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AN ASSOCIATION OF LGBTI PEOPLE IN ZIMBABWE

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Lessons Learned

Lessons learnt amongst MSM in the uptake of Male Circumcision (Zimbabwe)

EXECUTIVE SUMMARY

This report is a summary of the data collected in Harare to assess the uptake and acceptability of Male Circumcision (MC) among men who have sex with other men (MSM). GALZ with the assistance of COC Netherlands embarked on a project since 2012 with the main objective of increasing the uptake of male circumcision amongst MSM as an HIV prevention mechanism as well as to increase the uptake of VCT among the MSM community. The project also targeted health care workers and AIDS service organizations to promote MC among their MSM clients/ patients. This project was to compliment the Government Project/efforts in which MC is being advocated as an HIV prevention tool. Although there is no locally conducted research on male circumcision amongst MSM community, the available research conducted on the general male population (who are predominantly heterosexual) estimates that male circumcision reduces the chances of HIV transmission by at least 60%. Research conducted by MSMGF reveals that male circumcision mainly benefits insertive/top partners in MSM relationships.

The same review estimated that MSM who are primarily insertive ("top") during anal sex significantly benefited from circumcision. Those who were circumcised had 73% reduced odds of HIV infection, compared to other primarily insertive MSM who were uncircumcised. Some researchers believe that MSM who are primarily insertive may benefit from the same biological factors that account for the protective effects of circumcision among heterosexual men. The project also promoted male circumcision for during the baseline conducted in 2011, 50% of the MSM respondents cited being bisexual or engaging in bisexual behavior. Male circumcision has been advocated for in Zimbabwe as one of the measures taken in reducing the chances of cervical cancer in women. This project is a follow up of the recommendations made on baseline survey one. The result indicates that there is low uptake of Voluntary Medical Male circumcision amongst MSM.

ACKNOWLEDGEMENTS

Thanks are due to different parties, entities and individuals who contributed enormously to the fruition of this project. Special mention goes to GALZ staff members, Munyaradzi Nyamatendeza and Samuel Matsikure.

From the service providers, DR T Kasu and Caroline Maphosa deserves special mention. To the LGBTI community, this study would not have been successful without your participation.

Introduction to male circumcision

Male circumcision is a surgical procedure that involves the removal of the foreskin. It is identified as MC because it is done upon recipients who identify themselves biologically as such. In other words they have the penis upon which the procedure will take place. The surgical procedure under scrutiny is categorically different from Female genital mutilation, which is otherwise known as female circumcision. The former is done on men while the latter is done on women. MC is done for various reasons including among others, medical, religious and ethnic. The focus of this report however hinges upon the uptake of VMMC for HIV/AIDS prevention.

Background to male circumcision

Male circumcision is a surgical procedure that dates back to the immemorial past. It is done for various reasons. These reasons range from medical, religious and ethnic. It is of late that medical male circumcision has gained popularity, mainly in areas where HIV/AIDS prevalence rate is high. The efficacy of male circumcision in reducing HIV transmission has been observed, but it became more evidence backed after the 3 randomised trials. The trials as shall be clear were among heterosexuals. No conclusive studies have been done on the efficacy of male circumcision in reducing HIV transmission among MSM who practise anal sex.

VMMC among men who practise penile-vaginal sex (men who have sex with women-MSW)

Male circumcision significantly lowers risk of becoming infected with HIV among men who practise penile-vaginal sex. According to UNAIDS and WHO (2007), there is substantial evidence that MC protects against several diseases besides HIV, these includes, urinary tracts infections, syphilis, chancroid and invasive penile cancer.

Smith et al (2010) argues that, an association between MC status and HIV infection has biological plausibility.

The foreskin has a greater concentration of HIV target cells such as langerhans cells and macrophages, than does other penile tissue. Uncircumcised men penis has increased mucosal surface area that would be exposed to HIV containing secretions during penetrative sex, and the prepuce can trap secretions, resulting in prolonged contact with the mucosa. Male circumcision in a heterosexual encounter reduces chances of HIV transmission by 60% in Men. In these penile-vaginal sexual encounters women have reduced chances of cervical cancer.

As Smith et al (2010) further argues, it is less clear how the above protection would affect transmission in which a predominant mode of transmission to men is through receptive anal intercourse rather than insertive penile-vaginal sex.

Facilitators of acceptability of MC

Different men seek male circumcision for various reasons. Facilitators of acceptability may include, religion, ethnicity, health and sexual benefits, UNAIDS and WHO (ibid). Female preference, masculinity, sexual hygiene and sexual enjoyment are among others.

Deterrents to MC

VMMC has been heralded and is still being heralded, with some potential participants not seeking the services. Reasons that deters participants includes, but are not limited to, fear of pain, costs of the procedure, concerns for safety, fear of HIV testing, partner refusal, and reluctance to abstain from sex.

VMMC amongst MSM

Male circumcision is significant but partial efficacy in reducing risk for HIV acquisition. Insufficient data exist about the impact (if any) of MC on HIV acquisition by MSM, and additional research is warranted, (Smith et al 2010). Because the recent trials of MC provided no evidence that MC protects against HIV acquisition during anal or oral intercourse, there was no general support for providing MC as an HIV prevention strategy among MSM who do not also engage in penile - vaginal intercourse that places that places them at risk for HIV, Smith et al (ibid). Receptive and insertive partner are affected differently by male circumcision.

Among MSM, the risk to the receptive partner is significantly higher than to the insertive partner.

A study by Zhou et al (2013) in China among MSM found no evidence that male circumcision offered any protection against HIV transmission regardless of preference for top (insertive) or bottom (receptive) anal sex role. It is difficult to measure the impact of MC among MSM because there is sometimes lack of sex role consistence and the existence of oral sex which is not related to male circumcision directly. These studies however are not conclusive. There is need for further research on the efficacy of Male circumcision on HIV prevention among MSM like the 3 randomised African trials.

MC in Zimbabwe

After the 3 randomised trials on the efficacy of MC in HIV transmission many countries were eager to implement it, among them Zimbabwe. In 2009 Zimbabwe launched MC as an HIV prevention method. According to Zimbabwe policy guidelines on VMMC (2014), the current demand for male circumcision in Zimbabwe is not clear. The situational analysis of MC in Zimbabwe suggests that MC services availability and accessibility are limited in the country. It should be clear that whilst the circumcision of men living with HIV, shall be discouraged, HIV positive men shall not be denied MC, but where medically indicated MC shall be provided to all men irrespective of HIV status, Zimbabwe policy guidelines on VMMC (2014). According to Nhliziyo (2014), In Zimbabwe male circumcision uptake is very low with figures lagging behind set targets from 2010-2013.

Problem Statement

Though studies are beginning to take place in places such as China to specifically look at male circumcision and MSM, there is still paucity of literature on the area in Zimbabwe and many countries. Studies on acceptability of male circumcision and the related issues has focused much on heterosexual men.

Objectives

1a. To determine the level of Acceptability of MC among MSM in Harare.

1b. To explore the perceived social benefits and deterrents to MC among MSM.

2. To solicit perceptions and behavior practices amongst MSM on MC.

3. To determine other complimentary prevention methods used by MSM

4. To assess impact of messaging of MC and other complimentary commodities.

5. To evaluate the practice of taking up VCT or HTC amongst MSM.

Research Questions

1. What is the level of acceptability of MC among MSM since the inception of the project?

   1b. What are the perceived social benefits and deterrents that either motivated or demotivated MC uptake by MSM in the LGBTI community in Harare.

2. How do MSM perceive MC?

3. What other HIV/AIDS and STI prevention methods are available and utilized by MSM.

4. What impact has the messaging of MC and other complimentary commodities has had on MSM.

5. What influence does the practice of taking up VCT or HTC has amongst MSM.

Methodology

The research methodology for the study was based on a mixed research paradigm. Qualitative and quantitative paradigms were used concurrently. The adopted approach employed methodological triangulation of in-depth interviews, questionnaires and focus group discussion. The sample for this study consisted of MSM, MC Service providers, and VCT service providers. The quantitative part of the methodology was employed to understand the magnitude of uptake and acceptability while the qualitative was meant to tap the experiential and perception part of the participants.

Methodological challenges

Members of the LGBTI community, MSM and the service providers were reluctant to come forward for the research.

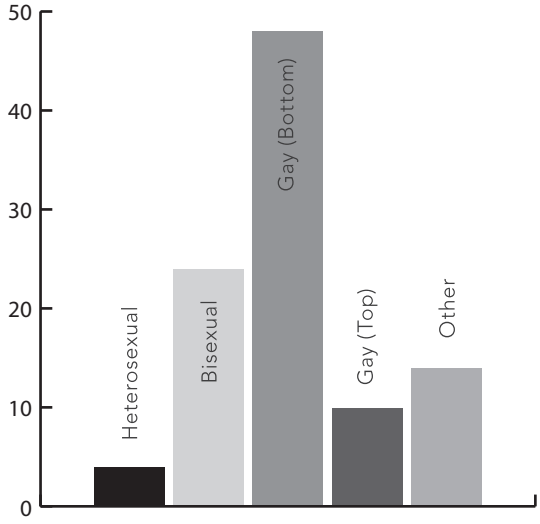
This delayed the process of research and data collection as well as the final production of the report.

FINDINGS

Introduction

This section presents the research findings from survey in-depths interviews, focus group discussion and questionnaires. Thematic data presentation is used to present data from interviews and FDG while SPSS is be used to present data from questionnaires. The data is then integrated together.

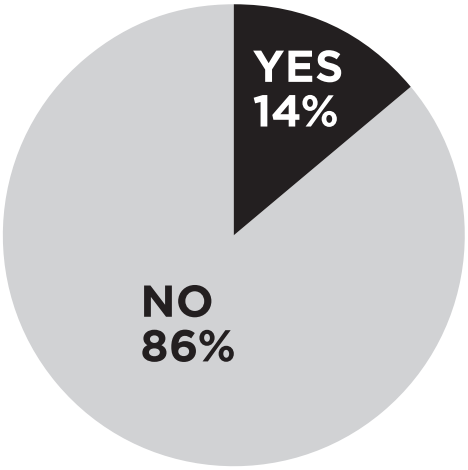
The above chart shows data from the survey questionnaires. It shows that the majority of the participants, 48% identified as receptive, whilst 10% identified as gay (top) and a significant number were bisexual (24%). The remaining 18 % represents



transgender women and unidentified sexual identity. From 20 in-depth interviews that were carried out with MC beneficiaries, 3 participants identified themselves as Bisexual. 11 participants identified themselves as gay, with 3 receptive, 1 insertive, 6 versatile and 1 unknown sexual identity. Only 6 participants identified themselves as Transgender. None of the participants from in-depth interviews identified as heterosexual. Despite these anomalies growing body of literature is now identifying Heterosexuals as part of MSM. The majority of the participants are thus receptive.

Existing literature purports that receptive partners do not feel the need to be circumcised. In the current study 86% of the respondents indicated that despite having heard about circumcision they had not taken it up. This corroborates with data from in-depth interviews where only 3 respondents were circumcised. Out of these 3 respondents however, 2 were circumcised not as part of VMMC but as religious observation.

Circumcision status



Though the low uptake of male circumcision is not shocking given that uptake is generally low in Zimbabwe. What was unique about the findings is that one respondent who identified as bottom indicated that he had been circumcised and had actually been ridiculed by his partner.

Factors for low uptake

There are a number of factors that were cited by the respondents which inhibited uptake of MC. 24% of the respondents noted that they did not see the reason why they should be circumcised as they said they do not use their genitals to have sex. Consistent with literature some individuals (22%) highlighted that they fear the pain associated with circumcision, whilst others cited religious reasons, not being comfortable with it, lack of time and not being prepared to abstain during the healing process. 2% of the respondents cited HIV serostatus as the reason for not taking up male circumcision.

Sex role

It is one of the observation in this study that many individuals who identified themselves as transgender women and receptive gays are not comfortable with male circumcision. This is because they do not use their genitals for penetrative sex. Responses were cited in various ways. Some could simply state that because he is transgender, has never used his genital or because it does not apply to him. During an in-depth interview a response was given, "I don't see any reason to be circumcised because I don't use my genital for sex". This runs across in all beneficiary target groups. It will be an interesting area of research to measure the correlation between sex role and one's propensity to be circumcised.

Pain

Pain during the surgical removal of the foreskin and afterwards as the healing process goes up to 6 weeks were among some of the barriers to the uptake of VMMC amongst MSM. Some participants view the healing process as more painful because of the associated salt bath and pain during an erection that may arise. One of the beneficiaries argued that, "I am not comfortable with being cut, anything to do with pain scares me away".

Failure to abstain from sex

Some MSM argued that they cannot do without sex for a long period. Since one has to abstain from sex until 6 weeks after Male circumcision, this presented a challenge to some individuals. Majority of the participants are sexually active. This is what participant A3 got to say, "Male circumcision is good maybe for others, not for me. I can't go for 6 weeks without sex..."

Trust amongst partners

A number of reasons surfaced during the data collection process. Partners who stayed long in a relationship or marriage are likely to drop some practises such as the use of condoms. The persistent use of these was sometimes viewed with suspicion and mistrust. "I have been married for the past 20 years. I have not cheated and my wife has not cheated. Is there a need for me to be circumcised? I am not circumcised because I am a responsible person."

Culture

In some instances especially among the Shangani and Chewa people as as well as Muslims circumcision is done as part of part of religion and culture. It is a requirement that members belonging to these groups are circumcised from childhood.

However, most ethnic groups in Zimbabwe are non-circumcising. Participants from the latter ethnic groups view circumcision as not part of their culture and hence not worth going for. One of respondents noted, "ISu tiri vanasamanyika, our forefathers were not circumcised, they were not infected with HIV/AIDS and I don't see the need to be circumcised as long as you are responsible and not sexually reckless". This same view was also shared with one MC Service providers.

Conspiracy

The advocacy of male circumcision as an HIV/AIDS intervention has been shrouded in obscurity as to its timing and motives by some participants. The use of VMMC has gained ground much in Africa though the efficacy was not yet established. After the 3 popular randomised trials MC began to be take a stronger and evidence backed medical footing. However, participants argued that they suspected that the process was associated with Satanism as their foreskin was in the hands of those who could have circumcised them, "The whole illuminate thing scared me away initially, now people are softening because there is now much information about it".

Penile appearance

While others view a circumcised penis as smart and easy to penetrate others view it on the other end of the continuum.

The permanent change of appearance which was pointed as 'ugly' was also another deterrent to the MC uptake. "A circumcised dick looks so ugly. I don't like it", argues one participant.

Nature of the message

An analysis of the message on male circumcision so far in Zimbabwe reveals the following. The beneficiary of male circumcision is depicted as heterosexual young man who cares about his hygiene, HIV/AIDS transmission reduction and reduction of cervical cancer risk of his female counterpart. In an interview with one of the service providers she argued that, "No poster or any advert has so far marketed the benefits of MC for MSM, Although I would want to see it. Advantages of MC for MSM should be marketed because some do not go well with the message". This was also echoed in an in-depth interview with respondent A4," The message is so heterosexual, my partner don't have a cervix and if I go for male circumcision how does that benefit him".

Not only is the message considered heterosexual in making. It is considered aggressive in some instances. One respondent argues that, "Preaching male circumcision like it is the only way to go, like it is a must is stereotyping people like you, you are promiscuous, come and get circumcised without putting into consideration my relationship".

Fear of reduced sexual pleasure and sensitivity

Male circumcision has been rumoured to reduces sexual sensitivity and pleasure to the circumcised partners. Participants argued that they either knew someone who was circumcised and has lost sexual pleasure or simply because of the biological existence of the foreskin. In an interview with Respondent A5, he argued that, "There is a reason for the foreskin. It is biologically good for sensitivity. The government is trying hard not to tell people about the disadvantages of male circumcision, such as the probable loss of sensitivity". Further research is warranted to look at whether male circumcision reduces sexual pleasure or not.

Fear of complications

Male circumcision can result in permanent damage and complication if done improperly. One respondent argued that one of his friends was circumcised wrongly and had to stay in hospital for a month.

Lack of time

Some respondent showed interests in being circumcised in the future. In an attempt to justify why they were not circumcised shortage of time was indicated. Mr A3 is a Teacher by profession, he is willing to be circumcised any time soon. What is holding him back from seeking the service is his tight schedule.

"Currently I have a very busy time table, I cannot accommodate anything. I will go for it anytime soon. I found it beneficiary for me to go for".

HIV status

In order to be circumcised one is required to be tested for HIV/AIDS. In instances that one is found positive he is discouraged from being circumcised. A10 in an interview argued that, "I wish if positive guys could be circumcised. I failed to be circumcised after I was found positive".

Motivations for uptake of MC

Of the 14% of the participants from the questionnaires who had taken up male circumcision the majority were motivated by the cleanliness that is associated with circumcision. Surprisingly none of those circumcised connected the decision to lessening the risk of contracting HIV. Only one individual from in-depth interview identified MC with HIV transmission reduction.

Increased sexual pleasure

In an interview with A10, he argued that "I wish that HIV positive Men could be circumcised. I could have been circumcised myself. Circumcised guys are good in bed. A circumcised penis penetrates easily. They stay long and sex is enjoyable with them".

Cleanliness

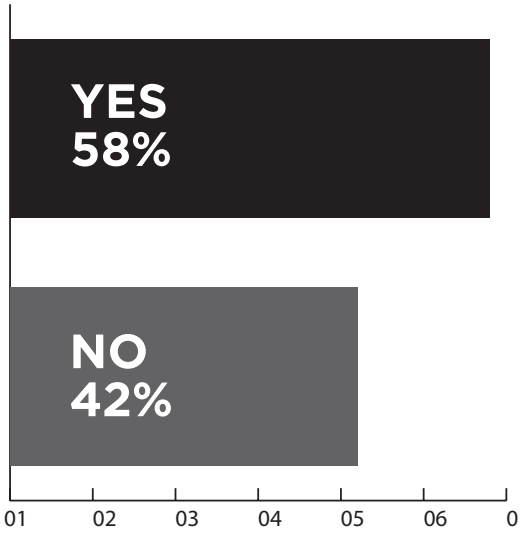
VMMC was mainly taken for hygiene purposes by MSM. In an interview with participant A1, he argued that, "Being circumcised feels good. I was mocked by my partner when I was circumcised because I am receptive, *kutotii munoishandisei?*, Besides I feel like I am a man, and I don't worry about hygiene".

Reduced HIV transmission

During the in-depth interviews and the Focus group discussion HIV transmission reduction was noted. It was clear to most participants that this reduction is amongst partners who engage in heterosexual penile-vaginal sex. A participant indicated that, "Male circumcision reduces HIV transmission by 60% for heterosexual partners. It is also known to reduce cervical cancer in women". However, caution should be placed on this argument.

The individual who purported to have gone for VMMC for HIV prevention was unlikely to have that HIV protection because he identified himself as exclusively receptive.

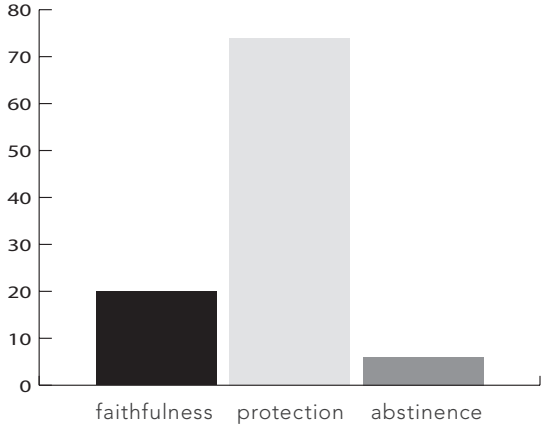
Would you recommend someone for MC?



When asked whether they would recommend uptake of MC to others 58% of the respondents said they would.

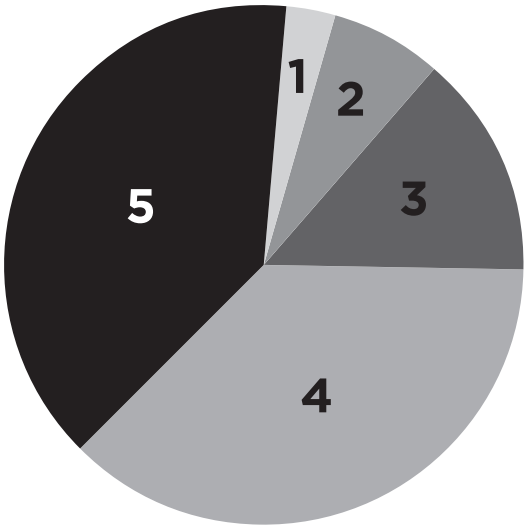
The beneficiaries were asked whether they would recommend an uncircumcised partner or friend. Even though a few (42%) were not willing to recommend someone, many (58%) were willing to recommend MC. Those who were not willing to do so argued that because they had no experience of the procedures and the benefits as well as challenges that may accrue as a result. Beneficiaries did not discuss about male circumcision with their partners. Those who were prepared to recommend it said those would recommend it knowing that at the end of the day that going for MC is a personal decision. MC was to be recommended as complimentary as some may end up engaging in compensatory behaviour.

HIV Prevention Methods



Despite not identifying MC as a preventive strategy 74 % of the respondents said that they use protection whilst others identified faithfulness and abstinence as a ways of protecting oneself.

frequency of VCT visit



When asked what was the last time the respondents had sought VCT the following, highlighted in the pie chart was found.

It is apparent from the above pie chart that many respondent had sought VCT within the a period of less than a year (category 5 N 27), a significant number (category 4 N 26) had not specified when was the last time they sought VCT services, about 10 respondent (category 3) had sought the service over a year ago. 5 participants (category 2), responded that the last time they went for VCT was over 2 years ago. The last category, category 1 with just 2 respondents had sought the service around over 10 years ago. One of the respondents in the last category had sought visit around 1980s

Marital status of the respondents

Marital status	Number of respondents	percentage
Married to a woman, but in a relationship with a man	7	10%
Single	43	61. 42%
widowed	1	1.42%
In a same sex relationship, not married	15	21%
unspecified	2	3%
In a relationship with opposite sex, not married	1	1.42%
Married to a woman, not in a relationship with a man	1	1.42%

N=70

Majority of the respondent cited being single, followed by a significant number who argued that they are in same sex relationship. 10 % cited being married to a woman but in a relationship with a man, about 3% did not specify their marital status. Those who are widowed, in a relationship with the opposite sex but not married and those married to opposite but not in a same sex relationship had the same values of 1.42%.

Complimentary prevention methods used by MSM in the prevention of HIV/ AIDS

As is highlighted in the bar graphs above a number of complimentary methods are used by MSM. Some of the methods identified include male and female condoms, Lubricants as well as abstinence.

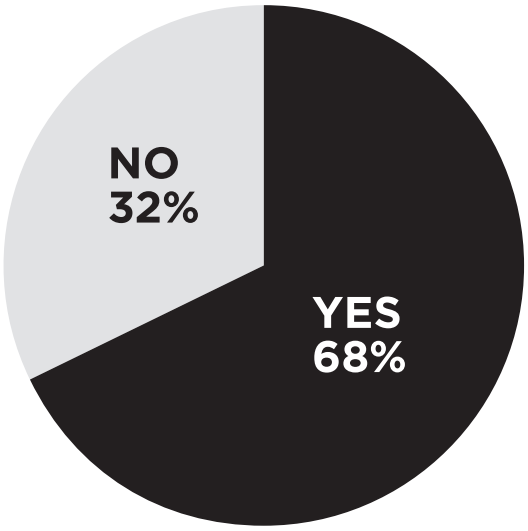
These apply directly to penile-anal sex. For other sexual practises such as oral sex, other prevention methods identified includes, dental dams, gloves and finger codes.

While these complimentary methods were identified and utilised by many participants, it is apparent that 3 respondents out 20 for the in-depth interviews had challenges with complimentary methods. The first one was a sex worker in South Africa. He disclosed that use of condoms is not as always as consistent because sometimes his clients would want sex without condoms. The second one is a bisexual individual who argued during in-depth interviews that he is in a stable relationship for long to such an extent that he and his girlfriend no longer use condoms. To him condoms will only be used in the near future if he breaks up with the current partner.

The final and last case concerns an individual who identifies as receptive gay. His partner has been insisting that they should stop using protection since they have known each other for a long time.

In a bid not to lose the partner the participant accepted withdrawal of any means of protective sex. In substitution for condoms the respondent went for MC. However, this presents a great challenge. MC is complimentary. Lack of this observation exposes one to great infections. Since the respondent identified himself as receptive MC is of less utility, if any in reducing his infection because he is already on the receiving end.

Have you gone for VCT?



The majority of the participants have gone for VCT which is encouraging and maybe a reflection of the work that is being done by GALZ. When asked to elaborate, participants indicated that their visit for VCT is regular and frequent which is encouraging.

DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS (MC BENEFICIARIES)

Distribution by Race

The racial distribution of the participants is as follows. 98% (N 83) of all the MSM participants is black while (N2) 2% is white.

Distribution by Age

None of the participants was below 18 years of age. The oldest was 71 years.

The study revealed that the largest percentage were in 18 – 28 years age group as 73 % of the respondents were in this age group. 22 % were in the 29-38 years age group. The age group 39-48 had 3% and 49-58 had not been represented. Age groups 59-68 and 69-78 had 1% each.

Age category	Number of respondents	percentage
18-28	51	73%
29-38	15	22%
39-48	2	3%
49-58	0	0%
59-68	1	1%
69-78	1	1%

N=70

Age presentation in the table above is that of respondents who participated in the in-depth interviews as well as questionnaires.

Academic distribution

Highest level of Education	Percentage
High school	54%
Tertiary	46%

N=70

The table above presents educational levels of 70 participants who took part in interviews as well as questionnaires. High school graduates constitute the majority of the participants.

KNOWLEDGE AND SOURCES OF INFORMATION ON MALE CIRCUMCISION

Knowledge on Male circumcision

99 % (N=69) of the participants during in-depth interviews and questionnaires had heard about male circumcision and only 1 % (N=1) had not heard about it. Some of the participants articulated clearly that male circumcision involves the surgical removal of the foreskin. This indicates that the messaging of male circumcision had great effect on the knowledge levels of MSM.

Some even elaborated that VMMC is circumcision that is not done out of compulsion because in its true sense it is called voluntary medical male circumcision. This knowledge was also apparent during the focus group discussion. During the focus group discussion 60% reduction of HIV infection was made clear by some of the respondents. It was also clear that benefits of male circumcision such as hygiene and cervical cancer reduction was also highlighted.

Sources of information

Various sources of information such as newspapers, magazines, pamphlets, billboards, internet, friends and workshops were identified. The majority of the respondents identified the social media, radio and television as the greatest sources of information. On social media Facebook was cited as the leading information platform as the MSM use various Facebook pages to discuss sexuality and sexual as well as reproductive issues.

Acceptability of VMMC amongst MSM

It is apparent from the data that participants had varying views on acceptance of MC. While others likes male circumcision and were eager to go for it in the near future. In many instances many disliked male circumcision and were not prepared to go for it. Those who did not want to recommend MC cited not having the experiential part of the procedure, viewing VMMC with animosity and as of less utility to MSM who identify themselves as either transgender women and receptive gays.

The two categories argues in many occasions that they would not recommend VMMC to any one like them because they do not use their genitals for penile - anal sex.

Perceptions, Knowledge levels and behaviour practises amongst MSM on Male circumcision

Participants were asked on what they know about MC. From the gathered data it is notable that many participants knew that MC is not a substitute for condoms. Only one participant had no knowledge of MC and had not heard about it. It was also highlighted that it is a complimentary method. Reasons such as religion, ethnicity and medical ones were pointed out.

From an in-depth interview with respondent A2 he argued that male circumcision is good for every men despite his sexual orientation, " I think MC is good for every men out there and besides you don't need to be straight to be circumcised".

In an interview with respondent A1 he argued that, MC reduces HIV transmission by 60% and as such he would recommend male circumcision with condom use and abstinence, though the latter as he articulated tends to be difficult for many youth who are sexually active. To him the youth should know that getting circumcised is not the passport to engage in unprotected sexual encounters with a multitude of concurrent partners.

However, in an interview with one of the respondents it was clear that he was circumcised because the partner did not want to use protective methods such as condoms. Chances are high as argued above that individual in long relationships end up engaging in unprotected sex.

Participants also noted that in as far as MC is good both the advantages and disadvantages should be made clear to the beneficiaries because some may think that the disadvantages outweighs the advantages and hence not told about it. Many participants emphasised the need for full information about MC to be disclosed so that individuals can decide consciously without any deceit.

Impact of messaging of Male circumcision and other complimentary methods

From the focus group discussion, in-depth interviews and questionnaires it is apparent that the heralding of various complimentary methods had a positive influence on MSM. The majority of in-depth interviews participants, 85% (N17) identified themselves as having been influenced by various media sources, friends and GALZ workshops to use complimentary methods. From the focus group discussion this was also a notable observation as individuals discussed of resorting to abstinence and self masturbation in desperate circumstances. From the questionnaires a number of complimentary methods cited above were identified. Existing data also highlighted a number of strategies and complimentary methods. Among them the popular ABC method (Abstain, being faithful and condomise).

Even though abstinence was cited to be difficulty and failure to abstain had made other individual not to go for MC other methods such as condoms were in great use.

MC messaging has much more mixed results. It has encouraged some members to seek the service. A respondent argued during an in-depth interview that, "I have understood the benefits of male circumcision and I am willing to go for it any time soon as my timetable loosens".

In extreme case it has been misunderstood and used in isolation as indicated above. In very controversial circumstances the messaging of MC has been criticized as heterosexual and a drive away tool rather than a pull factor. From the focus group discussion many participants argued that the message on MC is one sided. It displays the pros and not the cons of MC services, a stance that leaves many wondering and in fact afraid of the unknown. This was also an observation during in-depth interviews. One respondent wrote on the questionnaires that adverts and campaign on MC has encouraged him to do a research on the advantages of male circumcision to him and finally realised that it is not of any use to him. There is need to reshape the message if MC is to be effective to MSM. The majority does not go well with the message. Some even finds it offending.

Voluntary counselling and testing and MSM

Many MSM are young and sexually active. From the in-depth interviews 2 individuals argued that they are no longer as sexually active as they were in the past. One argued that he can have sex once a month on the average. The other once argued that he is too old now (71 years) and no longer sexually active. He could not even remember the last time he had sex. All other participant (18) argued that they are sexually active and can have sex as many as 2 times to 17 times per month.

The beneficiaries had knowledge on VCT and has been seeking the service regularly as indicated by the pie chart above. The frequency of visit ranges from 2-3 times per year. From the in- depth interviews respondents argued seeking services as for blood donation as well as knowing one status and as a requirement to be circumcised. Knowing one status has encouraged many want to maintain their statuses by sticking to one partner and using protection.

VCT goes hand in hand with male circumcision. In order for one to seek the service one has to be tested for HIV/AIDS. While positive men are discouraged from being circumcised it is not mandatory that they should not be circumcised in Zimbabwe, except otherwise medically proved so. As already indicated above some participants may be willing to get MC services but because they are HIV positive they are discouraged from doing so. VCT and MC are complimentary. HIV negative men are encouraged to be circumcised while HIV positive men are discouraged from doing so. Even though the case of A10 is an exception that he was not circumcised, though willing because of his HIV positive status no participant has argued that he was not circumcised because he was afraid to know his status.

CONCLUSION

The foregoing segment of the report presented data from the field survey. The data was collected from VCT and MC service providers as well as beneficiaries of MC who identify themselves as MSM. 2 MC services providers were consulted. Only one VCT service provider was consulted. 15 participants took part in the FDG and 20 took part in the in-depth interviews. 50 respondents participated through the questionnaires.

DISCUSSION OF THE FINDINGS

Introduction

While the above section of the report presented data as it came from the field from various sources without any attempt to analyse it. This section will analyse the data. This is done in the context of existing literature. Divergences as well as convergences will be noted.

Level of uptake and acceptability of MC among MSM

There is low level of uptake of male circumcision among MSM. Generally there is low uptake of male circumcision among the general male community as noted in the Sunday Mail of July 2012 and Government has tried to lure more men into male circumcision by offering them a US$5 allowance this has not helped in reaching the required targets.

According to Zimbabwe policy guidelines on VMMC(2014), the situational analysis of MC in Zimbabwe suggests that MC services availability and accessibility are limited in the country.

Low uptake of MC amongst MSM is due to a number of reasons. Some of these as was indicated above relates to surgical and post surgical pain, reluctance to abstain from sex, MC being not part of one's culture, fear of reduced sexual pleasure. This corroborates well with the growing body of literature on MC. According to UNAIDS and WHO (2007), some of the barriers to acceptability of MC includes fear of pain, concerns for safety as well as the cost of the procedures.

One of the divergences coming from this study is that there are certain factors that explain the low uptake of MC that are specific to MSM. While the above factors are universal to every men despite sexual orientation the following are specific for MSM. As the data presentation above has shown, factors such as nature of the message, homophobia (existing and imagined), as well as health benefits such as absence of cervix in one's male partner and not using genitals during penetrative sex are unique to the gay community. These are factors that are incomparable to MC of men who have sex with women. Men who have sex with women can go for MC because they want to protect their female partners from cervical cancer, but men who have sex with other men cannot go for the same reason because their partners do not have the cervix. While MSW might seek MC for reduced HIV/AIDS transmission MSM who are receptive do not see such benefits applicable to them because they do not use the genitals.

MC study on the efficacy of reducing HIV/AIDS transmission by 60% was done on men who identify themselves as heterosexuals and engaging in penile-vaginal sex. No similar study has been done on the efficacy of MC in reducing penile-anal HIV transmission. It is less clear how such protection would affect transmission in which a predominant mode of transmission to men is through receptive anal intercourse rather than insertive penile-virginal sex, (Smith et al 2010).

MSM engage in other sexual practise in which male circumcision could not offer protection. These includes among other things, oral sex as identified above. Such individuals will not see the direct HIV benefits of MC in those instances.

Templeton et al (2010) notes that an individual own circumcision status would not be expected to have any impact on other STIs acquired during receptive oral sex and receptive unprotected anal intercourse.

Perceived benefits and deterrents towards MC

Perceptions as was highlighted above were mixed. Those who perceive MC to be positive and beneficiary to them and others were more likely to recommend it. Those who perceive MC to be of less utility chose not to go for it, and not to recommend it to anyone. However, many respondents were not circumcised but they showed interests in recommending MC. This highlights the significance of Focauldian theory in viewing homosexuality as a regulation. Individuals own capacity seems to be regulated while they see the capacity of others as elastic in seeking MC services.

Perceptions and behaviour Practise amongst MSM on MC

MC does not offer 100% protection from HIV/AIDS. In fact it reduces HIV transmission by 60%, UNAIDS and WHO (2011). This augers well with the same level of understanding displayed by participant who had knowledge on MC. Since MC is complimentary those who lack this knowledge may end up engaging in compensatory behaviour. A participant in this survey has highlighted this also. However, in this study as opposed to the findings by Chikutsa et al (2013), no individual has reported engaging in behavioural disinhibition. Behaviour practise of the participant did not change as a result of MC status. What transpired was that an individual thought MC could protect him as a receptive partner.

Complimentary methods used by MSM

A variety of complimentary methods were identified. These are used for prevention of STI infections during penile – anal sex as well as oral sex. The existence of these complimentary methods have been recorded in various studies. The latter are the ones that are specific for MSM. This in fact tallies well with the argument by Zimbabwe policy guidelines VMMC (2014), that MC is used in conjunction with other prevention methods such as condoms.

Conclusion

In conclusion of the arguments there presented, one may come to a justified ending to the effect that some valid and reasonable grounds have been established to demonstrate that Mc uptake is low amongst MSM. It is also clear that both the uptake of MSM and the general heterosexual community is low.

Recommendations

Despite having high knowledge on MC many MSM did not go for the services. VCT knowledge was high, the frequency of visit was also very high. MC status did not negatively influence one sexual practise.

1. There is need therefore to rethink and reshape the messages on MC. Message on MC should be neutral in terms of sexual orientation. MC should be promoted in terms of other benefits such as cleanliness as well as prevention of penile cancer and urinary tracts. Shaping the message along prevention of cervical cancer and HIV to beneficiaries who does not have cervix and does not use the genitals will seem out of touch.

2. There is need to develop and utilise other MC message platforms such as one on one discussion concerning MC, VCT and complimentary methods. Sources of information identified were numerous and influential. However, one on one discussion can give the beneficiary opportunities for queries and clarifications. Sexual and reproductive issues are sensitivity and individuals feels comfortable discussing them in highly confidential contexts. Such a platform can help better the issues under scrutiny

3. There is need for continuous education concerning STIs. STIs do not respect longevity of one's relationships. There is no substitute for protection. Individuals needs to be educated continuously that despite the length and trust in one's relationship protection should always be used as other practises such as group sex places MSM at great risk.

4. There is need to promote self -employment, creativity and other income generating activities. Individuals are resorting to sex work. This places them at risk as clients sometimes rejects protected sex.

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ISBN: 978-90-6753-043-9