YOUNG MEN'S PERCEPTION OF MALE CIRCUMCISION AT THE UNIVERSITY OF ZAMBIA IN LUSAKA: IMPLICATIONS FOR HIV/AIDS PREVENTION

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Dedications

I dedicate this work to my family, for they were always there to encourage and give me support to take on and successfully complete this important academic phase in my life: My husband and son, Byman and Hichuunga Hamududu; my parents Gilbert and Lucy Lisulo, my brothers and sisters, nieces and nephews. I owe much to all of you and can only repay by asking God to continue giving his Love and Grace to you all.

Declaration

This dissertation is the original work of Monde Lisulo. It has been prepared in accordance with the guidelines for MPH dissertations of the University of Zambia. It has not been submitted elsewhere for a degree at this or another university.

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I have read this dissertation and approved it for examination.

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This dissertation of Monde Lisulo is approved as part of the fulfilment of the requirements for the award of the degree of Master of Public Health by the University of Zambia.

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List of Key Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
KAP	knowledge, Attitude and Practice
MC	Male Circumcision
STI	Sexually Transmitted Infections
UNZA	University of Zambia
VCT	Voluntary Counseling and Testing

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ABSTRACT

This is a report of the study that was conducted at The University of Zambia (UNZA) main campus to explore the perceptions of male students towards male circumcision (MC) and its effectiveness as a complimentary method of HIV/AIDS prevention. It was an exploratory study that used both qualitative and quantitative methods for data collection and analysis.

The population of the study was students at UNZA main campus. Data was collected using semi-structured questionnaires and through focus group discussions (FGD). Forty-two respondents answered the semi-structured questionnaires and 40 participants were involved in the FGDs. A tape recorder was used during the FGDs. The recordings were later transcribed for data analysis and interpretation. The age range of the study participants was 18 to 38 years, with a median age of 23 years.

The study shows that perception towards male circumcision is influenced by a number of factors including cultural and social upbringing, friends and the media. The media seemed to have greater influence on the perception (48%); because it was said to put forward facts about MC. The media in this case included television, radio, brochures, posters and workshop handouts. Cultural influence was minimal (18%). Moreover, 71% of the participants said their cultures did not have any preconceived beliefs about MC. Most of these also said their families would not react negatively if they decided to get circumcised, even if they were from non-circumcising cultures.

There was no particular non-circumcising tribe that was more against MC than other tribes. The case was similar with age, school, programme, year of study and areas where participants were brought up. Most students said they did not think that people who were circumcised were stigmatized. However, analysis of the findings revealed that there was some level of stigmatization because of the negative perceptions that some people seemed to have about MC as stated by the participants.

The general perception that came out about MC was that it is an “ok practice” although slightly over half of the study participants (57%) felt that it could not be used as an effective method of HIV/AIDS prevention. They felt that evidence available so far in favour of its effectiveness was not enough to convince them. However, about half (51%) of the study participants nevertheless felt that it should still be promoted and left for men to make their own decisions whether to adopt it or not. They also said that more research should be conducted, here in Zambia also and more evidence be presented to show just how effective it could be.

Some participants felt that promoting MC might encourage men to abandon use of condoms, and consequently increase infection rates. There was an indication that risk compensation did actually exist among the circumcised students. However, the tendency not to use any protection like condoms during sexual intercourse was reported even among non-circumcised students and those who had multiple sexual partners, making a conclusion that risk compensation exists among circumcised students inconclusive and invalid for now.

In conclusion, most male students’ perception about MC is mainly influenced by information they receive through various media. The campaigns to promote MC could therefore continue and work to provide the students with more information and facts about MC and its role in reducing the risk of HIV infection in men.

1.0 INTRODUCTION AND BACKGROUND

Male Circumcision (MC) is the procedure of removing part or the whole foreskin of the penis for health, cultural or religious reasons. It is an old practice that has been conducted by a lot of societies the world over as an act of cleansing the male to ensure better physical and spiritual health. Circumcision can range from a small snip to full removal of the foreskin, depending on the point of reference under which it is being performed. Culturally, if conducted in adolescence, MC is characterized by a maturation process that underscores it, as a rite of passage into manhood. In such cases, it also defines individual, group and gender identity (Rivers, Aggleton & Coran, 2002).

Male circumcision is practiced culturally in Zambia by a few societies; particularly those from Northwestern Province and parts of Western province - the Luvale, Lunda, Mbunda, Luchazi, Chokwe, Ovimbundu, and the Nkangala. The practice is also conducted by Muslim societies throughout the country. In these societies, the practice has been seen as a traditional rite of passage of boys to manhood for centuries (USAID, 2005). Traditionalists and custodians of the practice state that this ceremony has been, and continues to be, a very important part of the development and building of the boy child's character in terms of shaping personal discipline, livelihood skills, family life skills, community life and village systems (Rivers, Aggleton & Coran; 2002). It is the foundation of how the former boy (now a man) should live as a respected responsible citizen in his community – a hygienically clean, preferred social and sexual partner (USAID, 2005). Circumcised males in such societies are also considered immune to various physical and spiritual ailments that may befall uncircumcised males.

Studies have found that MC reduces the risk of heterosexual HIV infection in men by at least 60% (UNAIDS/CAPRISA, 2007). The biological basis for the protective effect of MC is that the foreskin contains a large number of target cells, such as Langerhan's cells, that are uniquely vulnerable to HIV infection. Uncircumcised men are more likely to acquire certain STIs, particularly ulcerative ones which facilitate HIV infection. Most importantly, keratin, the protective coating covering most exposed skin, is largely absent from the inner foreskin and thus renders those target cells much more accessible to HIV.

In the past few years, MC has received increased attention even among societies that do not traditionally conduct it as a cultural practice. The interest has been caused by the increase of the HIV/AIDS pandemic and reports of evidence suggesting that MC can help reduce chances of men contracting HIV/AIDS. In some of these societies, the number of men considering and actually undertaking MC has been reported to have increased (UNAIDS/CAPRISA, 2007).

UNZA presents a platform where many male students coming from different social and cultural backgrounds converge and eventually influence each others' perceptions about various things, including MC. The study assumed that up until the time when students come to UNZA, they maintain to a great extent, their traditional cultural beliefs regarding sexuality and MC. However, the possibility of influencing each others' views increases as the students continue to live together.

UNZA has an HIV/AIDS Policy that was formulated in response to the need for a policy document to direct creation of a safe, healthy working and learning environment. It came with the realisation that HIV/AIDS among students and staff was escalating. Moreover, there was lack of information on the prevalence of HIV infection within the UNZA community.

Studies within UNZA have shown that there are high levels of awareness and knowledge among students about HIV/AIDS, its modes of transmission, prevention, treatment and that there are organisations that students can access that work in the area of HIV/AIDS (Malungo, 2006). From these studies, it was also clear that the students were highly sexually active and many times did engage in very risky sexual behaviours (Malungo, 2006). Moreover, there was a disturbing revelation in the

studies that few students knew their HIV status and others even thought that they were not at risk of contracting HIV. Nevertheless, the good news is that the UNZA authorities well understand the situation and a number of interventions, through different organisations and programmes that work with students, have been put in place to combat the situation.

With regard to HIV/AIDS prevention among students, it seems emphasis has been placed on provision of condoms and encouragement of positive behaviours that help minimise risk, like abstinence and sticking to one sexual partner. Since October 2008, MC has been added to the health services and offered at UNZA clinic, free of charge to students. However, at UNZA, it is not known how students perceive MC and its effectiveness, and whether or not the male students would consider undertaking it as a complimentary method of HIV/AIDS prevention.

2.0 RESEARCH PROBLEM

2.1 Statement of the Problem

Zambia is located in Southern Africa, a region that has high HIV/AIDS prevalence rates and few societies that conduct MC as a cultural practice. Zambia has a population of about 12.5 million people with an HIV/AIDS prevalence rate that stands at around 14.3%, although with variations between the provinces as depicted in the table below (Central Statistical Office, 2003, 2007). It should also be noted that the prevalence rates vary between rural and urban areas within the provinces.

Table 1: HIV prevalence by socioeconomic characteristics (Percentage HIV positive among interviewed women age 15-49 and men age 15-59 who were tested, by background characteristics, Zambia 2007)

Background Xstic	Women Percentage HIV positive	Number	Men Percentage HIV positive	Number	Total Percentage HIV positive	Number
Age						
15-19	5.7	1,202	3.6	1,162	4.7	2,365
20-24	11.8	1,023	5.2	865	8.7	1,888
25-29	19.9	1,058	11.4	796	16.3	1,854
30-34	26.0	819	17.1	787	21.6	1,607
35-39	24.9	586	22.4	608	23.6	1,194
40-44	18.3	445	24.1	410	21.1	855
45-49	12.1	369	18.6	313	15.1	682
Residence						
Urban	23.1	2,317	15.9	2,148	19.7	4,464
Rural	11.0	3,185	9.4	2,795	10.3	5,980
Province						
Central	22.0	507	12.6	458	17.5	965
Copperbelt	21.6	973	12.3	949	17.0	1,922
Eastern	11.0	748	9.5	654	10.3	1,402
Luapula	11.5	408	15.3	317	13.2	726
Lusaka	22.4	902	19.0	878	20.8	1,780
Northern	7.7	744	5.7	662	6.8	1,406
Northwestern	9.1	281	4.5	251	6.9	532
Southern	15.8	560	13.2	513	14.5	1,073
Western	16.1	379	13.9	260	15.2	638
Total 15-49	16.1	5,502	12.3	4,942	14.3	10,444
50-59	na	na	12.7	432	12.7	432
Total men 15-59	na	na	12.3	5,374	12.3	5,374

na = Not applicable

Since HIV/AIDS has caused severe public health challenges in Zambia and the region as a whole, all possible avenues that could lead to decrease of the pandemic have to be explored. Therefore, it would seem appropriate that MC be considered and taken up as a possible intervention to reduce HIV/AIDS infection. A number of campaigns, including public discussions, television and radio programmes, have been conducted by HIV/AIDS advocates, medical personnel and some NGOs to encourage men in Zambia to undergo MC.

At the University of Zambia (UNZA) main campus, the biggest university in Zambia, the HIV/AIDS prevalence rate is not known. Nevertheless, some activities and programmes have been put in place to ensure students are kept informed about HIV/AIDS and helped to protect themselves and their partners. The UNZA HIV/AIDS Response Project was established to coordinate HIV/AIDS activities and develop an HIV/AIDS policy for students and staff at the university. The UNZA clinic offers VCT and ART services. The clinic also offers free MC services to students on appointed dates as well as during weekdays in collaboration with the SFH clinic located at YWCA. There is also a Counseling Centre available for students to provide among other things counseling and information about HIV/AIDS.

A Knowledge, Attitude and Practice (KAP) Baseline Study conducted at the university in 2006 suggested that most students had not been for VCT before and hence did not know their HIV status. Only 16.6% had been for VCT. Eighty one percent indicated being sexually active. The study also established that students were highly knowledgeable about the methods of prevention of HIV/AIDS and other sexually transmitted infections (STIs). Condoms were identified as the most commonly used prevention method. However, some students indicated that they did not always use condoms when engaging in sexual intercourse (Malungo, 2006). MC was not addressed in this study, probably because very little could have been known about it at that time.

Most students at UNZA belong to the age group (15 to 35 years) that is most sexually active and most at risk of contracting HIV/AIDS. The 2001-2002 Zambia Demographic and Health Survey (ZDHS) revealed that 41 per cent of all the infections in Zambia were among youths aged 15 to 24 years (Central Statistical Office, Central Board of Health & ORC Macro, 2003). The 2007 Zambia Demographic and Health Survey showed that the 15 to 35 years age group had a cumulative HIV/AIDS prevalence rate of 51.3%. This age group is also known to engage in high-risk sexual behaviours. As such, male students are among key populations targeted by HIV/AIDS advocates and promoters of MC as a complimentary method of HIV/AIDS prevention.

Since in the KAP study by Malungo (2006) mentioned above students indicated being highly knowledgeable about the methods of HIV/AIDS prevention, the study assumed that they may also have above-average knowledge of the benefits of MC in terms of HIV/AIDS prevention. However, one may wonder whether possession of this knowledge leads to the men seeking MC to be performed on them. Or probably there are factors that hinder them from acting on the information that they have, making the campaigns being conducted to promote MC have limited impact. Of particular interest for this study will be the response from male students who come from cultures that do not conduct MC as a traditional practice; whether their social and cultural backgrounds have any influence on their acceptance and adoption of MC.

2.2 Study Justification

Information from the study will be useful to provide a deeper understanding of the social and cultural factors that shape male students' perceptions of MC. It will help to better understand how they view their sexual and reproductive health and how their social-cultural upbringing impacts on decisions about MC. Also, such information might be useful in determining the relevance of MC promotion programmes,

as it would be established whether students are open to value and behaviour change due to the information they receive from promotional programmes or not.

2.3 Research Questions

Research Question: What are male students' perceptions of male circumcision as a complimentary method of HIV/AIDS prevention?

- How does social and cultural upbringing shape perception of MC?
- What factors are likely to influence acceptability and adoption of MC even among those who are from cultures that do not traditionally practice it?
- What factors hinder acceptance of MC?
- Can MC be used as an effective method of HIV/AIDS prevention?

2.4 Research Objectives

General Objective: The study sought to assess the perceptions about male circumcision and its effectiveness as a complementary method of HIV/AIDS prevention among male students at UNZA main campus.

Specific Objectives:

- To explore the socio-cultural factors that influence perception about MC;
- To assess acceptability of MC among male students from non-circumcising cultures;
- To assess knowledge and attitude about the effectiveness of MC as a complimentary method of HIV/AIDS prevention; and
- To recommend how best MC could be promoted among male students, using appropriate and relevant interventions.

2.5 Definition of Key Concepts

Below are definitions of key concepts that have been used in this study.

a. HIV/AIDS

HIV is a virus that is transmitted from person to person through the exchange of body fluids such as blood, semen, breast milk and vaginal secretions. Sexual contact is the most common way to spread HIV, but it can also be transmitted by sharing needles when injecting drugs, or during childbirth and breastfeeding. As HIV reproduces, it damages the body's immune system and the body becomes susceptible to illness and infection. There is no known cure for HIV infection yet (Cichocki, 2009).

Acquired immune deficiency syndrome or acquired immunodeficiency syndrome (AIDS) is a disease of the human immune system caused by the human immunodeficiency virus (HIV). This condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections and tumors.

b. Male Circumcision

Male Circumcision (MC) is the procedure of removing part or the whole foreskin of the penis for health, cultural or religious reasons.

c. Social Perception

Perception is the understanding of or knowledge about a specific idea, concept, impression and so on, that individuals so form. Social perception is the process of forming impressions of individuals or groups of individuals. The resulting impressions that we form are based on information available in the environment, our previous attitudes about relevant stimuli, and our current mood. Humans tend to operate under certain biases when forming impression of other individuals. (www.wikipedia.com)

3.0 LITERATURE REVIEW

This section of the report reviews literature that has been written about MC and HIV/AIDS infection. Most of it focuses on research work that has been done in Africa on the correlation between MC and HIV/AIDS infection. Some studies have also been cited that have been conducted in Zambia to assess sexual behavior among youths and students, attitudes towards MC, VCT and health seeking behavior, and knowledge levels among people of HIV/AIDS and preferred methods of prevention. Some of the literature was generated from internet searches of medical databases like Pubmed, plosmedicine.org and aidsonline.com. Other literature was extracted from documents obtained from Society for Family Health, UNZA Health Services and the UNZA HIV/AIDS Response Project. This review however, is not a comprehensive analysis of the available literature on the subject.

3.1 HIV/AIDS Prevalence

The AIDS pandemic can be seen as several epidemics of separate subtypes; the major factors in its spread are sexual transmission and vertical transmission from mother to child at birth and through breast milk. Despite recent, improved access to antiretroviral treatment and care in many regions of the world, the AIDS pandemic claimed an estimated 2.1 million (range 1.9–2.4 million) lives in 2007 of which an estimated 330,000 were children under 15 years. Globally, an estimated 33.2 million people lived with HIV in 2007, including 2.5 million children. An estimated 2.5 million (range 1.8–4.1 million) people were newly infected in 2007, including 420,000 children (Cichocki, 2009).

In September 2009, a United States of America Army and Thai government research team that had been conducting an experimental HIV vaccine study for seven years reported that the vaccine had for the first time cut the risk of infection by nearly a third. The vaccine, which was a combination of two earlier experimental vaccines which had not been successful, was given to 16,000 people, all HIV-negative men and women aged between 18 and 30 years in Thailand, in the largest ever such vaccine trial. The researchers nevertheless stressed that despite it being a significant scientific breakthrough, a global vaccine was still a long way off and there was still no known cure yet. (www.bbc.co.uk/health)

Sub-Saharan Africa remains by far the worst affected region. In 2007 it contained an estimated 68% of all people living with AIDS and 76% of all AIDS deaths, with 1.7 million new infections bringing the number of people living with HIV to 22.5 million, and with 11.4 million AIDS orphans living in the region. Unlike other regions, most people living with HIV in sub-Saharan Africa in 2007 (61%) were women. Adult prevalence in 2007 was an estimated 5.0%, and AIDS continued to be the single largest cause of mortality in this region. South Africa has the largest population of HIV patients in the world, followed by Nigeria and India. South & South East Asia are second worst affected; in 2007 this region contained an estimated 18% of all people living with AIDS, and an estimated 300,000 deaths from AIDS. India has an estimated 2.5 million infections and an estimated adult prevalence of 0.36%. Life expectancy has fallen dramatically in the worst-affected countries; for example, in 2006 it was estimated that it had dropped from 65 to 35 years in Botswana (Cichocki, 2009).

A world list of countries and territories by people living with HIV/AIDS and the prevalence rate among adults, based on data from various sources such as the CIA World Factbook, shows that Africa is in a clearly unfortunate position in the worldwide HIV/AIDS epidemic, as the 19 countries worldwide with the highest prevalence of reported infections are all African countries with more than 24.5 million, and more than 60% of the AIDS-infected population. In 2008, Zambia ranked number 8 on the list by HIV/AIDS population rate and had an estimated 1,100,000 people living with HIV/AIDS. It also ranked number 7 in the world by prevalence rate, and had 15.02% adult HIV/AIDS prevalence rate (Cichocki, 2009).

3.2 HIV/AIDS and Male Circumcision Correlation

MC has been known to prevent contraction of several sexually transmitted infections and also to help correct certain physical conditions. From a health point of view, reducing the risk of urinary tract infections and treatment of failure to retract the foreskin or failure to reduce the retracted foreskin are some of the reasons this practice exists nearly worldwide. Studies have also shown that MC greatly reduces the risk of cancer of the penis and sexually transmitted infections in males. It has also been shown to reduce the risk of cervical cancer in females whose male partners are circumcised (Lwatula; 2009). Several studies have also been conducted about MC that have contributed to knowledge by suggesting that it also reduces chances of men contracting HIV. This could provide part of the explanation as to why HIV/AIDS prevalence in regions where they have MC as a cultural practice is low. For example, in Senegal where MC is performed culturally at pre-adolescence, the HIV prevalence is 0.7%. However, the prevalence is greater than 10% among men who have sex with men, implying that the protective effect of male circumcision for penile-vaginal intercourse may not apply to penile-anal intercourse (Rivers, Aggleton & Coran; 2002).

Evidence from countries where MC is performed as a traditional practice and from scientific studies has compelled some countries that do not practice MC or have few societies conducting MC as a traditional practice to consider it as an option for HIV/AIDS prevention. A number of studies have thus been conducted in a bid to provide more evidence in support of MC in such countries. A study conducted in South Africa showed that MC reduced the chances of getting infected with HIV by up to 61%, equivalent to what a vaccine with high efficacy would achieve (Bertran et al; 2005). A similar study conducted in Uganda revealed that the chances of infection reduced with pre-pubertal circumcision, and that in men circumcised after puberty the chances of infection were more or less the same as for uncircumcised males (Weiss, Quigley & Hayes; 2000). More evidence from Kisumu, Kenya, and Rakai District, Uganda revealed an approximate halving of risk of HIV infection in men who became circumcised (Gray et al; 2000). In another study of discordant couples in Uganda in which the woman was HIV positive and her male partner was not, no new infections occurred among any of the 50 circumcised men over 30 months, whereas 40 of 137 uncircumcised men became infected during the same period (Szabo & Short; 2000).

UNAIDS/CAPRISA (2007) reported that numbers of people from non-circumcising societies taking up MC as a method of HIV/AIDS prevention were increasing. Following review of studies of acceptability of MC in sub-Saharan Africa to assess factors that influence uptake of circumcision in traditionally non-circumcising populations, Westercamp and Bailey (2006) found that in 13 studies from 9 countries, the median proportion of uncircumcised men willing to become circumcised was 65%. Sixty nine percent of women favoured circumcision for their partners, and 71% of men and 81% of women were willing to circumcise their sons. In 2000, the number of circumcised men in Zambia was estimated to have been about 17% (USAID; 2005); but could possibly be higher now due to reported increase in demand for the operation.

There are various perspectives of masculinity on the subject of MC for HIV prevention which are context-bound by determinants such as class, culture, religion, and geography. Constructions of

masculinity and HIV can affect perceptions of HIV risk (Rivers, Aggleton & Coran; 2002). Sometimes, regardless of medical information being available, these constructions which are largely a result of socio-cultural influence can play a more important role in decision making on matters of sexuality. For example, in Senegal and in circumcising Zambian societies, MC is a dynamic social construction process of gender, spirituality, health, and sexual control. All these are viewed from the cultural perspective where men are expected to be "superior" in these aspects as symbolized by their being able to handle circumcision pain and "shedding off" of boy-like and female-like characteristics when the foreskin is removed (Rivers, Aggleton & Coran; 2002).

In many ways, the constructions of masculinity pose communication challenges, especially about the partial protection afforded by MC and the importance of combination prevention. In some cases, men, and sometimes women, think that as a show of their sexual prowess, maturity and conquest over the woman, the man has to engage in the sexual act with a woman without any form of barrier. Therefore, messages formulated to encourage men to undergo MC as well as traditional messaging of the significance of MC should strongly stipulate that the method is not 100% HIV proof but should be incorporated with other methods such as condom use.

Programs to encourage condom use, including providing them free to those in poverty, are estimated to be 95 times more cost effective than circumcision at reducing the rate of HIV in sub-Saharan Africa. Some experts fear that a lower perception of vulnerability among circumcised men may result in risk compensation or more sexual risk-taking behavior, thus negating its preventive effects. Risk compensation, or behavioural dis-inhibition (Bailey, Neema & Othieno; 1999), is a potential increase in risky behaviour subsequent to adopting a preventive measure. With regard to HIV/AIDS and MC, risk compensation is potential increase in risky behaviour, such as abandoning use of condoms during sexual intercourse after one becomes circumcised and having multiple sexual partners. However, one randomized controlled trial indicated that adult male circumcision was not associated with increased HIV risk behavior (Cichocki, 2009).

Heterosexual transmission accounts for more than 85% of HIV globally. Multiple approaches are therefore needed for synergistic effect to prevent transmission through increased protected coital acts. In the face of HIV, cultural and social norms can change; and since condom use and MC are both methods that have been proven to work in preventing HIV infection to some great extent, it is important that youths are encouraged to adopt use of both methods simultaneously.

3.3 HIV/AIDS and Male Circumcision in Zambia

The United Nations Joint Programme on AIDS (UNAIDS) and the World Health Organisation (WHO) have been engaging National Governments to see how best MC can be used as an opportunity for fighting the AIDS pandemic. In Zambia, under the auspices of the Ministry of Health, Society for Family Health (SFH) is working with partners like JHPIEGO (Johns Hopkins University Programme on Information and Education on Gynaecology and Obstetrics) and health facilities including UNZA Clinic in scaling up MC as an intervention strategy against HIV/AIDS. In facilities where MC is offered so far, it has been observed that the demand for the service is high among students from higher institutions of learning (Lwatula; 2009).

A study funded by United States Agency for International Development (USAID) was conducted by Society for Family Health (SFH) and John Hopkins Program for International Education Corporation (JHPIEGO) to establish the attitudes of circumcising and non-circumcising societies towards the idea of MC for HIV/AIDS prevention in Zambia. The results of the study showed that in circumcising societies, not being circumcised was associated with un-cleanliness, premature ejaculation and unfitness for marriage. MC was also viewed as a milestone for manhood, protection from disease and an

enhancement for women's sexual pleasure as circumcised men were thought to be able to perform longer. Among non-circumcising societies, the men expressed limited interest in MC although some participants wished they had been circumcised because there was a common belief that women preferred circumcised men and that it reduced risk of STIs, including HIV, infection. Several participants said they were seriously considering the procedure (USAID, 2005).

In a study that assessed acceptability of male circumcision as an intervention to improve male genital hygiene and reduce STIs, including HIV-1 in Zambia, Lukobo and Bailey (2007) reported that in communities where circumcision is little practiced, the main facilitators for acceptance were improved genital hygiene, HIV/STI prevention, and low cost. The main barriers were cultural tradition, high cost, pain, and concerns for safety. The participants of the study also indicated that if MC was proven to reduce risk for HIV and STIs, they would seek it for themselves or their partners or their sons if it was free or at a minimal cost. The study concluded that MC in Zambia was embedded in a complex web of cultural and religious issues; though acceptability for STI and HIV prevention appeared to be high, especially among the younger generation.

However, there have been recorded statements from men in Zambia who felt that MC was not necessary. In response to Post Newspaper Columnist Edem Djokotoe's article on the publicised circumcision of BBC correspondent in Zambia Kennedy Gondwe, whose story was written about on Friday 21st December 2007, many men wrote in to say the act was "un-Zambian". These views were stated regardless of knowledge of the existence of circumcising tribes in Zambia. The reason for such a reaction could probably be due to the fact that this group constitutes a small minority in respect of the total number of tribes living in Zambia. Zambia has about Seventy Two (72) different tribal groups.

One of the respondents said it would be "an infringement of human rights if the government decided to roll out MC in its quest to reduce HIV infections in Zambia". Another respondent was concerned that MC was not part of the culture of the Province where he came from. He said MC was something they "did not understand and cannot pretend to, so to start doing it because that is what people are advocating could cause some cultural earthquakes in our society". He further wrote, "…. from this point of view, I think it is wrong for people to advocate for MC and to make it an issue for public debate because it is a very private thing."

Dr Manasseh Phiri, in his weekly column also of the Post Newspaper (13th January, 2008), responded to these statements by writing that it was ignorance and lack of understanding or refusal to understand presented information and facts that caused 'social earthquakes' like the HIV and AIDS pandemics. Similar ideas were presented in 2003 by Population Science International (PSI) after a study of young Zambian males revealed that their risk perception of STIs and HIV/AIDS was low due to misconceptions, folk beliefs and denial, which impeded personal risk assessment and interfered with the adoption of safer sexual practices. Dr. Phiri explained in the article that the intention of the roll out would be to make safe and high quality MC widely available, to make it accessible and affordable to as many men as would wish to have the operation. He also added that information about MC was being widely disseminated to help even more men make the choice to have MC and add to what is already available for them to do, to reduce chances of getting HIV. Bowa and Lukoba (2006) stated that MC may soon become an additional public health strategy in the fight against HIV/AIDS particularly in sub-Saharan Africa, and that governments may look at how best to integrate MC services in national HIV programmes in a cost effective manner.

In the same article, Dr. Phiri stated that currently, anyone going to any hospital where MC was provided would inevitably be put on a waiting list which in some places was as long as three or four months. He added that the lists consisted of Zambians of all ages, from all tribes and from all walks of life wishing to get circumcised for many reasons; one of which is the reduction of chances of HIV infection. The Strengthening Male Circumcision in Zambia End of Project Report (USAID; 2005) noted that three

tribes constituted two thirds of the clientele; these being the Bemba (25.1%), the Nyanja (21.5%) and the Luvale (21.5%). This piece of information may be valuable for this study, especially during data analysis to establish whether there are differences in social perceptions of MC and levels of acceptance of MC among the different tribes.

To help allay fears and misgivings about post-circumcision sexual performance, Dr. Phiri wrote that there was as yet no known harm - scientific, aesthetic and social – that came to men who lost their foreskin. He said the foreskin was one of those parts of the human body for which there was no demonstrable function or practical use. He gave an example of the study that was carried out in Uganda by a team of researchers from the Johns Hopkins University in the United States, led by Professor Ronald Gray. Their report indicated that among the 5,000 Ugandan men that were recruited for the study, there was little difference between the half that were circumcised and the other half that were not when they were asked to rate performance and satisfaction in relation to the presence or absence of the foreskin.

3.4 HIV/AIDS and Male Circumcision at UNZA

In a survey conducted at 12 institutions of higher learning, including UNZA, in Lusaka involving 1,228 students aged 16 to 24 years, it was discovered that there were high levels of awareness and knowledge on the modes of transmission of HIV (SHARES, 2003). Also, three quarters of the students who were sexually active knew about condoms preventing infection, though only about a third reported always using condoms. Not only was condom use among students low but its use was also inconsistent.

Results from a comparative baseline survey conducted among 912 first year students at UNZA to determine knowledge, attitudes and behaviours showed that many people at UNZA personally knew someone with HIV/AIDS and 76% also thought that they knew enough about the pandemic (Malungo et al, 2005). Some students even said they were sick and tired of hearing about HIV/AIDS. The study also revealed that many students came from schools where they had not received adequate and accurate information about HIV/AIDS and had also not been taught the life-skills necessary to assert themselves in high-risk situations.

74% of the students acknowledged that they had experienced vaginal sex before, though only 38% had used condoms during their last sexual encounter. Oral sex was also reported among 7% of the students. A number of students also revealed that they had multiple sexual partners. Some students also disclosed that they did not discuss HIV issues with their partners and that some students had experienced forced sex. Also, some students (17%) considered themselves not personally at risk of contracting HIV because they felt that they were not engaging in high risk behaviour. Another finding of the survey was that 85% of the students considered religion to be very important in influencing their sexual behaviours.

A similar study was conducted at UNZA for the UNZA HIV/AIDS Response Project and The Vice Chancellor's Standing Committee on HIV/AIDS. 759 students were covered in this study. The results revealed that all students had heard about HIV/AIDS with 76% saying they knew enough about the pandemic (Malungo, 2006). The study also revealed that 54% of the students had been in some relationship that involved vaginal sex. Some students had had more than five sexual partners the previous 12 months. 3% and 18% of participants respectively also said they conducted anal and oral sex, though condoms were not used in such acts.

The study revealed that most students were aware of VCT facilities, and 34% had visited such services. Of these, 83% got an HIV-test. Some students also revealed that they were on anti-retroviral therapy

and were visiting either the UNZA-clinic or government clinics for the therapy. Students were also aware of a number of organisations that provided HIV/AIDS services.

The above studies show that students are highly knowledgeable about HIV/AIDS and its modes of infection and methods of prevention. It is also clear that condom use and abstinence have been the most promoted and most commonly preferred methods of prevention.

MC commenced at the UNZA Clinic on 10th August, 2008 with the circumcision of 10 students. UNZA decided to add MC to the list of health services offered because in 2007, SFH approached UNZA to consider adding MC to its list of health services being offered as SFH was attending to a high number of students at their centre. Also, considering the evidence available in support of MC for HIV/AIDS prevention and increasing demand for the service, UNZA decided to make MC services accessible first of all to it students and members of staff, and also to the general public (Lwatula; 2009).

At UNZA clinic, MC was initially conducted every first Sunday of the month starting at 07.30 hrs. The service was offered free to UNZA Students. Members of staff who subscribed to the medical scheme were required to pay K20, 000. Non-scheme members and clients from outside the University community paid K30, 000. In response to increase in demand, UNZA clinic now schedules more days for the activity in a month than once as initially done (Lwatula; 2009).

To all students and other clients seeking MC services from the UNZA clinic, routine counseling for HIV is provided. Testing is also strongly encouraged since the current scale up is in the context of HIV prevention. Clients not ready for testing can opt out and still undergo circumcision provided that, like for any other candidate, there are no contra-indications to the procedure. Counseling specific to MC is also offered to all candidates and it is a requirement that clients sign consent forms before the operation. The response from students has been good although it varies according to stage in the academic calendar. Numbers seeking the service are high during recess and just after opening but reduce as the calendar progresses towards exam time (Lwatula; 2009).

Rivers, Aggleton and Coram (2002) reported that there were particularly low levels of health seeking behaviour among young people. For example, even where they were able to recognise signs and symptoms of STIs, young people interviewed in Tanzania indicated that they were hesitant to go to public clinics or hospitals, but were more likely to treat themselves with over-the-counter medicines. Similarly, young people in a variety of contexts reported that access to contraception and condoms was difficult (UNAIDS/CAPRISA; 2007).

The above reports concur with the results of a cross-cultural study involving three countries – the United States, Russia, and Japan (Sprecher et al; 1994) in which it was discovered that there usually was a discrepancy between the perceived sexual customs and activity and the actual wanted behaviour that people engaged in. In two studies conducted with youths on the HIV testing experiences of adolescents in Ndola, Zambia, it was discovered that about half sought the approval of family and friends prior to VCT. Disapproval tended to discourage them from going for VCT (Denison et al, 2008). This study wanted to find out if the situation was similar with youths seeking to undertake MC for HIV prevention.

4.0 METHODOLOGY

4.1 Research Design

This was an exploratory study that used both qualitative and quantitative approaches. It mainly applied qualitative approaches to obtain in-depth understanding of the factors that influence the students' perception of MC. Quantitative data were used to establish demographic details of the population as well as general norms and trends in perception about MC.

4.2 Research Setting

UNZA offers various undergraduate programmes through its nine schools, namely the School of Agricultural Sciences, School of Education, School of Engineering, School of Humanities and Social Sciences and School of Law. Others are School of Medicine, School of Mines, School of Natural Sciences and School of Veterinary Medicine.

The undergraduate student enrolment stood at a total of 10,102 during the first semester of the of the 2007 academic year. The majority of the students, 5,994 (59.3%) were male and 4,108 (40.7%) were female. The current student population is estimated at about 11, 500 (UNZA, 2008). The university main campus has 11 residential areas, each having at least 5 residential halls. Seven of the residential areas are occupied by male students only and 2 are shared with female students. In the residential halls, each room has about 4 students because of the limited space available to accommodate the large number of students enrolled at the university. The rooms were designed to harbour 2 students only. The most populated hall of residence has about 552 students and the least about 212 students. The accommodation situation at the university has led to an increase in cohabiting between male and female students, and encouraged an environment where students easily engage themselves in sexual relationships.

The University Health Services, in 2008, added MC to the list of health services offered free of charge to students at the UNZA clinic. This was done in acknowledgement of the positive impact that MC has in relation to reducing chances of HIV infection in men, and also as a response to reported demand for the service among male students. The University Health Services hopes that as many male students as possible would use the MC services, to contribute towards reduced infections and effective management of HIV/AIDS among students, in accordance with the purpose of the UNZA HIV/AIDS policy.

4.3 Study Population

The population of the study was students at the University of Zambia (UNZA), Great East Road Campus in Lusaka. The study targeted male students only to be participants because it intended to find out the views of the men themselves concerning MC, as they are the direct users and beneficiaries of MC services. Also, circumcision reduced chances of HIV infection in men.

The requirements to participate in the study were: to be a Zambian male youth aged between 18 and 35 years; be a resident student at the UNZA Great East Road Campus; be a full-time student and to be willing to participate in the study. The study targeted Zambians because it intended to obtain a more indigenous view about MC, and avoid any influence of foreign cultures in the overall perception to be deduced.

Students from UNZA Ridgeway Campus were excluded from this study because of anticipated logistical difficulties as Ridgeway campus is located far from the main campus. By virtue of their areas of study, the study assumed that students from Ridgeway campus were highly knowledgeable about MC and their perceptions about MC may have been greatly influenced by this. Female students were excluded from the study because they cannot undergo MC. Also, the study sought to get a general overview of the prevalence of circumcised male students at UNZA, which would not have been possible if female students had been included in the study.

4.4 Sample Selection and Size

The study involved 82 participants; 40 in focus group discussions and 42 as respondents of semi-structured questionnaires. Purposive sampling was used to recruit participants for focus group discussions (FGDs). With this method, criteria were provided for some Staff Development Fellows (SDF) to assist compose the groups for the discussions. The SDFs were requested to assist refer students for the FGDs because they had contact with a large number of students who could potentially be participants. Therefore, the SDFs helped by making announcements about the study to their students and registering the ones that were interested in participating in the FGDs.

Stratified random sampling was used to select respondents of the semi-structured questionnaires, using the male students' accommodation schedule as a sampling frame. Stratified random sampling divides a population into smaller groups, known as strata. The strata are formed based on their members sharing a specific attribute or characteristic; in this case, male students accommodated in the UNZA residences or hostels. A random sample, using room numbers as reference, from each stratum was then taken to make up the required number of respondents. This random sampling was done by drawing pieces of paper with room numbers from each stratum written on them from a box.

4.5 Data Collection Instruments

Two data collection instruments were utilised: Semi-structured questionnaire and FGD guide. Semi-structured questionnaires were used for the first part of the study. A list of questions and issues, or focus group discussion schedule was compiled that was used to guide the FGDs.

The semi-structured questionnaires solicited for personal information about the participants that was to be used to describe their demographics. They also contained personal questions that asked participants whether they were circumcised or not and issues about their sexuality; like whether they did engage in sexual intercourse and how often and if they knew their HIV statuses. There were also questions that asked about their perception of MC and HIV/AIDS preventions and whether it should be promoted or not. The semi-structured questionnaires were self-administered and collected from the participants on the date agreed with them when they got the questionnaires. The FGDs mainly focussed on the participants' opinions about MC in relation to HIV/AIDS prevention and on the issue of whether it should be promoted in Zambia or not. Personal questions that requested participants to explain aspects of their sex lives or whether they were circumcised were not asked during the FGDs. The FGDs were facilitated by the principal researcher, with the help of one research assistant.

A tape recorder was used to record the discussions with the participants.

4.6 Data Analysis

The analysis of data was mainly done using NVivo software. NVivo was used because it helps to analyse textual responses as well as quantitative data. Other quantitative data, particularly about demographic characteristics of the participants, were analysed using Microsoft Excel. In NVivo, cases were created about each question asked in the semi-structured questionnaires and during the

discussions to show the responses generated from them. From these cases, it was possible to deduce the participants' perceptions about MC and what could be the possible factors that influenced the perception. The responses from the recorded group discussions were first transcribed and grouped according to the questions that generated them before being incorporated with the rest of the responses in NVivo.

4.7 Limitations of the study

The following were the limitations of the study.

- There were some questionnaires that had a lot of unanswered questions. These were disregarded in data entry and analysis. This caused the number of respondents of the semi-structured questionnaires to be considerably reduced. 13 questionnaires were not included for data analysis. 27 were not collected from the respondents.

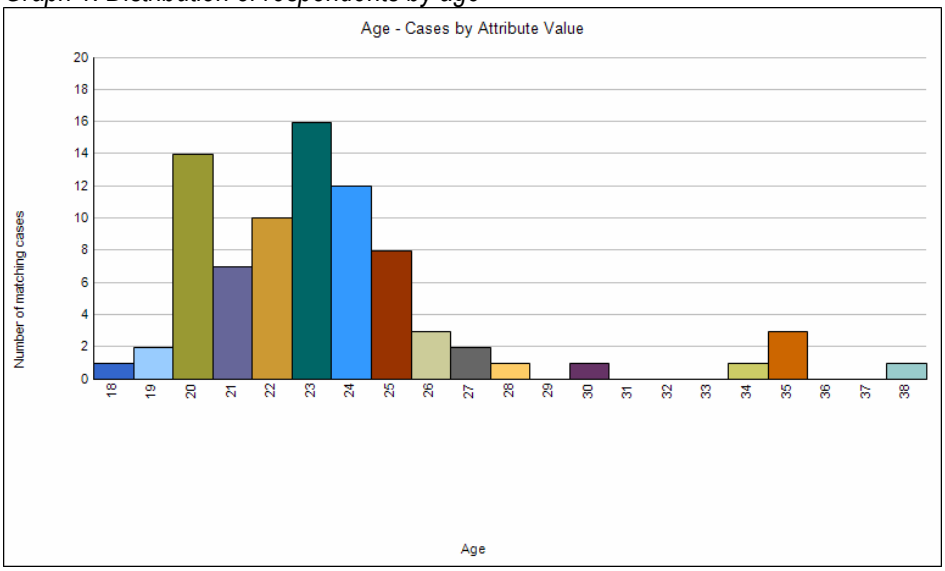
- In FGDs, the participants were more restrained with their responses than in the questionnaires. The study could have probably obtained more insights from the group discussions had it been conducted by males.

5.0 PRESENTATION OF FINDINGS AND RESULTS

5.1 Demographic characteristics of all participants

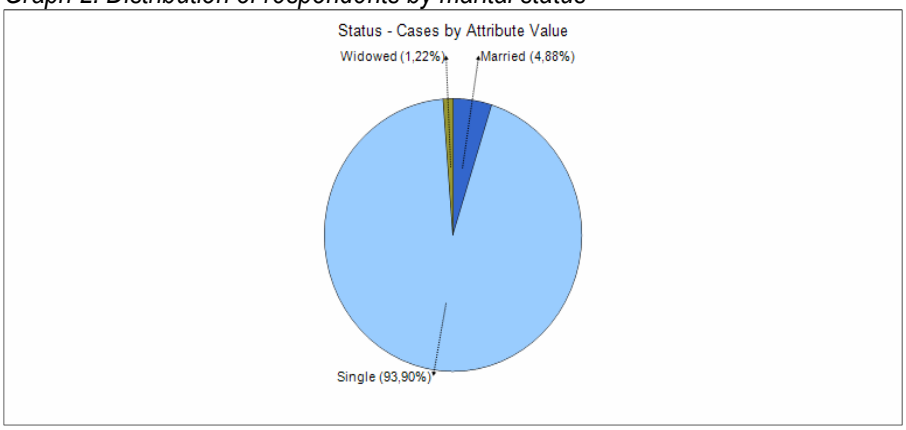
Age: The majority of respondents were aged between 20 and 25 years, although the age range captured was 18 to 38 years. The 38 year old participant was randomly selected through the stratified random sampling as a respondent to a semi-structured questionnaire. The median of the respondents' age was 23 years.

Graph 1: Distribution of respondents by age



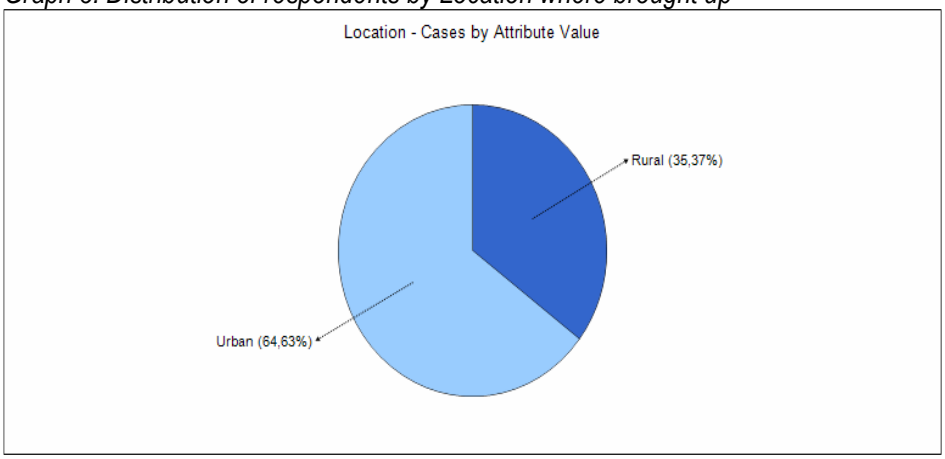
Marital Status: Most of the respondents were single as shown in the graph.

Graph 2: Distribution of respondents by marital status



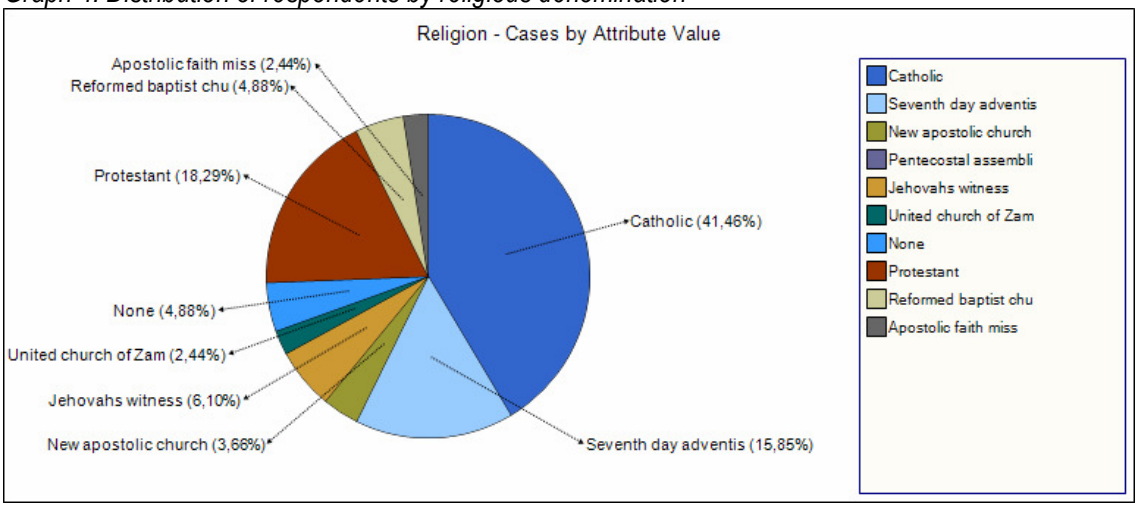
Area of Upbringing: Majority of the respondents said they had been brought up in urban areas.

Graph 3: Distribution of respondents by Location where brought up



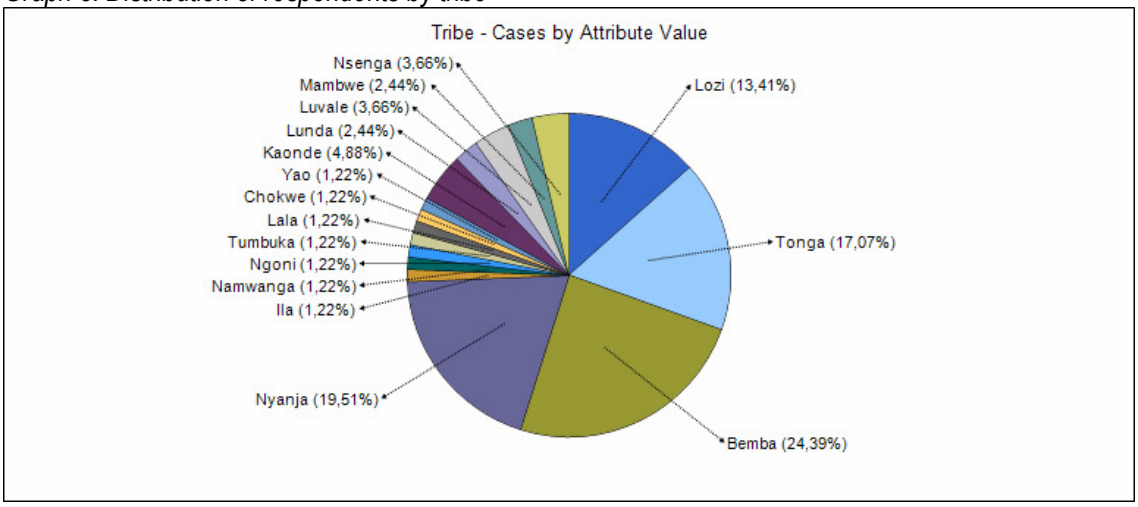
Religious Denominations: The majority of respondents were Protestant, although they belonged to different denominations. The rest were Catholic.

Graph 4: Distribution of respondents by religious denomination



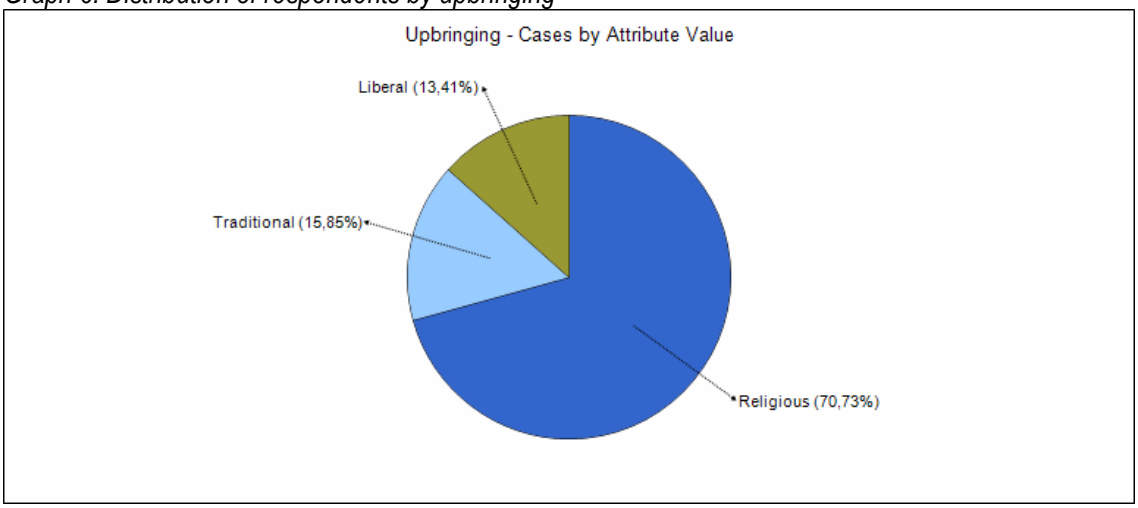
Tribe: The tribe that had most respondents was Bemba, followed by Nyanja, Tonga and Lozi. Twelve other tribes were also represented but with fewer respondents.

Graph 5: Distribution of respondents by tribe



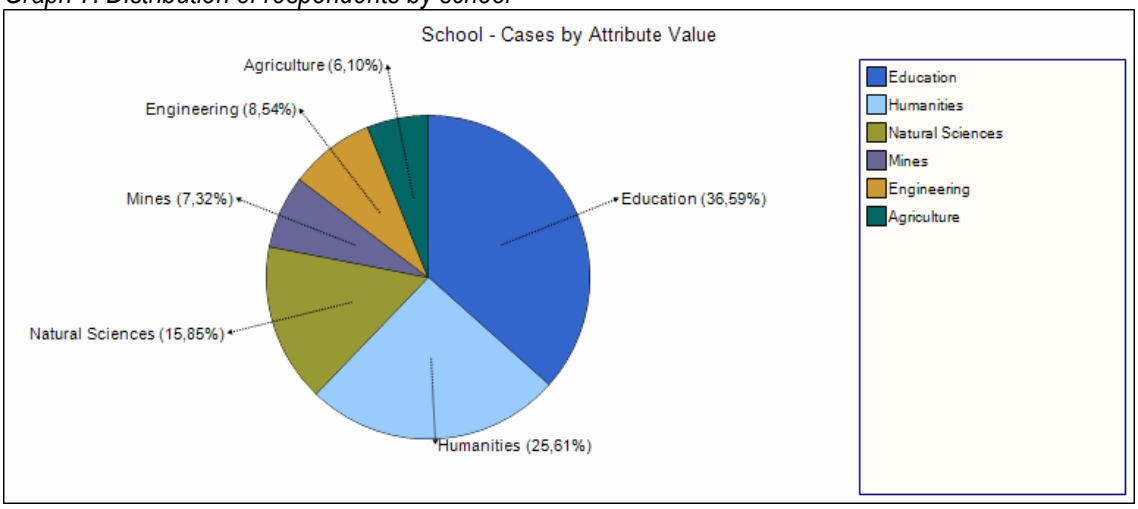
Family Upbringing: Most respondents said they had been brought up in religious households where emphasis was placed on following Christian doctrines in the everyday lives of the families. The remaining number of respondents was almost equally divided between those who said they were raised in traditional homes, where cultural values and principles were most important in guiding everyday life, and those who said they were raised in liberal homes, which were neither religious nor traditional.

Graph 6: Distribution of respondents by upbringing



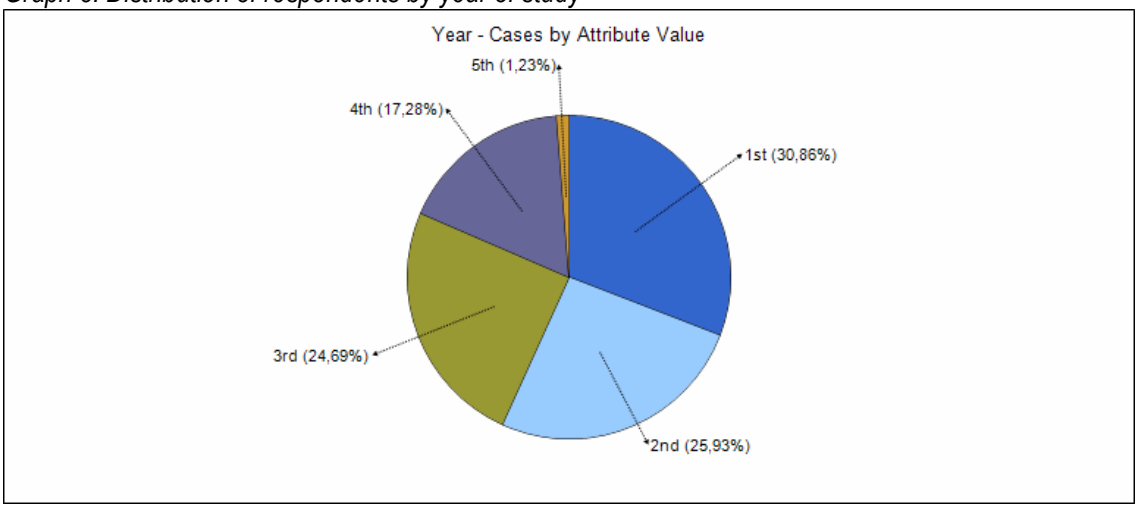
School: The school of education had a higher representation in terms of the number of respondents included in the study, followed by the school of humanities and social sciences, the school of natural sciences and the school of engineering. The schools of agriculture and mining engineering had the least numbers of respondents represented in the study.

Graph 7: Distribution of respondents by school



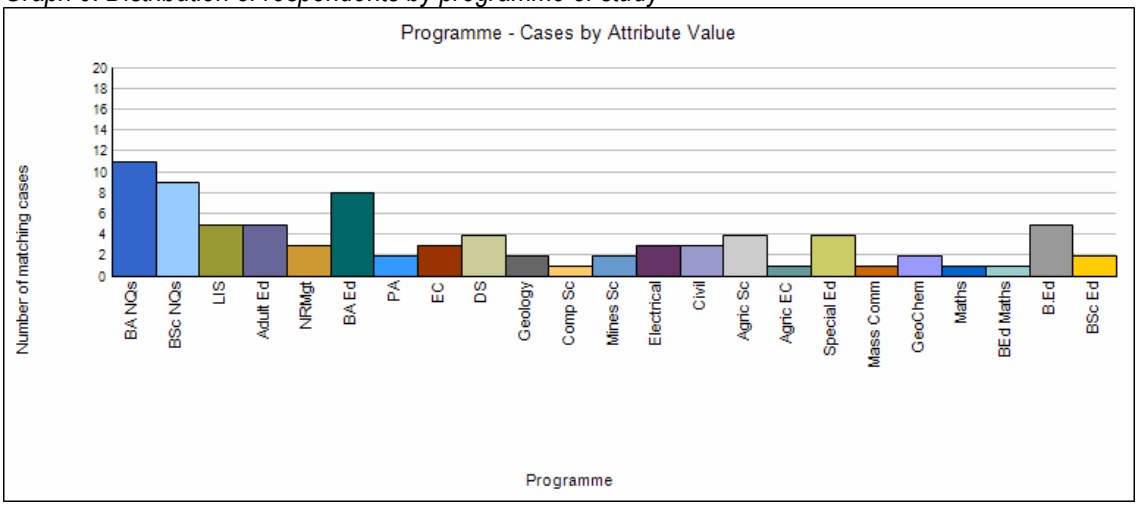
Year of Study: The first year of study had the larger number of respondents included in the study, followed by the second year, third year, fourth year and fifth year respectively.

Graph 8: Distribution of respondents by year of study



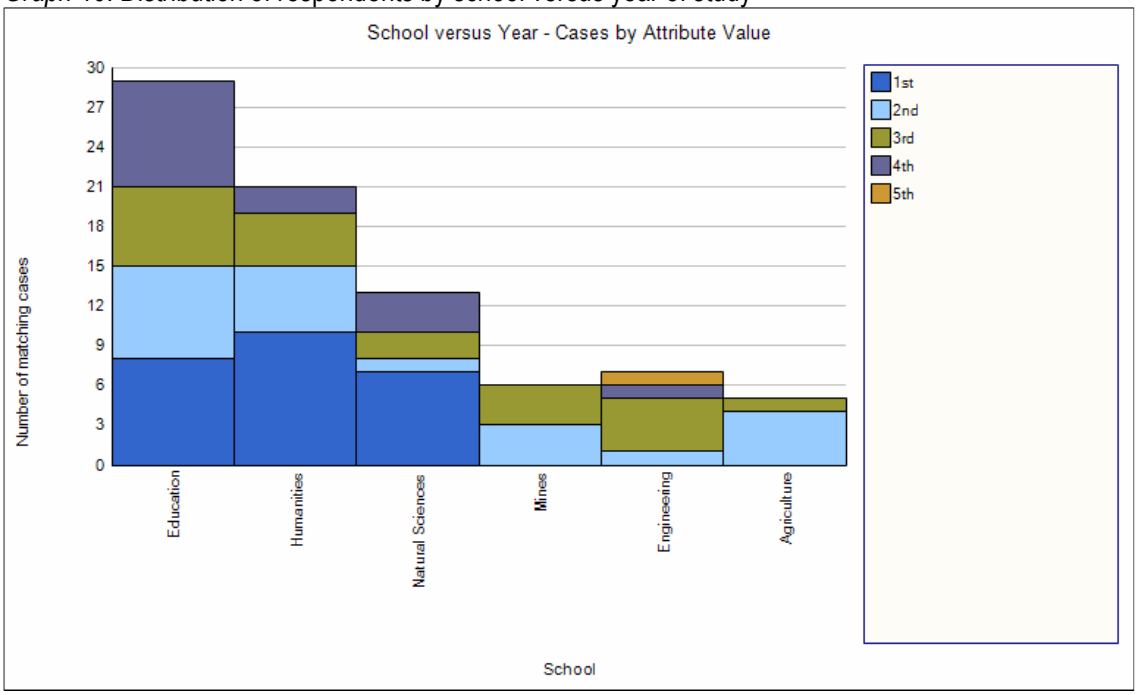
Programme of Study: The respondents were studying in 23 different programmes. As a lot of them were in first year, the Bachelor of Arts non-quota and Bachelor of Science non-quota programmes had the most numbers of respondents.

Graph 9: Distribution of respondents by programme of study



School and Year of study: The school of humanities and social sciences had the most number of first year students who participated in the study followed by the schools of education and natural sciences. The school of education had the most number of second, third and fourth year students.

Graph 10: Distribution of respondents by school versus year of study



5.2 Responses to semi-structured questionnaires

Social and Cultural Factors

Knowledge of what MC is: Almost all the participants, except 2 (2%), knew or had an idea of what MC was. It could be seen from the responses obtained that the differences were mainly in the wording of the answer, while the ideas were the same. Most participants indicated that MC *"is the removal of the foreskin from the penis".*

Where MC is done in Zambia: Only 6% of the participants said they did not know where MC was practiced in Zambia. Some participants had more than one answer to the question and indicated two or more provinces. Overall, 57% indicated that MC was mostly practiced in Northwestern province, followed by Western province which had 21%. The other participants indicated all the other provinces except Luapula and Copperbelt provinces which were not mentioned. 2% of the participants said MC was now being practiced countrywide.

Participants' own tribes that conduct MC as a cultural practice: 23% of the participants said they came from tribes that conducted MC as a cultural practice while 70% said their tribes did not. 2% of the participants were not sure whether their tribes had MC as a cultural practice or not. 5% did not respond to the question.

Circumcised participants: 20% of the participants indicated that they were themselves circumcised and 78% indicated that they were not. 2% of the participants did not respond to the question. Of the circumcised participants, 62% said they had been circumcised when they were still young, under the age of 13. 69% said they were circumcised at a health facility while 31% said they were circumcised at a traditional facility. 38% decided on their own to get circumcised while 62% said their parents decided for them as they were still young. The participants who decided on their own to get circumcised said they did so for health reasons and general cleanliness. Some of them also added that they believed it would enhance their sexual performance and that women liked circumcised men these days.

Informing someone of decision to get circumcised: 31% of the circumcised participants said they informed some family and friends of their decision to get circumcised and 25% said they did not. 44% did not respond to this question. 40% of the participants who said they had informed someone said the responses they got were positive and encouraging. Another 40% indicated that they received mixed reactions as some encouraged them while others were surprised at their decision. 20% did not respond to the question. 50% of those who said they had not informed anyone about their circumcision said they were young when it was conducted, 25% felt that there was no need to tell anyone as it was a private thing and another 25% said they felt embarrassed to tell anyone, even though they had decided for themselves to get circumcised and were over the age of 20.

Circumcision as a cultural requirement: 44% of the circumcised participants said it was a cultural requirement that they be circumcised while 50% said it was not. This shows that a lot of people are going for circumcision even if they come from tribes that do not conduct it as a cultural practice. 6% did not respond to the question.

Wishing had not been circumcised: All the circumcised participants said they had not experienced any problems as a result of being circumcised, therefore never wished they had not been circumcised. Those who said they came from circumcising tribes said they never regretted being circumcised because it was part of their tradition and indicated that they had become fully grown men. They gave statements such as;

"It makes me proud because my family regards me as an adult, a responsible man", "my tradition demands it and teaches me to be a grown man".

The other circumcised participants said they did not regret their decisions because they felt it was the right thing to do as it is important for health.

Contemplating circumcision: 44% of the uncircumcised participants indicated that they had at least once contemplated getting circumcised. 51% said they had never thought about it and 5% did not respond to the question. About 40% of those who said they had thought about it gave positive responses and said they would maybe one day get circumcised. The rest of them gave negative statements such as;

"HIV/AIDS prevention through circumcision is a myth",

"not to do it because when you're past the age of 12, the disadvantages outweigh the advantages",

"Its not worth the pain so decided not to",

"I can never decide to be circumcised" and

"Its really not worth it at all, there hasn't been any apparent reason for me to do so".

Most of the statements from the participants who said they decided not to get circumcised pointed to some misconceptions and misunderstanding of MC and its effect on the male reproductive organs and HIV transmission.

Cultural beliefs about MC: 14% of the participants said they knew that their cultures had some preconceived beliefs about MC. 71% said no and 10% were not sure. 5% did not respond to the question. This indicated that most participants relied on information from other sources like the media for their knowledge of MC, and not their cultures or elders. 75% of those who said their cultures had preconceived beliefs about MC gave positive views. Most of these were from circumcising cultures and said it was important for a man to be circumcised. 25% indicated that it was a foreign and immoral practice, saying;

"It makes men to be too hot for sex and cannot be satisfied by one woman" and

"It is immoral to be circumcised because it encourages men to go after many women".

Possible family reaction to decision to get circumcised: 26% of the uncircumcised participants said they did not know how their families would react if they decided to get circumcised while 5% said they would not tell anyone as;

"It wouldn't be such a good idea since it's kind of a taboo to talk about ones private parts".

51% indicated that they would get positive reactions from their families giving reasons such as;

"They would respect my decision as an adult individual" and

"Positive reaction as a health concern".

18% said they would receive negative reactions, with reasons such as;

"I might be considered a rebel against my family norms".

Knowledge of anyone circumcised: 78% of the participants said they knew someone who was circumcised. 18% said they did not and 4% did not respond to the question. 70% of the participants indicated that they knew of some students at UNZA who were circumcised. 24% said they did not know any students at UNZA who were circumcised. 6% did not respond to the question.

Stigmatisation of circumcised people: 7% of participants felt that people who were circumcised were stigmatised and 92% felt that people who were circumcised were not stigmatised. 4% of those who felt that circumcised people were stigmatised said they knew of someone who had been stigmatised by friends because they were circumcised. 95% said they did not know of anyone.

Personal views about MC: 67% of responses obtained indicated positive views that were in favour of MC. The rest of the views were negative and considered MC not to be a good thing or necessary. The participants who said positive views about MC gave statements such as;

"Its fine. You satisfy a woman and on top of that you prevent yourself from diseases" and

"It protects you from acquiring HIV/AIDS because the target cells under the foreskin get removed and these are the cells that attract HIV which easily identifies openings".

Some of the participants who gave positive statements nevertheless said they would not themselves get circumcised because;

"Some of its benefits can be obtained by self control and discipline so one can be ok even without it" and

"It's as good as condomizing but more demanding". Some of the negative views obtained were that "It is very misleading as people think they become immune once circumcised" and "It still relies on other prevention methods".

Encouraging factors: All the participants indicated that they thought people went for MC to reduce their chances of contracting HIV and other STIs. Further, 17% added that some men went for circumcision for general cleanliness and hygiene, and 41% added that some men wanted to increase their sexual performance and be sex machines, and to satisfy their women by not reaching orgasm fast. The fact that this reason was mentioned by so many participants could imply that many men do actually believe that MC does increase a man's sexual prowess by increasing their size and delaying achievement of orgasm.

Discouraging factors: Some participants had more than one response to this question, hence the total percentage being more than 100. Most participants (65%), felt that some men do not want to undertake MC because of fear of pain. 38% said it was due to lack of knowledge about it, 27% that some men's cultures did not allow them to get circumcised, 21% that religion didn't allow and 18% that they didn't know where to get it. 11% also said some men were afraid of stigmatisation by family and friends. The fact that few participants gave culture as a reason why some men may avoid MC may also go to shows that its influence of men's perception about MC may be minimal.

HIV/AIDS Prevention and Male Circumcision

Knowledge of own HIV status: 51% of participants said they knew their HIV status and 45% said they did not. 4% of the participants did not respond to the question.

Sexual partner: 47% of participants said they had sexual partners and another 47% also said they did not. 6% of participants did not respond to the question. 46% of those who agreed to having sexual partners said their partners were fellow students. 51% said their sexual partners were outsiders and 3% said their sexual partners were UNZA non-academic staff.

Sexual activity: 61% of the participants said they had had sexual intercourse before. 32% said they had never had sex before and 7% did not respond to the question. Of those who had had sexual intercourse before, 32% said they had first done so at 15 years and below. 46% said they first had sexual intercourse between the ages of 16 and 20 years. 12% had forgotten when they first had sexual intercourse. 10% said they first had sexual intercourse after the age of 20.

Frequency of sexual activity: 12% of participants who were sexually active said they had sex often, meaning once a week to everyday of the week. 22% said they had sex about once or twice in a month. 14% said they had sex sometimes, about once after three or four months. 40% said they rarely had sex and 12% said they had stopped having sex.

Use of condoms during sexual intercourse: 8% of the participants said they never used condoms during sexual intercourse. 10% said they often used condoms and 24% said they used condoms occasionally. 46% said they always used condoms during sexual intercourse. 12% did not respond to the question. In addition, 58% of the sexually active participants said they had used condoms during their last sexual encounter. 36% indicated they had not. This finding presents a very bad picture as it shows that students are at great risk of contracting HIV and other STIs because their use of condoms is low and inconsistent. Some said they did not use condoms at all.

Knowledge of MC as a complimentary method of HIV prevention: 61% of participants said they knew that MC could be used as a complimentary method of HIV/AIDS prevention. 28% said they did not know. 11% did not respond to the question. 48% of participants said they first learnt about the use of MC for HIV prevention from radio and television programmes, posters, brochures and billboards. The rest said they had first learnt about use of MC for HIV prevention through a variety of other means. The result shows that the media plays an important role in disseminating information and educating people about MC.

Effectiveness of MC: More than half of the participants, 57%, indicated that they did not think MC could be used as an effective method of HIV/AIDS prevention. The reasons given by the participants mainly pointed to them not being convinced that MC could be effective against HIV infection. They gave statements such as;

"Circumcision has nothing to do with the virus and fluid transfer",

"All circumcision does is remove the foreskin, I don't believe it creates a protective shield",

"Abstinence is the only most effective way because even if circumcised, men will have live sex and put themselves at risk" and

"People may be going for MC even if they are already infected, deceiving the subsequent partners".

32% said they thought it could be used as an effective method while 11% did not respond to the question. Those who said that it could be an effective method said this could be so if people who were circumcised did not abuse it and engage in sexual intercourse without condoms.

Discussing condoms and MC with sexual partners: Fifty one percent of the participant, accounting for 75% of those who indicated that they had had sex before, said that they had discussed condom use before with a sexual partners while 17% of the participants, accounting for 25% who had had sex before said they had never discussed condoms with a sexual partner. 16% of participants said they had discussed MC before with a sexual partner. 58% said they had never discussed MC with a sexual partner. 26% did not respond to the question. Most of those who said they had discussed MC with their sexual partners said they concluded that it was a good thing and they should get circumcised one day.

Current methods of protection: 57% of participants said they were currently protecting themselves against HIV/AIDS through abstinence. Most of these were the participants who said they had never had sex before and the ones who said they had currently stopped having sex. 22% said they always use condoms and 16% said they are sticking to one sexual partner. 2% said they are not doing anything to protect themselves, 1% said they got circumcised and 1% said they masturbate.

Male Circumcision Promotion

Promotion of MC: 51% of participants said that MC should be promoted as a complimentary method of HIV/AIDS prevention. 42% said it should not be promoted. 7% did not respond to the question. The participants who said MC should not be promoted still gave their reasons that they did not support it because they felt its effectiveness was very minimal and that it would only work to encourage a lot of men to engage in unprotected sex, thereby increasing infection among people.

The participants who were in favour of promoting MC gave some suggestions of how they thought it could be promoted so that more men could be encouraged to adopt it as a complimentary method of HIV/AIDS prevention. Most of the suggestions were about conducting educational campaigns for all categories of people including traditional leaders, parents and schools children. Some of the suggestions also indicated that MC should be promoted alongside condom use so that people understand that its effectiveness is enhanced when used with condoms. Some of the suggestions were that;

"Include it in school syllabuses from lower levels until university",

"Coming up with programmes on television and radio that focus on the merits of MC in local languages" and

"Should be promoted as a complimentary to condoms and not as a substitute".

Knowledge of institutions offering MC services: 77% of the participants said they knew of some institutions that were offering MC services while 17% said they did not know of any. 6% did not respond to the question. UNZA clinic was the most known with 68% followed by UTH at 35%. 14% indicated both government and private hospitals and clinics, 6% new start centre, 5% YWCA, 3% SFH and kara counselling and mukanda cultural institution with 2% each respectively.

57% of participants also said they knew of institutions that were promoting MC. The institutions that the participants listed included UNZA clinic and the HIV/AIDS response project with 32%, followed by SFH and ZANAMAWE with 11% each respectively. Others were YWCA, Zambia Interfaith Network on HIV/AIDS (ZINGO), Campus web, New Start Centre and USAID.

85% of the participants indicated that these institutions were promoting MC through printed publications, 38% through radio and television and 25% through workshops. 17% indicated that promotion was being done through public announcements. Others indicated were adverts, meetings and interpersonal announcements with 2% each and clinic posters with 6%.

94% said free circumcision was being offered by the institutions that were promoting and conducting MC as an incentive for men to go for it. 21% said free treatment in case of complications after MC was also being offered as well as reduced fees and free aftercare with 11% each.

5.3 Responses from focus group discussions

Knowledge of what MC is: All the participants in all the groups seemed to know what MC was. Like with the semi-structured questionnaires, differences were mainly in the wording of the responses while the basic ideas remained similar. An example of the responses obtained during the focus group discussions is that *"It's the removal of the foreskin on the male penis".*

Cultural preconceived beliefs about MC: In all the groups, there were participants who expressed ignorance about any beliefs that their tribes could have had about MC. Those who came from circumcising cultures had positive views about MC and gave statements such as;

> *"In my tribe they say to be a fully grown man, you have to be initiated and circumcision is the climax of that initiation"*.

Most of the other participants from non-circumcising tribes also indicated positive views about MC, saying it was an individual's choice whether to get circumcised or not if they came from a non-circumcising tribe.

There were a few participants however who opened up to say that their tribes believed that circumcision was "*foreign*" and something that had some negative undertone to it. In group one, a near-emotional debate ensued between the participants from circumcising tribes and the ones who felt that it was immoral. The argument brought out an issue suggesting that some people from non-circumcising tribes may have negative attitudes towards circumcision because they feel circumcising tribes look down upon non-circumcising tribes, because they say that one has to be circumcised to be considered a real man. The participants from non-circumcising tribes asked questions such as;

> "*What do you mean to be a man? So us who are not circumcised are not men?"*

The participants from circumcising tribes managed to clarify that their cultures' views about MC did not necessarily have to be applied to all the other Zambian tribes, and also that their expectations from their men did not necessarily mean they expected the same from men from other tribes. They also likened the practice to female initiation ceremonies which some tribes do, saying that they circumcised boys as initiation into manhood.

> "*Many tribes in Zambia conduct initiations for girls to prepare them to be responsible women. But does it mean tribes that do not initiate their girls don't have women? No. Its the same with us, its just that we also conduct initiation for the boys to prepare them to be responsible men too".*

Possible family reaction to decision to get circumcised: From the first group, only one participant said they were not sure how their family would react if they decided to get circumcised. The rest of the participants said their families would accept their decisions. From the second group, only one participant said they thought their family would react *"fairly, because it would be my decision"*. The rest of the participants from non-circumcising tribes felt that their families would react negatively. In the third group, all the participants said their families would respect their decisions as adults. The fourth group was divided with half of the participants from non-circumcising tribes saying their families would not be

happy if they got circumcised and the other half saying their families would encourage them. The participants who said their families would react badly gave statements such as;

"It would be considered as going against my family values or tradition, so I think they may not be very happy".

The participants who said their families would encourage them gave statements such as;

"They would be for the idea" and "I think they would encourage me".

Knowledge of anyone circumcised: All the participants from all the groups said they had heard about the circumcision project at the UNZA clinic. Two participants, from the second and fourth groups, were open enough to say they had been circumcised at the clinic. 27.5% of all the participants, representing 4 from group one, 2 from group two, another 2 from group three and 3 from group four said they did not know anyone who was circumcised.

Stigmatisation: All the participants from groups one and two stated that they did not think that people who were circumcised were stigmatised. This was disregarding the fact that some participants in these groups, like the ones whose discussion about the purpose of MC is quoted above, had earlier indicated that their tribes had it that MC was foreign and immoral. The study noted that the participants were either ignorant of what constituted stigmatisation and genuinely believed that circumcised people were not stigmatised, or purposely said there was no stigmatisation because they did not want to be viewed as perpetrating stigmatisation against circumcised people.

In the third and fourth groups, most of the participants said they did not think circumcised people were stigmatised. However, one participant from group three and two from group four indicated otherwise and said they felt that some people did stigmatise circumcision. The participant from group three gave an example of the student who was circumcised at the UNZA clinic and became a target for *"teasing"* by his friends.

"I actually think yes, or maybe some, because I know someone who was kind of stigmatised by his friends after he got circumcised. "They were teasing him that he had decided to become a Luvale and the next thing would be him wearing a likishi. The same friends even started calling him kalubale and likishi.

"At first he was easy with it I think but got upset when they started giving him the nicknames and told them to stop". ..... "Yes they did (stop calling him by the nicknames). But I think it goes to show just what some people think about circumcision, even if they may not say it out anyhow".

The other participants in the group started agreeing with the one participant and acknowledged that it was possible that some people could be stigmatising circumcision. One added that;

"Somehow I think its true. You know people don't say much about circumcision because it's about the manhood, and people generally do not like to talk about things that make them uncomfortable, especially about their manhood. So some people may even say bad things about circumcision because it is an uncomfortable topic to them".

One participant from group four stated that he felt that;

"some people just have this bad attitude towards circumcision which makes them look down on people" (who are circumcised).

He cited cultural differences as the cause, saying that;

".....with tribes that may have had tribal wars with people who circumcise in the olden days. So it's like circumcision has come to be associated with their tribal enemies. I think now people are trying to make it a thing to joke about but deep down am sure there are some who still feel that MC is for 'those' and not us".

The other participant who also felt that stigmatisation existed disagreed with the tribal cousinship reason and said he believed it was more to do with individual attitude. He also gave an example of a student who was teased by his friends after getting circumcised at UNZA clinic.

"I think tribal cousinship is there yes these days but not in the negative sense like you're saying it. I know someone who was sort of teased by his friends after being circumcised, but they were not like tribal cousins. So I think if stigmatisation happens, it's just with some people's individual attitude but not because culturally they are supposed to look down upon people who are circumcised".

When asked how the circumcised student was teased by his friends, the participant said;

"You know guys, just kind of saying now he had sharpened himself to blast more chicks and the like. It was just something that they were laughing about and the guy didn't take any offense".

The examples from the participants indicated that stigmatisation did exist although sometimes on very subtle levels such that people thought it was not stigmatisation.

Personal perception of MC: Most of the participants from all the groups felt that MC was a good thing that should be encouraged *"strictly"* for health reasons such as HIV prevention. They gave statements to this effect such as;

"I think it's a good practice that should be encouraged but done clinically"

"I think the main issue about it is that it promotes hygiene, which makes it advantageous in terms of prevention of diseases, which includes HIV. That for me is what makes it to be a good practice" and

"I think it is a good thing and men should consider doing it for the sake of good health".

The participants who had opposing views gave statements such as the following to put across their opinions;

"It's an ok practice but not entirely necessary",

"I think it's not ok because you're still at risk of catching HIV even after being circumcised" and

"For me I think there is no point of practising it since both those who have been circumcised and those not still get HIV".

Others were;

"It is good but in some cases it has led many males to go after ladies taking the advantage of being circumcised",

"Culturally it is immoral and on top of that painful" and

"It's been misused and misinterpreted. People who encourage others to be circumcised don't even have the statistics concerning the perceived advantages".

The study noted that the responses obtained from the participants who had negative sentiments about MC were similar to some that were obtained from semi-structured questionnaire respondents and gave an indication that they were looking at MC as a stand-alone method. Although few, some of the participants were looking at it from the cultural perspective and expressing the cultural biases that existed towards MC.

Encouraging factors: Most of the factors stated by the participants from all the groups were similar. They included factors such as the need for protection against HIV and other STIs and desire for cleanliness and hygiene. Others also included factors such as;

"to satisfy their women by not reaching orgasm fast",

"encouragement from partners and friends" and

"to increase the size of the penis".

It was interesting to note that even some participants who were pro-MC mentioned some factors such as *"desire to have prolonged orgasms"* as encouraging some men to go for MC.

Discouraging factors: A number of discouraging factors were mentioned from all the groups, though most of them similar. They included fear of pain, lack of knowledge of the benefits that come with MC or not being convinced that it works, fear of the risks involved after having the operation and lack of interest. Unlike in the other groups, some participants in group one also mentioned fear of stigmatisation as a reason why some men avoid going for MC. The participants who had started talking about stigmatisation as a discouraging factor said:

"I think from the way this discussion has gone, we may have some stigmatisation that we don't want to acknowledge. I have come to realise that actually we take for granted what we think and say about circumcision, and other peoples' cultures generally, not realising that we are creating a negative attitude towards it. I'll give an example of what has been said about circumcision here today, that it promotes immorality among circumcised men. No one actually has evidence to prove that this is true, but just because we heard it from someone out there we also go on and say that is the truth we know about circumcision. We're making this myth into a truth it is not. It is wrong".

How participants first learnt about use of MC: From all the four groups, participants mentioned various ways in which they first learnt about MC and its use for HIV prevention. Like with the responses obtained from the semi-structured questionnaire respondents, most indicated that they learnt about MC through the media, clinic brochures and posters, friends and AIDS talks at secondary school. The study noted that none of the participants indicated having learnt about MC from home. This reinforced the impression created by the study after review of the semi-structured questionnaire responses that culture has little influence on male students' perception of MC compared to other aspects such as the media.

Effectiveness of MC as a complimentary method of HIV prevention: From all the groups, few participants were quick to state that MC could be effective as a method of prevention against HIV. They gave reasons such as;

> *"yes, especially in the cultural context because they teach about responsibility that comes with being a man after circumcision and that includes sexual responsibility" and*
>
> *"...since there is no cure for HIV yet, all possibilities must be utilized to minimize spread of AIDS",*

One participant added that;

> *"We all know that abstinence is the only sure way of avoiding HIV through sex. So if we're sexually active, whether we use male condoms, or female condoms, or get circumcised, we are at risk. So it's up to one to decide to increase their protection by using one method or the other or a combination of several. And that also means we cannot condemn one method just because we wouldn't use it. Otherwise, we might as well not do anything to protect ourselves because even condoms are not 100% safe".*

The majority of the participants expressed some doubts about MC's effectiveness against HIV infection, giving reasons such as;

> *"I also think that all circumcision does is remove the foreskin, I don't believe it creates a protective shield",*
>
> *"the percentage of its effectiveness is very minimal, so I doubt it" and*
>
> *"I am more convinced that abstinence is the most ethical and genuine method".*

Some of these participants however indicated that there could be possibilities of it working as long as people did not abuse it. Some of them stated that;

> *"Yes, as long as people don't misinterpret circumcision as a passport to having sex everywhere, it could be effective" and*
>
> *"I think it can be effective if we really get the true concept behind circumcision. Just like condoms are not 100% safe, so is circumcision. So I think it's up to one to decide to use a combination of methods or just one method".*

Promotion of MC for HIV prevention: Similar to what was observed with the responses from the semi-structured questionnaires, despite most participants saying they doubted the effectiveness of MC as a prevention method against HIV, most supported the idea that it could still be promoted. Many of them however stressed that this should be done with care so that men do not abandon use of condoms thinking that they are protected because they got circumcised. They said;

> *".... it should be promoted but as a complimentary to condoms and not as a substitute",*
>
> *"it should be promoted and people will make their decision. People should also be told that it is available in hospitals and clinics and being done by qualified staff and not at Mukanda" and*
>
> *"I think with what is being said about it now, people can start promoting it because HIV is not waiting for anything. So people should also be working to protect themselves whichever way*

they can. So if circumcision has some benefits, then I see no reason why people cannot start using it".

The participants who were against promotion of MC continued with the arguments that;

"I say no because I think abstinence and self discipline are the ones that should be encouraged",

"there will be a lot of infections because people will take it for granted that they can no longer get infected when circumcised" and

"at the moment, I think it should not be promoted because it has not been proved beyond doubt that it can be used to prevent the HIV virus".

Other statements given against promotion of MC were that;

"The percentage value of its protection is minimal so people should be very careful when thinking about promoting it" and

"I think it should not be promoted because it just encourages sexual immorality".

The participants who were in favour of promoting MC gave some suggestions of how the promotion could be most effective. The main suggestions mentioned by these participants were that MC should be promoted together with condoms so that people understand that its effectiveness is increased if used together with condoms, and that information about its benefits should be provided to all people in the country through the media, school curricula, workshops and traditional councils.

6.0 DISCUSSION OF RESULTS

This section contains a discussion of the findings of the study, in relation to the objectives that guided it. It will therefore be divided into three parts with the themes of the three objectives as the subheadings.

6.1 Social cultural factors influencing attitude towards MC

From the responses obtained from the participants, it was clear that most of them knew what MC was. The differences were in the wording they used to define it, but their ideas of what it was were similar. Most of them also knew where MC was mostly done as a cultural practice in Zambia. Many also added that now it was widespread in the country because people were adopting it for health and hygiene reasons.

The majority of participants (70%) said they came from non-circumcising cultures and 23% said they were from circumcising cultures. Few participants were not sure whether their tribes conducted circumcision as a cultural practice or not. This was evidenced by responses from some students who actually come from non-circumcising cultures, but indicated that their cultures were circumcising ones and they themselves were circumcised. For example, there were some Lozi circumcised participants who said Lozis do circumcise. It was discovered that these participants were raised in rural circumcising societies where it was a requirement for everyone to be circumcised, among the Luvales and Nkoyas in Kaoma. There was also some confusion among some Kaonde and Chewa participants as some of them said their tribes did circumcise and others said they did not. This finding led the study to conclude that there could be many youths who did not have full knowledge about their cultures' practices and values in general and views about MC in particular. In the same vein, many youths could be getting their information about MC from friends and the media, and not from their family elders.

Twenty percent of the participants indicated being circumcised, and yet only 6% said they were from circumcising cultures. 63% of the circumcised participants said they had been circumcised when they were young, under the age of 13, and they had not decided for themselves to get circumcised. This finding gave the study the impression that the number of circumcised male students could soon become higher because of the circumcision project being conducted at the UNZA clinic. All except 2 of the 11 participants who said they had been circumcised after the age of 18 and at a health facility were circumcised at UNZA clinic. This means that more students are actually going for MC, even if they are not necessarily having it done at UNZA clinic. This could also be a sign that some people could be flexible and accept aspects from other cultures, such as MC, that they may deem beneficial in some way. The finding was in conformity with the findings of a study conducted in Tanzania where it was suggested that some people were adopting MC for its health benefits. The study found that MC was increasingly being disassociated from ethnicity, and the main factors reported for its increasing popularity were improved genital hygiene and reduced risk of STI and HIV infection. (Bailey, Plummer & Moses; 2001)

The participants who decided to get circumcised, 38% of them, said they did so taking into consideration the benefits of MC for HIV/AIDS/STI prevention and general cleanliness and hygiene. In the Tanzania study, it was concluded that in many traditionally non-circumcising areas of eastern and southern Africa, circumcision was increasingly being considered in the context not just of culture and religion, but also of hygiene and health. (Bailey, Plummer & Moses; 2001)

Some of the other circumcised students also added that they believed women liked circumcised men and it would help enhance their sexual performance. From this, it was deduced that misconceptions about MC that it enhanced the size of the manhood or sexual power could be prevalent among the

male students. There could be a possibility that some men may decide to become circumcised solely in the hope of increasing the size of their manhood or sexual longevity. With time and as many discover that MC does not meet up with these expectations, their perceptions about it may change because of disappointment and they may begin to disapprove everything that is said about MC, including the fact that it helps prevent contraction of HIV and STIs. There is therefore need for clarification of such misconceptions among the men.

Of the circumcised participants, 31% informed someone about their decisions to get circumcised and the responses were encouraging for most of them, again an indication that some people from non-circumcising cultures could be opening up to MC, probably because of HIV/AIDS and evidence being presented that MC offers some protection against infection among men. Many participants (44%) did not respond to the question that asked about informing somehow. 25% said they did not inform anyone and 25% of these said they kept it to themselves due to "*embarrassment*". The study assumed that so many participants did not respond to the question about informing someone because they were probably also "*embarrassed*" and did not want to disclose their feelings. However, when asked if they thought circumcised people were stigmatised or discriminated against, most of the participants said no, and only 7% said yes. Some of those who said yes even added that they knew of some fellow students who had been teased and nicknamed "*kalubale*" or "*likishi*" by friends after they got circumcised. The study got a sense of uncertainty among many participants concerning this topic. Many of them said circumcised people were not stigmatised but later on expressed negative personal opinions about it and that many men got circumcised because they wanted "*a passport*" to "*live sex*" and "*many women*". Some of the participants labelled it "*immoral*" as they considered is mainly aimed at enhancing sexual appetite in men. On this issue, the study concluded that there was more stigmatisation among the male students than they recognised and accepted.

Nevertheless, all the circumcised participants said they were happy and never wished they had not been circumcised. Of those who were not circumcised, 44% said they had contemplated getting circumcised before. Most of them decided not to get circumcised and only 40% said they were either still thinking about it or had decided to get circumcised in the near future. Most of the reasons put forward by those who decided not to get circumcised were tied to disbelief or not being convinced that it does offer some level of protection against HIV, fear of pain, cultural differences and that there were other less demanding and more effective methods that could be used for HIV prevention, such as condoms and abstinence. In relation to this were the issues of preconceived cultural beliefs and family reaction if the participants decided to get circumcised.

The participants from circumcising cultures said the practice was highly valued and it was a requirement for males to become circumcised for them to qualify to be considered as fully grown men. Most of the participants from non-circumcising tribes (71%) said their cultures did not have any preconceived beliefs about MC and some (10%) said that they were not sure. 5% of the participants did not respond to the question. Few participants indicated that their cultures held that the practice was bad or immoral. About telling family members about MC and the expected reaction, majority of participants (51%) said they would get positive reactions as they were considered adults and there would be few questions about their decisions. 18% indicated that the reactions would be negative and 5% said they would not inform anyone. Some of these clarified that it was because in their cultures it was considered taboo to talk about one's private parts. 26% said they were not sure. The above findings gave the study an impression that the decisions that most male students from non-circumcising cultures made pertaining MC were largely a result of their own contemplation and evaluation of information and probably peer opinion. Family or cultural background seemed to matter less, as there was no particular pattern of association observed relating attitude towards MC with where one was brought up or their tribe. The media therefore, as mentioned above, would have a greater influence on the students' perceptions. In the Tanzania study mentioned above, it was also discovered that advertisements in the

media made by private clinics advertising their MC services helped to make the practice popular. (Bailey, Plummer & Moses; 2001)

When asked to provide their own personal opinion about MC, most of the participants (67%) gave positive sentiments, although many still emphasized that they would not do it themselves because they felt it was just not necessary as there were better methods that could be used, were not convinced about its effectiveness or were not willing to bear the pain of the operation. 33% provided negative sentiments that mainly focused also on doubts about its effectiveness and the assertion that many men who were adopting the practice were driven by the desire to have greater sexual power, although they were hiding behind the pretext of HIV protection.

6.2 Knowledge and attitude about MC effectiveness

51% of the participants said they knew their HIV status and 45% said they did not. 47% said they currently had stable sexual partners and another 47% said they did not. 61% of all the participants said they were sexually active or had had sexual intercourse before and 32% said they had never had sex before. 21% of the sexually active participants, including some of those who said they had stable sexual partners, indicated that they occasionally had sexual intercourse with prostitutes. However, only 46% of the sexually active participants said they always used condoms during sexual intercourse. 8% said they never used condoms. 58% of the sexually active participants said they had used condoms during their last sexual encounter while 36% said they had not. The above findings indicated a situation where students were not always cautious and many conducted themselves in a manner that put them at great risk of contracting HIV and other STIs. The fact that some of them went out to have sexual intercourse with prostitutes and did not always use condoms is a situation of great concern. When asked how they were protecting themselves from catching diseases, most participants (60%) said they were abstaining, 22% said they always used condoms, and 16% said they were sticking to one sexual partner. One percent each said they got circumcised and masturbated respectively.

The above scenario calls for rejuvenation of the condom campaign, to remind students and the general population of the importance of always and correctly using condoms. MC could also be incorporated in such campaign to enhance its popularity and acceptability. Approximately 80% of the people worldwide living with HIV were infected through sexual intercourse. In adult men, an estimated 70% of HIV infections are acquired through vaginal intercourse and in Africa this figure is over 90% (Bailey, Plummer & Moses; 2001). Factors that may help reduce men's HIV susceptibility must therefore be of great interest and importance.

The inconsistency in the number of participants who said they were sexually active and those who later said they were abstaining indicated to the study that many participants did not have a permanent or stable plan of protection. One participant indicated that they were using MC as a method of prevention, although several had earlier said they were circumcised. This could be a good sign in relation to risk compensation as it shows that very few actually use MC alone as a method of prevention. The rest of the circumcised participants said they were using condoms, sticking to one sexual partner or abstaining. However, the study concluded that there still was need for concern and reassessment of the situation because of the high level of inconsistency in the use of condoms and the use of prostitutes by some students. There is need to ascertain that this condom inconsistency is not being aided by perception of low risk due to being circumcised.

Bailey, Neema and Othieno (1999) wrote that a major concern about promoting circumcision as an HIV prevention measure was the risk of behavioural dis-inhibition (Risk compensation) among those who choose to be circumcised. Even if circumcision was promoted as only reducing risk and not fully protecting a man from HIV acquisition, men might undergo the procedure and feel less inhibited about

engaging in risky sexual behaviour. Such behavioural dis-inhibition could result in increases rather than reductions in HIV incidence. They also wrote that there was evidence that some circumcised men engage in higher risk behaviours than uncircumcised men although the circumcised men still were found to have lower prevalence of HIV infection. They gave an example of the findings of a study that, among other aims, compared sexual behaviour among men from circumcising and non-circumcising cultures. In this study, it was found that men in Yaoundé Cameroon, where circumcision is prevalent, engaged in high risk sexual behaviour such as having multiple sexual partners than men in Ndola Zambia, where circumcision was not common.

Most participants said they had first learnt about the use of MC for HIV prevention through clinic brochures and posters, radio and television discussions and from colleagues. 32% said they felt it could be used as an effective method of HIV prevention and 57% said it could not be used as an effective method of HIV prevention, citing the fact that it was not 100% effective and could have a reverse effect from the desired due to risk compensation. Those who were in favour of it being used said that its effectiveness could be increased by using it together with condoms. They agreed that MC was not 100% effective, but so were other methods including condom use. They said it should therefore not be condemned because some people were not willing to use it as a prevention method, and that it should be encouraged because since there was no cure for HIV yet, all possible measures that could assist in some way should be promoted.

6.3 Promotion of MC as a complimentary method

Despite most participants saying they felt that MC could not be used as an effective method of HIV prevention, many (51%) still indicated that it should nevertheless be promoted as a complimentary method of HIV prevention and for general hygiene. They said it should be left to the individual men to decide whether they wanted to get circumcised or not. 42% were of the opinion that it should not be promoted as it would only help to increase HIV infection because many men would think they were safe to have multiple partners and others would abandon use of condoms, putting themselves at greater risk of contracting HIV.

The participants who said MC should be promoted offered some ideas of how the promotion could be done to encourage more students and other men to consider adopting MC as a complimentary method of HIV prevention. The suggestions were that:

- MC should be promoted with strong consistent campaigns both in the public and private media, the way condoms were promoted. The campaigns should highlight evidence that it offers protection against HIV, especially from research conducted in Zambia.
- MC facts should be included in all school curricula, from primary to higher education. Detailed facts-booklets and posters should also be available in schools and health centres.
- Programmes should be created targeting traditional leaders aimed at changing some cultural perspectives, so that they in-turn promote MC among their people. This could be done through television and radio programmes that could be aired in local languages.
- MC should be promoted alongside condom use so that it is emphasised that each of the methods' effective is increased when used in conjunction with the other.
- Parents should be targeted so that many people are circumcised when they are still young. It should also be offered in more health centres with minimal fees.

It was observed that during the FGDs, more participants were liberal about MC and supported it being promoted for hygiene and even possible HIV/AIDS prevention. However, in the semi-structured questionnaires more participants indicated that they did not support it. The study concluded on this aspect that participants felt freer to express their views about MC in the semi-structured questionnaires

than in the FGDs. During the FGDs, some participants could have been supporting MC to conform to views of other participants who were supporting it and avoid being seeing as controversial.

The reluctance by some participants to afford MC some credit based on the evidence available so far that it does offer some protection against HIV could partly be due to cultural factors, even if this was not so apparent in the findings of the study. In the study, a few participants from non-circumcising cultures gave an indication that they felt that circumcising cultures stigmatised non-circumcising cultures because they believed that people only became men after circumcision. This could be the case with many other people from non-circumcising cultures. Peltzer et al (2007) wrote that the analysis of MC cannot avoid consideration of cultural constructions of the penis and of the body, and the issue of how these are linked to constructions of masculinity and womanhood, which in turn raises issues of gender constructions. They said from a cultural analysis perspective, the body functions as a fundamental metaphor, an important surface on which the marks of social status, family position, tribal affiliation, age, gender and religious condition may be displayed or hidden. They also said that according to many social scientists, the body formed an implicit foundation of stigma. The study assumed that probably some participants wanted to quickly dispel MC because it was not a comfortable issue for them to talk about as it was not part of their culture to discuss topics related to private aspects of their bodies, and because they were in the presence of other people (from circumcising cultures) that they felt belittled them as they came from non-circumcising cultures.

7.0 CONCLUSION

Almost all students have heard about the use of MC as a complimentary method of HIV/AIDS prevention. However, many male students still harbour doubts about its effectiveness and even actual purpose as to why some men go for it. There is a likelihood that some male students still think of it in the cultural context as a standalone and that is most probably why there is still some doubt about its effectiveness and some contention about its purpose. This calls for more sensitization about the benefits of MC and emphasis should be placed on how men should use it together with condoms to realise its full benefits in terms of HIV/AIDS prevention. This is very important and will work to prevent or reduce any chances of risk compensation.

The fact that many students seemed not to take their cultural backgrounds as strong references when making decisions about issues such as MC could work in favour of MC promotion; as there would be less barriers to break through to convince people to adopt MC. What seemed to be of greater importance was the availability of evidence that it does really work. With the suggestions that were provided by some participants of how to make the promotion of MC more successful, it could be possible to increase MC's acceptability among the male students and the general population as a whole.

8.0 RECOMMENDATIONS

The following are the recommendations offered from the study.

- Even if the study could not conclude that MC increases risk compensation, it would be vital to follow up the circumcised students to ascertain that they are not abusing their status of being circumcised and engaging in activities that could increase the likelihood of them getting infected with HIV.

- MC should be promoted with strong consistent messages alongside condom use so that people learn to associate the two with each other and get used to the idea that each methods' effectiveness is increased when used together with the other. The promotions should also have as an aim rejuvenation of the condom campaign so that people begin to use condoms always.

- As the media came out as the most popular source of information that helped to shape the students' perceptions and decisions about MC, researchers, health workers and promoters of MC should work closely with the media so that it helps to disseminate correct and persuasive information about MC and its benefits in relation to HIV/AIDS prevention.

- The campaigns promoting MC should highlight evidence that it reduces the risk of contracting HIV.

- MC facts should be included in all school curricula, from primary to higher education where possible, together with topics on HIV/AIDS and condom use.

- Promotion programmes should also target traditional leaders in order to change some cultural perspectives, so that they in-turn promote MC among their people.

- Parents should also be targeted and encouraged to consider having their young sons circumcised so that many people are circumcised when they are still young.

- A wider study with more participants should be conducted at UNZA, and other institutions of higher learning, to get a deeper understanding into the factors that influence the male students' perception of MC in relation to HIV/AIDS prevention. The study should also explore in greater detail the issue of risk compensation, as many participants against MC mentioned it several times as a potential outcome if MC were to be promoted. The study should also include females as participants because their perceptions or views about MC could also be valuable and key in the promotion of MC. Some participants indicated that their partners encouraged them to go for MC.

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Appendices

Appendix A: Participant Information Sheet and Consent Form

Study Information Sheet

Title of the Research study
Young Men's Perception of Male Circumcision at the University of Zambia in Lusaka: Implications for HIV/AIDS Prevention.

Investigator
Monde Lisulo, Social Worker, MPH Student, Department of Community Medicine, School of Medicine, University of Zambia, Lusaka, Cell No. 0955792806; Email: nowanga77@yahoo.com. Other address, C/O Precious M. Lisulo, Ministry of Science, Technology and Vocational Training, P. O. Box 50464, Lusaka, Zambia.

Purpose and Background
In some studies conducted at UNZA, it was suggested that students were highly knowledgeable about methods of HIV/AIDS prevention, which included male circumcision (MC). This made the researcher become interested in finding out whether men in particular where acting upon information that they had about MC and its benefits in terms of HIV/AIDS prevention. Or probably there were factors that hindered them from seeking MC to be performed on them. Of particular interest to the researcher was the response from men who came from cultures that did not conduct MC as a traditional practice; whether their social and cultural backgrounds had any influence on their acceptance and adoption of MC or its rejection. Therefore, this study was set up with the aim to assess the perceptions of male students at UNZA main campus concerning MC and its effectiveness as a method of HIV/AIDS prevention.

Procedures
If you agree to participate, the following things will happen:

- After signing the consent form, you will be requested to answer the questions contained in the questionnaire.
- If you are participating in a focus group discussion, after signing the consent form and before the discussion starts, you will be asked to choose a code name, number or letter that will be used in case there is need to refer to you by name.
- You will be engaged in a discussion with other group members by the researcher concerning what you think about the use of male circumcision for HIV/AIDS prevention and what your culture's stance is on the issue. This will take about 45 minutes to one hour.
- A tape recorder will be used to record the discussion so that the researcher is able is capture your exact statements.
- After the recorded discussion, you will be asked to write down in brief your tribe, whether you are circumcised or not and what your personal perception is about male circumcision and its use as a complimentary method of HIV/AIDS prevention.

Benefits
There may be no direct benefit to you from participating in the study. However, you may find the provided list of institutions providing HIV/AIDS counseling and male circumcision services useful. Some of these institutions offer their services free of charge or at a minimal fee. Moreover, by participating,

you will contribute to generation of a better understanding of the factors that influence young men's perceptions of MC. You would have helped to gather information that may be necessary for organisations dealing with HIV/AIDS and MC in decision making about how to package information about HIV/AIDS and MC.

Risks
You will decide how much information to provide in the interviews. As a result, there are no personal risks inherent in the study. However, you may feel uncomfortable with some questions which may be unusual to you. In the event that you feel that the study has generated some uncomfortable/negative emotions/feelings in you, you may wish to withdraw from the study or talk about the emotions/feelings with the researcher. Furthermore, you may wish to seek professional advice from the organisations in the list provided.

Reimbursement
You will be paid a token of appreciation for the time taken to participate in the study.

Confidentiality
All information obtained in this study will be considered confidential and used only for research purposes. Your identity as a participant will be kept confidential as far as the law allows. A summary of the results from this study will be available to all participants through the researcher.

Injury Clause
In the event that you become injured during the course of the study, immediately notify the principal investigator. If you believe that your injury directly resulted from the research procedures of this study, you can file a complaint with the **Principal Investigator or the Chairperson of the Biomedical Research Ethics Committee at University of Zambia, Ridgeway Campus, P.O Box 50110, Lusaka. Telephone: 256067, Fax: 250753, Email: unzarec@zamtel.zm. Telegram: UNZA, Lusaka; Telex: UNZALU ZA 44370.**

Right to Refuse or Withdraw
Your participation in the study is entirely voluntary, and you are free to refuse to take part or withdraw at anytime without affecting or jeopardizing your future medical care.

Questions
The researcher has discussed this information with you and offered to answer your questions. If you have further questions, you can contact her on 0955792806 or the **Chairperson of the Biomedical Research Ethics Committee at University of Zambia, Ridgeway Campus, P.O Box 50110, Lusaka. Telephone: 256067, Fax: 250753, Email: unzarec@zamtel.zm. Telegram: UNZA, Lusaka; Telex: UNZALU ZA 44370.**

Consent Form

The purpose of this study has been explained to me and I understand the purpose of the study. I further understand that if I agree to take part in this study I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntary.

I _____ (Participant's Names**)**

Agree to take part in the study.

Signed: _____ Date: _____ (Participant)

Signed: _____ Date: _____ (Witness name and signature)

Institutions that could be consulted for male circumcision services

In case you are interested to find out more about HIV/AIDS and the use of Male Circumcision as a complimentary method of prevention, you could visit any these institutions.

1. Society for Family Health – Male Circumcision Project
2. Kara Counselling and Training Trust
3. New Start centre
4. UNZA Clinic
5. UNZA HIV/AIDS Response Project
6. UNZA Students' Counselling Centre
7. University Teaching Hospital – Urology Department
8. Young Women's Christian Association (YWCA)

Appendix B: Study Questionnaires and Responses

Social and Cultural Factors

*Number in brackets indicates instances where the number of participants who had similar views was more than one.

No.	Questions	Participants' responses	Percentage
1.	What is male circumcision?	- Removing penis front part (2)	2
		- Cutting off the top of the penis	1
		- Its the removal of the foreskin on the male penis (21)	26
		- Its removing the foreskin of the penis from the glance of the penis	1
		- The cutting/removal of the foreskin of the penis (18)	22
		- Its the cutting of the front part of the penis (3)	4
		- Getting rid of the foreskin of the penis	1
		- An operation carried out to cut the foreskin of the male reproductive organ (3)	4
		- Cutting of the penis foreskin (4)	5
		- Removal of male foreskin (5)	6
		- Removing of the foreskin from the manhood (3)	4
		- Its simply the cutting of the front skin of the penis	1
		- Cutting of the male genital foreskin	1
		- Removing the top part of the penis	1
		- No idea (2)	2
		- Cutting of the outer part of the penis	1

No.	Questions	Participants' responses	Percentage
2.	Which parts of Zambia is the practice of male circumcision common?	Northern (2)	2
		North western (47)	57
		Lusaka (5)	6
		Western (17)	21
		Eastern (6)	7
		Southern (3)	4
		Central (1)	1
		All provinces (2)	2
		Don't know (5)	6

No.	Questions	Participants' responses	Percentage
3.	Does your tribe conduct male circumcision as a cultural practice?	Yes (19)	23
		No (57)	70
		Not sure (2)	2
		No answer (4)	5

No.	Questions	Participants' responses	Percentage
4.	Are you yourself circumcised?	Yes (16) No (64) No answer (2)	20 78 2

No.	Questions	Participants' responses	Percentage
5.	If yes, at what age were you circumcised?	22 20 Infant (5) 24 (2) 23 26 13 Between 7 and 10 (4)	6 6 31 13 6 6 6 25

No.	Questions	Participants' responses	Percentage
6.	Where were you circumcised?	Health facility (Eg. Hospital/Clinic) (11) Traditional facility (Eg. Mukanda) (5)	69 31

No.	Questions	Participants' responses	Percentage
7.	Who conducted the circumcision operation on you?	Medical person (11) Traditional appointee (5)	69 31

No.	Questions	Participants' responses	Percentage
8.	Did you decide on your own to get circumcised?	Yes (6) No (10)	38 62

No.	Questions	Participants' responses	Percentage
9.	If YES, why did you decide to get circumcised? If NO, who decided that you get circumcised?	- YES: To protect myself from partial HIV/AIDS and STI infections (2) - For cleanliness (2) - Enhanced sexual performance and reduce risk of contracting STIs (2) - Personal interest - Women like circumcised men - NO: Parents (4) - Mother - Uncle - No answer	13 13 13 6 6 25 6 6 12

No.	Questions	Participants' responses	Percentage
10.	Did you inform any family members or friends about your decision?	Yes (5) No (4) No answer (8)	31 25 44

No.	Questions	Participants' responses	Percentage
11.	If yes, what was their reaction?	- Positive - Some were surprised and others liked the idea - They encouraged me - Most of them encouraged me - No response	20 20 20 20 20

No.	Questions	Participants' responses	Percentage
12.	If no, why not?	- There was no need to tell them - I was young (2) - Embarrassment	25 50 25

No.	Questions	Participants' responses	Percentage
13.	Was it a requirement of some sort for you to get circumcised?	Yes (7) No (8) No answer	44 50 6

No.	Questions	Participants' responses	Percentage
14.	Did you experience any problems after your circumcision?	Yes (0) No (16)	0 100

No.	Questions	Participants' responses	Percentage
15.	If you are circumcised, have you ever wished you had not been circumcised?	Yes (0) No (16)	0 100

No.	Questions	Participants' responses	Percentage
16.	If NO, why	- Because it was the right thing to do - It makes me proud because my family regards me as an adult, a responsible man - I am comfortably healthy - Because that is what I wanted to do and I decided to do it - I enjoy being like this - Its healthier - Because my tradition demands it and teaches me to be a grown man - Because I changed status from a child to a man - Because I am regarded as a fully grown man - I am comfortable with it - Because it is something I really wanted to do	6 6 6 6 6 6 6 6 6 6 6

		- No answer (5)	31

No.	Questions	Participants' responses	Percentage
17.	If you are not circumcised, have you ever contemplated getting circumcised?	Yes (29) No (34) No answer (3)	44 51 5

No.	Questions	Participants' responses	Percentage
18.	What decision did you arrive at after thinking about it?	- That it is a clean practice but I'll never go for it as long as I live - Its not worth the pain so decided not to - I missed my opportunity when I was young - Never took time to think about it (3) - HIV/AIDS prevention through circumcision is a myth - I saw no significant reason to do it - I will go for it later (3) - Its really not worth it at all, there hasn't been any apparent reason for me to do so (2) - Not yet decided/still thinking about it (3) - Not interested - To get circumcised (2) - Not to be circumcised (8) - Maybe one day (3) - That maybe I should do it - I can't handle the pain, bleeding and time to heal - Not to do it because when you're past the age of 12, the disadvantages outweigh the advantages - Its not necessary - I can't get circumcised (2) - I won't ever get circumcised - Never to get circumcised - I can never decide to be circumcised	3 3 3 10 3 3 10 7 10 3 7 28 10 3 3 3 3 7 3 3 3

No.	Questions	Participants' responses	Percentage
19.	Does your culture have any preconceived beliefs about MC?	Yes (12) No (58) Not sure (8) No answer (4)	14 71 10 5

No.	Questions	Participants' responses	Percentage
20.	If yes, what are they?	- To be a man you have to be circumcised (3) - It makes men to be too hot for sex and cannot be satisfied by one woman - It is immoral to be circumcised because it encourages men to go after many women - It is a foreign culture - Adds to sexual excitement	25 8 8 8 8

		- It shows bravery and also hardening of the head of the penis - Its good - They encourage it because it is good - That it is easy to satisfy a woman sexually if you are circumcised - No answer	8 8 8 8 8

No.	Questions	Participants' responses	Percentage
21.	If you come from a non-circumcising culture and decided to get circumcised, how would your family react?	- The reaction would be positive - They would accept it (5) - They would respect my decision as an adult individual (9) - They would understand I guess - I don't know (14) - They may oppose (2) - Fairly - Negatively (3) - It wouldn't be such a good idea since its kind of a taboo to talk about ones private parts - At my age they would have no say - Positive reaction as a health concern (2) - I wouldn't say so they wouldn't know (3) - They would not say anything - Its entirely up to me, they can't do anything (2) - I might be considered a rebel against my family norms - They would be for the idea - They would encourage me - I've never talked about it with them so I am not sure how they would react - Bad feelings - They would obviously want to know why I did it and what experience I've acquired - I would have difficulties - I don't think they would mind - They would be very surprised as most of them are ignorant about its importance - They would react badly - No contentions at all - No reaction	2 9 16 2 24 3 2 5 2 2 3 5 2 3 2 2 2 2 2 2 2 2 2 2 2

No.	Questions	Participants' responses	Percentage
22.	Do you know anyone who has been circumcised?	Yes (64) No (5) No answer (3)	78 18 4

No.	Questions	Participants' responses	Percentage
23.	Do you know any student at this	Yes (57)	70

	university who has been circumcised?	No (20) No answer (5)	24 6

No.	Questions	Participants' responses	Percentage
24.	Do you think that people who are circumcised are stigmatised?	Yes (6) No (75) No answer	7 92 1

No.	Questions	Participants' responses	Percentage
25.	Do you know of anyone who has been discriminated against or stigmatised because they are circumcised?	Yes (3) No (78) No answer	4 95 1

No.	Questions	Participants' responses
26.	Who was the perpetrator of the discrimination/stigmatisation?	- A fellow students - His friends (3) - 'enemies' from non-circumcising cultures

No.	Questions	Participants' responses	Percentage
27.	What do you personally think about the practice of male circumcision?	- Its as good as condomizing but more demanding - Its ok though I wouldn't take it as a protective measure - It's a right decision one can ever make - It should be promoted - I am neutral about it - Prevents STIs but the percentage is very small - The practice is okey even though some people misuse it by thinking that they can't be infected with HIV/AIDS - It's a very good practice since it reduces HIV and other STIs (7) - It is hygienic - It's a good decision (2) - Its not really necessary - It is a good healthy practice (4) - I think it is ok (7) - It gives wrong signals to males - Its all up to an individual - I think it I ok and should be a personal decision - No real benefit - Its bad (2) - It protects you from acquiring HIV/AIDS because the target cells under the foreskin get removed and these are the cells that attract HIV which easily identifies openings - I've never really thought about it - It is very misleading as people think they become	2 2 2 2 2 2 2 17 2 5 2 10 17 2 2 2 2 5 2 2

		immune once circumcised	2
		- It is a good practice when done with good intentions	2
		- In as far as HIV/AIDS prevention is concerned, if it really does decrease chances of being infected then its good, but I think it encourages live sex	2
		- It has to be a personal decision and should not be preached as a form of prevention	2
		- Its fine. You satisfy a woman and on top of that you prevent yourself from diseases	2
		- Some of its benefits can be obtained by self control and discipline so one can be ok even without it	2
		- There's nothing wrong with it	2
		- It still relies on other prevention methods	2

No.	Questions	Participants' responses	Percentages
28.	What do you think are the factors that encourage men to go for circumcision even when they are from non-circumcising cultures?	- They think it will reduce their chances of contracting HIV and STIs (42)	100
		- Health precautions	2
		- They believe it will increase their sexual performance (5)	12
		- Cleanliness/hygiene (7)	17
		- To be sex machines, to last longer in bed (7)	17
		- Satisfying their women by not reaching orgasm fast (5)	12
		- Prolonged orgasm	2
		- Its healthy to enjoy sex (2)	5
		- To increase sexual pleasure	2
		- To enjoy sex	2
		- It makes one have a prolonged erection although you do not get it easily	2
		- Acquired knowledge about it	2

No.	Questions	Participants' responses	Percentage
29.	Why do you think some men avoid going for male circumcision?	Fear of pain (53)	65
		Cost (5)	6
		Lack of knowledge (31)	38
		Don't know where to get it (15)	18
		Culture doesn't allow (22)	27
		Religion doesn't allow (17)	21
		Fear of stigmatisation by family and friends (9)	11
		Not just interested (5)	6
		The risk involved when healing	1
		Principle differences (3)	4
		Not convinced of any benefits	1
		They think they may not enjoy sex	1
		Fear that it cannot be reversed if anything goes wrong (3)	4
		It is not necessary (2)	2
		Fear of loss of blood	1
		Fear of complications after MC	1

HIV/AIDS Prevention and Male Circumcision

No.	Questions	Participants' responses	Percentage
30.	Do you know your HIV status?	Yes (42) No (37) No answer (3)	51 45 4

No.	Questions	Participants' responses	Percentage
31.	Do you have a girl friend (as in a sexual partner)?	Yes (39) No (39) No answer (4)	47 47 6

No.	Questions	Participants' responses	Percentage
32.	What kind of girl friend do you have?	Fellow student (18) UNZA non-academic staff Outsider(landlord) (19) (Wife (4), School girl/student elsewhere (2), Foreigner, Prostitutes sometimes (8), Fiancé	46 3 51

No.	Questions	Participants' responses	Percentage
33.	Have you ever had sexual intercourse?	Yes (50) No (26) No answer (6)	61 32 7

No.	Questions	Participants' responses	Percentage
34.	At what age did you first have sexual intercourse?	16 (6) 18 (7) 20 (6) 12 (2) 19 (3) 9 (4) 15 (5) 21 (3) 11 6 8 17 14 23 (2) 13 Have forgotten (6)	12 14 12 4 6 8 10 6 2 2 2 2 2 4 2 12

No.	Questions	Participants' responses	Percentage

35.	How often do you have sexual intercourse?	Often (Once a week to everyday of the week) (6) Not so often (Once in two, three or four weeks) (11) Sometimes (Once in months) (7) Rarely (Once or twice in years) (20) Never/Have stopped (6)	12 22 14 40 12

No.	Questions	Participants' responses	Percentage
36.	When you have sexual intercourse, do you use condoms?	Never (4) Often (5) Occasionally (12) Always (23) No answer (6)	8 10 24 46 12

No.	Questions	Participants' responses	Percentage
37.	Did you use a condom during your last sexual intercourse?	Yes (29) No (18) No answer (3)	58 36 6

No.	Questions	Participants' responses	Percentage
38.	Do you know that male circumcision could be used as a complimentary method of HIV/AIDS prevention?	Yes (50) No (23) No answer (9)	61 28 11

No.	Questions	Participants' responses	Percentage
39.	If yes, how did you first learn about the use of male circumcision for HIV/AIDS prevention?	- At secondary school (3) - From medical doctors (3) - Television discussion (6) - Posters, clinic brochures, billboards (39 - Through the media (5) - Through clubs, seminars (2) - Reading (6) - UNZA radio - It has been well advertised - Educators - Magazines (3 - Newspapers - Literature (2) - Journals (4) - Friends (6) - Radio (7) - Because I was circumcised when I was young - AIDS talks - From Dr. Manasseh Phiri's column in the Post newspapers - Clinic posters (2) - On ZNBC 'your health matters' programme	4 4 7 48 6 2 7 1 1 1 4 1 2 5 7 9 1 1 1 2 1

		- Workshop at Society for Family Health (3) - Peer educators - ZANAMAWE at UNZA - When I went for VCT I asked the counsellor	4 1 1 1

No.	Questions	Participants' responses	Percentage
40.	Do you think male circumcision can be used as an effective method of HIV/AIDS prevention?	Yes (26) No (47) Not sure (9)	32 57 11

No.	Questions	Participants' responses
41.	If you think not, why?	- Circumcision has nothing to do with the virus and fluid transfer - Because it doesn't add any extra protection to the penis - It has some loop holes that put people at risk - All circumcision does is remove the foreskin, I don't believe it creates a protective shield - Abstinence is the only most effective way because even if circumcised, men will have live sex and put themselves at risk (2) - Because there is no 100% guarantee of protection (4) - I am more convinced that abstinence is most ethical and genuine method - It is not 100% blood free contact - People may be going for MC even if they are already infected, deceiving the subsequent partners - MC cannot prevent sexual intercourse which has a higher HIV infection risk. - It is not 100% effective (5) - The percentage is very minimal - The only way to protect yourself from getting infected is to use a condom (2) - It can't be effective, HIV/AIDS infection is by chance - HIV is a stubborn virus - Because even in Uganda where most men are circumcised HIV/AIDS is prevalent - Because the virus is so tiny it can pass through whether there is skin or not - A high risk factor still remains - Because either circumcised or not one can still get AIDS - It will encourage sex - Scientifically not preferable - The mechanism of HIV transmission is not through the foreskin - It has demerits that do not make it perfect - Because it misleads people as they start to think that they are 100% protected even without using condoms - When having sex and you are circumcised, you can still get minor cuts and sores that can be entry points for the virus (2) - It has not been proven that it prevents HIV/AIDS - There are better methods - Not effective - Just like a condom is not 100% safe so it MC

		- It is still risky because it is only about 60% safe - Even after MC you're still at risk so doesn't make much difference - Leads to increase in immorality hence more STIs and HIV

No.	Questions	Participants' responses	Percentage
42.	Have you ever discussed condoms with a sexual partner?	Yes (42) No (14)	75 25

No.	Questions	Participants' responses	Percentage
43.	Have you ever discussed male circumcision with a sexual partner?	Yes (13) No (48) No answer (21)	16 58 26

No.	Questions	Participants' responses
44.	If yes, what did you conclude with your sexual partner about male circumcision?	- That it's a very good practice - It is vital for every male to be circumcised - That it is ok (2) - She thinks I should do it - Its better to do safe sex using condoms - Its too late to undergo it now at 35 - That I should go for MC - Still talking about it - We won't do it - Since we don't have sex yet we agreed that I can always do it later in future - She agreed that I should go for it - Not to do it

No.	Questions	Participants' responses	Percentage
45.	How are you currently preventing yourself from getting HIV/AIDS?	Abstaining (47) Always use condoms (18) Sticking to one sexual partner (13) Not doing anything (2) Got circumcised Won't do sex again Masturbating	57 22 16 2 1 1 1

Male Circumcision Promotion

No.	Questions	Participants' responses	Percentage
46.	Do you think male circumcision should be promoted as a complimentary method of HIV/AIDS prevention?	Yes (42) No (34) No answer (6)	51 42 7

No.	Questions	Participants' responses
47.	If no, why not?	- There are better methods - Abstinence and self discipline are the ones that should be encouraged - There will be a lot of infections because people will take it for granted that they can no longer get infected when circumcised (6%) - People will take it for granted and have unprotected sex most of the time - Whether you do MC or not you're still at risk (6%) - Because it is still highly possible for one to contract a disease even after circumcision - Because it is not 100% effective/safe, hence it would encourage further spreading of HIV (15%) - It cannot be used to prevent the HIV virus - I am not yet convinced that it is preventive - Because I doubt that it works - Cannot be used to prevent HIV - The percentage is minimal - Because it cannot help in preventing HIV infection - Because you are still at risk of getting HIV if you don't use a condom - Because it does not prevent the transmission of HIV/AIDS - Because many people will take it as a gospel truth and thereby sleep around carelessly without condoms - Because circumcised people will be going for sex hence getting infected - It will increase sex - Just getting a lot of people into trouble with HIV/AIDS - Its not necessary - It has not been proven 100% effective scientifically but just with assumptions - It encourages sexual immorality (6%) - Not effective - It would be misinforming people - People end up having wrong perspectives and become immoral

No.	Questions	Participants' responses
48.	If yes, how do you think it should be promoted so that even men who come from non-circumcising cultures could accept it?	- It should be done in such a way that people see real benefits and not in a way that will promote immoral behaviour among men - It should be done for free in all health centres - Encouraging men for it is beneficial in terms of HIV prevention and hygiene - By doing it in hospitals and clinics by qualified staff - By sensitizing people of its importance (12%) - By educating a lot of people about the benefits of MC (14%) - Should be promoted as a complimentary to condoms and not as a substitute - Sensitizing e.g. workshops, handouts, advertisements (7%) - The way condoms have been promoted (5%) - Give knowledge to the non-circumcising cultures on the advantages of MC - Increase on awareness (5%) - Through education and transfer of information

		- Talk to people - Send out persuasive information - Put out the advantages of the practice in all education and health institutions - Encourage and advise about HIV/AIDS - Fully detailed booklets, radio and television programmes, newspaper columns - It should be promoted among married people and those who are not married should be asked to do it for cleanliness so that people do not misuse the practice - Hold more workshops and campaigns about it by different organisations (5%) - Include a number of programmes on the media (7%) - Include it in school syllabuses from lower levels until university (5%) - Coming up with programmes on television and radio that focus on the merits of MC in local languages - Do tests and prove that even after having sex with infected people, men won't get infected - Launching campaigns in schools, colleges and universities

No.	Questions	Participants' responses	Percentage
49.	Do you know of any institutions offering male circumcision services?	Yes (63) No (14) No answer (5)	77 17 6

No.	Questions	Participants' responses	Percentage
50.	If yes, which ones are they?	YWCA (3) UNZA clinic (43) UTH (22) SFH (2) Mukanda cultural institution New start counselling centre (4) Hospitals and clinics (both government and private) (9) Kara Counselling	5 68 35 3 2 6 14 2

No.	Questions	Participants' responses	Percentage
51.	Do you know of any programmes or institutions that are/have promoted male circumcision?	Yes (47) No (30) No answer (5)	57 37 6

No.	Questions	Participants' responses	Percentage
52.	If yes, which ones?	YWCA (2) Zambia Interfaith Network on HIV/AIDS (ZINGO) UTH (2) SFH (via workshops and currently targeting academic	4 2 4

		institutions) (5) UNZA clinic and Response project (15) Mukanda cultural institution (2) Clinics (3) Campus Web (2) Ministry of Health and health institutions (3) Student research programme at ridgeway campus ZANAMAWE (5) Shares (2) New Start Centre (2) Student groups USAID	11 32 4 6 4 6 2 11 4 4 2 2

No.	Questions	Participants' responses	Percentage
53.	How are/were they promoting male circumcision?	Publications (Print) (40) Radio/Television (18) Public announcements (8) Workshops (12) Adverts, Meetings, Clinic posters (3) Interpersonal announcements	85 38 17 25 2 2 6 2

No.	Questions	Participants' responses	Percentage
54.	What incentives were they offering to encourage men to go for male circumcision?	Free circumcision (44) Reduced fee (5) Free aftercare (5) Free treatment in case of complication (10)	94 11 11 21

No.	Questions	Participants' responses	Percentage
55.	Do you know how much it costs financially to get circumcised? If yes, how much is it?	Yes (11) No (64) No answer (7) K10,000 K20,000 (2) K35,000 K30,000 K200,000 Doesn't cost anything Free for UNZA students	13 78 9

Focus group discussions

The following summarises the responses of the participants during the focus group discussions.

Social and Cultural Factors

Facilitator: What is male circumcision?

Group 1

B: Male circumcision is the cutting of the front part of the penis.
G: I think it is the cutting of the foreskin of the penis.
A: Yes, it is an operation carried out to cut the foreskin of the male reproductive organ, and it is done for some reasons, either health, cultural or religious.

Facilitator: Does everyone agree with what has been said so far as to what male circumcision is?

E: Yes, so we can simply say that male circumcision is the removal of the foreskin on the male penis for whatever reason.

Group 2

C: Circumcision is the cutting of the penis foreskin
J: Cutting of the tip skin of the penis for bravery test and health.

Group 3

D: Removal of male foreskin
G: Removing of the foreskin from the manhood
E: It is the removal of the foreskin from the male sexual organ using sharp instruments
B: The cutting of the foreskin of the penis

Group 4

G: It's simply the cutting of the front skin of the penis
J: Cutting of the male genital foreskin
A: The cutting of the foreskin of the penis
I: It's the removal of the foreskin on the male penis

Facilitator: Do your tribes have any preconceived beliefs about circumcision? Like things that people in your culture generally say and believe about MC.

Group 1

A: Yes, in my tribe they say for one to be a man, you have to be circumcised.

G: What do you mean to be a man? So us who are not circumcised are not men?
C: No, let me come in there. Its not to say those who don't circumcise are not men. But this is our culture and in our culture also as Chewas, you have to be circumcised to be a real man and clean also.
A: You know when boys are taken to mukanda, its not just to be circumcised. There are a lot of things that happen there, all aimed at teaching the boys real life things to help them be able to rejoin their families and communities as responsible men.
C: Its like an initiation. Most of the tribes in Zambia, even the one you come from G, conduct initiations for girls to prepare them to be responsible women. But does it mean tribes that do not initiate their girls don't have women? No. Its the same with us, its just that we also conduct initiation for the boys to prepare them to be responsible men too.
E: You know to be honest, among most of us who come from tribes that do not circumcise, we think that circumcision is just done to make the men too hot for sex and they cannot be satisfied by one woman.
G: I agree, so its like just for creating an excuse for the men to have many women. Actually some people think it is immoral.
A: We are a circumcising tribe but we do not have polygamy. E you said you are Tonga and Tongas are known to be a polygamous tribe. Just as circumcision is our culture, polygamy is also your culture. So where can that talk about morals actually be best applied?
E: Its not all Tongas who have polygamy, and I didn't talk about morals.
A: Yes, but am just trying to make a point here so that people can start having open minds about other people's cultures and stop judging before they get any knowledge about them.

Facilitator: Thank you A, and I think we've gotten your point quite clearly. So does anyone else's tribe have any other beliefs about male circumcision, apart from what has been said already? Nothing, ok, we continue.

Group 2

F: In my tribe they say to be a fully grown man, you have to be initiated and circumcision is the climax of that initiation.
J: It is the same in our tribe also. It shows that now you're a man ready to take on manly responsibilities of all kinds.

Facilitator: Thank you: How about the others.

A: I don't really know if there's anything that is said about circumcision since we do not do it.
B: In my culture they say that it is immoral to be circumcised because it encourages men to go after many women.

Facilitator: Really? Why is there such a perception about circumcison in your culture?

B: I don't know. Its just what people say. And I think its not just people from my tribe who say that.
E: I think it is a foreign culture to many people in Zambia, maybe that's why people say such things about it.

Facilitator: What do you mean when you say 'foreign?' We have Zambian tribes that do it culturally.

E: I think it is very few tribes that do it in Zambia, so it is kind of foreign to other tribes that don't.

Group 3

J: Since in our tribe we don't do it, I don't think there's much that people think or say about it. I don't know.
G: Yes, I don't think there is much also.
A: I think some people say it adds to sexual excitement. I don't know how true that is.
I: In my tribe they say it shows bravery and also hardening of the head of the penis is good for sexual power.
F: I don't know if my tribe has a specific belief about circumcision, but i've heard some things about it just from friends and media and through reading.
H: I had something similar on my mind also. I am not sure if what we say or know about circumcision now is from our culture because we do not do it, so people say very little if anything about it. I think what we say comes from what we here around us from friends and the media.
C: It seems many students are town mice so they don't know much about their cultures.
B: Yes, but circumcision is not even part of our culture, so why force ourselves to learn about other people's cultural values when we even have little knowledge of some of our own?
I: But I think all hope is not lost, because there's a lot of information out there about circumcision, and we have learnt a lot of facts about it even if they were not learnt from our parents or elders.

Group 4

J: Us Lundas say one has to be circumcised to be considered a fully grown man.
G: Its the same with us also, its good.
K: I don't know if there's anything that people say.
A: Most people say its a way to make yourself last longer in bed and therefore be able to satisfy your partner.

Facilitator: For those of you who come from non-circumcising cultures, how would your families react if you decided to get circumcised?

Group 1

B: The reaction would be positive I think.
D: They would accept it I suppose because it would be my decision.
J: They would respect my decision as an adult individual.
I: They would understand I guess.
E: I am not sure really.
H: I think it would be ok, though some people would probably ask why i've done it, but it's ultimately my decision.
G: Yes as an adult now, there would be few questions asked. But maybe it would be very different if someone said they wanted to have their child circumcised. I am sure many people would say that why subject a child to such unnecessary pain, and maybe that when they grow up, they'd want their foreskin back. You know we can laugh about it but who knows, maybe when the child grows they'll say they don't like being circumcised. And you'll live knowing that you did something to your child that makes them unhappy, and it is irreversible.

Group 2

A: Hmm! I don’t know.

E: I think they may oppose.
I: I think fairly, because it would be my decision.
D: I think they would react negatively.
B: It wouldn't be such a good idea since its kind of a taboo to talk about ones private parts.

Group 3

A: At my age they would have no say
I: I think there would be a positive reaction as a health concern
F: I wouldn't say so they wouldn't know
J: They would not say anything
E: It's entirely up to me, they can't do anything

Group 4

A. It would be considered as going against my family values or tradition, so I think they may not be very happy.
C: They would be for the idea
F: I think they would encourage me
H: They would react badly
I: I am not sure how they would react since it's not part of my culture
K: As an adult, I think they wouldn't have much to say.

Facilitator: I heard that there is a circumcision project going on at the UNZA clinic. Is everyone aware about it? Ok, everyone says yes. So do you know any students who have been circumcised? How many?

Group 1

A: I know of 2.
C: I have a friend who went there.
J: I know one.
H: I have three friends who registered at the clinic, and I think they actually went through with everything.
F: I haven't heard of anyone.
D: Yes, one guy.
I: I don't know anyone
B: I know three people.
E: I haven't heard of anyone
G: I don't know anyone who has been there.

Group 2

F: I know four people who have been circumcised.
A: I know one coursemate.
B: I haven't heard of anyone.
C: I have two friends

D: I also know two.
E: I think I just know one.
G: One also
H: I know of three.
I: I don't know anyone who has been circumcised.
J: I only know one guy.

Group 3

J: I don't know of any
I: I know quite a number who have been part of the project, including myself.
H: I know one.
G: Two friends
F: Two also.
E: I know three.
D: I know some people who are circumcised but not through the project, from somewhere else
C: I have one friend.
B: I don't know anyone.
A: One

Group 4

A: I haven't heard of anyone who has been circumcised at the clinic
B: I know two people
C: I know eight, plus myself making it nine
D: I think about three
E: Two
F: I know four
G: I have heard of about three
H: I don't know anyone
I: I think I know about five
J: About six
K: I have heard about the project but I don't know anyone who has been there.

Facilitator: Do you think people who are circumcised are stigmatised?

Group 1 and Group 2

(Everyone said no to this question)

Group 3

I: No, I don't think so.
F: I actually think yes, or maybe some, because I know someone who was kind of stigmatised by his friends after he got circumcised.

Facilitator: Was that here at UNZA? What were the friends saying?

F: Yes it was here after one guy got circumcised at the project. Some friends were teasing him that he had decided to become a Luvale and the next thing would be him wearing a likishi, ha ha! The same friends even started calling him kalubale or likishi.

Facilitator: How did that student react to that?

F: At first he was easy with it I think but got upset when they started giving him the nicknames and told them to stop.

Facilitator: Did they stop?

F: Yes they did. But I think it goes to show just what some people think about circumcision, even if they may not say it out anyhow.

Facilitator: That is interesting. What do the others think about that story. Have you also come across something similar?

B: Somehow I think its true. You know people don't say much about circumcision because it's about the manhood, and people generally do not like to talk about things that make them uncomfortable, especially about their manhood. So some people may even say bad things about circumcision because it is an uncomfortable topic to them.

Group 4

K: No I don't think so.

G: I think some people do

Facilitator: Why do you say that?

G: You know some people just have this bad attitude towards circumcision which makes them look down on people from northwestern especially.

Facilitator: What do you think is the reason why some people have that bad attitude that you're talking about? Anyone can talk if you also think the same.

G: I think there could be a number of reasons, but one I can think of right now is that it is probably cultural differences. Especially with tribes that may have had tribal wars with people who circumcise in the olden days. So its like circumcision has come to be associated with their 'tribal enemies'.
I: I think tribal cousinship is there yes these days but not in the negative sense like you're saying it.
G: I think now people are trying to make it a thing to joke about but deep down am sure there are some who still feel that MC is for 'those' and not us.

Facilitator: What do the others think?

B: I know someone who was sort of teased by his friends after being circumcised, but they were not like tribal cousins. So I think if stigmatisation happens, it's just with some people's individual attitude but not because culturally they are supposed to look down upon people who are circumcised.

Facilitator: You said someone was being teased by friends for being circumcised, so what were they actually saying, and how did the person react?

B: You know guys, just kind of saying now he had sharpened himself to blast more chicks and the like. It was just something that they were laughing about and the guy didn't take any offense.

Facilitator: What do you personally think about the practice of male circumcision, especially in relation to HIV/AIDS prevention?

Group 1

B: I think it's a good practice that should be encouraged but done clinically.
J: It's an ok practice but not entirely necessary.
G: I think it's not ok because you're still at risk of catching HIV even after being circumcised.
C: It's a very good practice since it reduces HIV and other STIs.
E: For me I think there is no point of practising it since both those who have been circumcised and those not still get HIV.
A: It is part of who I am, it is a way of upholding my cultural values.
D: It is a good healthy practice despite the side effects it may have.
I: I think the main issue about it is that it promotes hygiene, which makes it advantageous in terms of prevention of diseases, which includes HIV. That for me is what makes it to be a good practice.

Group 2

A: I think it's beneficial when performed properly
D: It is good but in some cases it has led many males to go after ladies taking the advantage of being circumcised
I: To them that are willing and are doing it for the purpose of cleanliness its ok, otherwise not
F: It's a good decision
B: Culturally it is immoral and on top of that painful
Facilitator: Could I just say that let us be cautious with the way we describe it, as you know it is a cultural practice for some tribes in Zambia, and it is very important for people who do it.
F: Depends on the person and their family beliefs. For me, it's a very good practice and it is vital for every male to be circumcised
H: I think people are taking it for granted on the pretext that it can help them avoid contracting HIV
J: Although not yet circumcised, it is hygienic, not only this but also in the prevention of STIs

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Group 3

A: When practiced in cultural boundaries it is ok
H: Its not really necessary
C: It is a good healthy practice, my girlfriend actually thinks I should do it.
G: It is better at a tender age
B: I think it is ok
I: Its great
E: Its fair, a game of chance
D: Its all up to an individual

Group 4

J: I think it is a good thing and men should consider doing it for the sake of good health
A: Its been misused and misinterpreted. People who encourage others to be circumcised don't even have the statistics concerning the perceived advantages
K: Its some kind of fun game to be practised by ignorant people or those who don't have anything to do
B: Its cool
G: Its good and important
D: I think there's no real benefit. I come from a circumcising tribe but I opted out.
F: I have no problem with it, anyone who feels like getting circumcised can go on
H: Its better to do safe sex using condoms

Facilitator: What do you think are the factors that encourage men to go for male circumcision even when they are from non-circumcising cultures?

Group 1

I: The need of protecting themselves.
J: They think it will reduce their chances of contracting HIV and STIs.
E: They believe it will increase their sexual performance.
B: They want cleanliness and hygiene.
G: They think they will be able to satisfy their women by not reaching orgasm fast.

Group 2

J: Traditional beliefs
A: For cleanliness and hygiene
H: It is something lots of males are doing these days hence influencing participation
C: Encouragement from partners and friends
E: Depends on the intentions; others for protection while others so that they can be sleeping with many ladies
B: To be sex machines, to last longer in bed

Group 3

C: Pressure from partners, like in my case, ha ha!
G: They desire to have prolonged orgasm
I: Protection from diseases
D: Hygiene
B: Increase the size of the penis
J: Its healthy to enjoy sex
E: Mainly most of them are going for it in order that they may be satisfying the sexual partner

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Group 4

K: Ignorance and imitating other people
C: For HIV/AIDS protection and enhanced hygiene
A: To increase sexual pleasure
H: They want to practice sexual intercourse before marriage
I: To be able to have live sex

Facilitator: And why do you think some men avoid going for male circumcision, even after hearing about its advantages?

Group 1

D: Many people fear the pain.
H: The cost.
A: I think there is still lack of knowledge and understanding about the full benefits of circumcision out there.
C: I agree, some people once they hear circumcision, their minds jump to the incorrect information and prejudices they have such that they do not pay attention to facts being presented to them. As a result, they end up learning very little about it even if information is being made available.
F: Others don't know where to get it.
J: For some, their culture doesn't allow
B: Religion doesn't allow in some cases
I: I think some people fear to be stigmatised by family and friends.

Facilitator: Oh! But you all said you thought people who are circumcised are not stigmatised earlier. You have some different thoughts now?

I: Yes. I think from the way this discussion has gone, we may have some stigmatisation that we don't want to acknowledge. I have come to realise that actually we take for granted what we think and say about circumcision, and other peoples' cultures sometimes, not realising that we are creating a negative impact or attitude towards it. I'll give an exapmle of what has been said about circumcision here today, that it promotes immorality among circumcised men. No one actually has evidence to prove that this is true, but just because we heard it from someone out there we also go on and say that is the truth we know about circumcision. We're making this myth into a truth it is not. It is wrong.

Facilitator: Thank you I for that thoughtful insight. Would anyone else like to say something about stigmatisation of circumcision? Or why some men avoid it?

E: Fear of the risks involved when healing,
G: They think they may not enjoy sex after being tampered with.

Group 2

G: Not just interested
E: Not convinced of the benefits
H: Fear of loss of blood

Group 3

H: Principle differences
I: It is not necessary
J: Fear of complications after MC

Group 4

F: Not just interested
G: Fear that it cannot be reversed if anything goes wrong

HIV/AIDS Prevention and Male Circumcision

Facilitator: How did you first learn about the use of male circumcision for HIV/AIDS prevention?

Group 1

I: At secondary school
D: From a brochure from the local clinic
J: From medical doctors
B: Television discussion
H: Posters, billboards
A: From home when I was a child about to be circumcised, because we were told circumcision keeps you clean and you don't get diseases.

Group 2

A: Through the media
B: Health posters at the clinic
C: Through clubs,
H: Seminars
D: Reading
E: UNZA radio
G: Educators

Group 3

E: Magazines, newspapers, literature, journals
A: Friends
I: From the clinic
G: Radio and television
D: At home because I was circumcised when I was young

Group 4

H: AIDS talks at secondary school
F: From friends

E: Radio and TV programmes
I: From Dr. Manasseh Phiri's column in the Post newspapers
C: Clinic posters
K: Workshop at Society for Family Health

Facilitator: Do you think that male circumcision can be used as an effective method of HIV/AIDS prevention?

Group 1

A: Yes, as long as people don't misinterpret circumcision as a passport to having sex everywhere, it can be effective.
C: I also think so, there's even a story I read about HIV/AIDS and the prevalence rates in different countries. It was said that in countries where they had most people circumcised, the prevalence rates were low compared to countries where circumcision was low like here in Zambia.
I: I also think it can be effective, just like any other method that is being promoted as long as people do not abuse it.
E: I don't think it can be effective because I think it doesn't add any extra protection to the penis.
G: I agree to that. I also think that all circumcision does is remove the foreskin, I don't believe it creates a protective shield.
J: It has some loop holes that put people at risk
F: Abstinence is the only most effective way because even if circumcised, men will have live sex and put themselves at risk
H: I don't think it can be effective because there is no 100% guarantee of protection

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Group 2

I: I am not really sure, there's still a lot of talk going on about it.
F: I think it can.
J: I think so too.
C: I kind of think so too because since there is no cure for HIV yet, all possibilities must be utilized to minimize effects of AIDS.
A: I am more convinced that abstinence is the most ethical and genuine method
H: I don't think it is very effective because it is not 100% blood free contact
B: People may be going for circumcision even if they are already infected, deceiving the subsequent partners
D: Circumcision cannot prevent sexual intercourse which has a higher HIV infection risk.
E: It is not 100% effective

Group 3

I: Yes, I think it can be effective, though not on it's own. Even at the clinic they told us that we still have to use it in combination with other methods like condoms for increased protection.
A: The percentage of its effectiveness is very minimal, so I doubt it.
J: The only way to protect yourself from getting infected is to use a condom
E: It can't be effective; HIV/AIDS infection is by chance
H: HIV is a stubborn virus
F: Because even in Uganda where most men are circumcised HIV/AIDS is prevalent

D: I think it can be effective if we really get the true concept behind circumcision. Just like condoms are not 100% safe, so is circumcision. So I think it's up to one to decide to use a combination of methods or just one method.
B: I agree with that. We all know that abstinence is the only sure way of avoiding HIV through sex. So if we're sexually active, whether we use male condoms, or female condoms, or get circumcised, we are at risk. So it's up to one to decide to increase their protection by using one method of the other or a combination of several. And that also means we cannot condemn one method just because we wouldn't use it. Otherwise, we might as well not do nothing to protect ourselves because even condoms are not 100% safe.

Group 4

J: Yes, especially in the cultural context because we are taught about responsibility that comes with being a man after circumcision and that includes sexual responsibility.
F: I don't think it can work because the virus is so tiny it can pass through whether there is skin or not
K: I think whether circumcised or not, a high risk factor still remains as long as one is sexually active
C: I think it can work if people don't abuse it. They advise that even after circumcision, its better to use condoms.
A: So what's the point of getting circumcised because whether circumcised or not one can still get AIDS
E: I think it would just encourage sex
F: I think even scientifically it is not preferable
H: When having sex and you are circumcised, you can still get minor cuts and sores that can be entry points for the virus

Male Circumcision Promotion

Facilitator: So with what has been said, do you think male circumcision should be promoted as a complimentary method of HIV/AIDS prevention? If not, why do you think so and if yes, how do you think it should be promoted so that even men who come from non-circumcising cultures could accept it?

Group 1

C: Yes it should be promoted by educating a lot of people about the benefits.
I: I also think it should be promoted but as a complimentary to condoms and not as a substitute.
A: The key is to sensitize people of its importance and I think with time, many people would go for it.
B: Yes it should be promoted and people will make their decision. People should also be told that it is available in hospitals and clinics and being done by qualified staff.
F: I say no because I think abstinence and self discipline are the ones that should be encouraged
G: There will be a lot of infections because people will take it for granted that they can no longer get infected when circumcised
E: Whether you do it or not you're still at risk, so what's the point?
D: I think not because it is still highly possible for one to contract a disease even after circumcision.

Group 2

D: At the moment, I think it should not be promoted because it has not been proved beyond doubt that it can be used to prevent the HIV virus
C: I think with what is being said about it now, people can start promoting it because HIV is not waiting for anything. So people should also be working to protect themselves whichever way they can. So if circumcision has some benefits, then I see no reason why people cannot start using it.
E: I am not yet convinced that it is preventive
B: I also have some doubts that it works
F: I think it should be promoted the way condoms have been promoted, through sensitizing e.g. workshops, handouts, advertisements
G: I think circumcision cannot be used to prevent HIV
A: The percentage value of its protection is minimal so people should be very careful when thinking about promoting it.
J: I think it should be promoted by giving knowledge to the non-circumcising cultures on its advantages
I: I agree, so education and transfer of information is very important if circumcision is going to be promoted effectively.

Group 3

A. I think it should not be promoted because it cannot help much in preventing HIV infection
B: I think it should be promoted by talking to people about it
C: It shouldn't be promoted because you are still at risk of getting HIV if you don't use a condom
D. I think it is important that people are given information that they need to help them decide how to protect themselves against HIV, so persuasive information promoting circumcision should be sent out through the media and other means.
E: I am not convinced yet that it does prevent the transmission of HIV/AIDS, so it should not be promoted meanwhile until all doubts are dispelled.
F: It should not be promoted because many people will take it as a gospel truth and thereby sleep around carelessly without condoms
G: It should not be promoted because circumcised people will be going for live sex hence getting infected
H: I think it should be promoted by put out the advantages of the practice in all education and health institutions
I: Circumcision should be promoted as a choice or an option for HIV prevention. I think this can be done just the way condoms have been promoted.
J: I think it will be more convincing if tests are also done in Zambia and prove that even after having sex with infected people, men won't get infected

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Group 4

E: As I said earlier, I think it will increase illicit sex if circumcision is promoted
F: It should not be promoted because it would just be getting a lot of people into trouble with HIV/AIDS
G: I think it should be promoted by including a number of programmes on the media and in school syllabuses from lower levels until university
I: It has not been proven 100% effective scientifically but just with assumptions
J: It should be promoted by coming up with programmes on television and radio that focus on the benefits of circumcision in local languages
A: I think it should not be promoted because it just encourages sexual immorality
B: I think circumcision does not stop one from being at risk if they are sexually active, so it should not be promoted
D: I think it's ok in the face of HIV so it can be encouraged

C: I think it should be promoted by making fully detailed booklets to distribute, radio and television programmes, newspaper columns and the like.
H: I think it can be promoted by hold more workshops and campaigns about it by different organisations to increase people's choice, but it must be emphasized that it doesn't work alone.

Appendix C: Budget and Research Duration:

The total budget is projected at K9, 863, 000 as elaborated in the table below. Using the number of days calculated in the budget, the research process is expected to be implemented in 27 working days. However, the entire project is expected to be completed in four months, due to an allowance of 3 months provided for review sessions with the supervisors and examiners.

BUDGET FOR MPH RESEARCH

Item	***Unit***	***Quantity***	***Unit Cost***	***Total ZMK***
Tape recorder	Quantity	1	800,000.00	800,000.00
Stationery	Lump sum	1	1,000,000.00	1,000,000.00
Production of questionnaires	Participants	82	1,500.00	123,000.00
Data collection (Payment for research assistant)	Days	10	50,000.00	500,000.00
Data analysis (Payment for research assistant)	Days	10	50,000.00	500,000.00
Transport for researchers	Days	10	75,000.00	750,000.00
Lunch allowance for researchers	Days	20	50,000.00	1,000,000.00
Report writing & production (Draft)	Days	5	150,000.00	750,000.00
Final report writing and production	Lump sum	2	500,000.00	1,000,000.00
Allowance for participants	Quantity	122	20,000.00	2,440,000.00
Contingency	Lump sum	1	1,000,000.00	1,000,000.00
Total in ZMK				**9,863,000.00**