The study adopted a qualitative approach and was carried out at Midlands State University as a case study. Interviews were used to collect data. Students were sampled according to faculty to a sample of 100 students. The findings were that the students lacked information making them suspicious of the programme which was clouded with myths and misconception. Their decisions were affected by culture as well. The recommendations made include massive campaign strategies with outreach programmes to correct the attitudes of the Zimbabwean males. Finding shall be used to sensitise and disseminate information to males so that they take up this noble cause and fight the HIV / AIDS pandemic

Key words: voluntary male circumcision, HIV/AIDS, prevention strategy

Background

Human Immune Virus (HIV) related illness is the largest cause of death among adults of the reproductive age (UNAIDS, 2011). These are the people in the prime of their lives and are responsible for economic growth of the country, but illness and death does not sustain economic growth and development. The death toll of HIV/AIDS in 2007 only was 2.1 million and this has prompted a lot of research work on prevention of HIV/AIDS in order to reduce the death toll as there is no cure for the disease (WHO, 2010). In heterosexual contact, (50%) of all HIV cases in men were infected through their penises (Kahn & Walker, 1999). According to Fink (1986), the foreskin was implicated as predisposing to HIV infection as early as 1986. It has therefore, been proved that removal of the foreskin (circumcision) can greatly reduce the rate of HIV transmission (Honey, 2007). According to readily available data from UNAIDS (2008), about thirty-three (33)
55 million people (including 22.5 million in sub-Saharan Africa) are currently infected with HIV, the virus that causes AIDS. Although antiretroviral drugs keep HIV in check, there is no cure for HIV/AIDS. Consequently, prevention of HIV transmission is extremely important. Because HIV is usually spread through unprotected sex with an infected partner, individuals can reduce their risk of becoming infected with HIV by abstaining from sex, by having only one faithful partner, and by always using male or female condoms (NAC, 2009). In the HIV prevention toolbox of behavioural, biomedical, and structural approaches for maximum effect, voluntary medical male circumcision (VMMC) is an essential tool in all high HIV prevalence, predominantly heterosexual epidemic settings. Observational data and ecological studies have suggested for decades that male circumcision provides a level of protection from HIV infection for men. Three randomized controlled trials conducted in the last decade in South Africa, Kenya and Uganda found a (60%) protective effect against HIV for men who became circumcised (UNAIDS report, 2011).

In addition, trials in sub-Saharan Africa have shown that male circumcision reduces the risk of HIV infection in men by 60% (UNAIDS, 2008). In 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommended that voluntary medical male circumcision (VMMC) should be part of HIV prevention programmes in regions with a generalized HIV epidemic and a low level of male circumcision. Together with the United States President’s Emergency Plan for AIDS Relief (PEPFAR), WHO and UNAIDS prioritized 14 countries (Zimbabwe included) in Eastern and Southern Africa for VMMC program scale-up. Mathematical models suggest that, if 80% VMMC coverage is reached by 2015 (which will entail performing 20.33 million circumcisions between 2011 and 2015) and sustained thereafter, VMMC programmes in these priority countries will avert more than 4 million HIV infections among adults males between 2009 and 2025 (UNAIDS, 2010).

What is implied by these figures is that, if the 20.33 million circumcised men go for one faithful partner each, then 40.66 million people will be spared the HIV infection. If circumcision can avert 4 million HIV infections in men only, then 8 million HIV infections can be averted when their spouses are added, provided they are all faithful to one partner each.

As a result in March, 2007, the World Health Organization and UNAIDS issued a statement that, “the efficacy of male circumcision in reducing female to male HIV transmission has now been proven beyond reasonable doubt and is an important landmark in the history of HIV prevention”. They went on to recommend circumcision for men and boys. However, Zimbabwe has a very low male circumcision prevalence rate of 10%, according to the Zimbabwe Demographic Health Survey (ZDHS), 2005/6; hence it should scale up male circumcision rate. According to the Herald dated 5 May, 2010, the Ministry of Health has targeted at least 1.2 million male circumcisions by 2015. To reach this target, the Ministry of Health and Population Services International (PSI) are implementing a number of strategies, one of which is outreach targeting the 15-29 age groups in the community of which Midlands State University (MSU) is one of them. The researchers therefore sought to find out the perceptions of MSU male students on circumcision as an HIV prevention strategy.

In order to scale up the circumcision of males, the Ministry of Health and Child Welfare (MOHCW) introduced the programme of voluntary free male circumcision in 2009. Centres for circumcision were set up at various places throughout the country. Thornhill Air Base Hospital is the centre for Gweru. As a follow
up to the male circumcision programme, the Deputy Prime Minister of Zimbabwe, requested all ministers (Men of Government) to be circumcised as an example to the people; this took place in June 2012 (The Herald, 22 June, 2012). The Government started working with PSI to get mass circumcision underway using funding from the Bill and Melinda Gates Foundation and aiming to circumcise at least 80% of all young men between 15 and 29 – a total of 1.2 million. According to the Herald, 4 July, 2011, the news that circumcision could prevent HIV infection created high demand, with a waiting list of 700 in the capital, Harare, but this was not the same with Gweru.

Shelton et al (2006) advised that male circumcision could extinguish the HIV epidemic. This was supported by Gray et al (2007) who pointed out that, “Given its effectiveness, circumcision, if implemented widely, has the potential to drive the prevalence of HIV virtually to extinction”. In Gweru voluntary male circumcision is being done at Thornhill Airbase Hospital. The team move around Gweru educating men to partake in the programme and this includes male students from MSU. However, the researchers’ interaction with the students at MSU revealed that they were not keen to partake in the programme. The researchers therefore sought to find out the perceptions of these students on circumcision as a method of preventing HIV/AIDS transmission.

Statement of the problem

The researchers observed that in spite of male circumcision predating recorded history and the foreskin being implicated as responsible for (50%) of all male HIV infections (Fink, 1986); very few men are opting for male circumcision in Gweru. The voluntary medical male circumcision was introduced in January 2011 by the Government in conjunction with Population Services International as a method of preventing HIV transmission coupled with the already known measures like abstinence, condom use, knowledge of one’s status and faithfulness to one partner. According to the statistics obtained from Thornhill Airbase hospital in Gweru, 18000 men have been circumcised in Zimbabwe and only 948 in Gweru up to date (June 2012). The number of MSU male students circumcised to date was 300 out of 8000 which is 3.75%. This is very low considering that the programme is free. Why then, this low involvement? The researchers therefore, sought to find out why the male students were resisting.

Purpose of the study

The purpose of the study was to explore the perceptions that male students at MSU have on male circumcision as a method of preventing HIV/AIDS transmission and then identify ways of promoting maximum volunteering for the procedure so as to work towards an HIV –free generation.

Research questions

- How are the perceptions of male students at MSU influencing the VMMC strategy?
- How does the male students’ knowledge on HIV influence the acceptance of male circumcision as an HIV prevention strategy?
- How do socio-cultural factors affect male students’ perceptions towards male circumcision?
- What is the influence of health facility factors on male students’ perceptions towards male circumcision?

Study objectives

- To identify the perceptions that male MSU students have on male circumcision as an HIV prevention strategy.
• To investigate the knowledge these male students have on the health benefits of MC.
• To determine their beliefs and attitudes towards MC.
• To explore myths and misconceptions that the male MSU students have towards MC.

**Significance and rationale of the study**

The HIV menace calls for exploration of all avenues to arrest its spread. The abstinence, being faithful and to condomise (ABC) strategy has not been enough to arrest the spread of HIV. Even the ARV therapy which prevents the replication of the HIV virus does not stop the spread of HIV. The introduction of the voluntary male circumcision as another prevention package should have been embraced by the youths. Their apathy in embracing this method aroused the interest of the researchers to investigate, why. This study was carried out to find the reasons for the negative attitudes of the youth to undergo this free procedure.

The findings of the study could be used to sensitise and disseminate information to males so that they take up this noble cause and fight the HIV/AIDS pandemic. This would then result in a healthy nation which could sustain economic growth and development. The results of the study would not only help the authorities in the Ministry of Health and Child Welfare but might also help other tertiary institutions like MSU on the strategies that could improve male circumcision up-take. In addition, a knowledgeable community would be able to reduce the number of HIV infections and this could lead to an HIV-free Generation which would concentrate on economic growth and development. The results of the study would also serve as a foundation for further research on male circumcision.

**Theoretical framework**

The Theory of Reasoned Action, which was developed by Daniel in 1997, was used to guide this study. The theory explains that volitional behaviours are based on the assumption that social behaviours are under volitional (wilful) control. According to this theory, a person’s intention to perform a specific behaviour is controlled by two factors; the attitude (negative or positive) towards the behaviour and the influence of the social environment (general subjective norm) on that behaviour (Fishbein and Ajzen, 2010). The person’s attitude is determined by the person’s belief that a given outcome will occur if the behaviour is performed. (Fishbein and Ajzen, 2010). A person who holds strong beliefs that positive outcome will result from MC, will have a positive attitude towards that behaviour and will be circumcised. On the other hand, a person who holds strong beliefs that negative outcomes will result from MC, will have a negative attitude towards it and hence will shun circumcision. This concurs with the health belief model which states that a person will perform certain behaviour if the person perceives or anticipates benefits from the action. This means that the attitudes engrained in man will determine how that man will react to MC. If he believes that the outcomes will be positive then he will take positive action.

The general subjective norms are determined by the person’s normative belief about what the important or significant people think should be done and also by the individual’s motivation to comply with those other people’s wishes or desires. So the behaviour of men towards MC is determined by the important people in the man’s life and his reaction towards it is influenced by the perceptions of these people. He will react in a way that those people will expect him to. If he believes that most of the people in this social group will expect him to be circumcised
then he will do so depending on his motivation, to comply with them. The influential people in the man’s life are his parents, spouse, peers and high profile people like singers and actors. If these people are positive towards MC, they can positively influence the young men. The Theory of Reasoned Action, therefore, provides excellent frameworks for conceptualizing and identifying factors that determine behaviour. Therefore, this model is ideal if we are to understand and identify the underlying beliefs that determine an individual’s attitude and subjective norms that have a bearing on MC.

Methodology

The study was done as a case study of MSU as it encompassed the age group in question (19-29 years). Qualitative research methodology was used for this study since it can be used to investigate phenomena as well as understanding human behaviour and the reasons that govern such behaviour. As a result this methodology was chosen in order to understand the perceptions of the male students on MC. The case study was chosen in order to obtain personal opinions, inner feelings and experiences which this study was all about. The study population was the male students of Midlands State University. Convenient sampling was done and 20 students were interviewed from each faculty (Law, Commerce, Social Sciences, Science and Education and Arts) to a total of 100.

The data collection instruments were interview-guides. The interview-guides were used because they occupy an important place in the investigation, as they seek to extract data that is embedded deep in the minds or within the attitudes, feelings, interactions and reactions of the people involved. The researchers felt that the students were likely to be too shy to disclose such sensitive information during interviews; hence they were interviewed by a man. The data were analysed using themes.

Findings and discussion

The results showed that poor up-take of the MC programme at MSU was related to:

- Age
- Religion
- Ethnic group
- Knowledge
- Beliefs
- Myths and Misconception

Age

The greater numbers of participants (40) were aged between 21-23 years. The 18-20 years age group had 20 participants whilst the 24-26 years groups had 28. There were 4 participants in the 27-29 years age group. The mean age of the participants was 23.5 and these ages fell within the 15-49 years age group which is mostly affected by the HIV/AIDS.

Of the 100 participants, only 11 were circumcised. This is nearer to the Zimbabwe Demographic Health Survey’s 2005 findings that only 10% of the Zimbabwean men are currently circumcised. The Zimbabwean men seemed not to be partaking in the MC programme and this derailed the MOHCW’s efforts to reduce new HIV infections. Figure 4.1 shows the comparison of circumcised and uncircumcised males according to age group.

As depicted by Figure 4.1, the majority of the participants were uncircumcised across all age groups. In the 18-20 years age group, 20% were circumcised against 80%. Only 5% of 21-23 years age group were circumcised. The 24-26 years age group had 21% circumcised participants whilst there were 11% in the 27-29 years age groups.

The lowest prevalence of circumcision was in the 21-23 years and the 27-29 years age groups. It is sad to note that the 21-23 years age group seemed not to be going for circumcision yet this is the group that is highly sexually active. According to UNAIDS (2008), the majority of HIV infections in men...
take place around 22 years of age as this is the time that young men experimented and indulged in sexual relationships. After passing the age of 22 years, men settled down in long term sexual relationships. Peer pressure and the need to try out new things, caused young men between the ages of 21-23 years to succumb to the deadly HIV/AIDS. However, it would appear that those in the study were not keen to take up MC as an HIV prevention strategy to add on to the already known “ABC” HIV prevention strategies. What could be the cause?

### Religion

The students were of various denominations. The prevalence of circumcision was analysed according to their religion to find out if religion affected the uptake of the male circumcision programme. Table 4. 1 shows the religion and circumcision status of the participants. Ninety four (94 %) were Christians and only 8 (8.5%) of them were circumcised leaving 86 (91.5%) of the Christians uncircumcised. Four participants (4%) were traditionalists and 1 was circumcised whilst the other 3 were not. The two Muslims (2%) were both circumcised.

According to the data in Table 4.1, (94%) of the participants were Christians and only a few of them were circumcised (8.5%). This corresponds with the findings by Bailey and Lukobo (2000) that MC was considered fundamental to some minority Christians who still practiced it. Rain-Taljiaard et al (2003) concurred when he stated that some Christians condemned MC as a pagan practice leading to it being shunned. The 2 Muslim participants were circumcised and

#### Table 4.1 Religions of the respondents versus their circumcision status

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Circumcised Frequency</th>
<th>Circumcised Percentage</th>
<th>Uncircumcised Frequency</th>
<th>Uncircumcised Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christians</td>
<td>94</td>
<td>94</td>
<td>8</td>
<td>8.5</td>
<td>86</td>
<td>91.5</td>
</tr>
<tr>
<td>Muslim</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Traditionalist</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>25</td>
<td>3</td>
<td>75</td>
</tr>
</tbody>
</table>
this can be attributed to the fact that Muslims are the largest religious group which practice MC based on their beliefs (Lukobo and Bailey, 2000). However the Muslims are very few at MSU to make a significant impact on MC up-take. These results suggest that Christians were not for male circumcision and since they constituted the biggest number (94%), the programme was not taking off as expected.

**Ethnicity**

The failure of the male circumcision programme could be related to different beliefs within the different Zimbabwe ethnic groups. The different ethnic groups at MSU were assessed in relation to male circumcision.

Most, 90 (90%) of the participants were Shona with a 5.6% prevalence of MC. Two (2%) were Ndebele and were both uncircumcised. Four (4%) were Tonga and three (3) were circumcised whilst one (1) was not. The 2 (2%) Rembas and one Xhosa were all circumcised because of their cultural and religious beliefs. There was one Tshangani participant, who was not circumcised.

The above findings implied that MC prevalence was low among the Shona and Ndebele ethnic groups. This confirms the NAC (2009) findings which stated that MC is rare among the dominant Shona and Ndebele ethnic groups. The majority of the Tonga (75%) and Remba (50%) and all the Xhosa participants were circumcised. The above findings were in agreement with the report given by PSI (2009) that, Zimbabwe has small (about 1%) pockets of traditionally circumcising ethnic communities such as the Remba, Xhosa, Tonga and Tshangani. Of note however, was the one Tonga who was not circumcised when it is part of his culture.

“If a Tonga, Remba or Xhosa is not circumcised, then he remains a boy irrespective of his age” said one circumcised Tonga.

As a result of this culture, these ethnic groups would gladly embrace the MC programme unlike the Ndebeles and the Shona. The ethnic mixing at MSU with the majority being the Shona and Ndebeles could be the cause of the poor up-take of the MC programme at the institution.

Ethnicity seemed to be a determinant for MC in Zimbabwe where the dominant ethnic groups were non-circumcising. As a result, efforts to implement and improve as well as maintain MC services were bound to encounter resistance. Therefore, there was need for stringent measures to educate men about the positive benefits of the procedure if the programme was to be a success.

**Table 4.2 Ethnicity versus Circumcision state**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>frequency</th>
<th>percentage</th>
<th>Circumcised frequency</th>
<th>Circumcised percentage</th>
<th>uncircumcised frequency</th>
<th>uncircumcised percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shona</td>
<td>90</td>
<td>90</td>
<td>5</td>
<td>5.6</td>
<td>85</td>
<td>94.4</td>
</tr>
<tr>
<td>Ndebele</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>100</td>
</tr>
<tr>
<td>Tonga</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>75</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Remba</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Xhosa</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tshangani</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>
**Knowledge of HIV**

The researchers wanted to know if knowledge of HIV had any effect on the acceptance of the VMMC. The students were assessed on knowledge of HIV transmission and prevention and their knowledge on the procedure of medical male circumcision.

**Knowledge on transmission**

The responses indicated that MSU male students had good knowledge on HIV transmission. The greater number of participants gave correct answers on how HIV is transmitted. This clearly shows that a huge amount of information about HIV is available in Zimbabwe and men were well informed about HIV transmission. The participants knew the three modes of HIV transmission: mother to child; sexual contact with an infected person and contact with infected blood. They were also aware of the fact that the virus was not spread by social contact such as kissing, hugging, toilet seats and sharing utensils. These results tally with Wangulu (2005) who states that research findings indicated that the majority of the population in Zimbabwe was aware of how HIV is transmitted. However discrepancies were on blood transfusion where some did not know that blood transfusion had a risk of transmitting HIV. The majority (46%) of the students knew that blood transfusion spreads HIV which is true. In Zimbabwe however, all the blood that is donated is thoroughly screened for HIV, Hepatitis B virus and syphilis (PSI 2009). Chances of HIV infection by transfusion are therefore slim.

**Knowledge on prevention**

The responses suggest that the MSU male students generally knew the ways of preventing HIV transmission. However, it would appear that some of the participants were not aware of the fact that the Prevention of Mother to Child Transmission (MTCT) programme reduced the transmission of HIV from the infected mothers to their infants. Very few knew that delaying sexual debut reduces the chances of acquiring HIV. PSI (2009) stated that delaying sexual activity lowered the risk of HIV in youths. This is one way of protecting them from becoming infected with HIV through sex. If the youths were not aware of this then they were at a very high risk. The students were not sure that MC could reduce HIV infection. This lack of information made them reluctant to be circumcised. However, abstinence appeared to be known as one of the ways to prevent HIV transmission by all the participants. The other method cited by a few of the participants was having sex with a minor as indicated by the following sentiments from some of the students:

“Traditional healers tell us that having sex with a child prevents AIDS”

“A virgin girl can cure you of AIDS”

It was however, sad to note that students at a higher institute of learning seemed to have the notion that HIV could be prevented by having sex with a minor. This notion could expose minors to a higher risk of HIV infection from college boys. Influential persons, according to the Theory of Reasoned Action, can influence behaviour. As a result, such influence from traditional healers could negatively affect the up-take of MC as the boys already have a solution hence, there was need to clear these myths and misconceptions so as to prevent the spread of HIV and enhance an HIV –free generation. The perpetrators should be brought to book so as to discourage this practice.

**Knowledge of the procedure**

Ten of the participants knew how MC prevents the transmission of HIV. They correctly stated that the foreskin is the portal of entry for HIV hence its removal (MC) brings about reduced chances of HIV
infection. The majority of the participants (90%) did not know the link between MC and HIV prevention. They thought that the removal of the foreskin could increase their exposure to HIV. The former Minister of Health was quoted by the Zimbabwe Standard dated 22 July 2012 as scoffing at male circumcision. Such negative publicity by influential people derails the MC programme. Lukobo and Bailey (2006) in their study carried out in Zambia found out that some respondents had the notion that a circumcised penis was always dry and susceptible to cracking thus predisposing one to viruses and bacteria. Probably these negative attitudes could be influencing acquisition of information on MC by the male students at MSU. The above findings also indicate that there were knowledge gaps that needed to be filled concerning how MC actually brought about partial protection (60%) against HIV infection.

The participants were asked to explain how they got the information on MC as a strategy for HIV prevention. The main sources of information were the health practitioners and internet. The media was cited as giving contradictory information. Other sources cited included posters, a friend or relative but 6% did know anything about MC as an HIV prevention strategy. The above findings indicated that the Health practitioners are doing a commendable job about MC awareness campaigns. The media, however, has done a tremendous job in advertising MC, but there was need to improve on positive publicity. This was supported by UNAIDS, (2000) which stated that negative publicity by the media concerning MC negatively impact on the up-scaling of the programme. A single case of negative publicity can undo the good that the media would have done especially coming from a doctor and former Minister of Health (Zimbabwe Standard, 22 July, 2012) or the ministers denouncing circumcision (Newsday 30 August 2011). How can a young adult who is uncertain go for circumcision after reading a story such as, “mass circumcision of African males increase spread of HIV,” which was in the Zimbabwe Daily News of December 15, 2011

Knowledge on Health Benefits of MC

The male students of MSU were assessed on knowledge of health benefits of MC. From the results, it was evident that the most prominent advantage of MC was STI prevention. The above confirmed the findings by the USAID (2006) that circumcised men were at a lower risk of contracting STIs. Penile hygiene was the second most prominent MC health benefit. This corresponded with the results of the study carried out by Bailey (2002) and Halperin (2005) which indicated that penile hygiene was universally recognized as being extremely important and was viewed as a major health benefit of MC. A few mentioned that MC reduces cancer in men and in females. HIV prevention was only mentioned by 16 of the male students. This concurred with Halperin et al (2005) that men are willing to be circumcised but very few mention HIV prevention as one of the reasons for being circumcised. Those who were circumcised gave the indication for the circumcision as religious, medical, cultural and social reasons. Only one mentioned having undergone the procedure to reduce the chances of getting infected by HIV. These results concurred with findings of the survey done by NAC (2009) which claimed that very few of the men who underwent MC mentioned HIV as being the reason. The findings demonstrated that men were willing to be circumcised for medical reasons, and HIV prevention is a medical reason. The explanation for the poor up-take of the VMMC programme could be that there were knowledge gaps on MC as an HIV prevention strategy and as long as these gaps were not closed, it would be
difficult to add MC as an HIV prevention strategy.

Beliefs and attitudes towards MC

The responses revealed that MSU male students had negative perceptions towards MC. This could probably be due to the wrong impressions that they had towards the procedure. “If I am circumcised, then there is no need for a condom.” There was an expressed belief that there was no need for safer sex if one was circumcised as indicated by such sentiments. This confirmed the current ZDHS (2010-2011) results that circumcised men had an overall higher risk profile with a 14% HIV prevalence rate as compared to the 12% HIV prevalence rate in the uncircumcised men. Lyndon (2000) concurred in his statement, which revealed that MC is a dangerous distraction against HIV. He held the view that risk compensation would occur as men would think that they were immune to HIV calling circumcision a “vaccine” or “invisible condom”. Sixty five percent did not know that MC offers partial prevention, sixty percent (60%) protection against HIV transmission. This might mean that they could do away with the condoms after MC. However, it was encouraging to note that there was a general consensus from the participants that it was easier for a man to keep a circumcised penis clean as compared to the uncircumcised one.

In response to why they were not taking up MC, 75% of the participants thought the procedure was very painful even if performed in a hospital and that there would be pain during sexual intercourse long after the MC procedure thereby reducing sexual performance or pleasure for man. These findings confirmed the result of the studies carried out by Bailey et al (2002), Kebaabetswe et al (2003) who lamented that apprehension of pain during and after the MC procedure was the major barrier to MC acceptability. The major reasons why some men shun circumcision were: fear of pain which was based on knowledge of traditional circumcisions where endurance of pain during procedure was an integral part of manhood, Lukobo (2005). The majority (80%) of the students mentioned lack of knowledge on how MC actual brought about prevention of HIV transmission and hence could not be involved in a procedure they were not sure of. This was worsened by negative publicity on MC by the media. The other reasons mentioned for not taking up circumcision lack of time to visit the clinic and that MC was a waste of time. There were some students who claimed that they were shy to discuss MC with a female health practitioner.

Myths and Misconceptions towards MC

The findings of the study revealed that MC was surrounded by myths and misconceptions on whether the Bible allowed it or whether women preferred circumcised men and its effect on sexual pleasure. These responses displayed the ignorance of MSU male students’ about MC. The majority did not know whether women preferred circumcised men or not. They raised the sentiments that, “if they knew that women preferred circumcised men, they would go for it”. Some did not know whether MC was against the Bible or not whilst others were not aware if circumcised men enjoyed sex more, less or the same as uncircumcised men.

This confusion about MC resulted in male students losing interest in it. Negative attitudes arose when one is misinformed. Therefore, it would appear that there was need for the male students to be fully equipped with the facts pertaining to MC so that they would be able to partake in the programme. These results suggested that the male students were misinformed about the procedure. The results tallied with Bailey (2005)’s findings that there was a lot of debate about sexual life after procedure. Such debate could result in
misconceptions about the procedure. With such attitudes the MSU male students shunned MC and this negatively affected its inclusion in the HIV prevention strategies.

However, should the procedure be done, (90%) of participants preferred to be circumcised by a doctor, 6% by a male nurse, 2% by a traditionalist or a religionist. These findings indicated that male students had confidence in Doctors compared to others. This concurred with NAC (2009) which stated that men’s fear of complications resulted in men wanting to be circumcised by a Doctor. Sustained up-take of MC therefore, required well trained professionals to carry out the procedure with fewer chances of mistakes and complications. In addition, the participants preferred to have the procedure done in a private hospital than a public hospital. This could be the reason why there was a poor up-take of the VMMC programme as the procedure was currently being done in public hospital for free. The MOHCW in conjunction with PSI, were unrolling a free MC programme to those between the ages of 15-29 years as an HIV prevention strategy to the participants who fall within this age group. In most cases people, did not place value on cheap things as supported by the findings by NAC (2009) that once men considered the “unnecessary cost” of the procedure, they would shun the idea. The above findings however, agreed with Doctor Rech’s (2009) opinion that some viewed free services as of poor quality and risky. If men perceived public hospitals this way, they were bound to shun MC clinics as they were operating at these public institutions, free of charge. This programme was however, not free as it was funded, but offered for free as the sponsors could have taken the view of Ngalande and Bailey (2006) that men preferred to undergo the procedure at health institutions (public hospitals) that offered services for free.

The participants suggested strategies to improve the up-take of the programme. The most common suggestions were that MC be done in childhood and that its benefits be included in HIV/AIDS school curriculum. Some had the opinion that role model involvement could work wonders with the youths as well as use of the electronic media and social networks and 5% were of the opinion that road shows on MC could help. However, all the participants suggested that more positive publicity on MC should be done through the media. This indicated that there was lack of information on MC among MSU male students.

The above findings were in agreement with the view of Halperin et al (2005) that there was absence of specific educational and promotional efforts on circumcision’s efficiency in preventing HIV. Therefore, if the male students had scanty information regarding the procedure resulted in them having no interest in MC as its benefits would be having no relevance.

### Summary of findings

- The male students at MSU were not keen to be circumcised. Very few male students (11) out of the 100 participants were circumcised and this was a mere 11%.

- Ethnicity seemed to be a determinant for MC with a low prevalence among the Shona and Ndebele ethnic groups. In Zimbabwe, where the dominant ethnic groups (Shona and Ndebele) were non-circumcising, efforts to introduce, implement and improve as well as maintain MC services were bound to encounter resistance. The Tonga, Xhosa and the Remba ethnic groups had no problems with MC as they had a circumcising culture. However, men were willing to be circumcised for religious, medical and cultural reasons, but not for HIV prevention.

- Even though MSU male students had
Adequate information was essential for one to make an informed decision. Since the students were ignorant on the procedure of MC and how it actually reduced the rate of transmission, they were not interested in it. Negative attitudes arose when one was misinformed. Therefore, it would appear that there was need for the male students to be fully equipped with the facts pertaining to MC so that they would be willing to partake in the programme. Adequate information would also expel the myth and misconceptions on HIV and MC. Lack of effective educational and promotional efforts targeting the college male also contributed to their negative attitude. The negative publicity worsened the situation. Much needed to be done to improve the situation.

Recommendations

• The Ministry of Health and Child Welfare and other stakeholders’ holders need to get to the colleges and engage the male students in discussions so that they are informed and their fears dispelled
• Since the youths spend most of their time on the phone or the laptop, the use of these electronic media to sell the programme of MC would be very effective. This can be coupled with use of drama and posters at the colleges
• Toll free lines should be introduced and publicized so that any male in a dilemma can phone and be assisted
• Using the students’ role models in advocating for the procedure may improve the attitudes of the students
• Since colleges have health facilities, outreach programmes can be organized where the procedure is done at the institution. When some are circumcised, the others can follow suit. Mob psychology can work very well with the youth.
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