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Exploring Aspects of Demand Creation and Mobilization for Male Circumcision among Older Men in Turkana, Kenya

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Authors: Kate Macintyre, Natome Moses, Katherine Andrinopoulos, Marta Bornstein, Athanasius Ochieng, Nicholas Muraguri, Erin Peacock, Peter Cherutich, Emily A. Hurley, Jane T. Bertrand

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EXECUTIVE SUMMARY

Background

A large body of epidemiological and experimental scientific literature has concluded that male circumcision reduces risk of HIV infection. For a maximum population-level impact in the reduction of HIV incidence, circumcision should be promoted not only for infants, young boys, and younger men, but for the full range of sexually active adult men. In Kenya, the National AIDS and STI Control Programme (NASCOP) began incorporating voluntary medical male circumcision (VMMC) as a key component of the national HIV prevention strategy in September 2008. NASCOP is now in the process of scaling-up services in Turkana County, where HIV infection rates are among the highest in the country. This scale-up may face local challenges, as the predominate ethnic group, the Turkana, traditionally do not circumcise their men or boys. Based on prior VMMC efforts in other areas in Kenya, as well as preliminary research in Turkana, it appears that creating demand for these services will be particularly challenging among older men (ages 25-49). This situation is concerning considering that among Kenyan men, HIV prevalence is highest among the middle-aged (35-39 years; KNBS, 2010). Though previous research sheds light on potential facilitators and barriers of VMMC service demand, little research has been conducted on the factors specifically influencing older men's uptake of VMMC. Further, the unique meaning of circumcision in Turkana culture has not been deeply explored in the context of the recent plans for VMMC program scale-up in Kenya.

Objective

The overall objective of the study is to identify approaches to increase demand for VMMC services in Turkana County, with particular emphasis on reaching men 25-49 years of age. Specifically, this study aims to describe and establish the relative importance of social, economic, and cultural facilitators and barriers that influence the demand for VMMC among older men. Additionally, this study aims to synthesize results and previous literature in order to provide a framework for conceptualizing demand creation among older men that can be adapted and utilized in similar settings.

Methods

A cross sectional study using qualitative research methods was implemented over three months in 2012. The methods included 20 focus groups discussions (FGD), 12 key informant interviews (KII) and 64 in-depth interviews (IDI). The FGDs and IDIs were distributed across four geographic strata and across urban, peri-urban and rural sites. Individual participants were further grouped as follows: uncircumcised men, circumcised men, and the female sexual partners of either circumcised or uncircumcised men. The KII respondents were selected purposively to elicit the views of traditional healers as well as local and regional HIV service coordinators. The protocol, interview guides, and consent forms were translated, back-translated and approved by the ethics committee of Kenya National Hospital and by Tulane University's Institutional Review Board for Human Subjects Research. Transcripts were translated from Ngaturkana to English and coded thematically with the aid of Atlas.ti 4.2 software. The research team synthesized key themes generated through its analysis in relation to the primary research questions and aims.

Results

The data reveal a number of barriers and facilitators to VMMC demand among older men in Turkana. Culturally, the major obstacle to creating acceptance and ultimately demand for VMMC services is that the Turkana often equate VMMC with the circumcision traditionally practiced as a rite of initiation by the tribal enemies of the Turkana. Urban and younger respondents, however, spoke of the growing recognition and acceptance of circumcision as a biomedical procedure to prevent HIV. Differences in stigma were evident between rural and urban respondents; respondents explained the stigma that equates circumcision to nakedness accompanied circumcised men in some rural areas and the stigma of being unhygienic accompanied uncircumcised men in some urban areas. Another common belief was that older men were not at risk for HIV as most were no longer having relations with multiple sexual partners and some were no longer sexually active. The influence of peers or family on the decision to circumcise varied among respondents. Though some indicated that they kept their decision to be circumcised private, many uncircumcised men admitted that they would be more likely to seek VMMC if they thought the practice was common among their peers.

Respondents made recommendations to increase demand for services among older men, including providing incentives, increasing education, and ensuring quality service delivery. Service delivery and access issues, especially for men in rural areas, came up as a major barrier to success of the VMMC program, particularly among HIV service coordinators (key informants).

Discussion

Respondents regarded the new VMMC program as promising, assuming the barriers are addressed to create demand among older men. The barriers and facilitators to demand creation revealed in this study are consistent with previous demand creation studies for VMMC in sub-Saharan Africa with one notable exception: the negative cultural weight of circumcision was a prominent barrier for uptake, particularly among older men, for the people of Turkana.

Though specific results from this study cannot be generalized beyond the Turkana people, we have attempted to integrate these local findings with previous literature from sub-Saharan Africa to create a conceptual framework of VMMC demand in older men. The model presents four thematic categories of influences on demand for VMMC on older men in sub-Saharan Africa: (1) social acceptance of circumcision for older men, (2) belief of personal benefit related to HIV, (3) attitudes and beliefs beyond HIV, and (4) acceptance of procedures and service delivery. Each theme may have variable relative influence depending on the location.

Recommendations for Turkana

Creating demand for VMMC among older men in Turkana has the additional challenge of addressing the county's remoteness from the political and social centers of the rest of Kenya. The VMMC scale-up presents an important opportunity for the government and its partners to demonstrate a strengthening of relations with the many people of Turkana who have felt that their county has been isolated or neglected. Based on the data from this specific study, the following actions are recommended for creating demand for VMMC services among older men in Turkana:

1. Focus social and behavior change communication on the biomedical benefits and social acceptability (and ultimately, desirability) of circumcision.
2. Employ separate communication strategies designed specifically for urban or rural areas, ensuring adequate HIV education as a prerequisite for promoting VMMC in a particular community.
3. Address the distance-to-service barrier for older men in rural areas by increasing outreach and mobile sites or offering transportation assistance.
4. Target the lower end of the age range for older men.
5. Utilize and educate local traditional leaders to mobilize communities.

This study suggests that older men can be successfully mobilized to use VMMC services in Turkana if program efforts work to address some significant barriers. Strategically creating a program that will result in high rates of circumcision among older men in Turkana can have substantial benefits for the public health of this population and the nation of Kenya, particularly in terms of reducing HIV. Lessons learned for creating demand for VMMC services among older men may also be useful for program planners in similar sociocultural settings.

INTRODUCTION

HIV/AIDS and male circumcision

A large body of epidemiological and experimental scientific literature has concluded that male circumcision reduces risk of HIV infection (Auvert et al., 2005; Gray et al., 2007; Bailey et al., 2007; Weiss et al., 2010). A recent meta-analysis of randomized controlled trials suggested that circumcision reduces a man's risk of contracting HIV by around 56% (confidence interval 40-67%) (Mills et al., 2008). This compelling evidence has motivated many countries with a high prevalence of HIV and concurrent low prevalence of male circumcision to launch or scale up voluntary medical male circumcision (VMMC) programs.

Across most cultures that practice circumcision, infants or boys are typically the target population for the procedure. Circumcision for infants and young boys has many advantages, including improved recovery for boys not yet sexually active and the cultural significance of initiation into manhood in many traditions (Ngalande et al., 2006). Though circumcision among infants and boys will help reduce their risk of HIV infection later in life, VMMC needs to be adopted by uncircumcised older, sexually active men to achieve its potential impact for population-level reductions in HIV incidence.

In 2007, the United Nations Joint Programme of HIV/AIDS prioritized VMMC for HIV-negative males ages 12-30 (UNAIDS, 2007). However, a subsequent epidemiologic simulation study evaluated this recommendation and showed that while this age group may prove most cost-effective in the short term, targeting adult men of any age will save costs in future HIV treatment (Glynn et al., 2008). The authors strongly recommended VMMC programs to widen the target age group to include older men.

VMMC in Kenya and Turkana County

In Kenya, the population continues to experience a high burden of HIV, with 6.3% prevalence among adults aged 15-49 (KNBS, 2010). Further, the evidence of the protective aspects of circumcision is corroborated by discrepancies in HIV prevalence among uncircumcised Kenyan men (13%) and circumcised Kenyan men (3%) (KNBS, 2007). In light of this evidence, Kenya's National AIDS and STI Control Programme (NASCOP) began incorporating voluntary medical male circumcision (VMMC) as a key component of the country's HIV prevention strategy in 2008.

In 2003, the Demographic Health Survey estimated that 84% of males in Kenya were circumcised (Central Bureau of Statistics, 2003). Yet in some regions, circumcision is much less common, and the nation's expanding VMMC program has been recently examining ways to focus efforts in these specific areas. Non-circumcising tribes in Kenya include the Luo, Teso, and Turkana ethnic groups. To date, most VMMC services have been offered to the Luo in Nyanza province. Expansion of services to the Turkana and Teso ethnic groups is an important goal of NASCOP, one that requires a deeper understanding of the unique cultural and contextual factors that may influence demand for services for these groups.

This study focused on the Turkana tribe, located in Turkana County,[1] the largest county in Kenya. Turkana County is situated in the northwest region of the Rift Valley, making it geographically isolated from the rest of the country. The Turkana are mainly nomadic or semi-nomadic pastoralists, with some professionals, business people and internally displaced persons living in or near the towns in the county. Traditionally, the Turkana live with extended family in *kraals*, or groups of households with between 200 to 1,000 people. They also live in more permanent hamlets (*ngirea*) where older people, women and children stay as permanent residents, while men and boys seek grazing and water for their livestock. Almost all livelihoods for Turkana in rural areas are centered on livestock including camel, cattle, goats and sheep. Insecurity, both internal from bandits inside Turkana, and external from other parts of Kenya and from outside the country, is constantly present.

Current estimates report that Turkana County has a 6.9% adult HIV prevalence overall. Though there are higher levels in urban areas, recent evidence shows that the epidemic is increasing in peri-urban and rural settings. Risk factors for transmission likely emanate from the urban areas where traders, armed forces, and seasonal labor force migration patterns exacerbate the social practices of sexual concurrency. Polygamy is the norm outside of the urban communities and multiple concurrent partnerships are prevalent everywhere. There are also high rates of sexually transmitted infection (STI), and low access to health services overall, and specifically for testing and treatment of HIV/STI. The lack of traditional circumcision in the area also puts men and their partners at increased risk of transmission (Macintyre et al., 2011).

The VMMC program aims to scale up services so that 188,500 men in the Rift Valley undergo circumcision by 2014. This target represents a scientifically based goal of 60% prevalence of circumcision among adult males, or the *saturation point* required for a significant reduction of HIV incidence on the population level (GoK, 2010; GoK 2011). It is estimated that reaching this *saturation point* for male circumcision could avert more than 47,000 HIV infections cumulatively between 2009 and 2025 (USAID/Health Policy Initiative, 2009). Of the 188,500 target for the Rift Valley, it is estimated that about 105,000 circumcisions would be done in Turkana County. These services would be provided free of cost to the client, which would remove a major access barrier to the 95% of Turkana County residents who live below the poverty line (Turkana County Report, 2010). However, beyond eliminating the fee for the services, program planners must also work to understand and address potential social and cultural barriers to creating service demand.

Service delivery sites in Kenya follow WHO guidance for VMMC services (PEPFAR, 2013). This includes three types of sites: fixed, outreach and mobile.

[1] The terminology for administrative zoning has recently changed in Kenya. The use of the word County now approximates the old "District." It will also, under the new Constitution of Kenya, designate more power such that the "Counties" will carry more authority over funds and local decisions than the old Districts.

- *Fixed sites* are permanent structures located in or near existing healthcare facilities such as public and private hospitals and large health centers. These sites operate on a continuous basis. Dedicated space within fixed sites is permanently available to provide VMMC services.
- *Outreach sites* are similar to fixed sites in that they capitalize on existing permanent structures. However, the structures used by outreach sites are modified from their primary purpose to accommodate the VMMC package. For example, smaller dispensaries and health centers, schools, and community centers may serve as outreach sites through the reorganization of the facility or the addition of space using tents or prefabricated structures. Additional personnel are sent to the outreach site to support the VMMC package of services.
- *Mobile sites* are temporary structures composed of basic tents and prefabricated structures. They are used in areas with lower demand or in areas with high demand at certain times during the year. In addition to the physical infrastructure, teams of healthcare personnel temporarily staff the mobile site. Both outreach and mobile sites may rely on the fixed sites for support during campaign service delivery, when a high volume of services during a short period of time are provided.

As of May 2011, a total of 230 sites (including fixed, outreach and mobile) across 15 districts in Nyanza, and a few sites in Nairobi, Teso and Turkana, were in operation. Over 1,300 health workers had been trained to offer these services, and more than 250,000 men and boys had been circumcised between October 2008 and March 2011 (personal communication, Loolpapit, MCC, 2011). The majority of the sites offering VMMC are in health facilities through the "outreach" delivery method.

Until recently, national VMMC efforts have focused primarily on men in the urban capital of Nairobi and the county of Nyanza, another region where cultural traditions are the primary explanation for the low prevalence of male circumcision among certain ethnic groups (KNBS, 2010). Observations of the program in Nyanza, as well as of early efforts to promote VMMC in Turkana, suggest older men (25-49 years) may be the most difficult to reach (Herman-Roloff et al., 2011a). This is particularly concerning considering that, among men, HIV prevalence in Kenya is highest among the middle aged (35-39 years KNBS, 2012). Since the Nyanza program's launch in 2008, only 15% of all circumcisions performed were among men 25 years and above (M. Onyango, Male Circumcision Consortium, personal communication, January, 2011). Preliminary reports from Turkana County echoed this problem. Among the 2,558 circumcisions performed through the VMMC program in 2011, about 88% were of men under 25 years (Onyango, 2011). As national VMMC programs look to scale up services in Turkana, creating demand for circumcision in this culture will require strategic communication, messaging and mobilization, especially when targeting older men.

Barriers and facilitators to VMMC demand

Acceptability studies in other areas of Kenya have investigated barriers and facilitators of VMMC demand (Westercamp & Bailey, 2007; Herman-Roloff et al., 2011b). Cultural and religious beliefs, financial cost, physical pain, the required abstinence period following the procedure, and fear of improperly performed surgeries and related complications were all identified as potential barriers to acceptability and uptake of circumcision. In addition to partial protection against HIV and improved

hygiene, increased sexual satisfaction and social acceptance were reported as facilitators by both men and their female partners (Westercamp & Bailey, 2007; Herman-Roloff et al., 2011b). In a study of men in Lodwar, Turkana's urban capital, 86% were aware that circumcision protected against HIV transmission and acquisition. Other research suggests women may have some influence over men's decisions to undergo circumcision (Bailey et al., 2002) and some men are likely influenced to elect or refuse VMMC according to the wishes of their female partners (Rain-Taljaard et al., 2003).

Similar barriers and facilitators to VMMC have been reported in neighboring countries including Uganda (Albert et al., 2011), Rwanda (Gasasira et al., 2012), Botswana (Jayeoba et al., 2012), South Africa (Bridges et al., 2011), and Zimbabwe (Mavhu et al., 2011). Interestingly, one study in Uganda failed to demonstrate that beliefs about the protective effects of circumcision were associated with willingness to seek VMMC (Wilcken et al., 2010). Older men in South African focus group discussions revealed that the primary reason they would consider getting circumcised is the potential to give their partners greater sexual satisfaction (Scott et al., 2005). Distinctively, the younger men's focus groups also emphasized another main reason for considering circumcision in addition to sexual satisfaction: protection from sexually transmitted infections.

In a small study of a rural village in northern Turkana, similar barriers (cost, pain, fear) and facilitators (hygiene, sexual satisfaction) to VMMC appeared influential among the population (Moses, 2011). Specific to this area, cultural tradition and associated stigmas emerged as commonly perceived barriers for male circumcision. For instance, some men reported that circumcision "is not our tradition," while others felt circumcision was exclusively for young men, boys or even infants.

Together, the studies described above comprise a preliminary picture of factors that may influence VMMC demand in Turkana. Yet further research into the cultural and social influences specific to this region is needed. Further, as Herman-Roloff and colleagues (2011b) pointed out, research on barriers and facilitators specifically among older men is lacking. Considering the relatively slow adoption of VMMC among older men in Kenya, most specifically in Nyanza, it becomes critical to assess the facilitators and barriers among this population and strategically target interventions to increase uptake of services among men 25-49 years of age (Mahler et al 2011; Plotkin et al 2011). Failure to reach older men could result in a delay of expected public health benefits including reductions in HIV incidence at the population level.

Objective

The overall objective of the study is to identify approaches to increase demand for VMMC services in Turkana County, with particular emphasis on reaching men 25-49 years of age. Specifically, this study aims to describe and establish the relative importance of social, economic, and cultural facilitators and barriers that influence the demand for VMMC among older men. Additionally, this study aims to synthesize results and previous literature in order to provide a framework for conceptualizing demand creation among older men that can be adapted and utilized in similar settings.

METHODS

Study design

This cross-sectional, qualitative study included 24 focus groups discussions (FGDs) and 12 key informant interviews (KIIs) and 64 in-depth interviews (IDIs). Iterative stratified sampling was used to recruit a range of respondents for FDGs and IDIs. Table 1 on the following page illustrates the three levels of stratification in the design. First, the sample was divided amongst four population groups: (1) circumcised men aged 25-49 years, (2) uncircumcised men aged 25-49 years, (3) female sexual partners, and (4) men and women over 50 years old. These groups were also stratified by residence in urban, peri-urban or rural areas.[2] The third stratum was composed of four geographic regions: the county's three political demarcations/administrative subunits ("constituencies" North Turkana, Central Turkana, South Turkana) and the urban capital Lodwar. Lodwar was added as a separate unit because of its unique social, political and economic environment, and the fact that residents in this town may have had greater exposure to HIV and VMMC information.

Sample selection – communities

All major urban towns (outside of Lodwar) were listed from administrative sources. Of 14 eligible towns, four were dropped because they were deemed unsafe for data collection.[3] The remaining safe urban areas were stratified by North, Central and South constituencies. One town was randomly selected from a list of all towns in each constituency. Next, all peri-urban areas within 45 km of each selected town were listed. A total of 14 areas that were all considered unsafe were dropped. One peri-urban site was randomly selected from each constituency. Using a County Administrative Map, all rural locations,[4] approximately 51, were listed. Next all locations on an international border and considered insecure were also dropped (an additional 11). From the remaining list (40), one rural location in each constituency was randomly selected.

Sample selection – individuals

Procedures for recruiting individuals for FGDs in towns, peri-urban and rural centers depended on the local experts and leaders of community-based organizations who were available and willing to assist the research team. Many participants were selected using snowball sampling: a single individual was asked to gather his or her friends. In rural areas, the team used the local chief to contact men of the appropriate age. The process of informed consent required that the participant understand that he or she could refuse or discontinue participation at any time. FGDs had a low refusal rate; 2.7% (5 out of 188

[2] Definitions of urban/ peri-urban and rural were established by the National Bureau of Statistics (KNBS, 2009). Peri-urban was defined as any relatively dense population (away from rural livelihoods) and within 45km of a town. This is likely to be somewhat subjective, but we confirmed with local opinion and this definition was reasonable for identifying areas that were neither urban (as in town) nor rural (as in purely pastoralist) and a mix between pastoralist and urban.

[3] "Unsafe" was defined as an area that had experienced significant insecurity from attacks or banditry in the last year. In some cases, even when towns themselves were considered safe, attacks on the highways make the roads impassable.

[4] "Locations" are the administrative subunits of a division; "rural locations" are those that do not contain a town or peri-urban area.

people) decided not to consent to participate after hearing the details of the study goals and procedures.

Sample selection- key informants

The KII respondents were not stratified, but were selected purposively to elicit the views of senior decision makers or leaders. The 12 respondents included traditional healers, as well as regional and local HIV/STI public health officials. These public health officials occupied leadership positions in HIV prevention programming in the Rift Valley Provincial and Turkana County administrative levels, including three Constituency AIDS Control Coordinators, three District AIDS and STI Control Coordinators, the District Medical Coordinator of Health, and the Senior Delivery Specialist for a non-governmental organization. In order to protect their identities, these titles are not linked with specific responses in this report. Throughout the results, these key informants are referred to as "Public Health Officials."

Table 1. Number of focus group discussions, in-depth interviews and key informant interviews by type of participant and research site

Method	Type of research site			Total
	Urban	Peri-urban	Rural	
Focus Group Discussions				
Circumcised men (25–49)				
North Turkana	1	1		2
Central Turkana	1	1	None*	2
South Turkana	1	1		2
Lodwar	1	1		2
Subtotal	4	4	0	8
Uncircumcised men (25–49)				
North Turkana	0	1	1	2
Central Turkana	1	0	1	2
South Turkana**	1	1	1	3
Lodwar	1	0	0	1
Subtotal	3	2	3	8
Female partners (18-49)				
North Turkana	0	0	1	1
Central Turkana	0	1	0	1
South Turkana	1	0	0	1
Lodwar	1**	0	0	1
Subtotal	2	1	1	4
Total FGDs	**9**	**7**	**4**	**20**
In-depth interviews				
Circumcised men (25–49)				
North Turkana	3	1	1	5
Central Turkana	4	2	0	6
South Turkana	2	2	0	4
Lodwar	1	1	2	4
Subtotal	10	6	3	19
Uncircumcised men (25–49)				
North Turkana	3	1	2	6
Central Turkana	5	2	1	8
South Turkana	1	2	1	4
Lodwar	2	1	0	3
Subtotal	11	6	4	21

Table 1. (continued)

Female partners (18-49)				
North Turkana	2	1	2	5
Central Turkana	2	2	1	5
South Turkana	1	2	1	4
Lodwar	1	1	1	3
Subtotal	6	6	5	17
Older women and men (50+)				
North Turkana	1	0	1	2
Central Turkana	1	1	1	3
South Turkana	0	1	1	2
Lodwar	0	0	0	0
Subtotal	2	2	3	7
Total In-depth Interviews	**29**	**20**	**15**	**64**
Key informant interviews				
Total Key Informant Interviews	**5**	**4**	**3**	**12**
* there were never enough circumcised men in rural communities to form an FGD **Partners of circumcised men; all other FGDs in this category were partners of uncircumcised men*** Includes one FGD of men 50+;				

Data collection

All data were collected between January and April 2012. All FGDs, IDIs and KIIs were conducted using semi-structured guides. The guides were designed to provide interviewers and focus group moderators with a structure for collecting data related to the study objectives while also allowing flexibility for probing and discussion on related topics. Guides were developed through a review of the existing literature, local pretesting, and translation and back-translation between English and Turkana.

All participants provided informed consent prior to participation. Interviews and FGDs were all conducted in a private setting. Respondents were given a small incentive (a flashlight and a soda) for participation. Male interviewers administered all of the FGDs and IDIs for male respondents. For women, female interviewers conducted most FGDs and all IDIs. Each FGD and IDI session lasted up to two hours. Each FGD had between five and twelve participants, was facilitated by a moderator, and included another fieldworker who took notes and recorded the discussion with a digital recorder. All interviewers of IDIs also audio-recorded and took notes during sessions.

A list of potential key informants was generated and discussed with the local research team for appropriateness and accessibility before requests for participation were made. KIIs lasted up to one hour.

Data analysis

Recordings were transcribed by the interviewers, and field notes were incorporated into the final transcripts. Data from FGDs, IDIs and KIIs were analyzed separately and results were compared to identify common themes and emerging trends. All data was transcribed in Turkana and then translated into English. In the case of the KII or IDI, transcripts were then coded thematically with the Atlas.ti 4.2

software. A coding scheme based on the research questions of interest and emergent themes was developed after reviewing all 76 transcripts. For FGDs, two members of the research team reviewed the complete transcripts from each group discussion and then discussed their interpretation of emerging themes in relation to the research questions, with particular attention paid to conflicting opinions or clear consensus of the groups. These points were in turn compared to findings from the coded IDIs.

Ethical approval

This study was reviewed and approved by the Kenyatta National Hospital's Ethics and Research Committee and Tulane University's Institutional Review Board (IRB). The Johns Hopkins Bloomberg School of Public Health IRB deferred to the Tulane IRB via an IRB Authorization Agreement (IAA). Permissions were also obtained from the District Health Commissioners in the four areas, and the Local Chiefs in all rural and peri-urban areas.

RESULTS

Results are comprised of qualitative data from a total of 247 respondents: 183 focus group members (distributed over 20 groups), 64 in-depth interview participants, and 12 key informants (Table 1).

In this analysis, data from the IDIs and the FGDs have been synthesized due of the similarity of the demographics of target respondents, questions posed, and themes identified. KIIs are presented in a separate section to isolate the view of this unique type of respondent. Findings are summarized under the following categories: (a) perceived barriers and facilitators of demand for VMMC among older men, (b) supply side issues and challenges for increasing VMMC, and (c) recommendations from respondents to improve VMMC services and specific ideas to increase uptake among older men ages 25-49 years old.

Perceived barriers and facilitators of VMMC

Factors influencing demand of VMMC are described below in the following categories: cultural significance of circumcision, modernization and disease prevention, variations in perceived stigma associated with VMMC, age and its relationship to VMMC uptake, and social relationships.

Cultural significance of circumcision

Respondents consistently spoke of circumcision as a practice of other ethnic groups, and as something not traditionally aligned with Turkana culture.

> In our culture, we don't know about 'the cut' that is carried out in other tribes that are not Turkana. (Circumcised man, urban central Turkana, age 35)

This act of adopting a traditional practice of another culture sometimes carried negative symbolism, as most of Turkana's traditional territorial enemies are from tribes that circumcise men as a rite of passage (e.g., Pokot, Samburu, Marakwet). For some, circumcision signified cultural infidelity and devalued a long-established physical means of marking tribal membership.

> Circumcision is a tradition that is done or practiced by tribes like Pokots. So, by them getting circumcised, it will be like leaving their traditions for a different one. (Partner of uncircumcised man, southern Turkana, age 31)

Older Turkana men were apt to see circumcision as disregarding tradition and assimilating to other cultures. Another prevalent view was that the older men were the keepers of culture, and were therefore especially expected to uphold Turkana traditions. This man from a rural area claimed:

> The Turkana men who circumcise are the assimilated group, who stay with the Somalis as workers or their servants. They are influenced by the Somalis culture and beliefs […] Circumcision is a strong departure from the norm and other practices stipulated by the laws of this community. (Uncircumcised male, age 52)

While these neighboring cultures circumcise men as part of a ceremonial rite of passage, the Turkana practiced a different ceremony intended to raise certain men into elder status. The significance of this

ceremony, called *Asapan*, is sometimes compared to that of circumcision in other cultures. *Asapn* is a symbolic and ceremonial promotion raising an individual to senior elder status, and is regarded as one of the most important ceremonies that a Turkana man can and should go through if he can afford to do so. It is not practiced by all, but is instead something that men hoping to become senior leaders in their community aspire to. It was these older men, candidates or past participants of *Asapan*, who seemed most likely to consider circumcision to be incongruent with Turkana culture.

> Our culture requires that a man should […] undergo *Asapan*. Circumcision is a strong departure from the norm and other practices stipulated by the laws of this community. (Uncircumcised male, age 52)

Some older men regarded *Asapan* as a divine gift specific to Turkana and distinctive from circumcising cultures.

> On my side, God gave me *Asapan* and circumcision to the other tribes as their culture. What has meaning to Turkana is *Asapan* but not circumcision. (Uncircumcised male, age 38)

This sentiment was echoed as well by some female respondents.

> According to my community, men did not practice circumcision. Instead, they practiced what we call *Asapan*. *Asapan* is a traditional ritual similar to circumcision but one does not undergo the cut. (Partner of circumcised man, peri-urban southern Turkana, age 65)

Another idea that emerged from discussions outside the FGDs and IDIs gave insight as to why some older Turkana men may fear this mixing of cultural traditions. According to legend, a man who is circumcised and who then goes for *Asapan* may go mad from being caught "between cultures." The stress of being on two "sides" could potentially destabilize him and drive him toward insanity. Two separate men, outside of the interviews, told the research team an example of a man from south Turkana to whom this had supposedly happened (Moses, field notes, April 2012).

While many respondents discussed culture as a barrier to VMMC, others concluded that Turkana cultural practices and rituals did not at all forbid the practice. Several men discussed that circumcision actually has "no meaning" for Turkana and that this lack of meaning made it a viable, culturally neutral, medical intervention. A 38-year-old man from southern Turkana stated succinctly, *"[Circumcision] does not mean anything since it is a new thing in Turkana*." Another, a 27-year-old man from Lodwar, suggested that "*circumcision does not have any meaning to our Turkana community… it means nothing because we do not practice it*."

Modernization and disease prevention

Circumcised men commonly cited disease prevention as a primary motivating factor in their decision, and both circumcised men, uncircumcised men, and female partners who regarded VMMC primarily as a preventive measure for HIV were likely to approve of the practice. Many respondents used words like "new" and "modern" to describe circumcision and its emerging presence in their society as a way to

confront "new" diseases. These respondents equated STIs with something new and foreign; therefore, a new and foreign approach like VMMC to prevent them would be acceptable, regardless of cultural roots.

> What brought circumcision to my community is because of so many issues that have come to the earth… diseases that have come like 'elepot' (Gonorrhea) 'Lokwakel' (HIV/AIDS). These have made people to see if they can change and follow recent way of living rather than staying uncircumcised. (Uncircumcised male, age 30)

A circumcised man from urban Central Turkana discussed circumcision as his preferred option for STI prevention.

> I had decided earlier on to go for circumcision when I got infected with gonorrhea. The doctors told me to either use condom or get circumcised in order to prevent this disease. I decided to get circumcised, rather than using condoms because condoms could still bring harm to me. (Circumcised male, age 26)

Others also acknowledged disease prevention as outweighing the cultural significance of the practice.

> For the Turkana people who are doing it, they do it for purposes of protection against diseases but not as an observance of any culture. They believe that protection is good for disease control and prevention. (Uncircumcised male, age 34)

For many female partners as well, circumcision was equated with health. Like their male partners, most women knew that circumcision was a "new" means of protection from "new" diseases. For example:

> Circumcision was not practiced in the past in the Turkana community but due to the spread of the diseases that have come these days, circumcision has been introduced as one way of prevention to these diseases. However, not all Turkana people accept circumcision; there are those that reject while a few of them accept it. (Partner of uncircumcised man, urban central Turkana, age 39)

While those in urban areas were often well aware of the protective effects that circumcision has for prevention of STIs, respondents in rural areas were less able to discuss the specific protection that circumcision can offer. These individuals tended to speak of the medical benefits of circumcision as a legend or a rumor, rather than as a well-understood public health tool.

Variations of stigma

Evidence emerged from the data that men both circumcised and uncircumcised faced certain stigmas within Turkana and Kenyan societies. For some respondents, especially in urban and peri-urban areas, circumcision represents the necessity of being like others in Kenya. Although circumcision is a physical practice that distinguishes the Turkana from other cultures, there is some evidence of internal stigma directed toward the tradition of not circumcising amongst urban dwellers. Circumcision was also often associated with cleanliness, an emerging value of modern Kenya rooted in both religious and public health messages. According to one uncircumcised male:

> Our people carry a lot of dirt in their foreskin after playing sex. This shows that we are still dirty; we have to practice circumcision so that we can be like other people. (Uncircumcised male, age 35)

In other contexts however, circumcision itself was stigmatized and equated to nakedness, especially in rural areas. Without a foreskin to protect against embarrassing exposure, a circumcised man will be ridiculed in communities where it is common for adult men to bathe or walk publically without clothes. As a circumcised man from urban northern Turkana discussed:

> Those men who refuse to circumcise mostly fear "Ng'imeny" (ridicule) by either men at the "Alokitoe a Ng'ikiliok" (social gatherings) or women when bathing naked at the water point; while those who circumcise do it because they understand its importance. (Circumcised male, age 29)

Some women as well, recognized this same stigma as a potential barrier to the adoption of VMMC services.

> However, I think those Turkana women in the rural [areas] may not be aware of the benefits of circumcision and may not accept their men to be circumcised because their men do not have enough clothes to cover themselves. (Partner of circumcised male, age 29)

Others suggested that educated men who recognized the benefits of circumcision were less likely to hold this stigma.

> Stigma comes from… the majority of men in the community who do not approve it. Thus the circumcised cannot mingle with other men in bathing at the river… however… the educated embrace the cut for its obvious benefits. (FGD of uncircumcised men, rural central Turkana)

These data suggest that the stigmatization exists both for and against circumcision. While the fear of stigma from being circumcised may prevail in more rural areas of Turkana, fear of stigma from being uncircumcised may be a major catalyst for men to seek VMMC services in more urban areas.

Age

Even men who were not necessarily opposed to VMMC often admitted that they would not seek out the procedure because their advanced age or marital status negated its necessity. Though respondents often acknowledged the importance of circumcision for younger males, the procedure was not seen as being as valuable for many older men.[5] Older age may be a barrier to VMMC because of the belief that

[5] The word for "old" in Turkana was used in the interview guides for those over 25 years old—translated directly from English. Though interviewers directed respondents to refer to men 25-49 years of age, interpretation of results must consider the possibility that several respondents may have interpreted the word "old" to mean elderly, and over the target age of this study.

older men are not sexually active, or not as sexually active as younger men, and thus less susceptible to contracting STIs or HIV. Men and women repeatedly said that older men did not need to undergo circumcision "because they were no longer having sex." Others acknowledged that older men may still be sexually active, but have (or should have) settled down and committed to faithful monogamy with their wives.

> Old men also say that 'Lokwakel' (HIVAIDS) was not there in the past. So according to them it is the new generation that has brought 'Lokwakel'. Therefore, circumcision should be done to the young people because they are the ones that are still active in sexual intercourse. (FGD with Partners to uncircumcised men, rural, Turkana North)

Another woman from southern Turkana worried that circumcising older men could pose health risks.

> There is no sense in circumcising [older men], it would even pose some problems to them like taking long to heal and bleeding. To me it is true that circumcision should be done to young energetic men who are still active in playing sex. (Partner of circumcised man, urban southern Turkana, age 29)

Because circumcision was brought in as a means of preventing "new" diseases, some understood it as the youths' responsibility to undergo circumcision to prevent diseases from spreading in the community. One woman shared that the "new generation" bore the responsibility for the diseases and therefore should be the ones being circumcised.

> I am dead sure that old Turkana men will not agree with the issue of circumcision because they trust their culture so much … Furthermore, there were no deadly diseases in the past, it was malaria that was common, But, many diseases have arisen with the new generation, therefore, everything that is initiated should be directed to the young generation (Partner of circumcised man, peri-urban, northern Turkana, age 31).

Some respondents also believed that in Turkana culture, men of advanced age are not supposed to openly discuss sexual topics like circumcision, and that this might be a potential a barrier to VMMC adoption among older men.

> I do not discuss [circumcision] with any of [my brothers]. This is like telling them to go to sin. I will then be considered as a man possessed by spirits. Our age does not allow us to discuss about this. The societal norms may also not allow that. (Uncircumcised male, age 45)

A focus group of women in a peri-urban area brought a different perspective on older men and circumcision. While most men were quick to dismiss circumcision as only necessary for young men, some women thought that it should be the responsibility of the older men to set a good example.

> Circumcision should start from old men so that young boys see or learn from them because children learn from their parents. And again, none of these men have stopped

> playing [having] sex. Even the old men are still active in sex. (FGD with partners of uncircumcised men, peri-urban, central Turkana)

Social influences

According to the respondents, the decision to circumcise was often influenced by family and community relationships. A circumcised man from southern Turkana narrated his version of how circumcision was becoming accepted in Turkana due to the familial and community burden of HIV.

> We used to hear our parents say 'it's the Pokot, Samburu, Borana and Somali who circumcised.' But somewhere between there emerged this "Lokwakel" (HIV/AIDS), which wiped out families leaving destitute children. We cried and we decided to circumcise because it was important for us to take care of ourselves and our families. (Circumcised male, age 37)

Many circumcised respondents, especially those on the younger end of the age range of participants, relayed stories of peer-influence in their decision to get circumcised. For example:

> There was a friend of mine who had decided to go for circumcision and told me, "Let's go and circumcise. How can we continue like this and let other people ridicule us?" The fear of ridicule and abuse from age-mates [already circumcised] influenced our decision. (Circumcised male, age 35)

Likewise, a circumcised man in urban northern Turkana discussed bathing with friends as a deciding factor in choosing to be circumcised.

> I decided to get circumcised after bathing with my friends at the river who all happen to be circumcised. They could always laugh at me just because I was not circumcised. Another thing during our bathing, I could note that I am the only one washing my foreskin using my hands to get rid of the dirt. (Circumcised male, age 25)

Similarly, some uncircumcised men in areas where circumcision was less common among their peers admitted that they would be more likely to undergo the procedure if the majority of their peers had.

Some other accounts, however, revealed that to some men, deciding to get circumcised was a private, personal affair. This man from urban northern Turkana did not discuss the procedure with anyone except his wife.

> I did not talk to anybody about my decision. I did it alone by going to hospital and after circumcision I returned home. (Circumcised male, age 30)

Service delivery concerns

This study looked primarily at the potential issues around demand and acceptability for VMMC among older men. However, demand cannot be ensured without adequate supply and quality service delivery. The remoteness of Turkana County has long been a barrier to consistent and equitable service provision

for other health services. These same barriers will likely impact the expansion of VMMC programs. Many respondents expressed cynicism toward government programs in the region in general, describing Turkana as isolated and even neglected by the central government and its public programs. Respondents expressed fears relating directly to VMMC service delivery, including low quality of care, absent, disrespectful or possibly unqualified clinicians, and lack of medications or equipment that could have a significant effect on demand creation.

Accounts of improper conduct of VMMC in the data were rare but notable. One respondent discussed being circumcised by a "novice" because he could not pay a bribe at the hospital. The community outreach worker who first contacted him had said the surgery would be free. When this respondent refused to pay the extra money demanded of him at the hospital, the doctor reportedly walked out and handed over the operation to a junior who admitted to the respondent that he had not finished training.

Privacy needs of clients were also a voiced concern, as one respondent reported that the curtains around the space where he was lying during his operation were blown off by the wind, and his discomfort with the fact that people standing outside could see right inside the room.

Supply of VMMC depends on many aspects of a strengthened health system that have yet to reach Turkana adequately. Consistent supply of clean water, electricity, and sterile spaces for performing circumcision are often lacking. Several key informants acknowledged the presence of adequate space to set up VMMC services, but feared the absence of quality space, equipment or health care personnel. Distance to access VMMC facilities was an additional concern, particularly among rural respondents.

Recommendations from respondents to improve VMMC services

Respondents offered the following suggestions on how VMMC can be successfully introduced in Turkana.

Incentives: Many respondents suggested offering incentives to men to get circumcised. Some suggested incentives in a general sense, and others made specific suggestions including cash, food, animals, medications and other material goods. Food aid was recommended notably by women, who presumably bare costs associated with the healing process when men may be unable to work or support their families.

Education and communication: Many respondents favored strong education programs led by local leaders, doctors, or the Ministry of Health, to encourage the practice in their communities. Some recommended using "*the radio as a tool for outreach, as many households in Turkana now have a radio*." One focus group pointed out that many people could be reached with information and perhaps even the service itself on the food distribution days that occur in most parts of the county. Individuals also saw opportunity in mobilizing NGOs that already have a local presence, like Oxfam, IRC and World Vision. Some suggested peer leaders, especially those who have already been circumcised, should be used as agents to address persistent fears associated with circumcision. Several emphasized the need for information on VMMC in the Turkana language, as most in the region would not be able to interpret messages in Kiswahili or English.

Service provision: Respondents were conscious of the scarcity of facilities and people to manage them. Privacy concerns were also prevalent, and participants also wanted to feel confident that they were receiving quality services from highly competent professionals. One focus group recommended designating circumcision spaces in hospitals in order to make older men more comfortable.

Recommendations revealing misconceptions: In eliciting recommendations from respondents, it became clear that further education on VMMC is needed, as some of the responses reflected misinformation. Some respondents, especially those from the northern region, suggested, *"VMMC should be free,"* revealing their lack of awareness that these services are largely available free of charge. One man said all those reporting to any clinic with an STI should be circumcised. This man also thought that circumcision was a cure for all STIs, and others shared in this view. Several respondents suggested training local traditional healers to perform VMMC, revealing a generalized lack of understanding of what is required for VMMC, e.g., including HIV testing and counseling, infection control and surgery in a sanitized surgical theater.

Key informant interviews

Twelve key informants included traditional healers and HIV service coordinators. Many views of key informants echoed those of the community members.

Traditional healers

Because of their respected role in Turkana society, the views of the traditional healers carry a particular importance in this study. The two fairly elderly, experienced, traditional healers (one 55 years and the other 70 years) were approached with caution and great respect by the eldest interviewer. A number of other leaders and community members emphasized the very important gatekeeper role that these men play for the Turkana society. The research team had heard stories of potentially negative attitudes by some of these men towards circumcision in general. However, these key informants welcomed the questions and discussion with interest and openness. They expressed concern about the increasing burden of HIV and seemingly accepted medical circumcision as a possible means of reducing the incidence of new infections. This was especially true of the elder healer, although his words emphasize that the traditional healers must be involved and must be given information by the government:

> I accept that these services should be brought to assist the people so that people can care for the wellbeing of their bodies…my opinion [on circumcision] has changed because the disease is very much here in the community and that probably circumcision can help the people to reduce their infections. (Traditional Healer, male, age 70)

> Circumcision is accepted in Turkana but not by everybody. We, traditional healers and leaders, shall make the people understand how good it is through the ways that the government will instruct us. The people themselves cannot accept alone without information from us since the services have not begun in peri-urban and the rural

> [areas]. And through these discussions and agreements between us and the government, the people shall accept the idea. (Traditional Healer, male, age 70)

Both traditional healers felt the prospect of widespread adoption of VMMC in Turkana communities was possible. The younger healer agreed that if the local administrators (chiefs) and the community leaders (themselves) are "together with the elders in this thing… then it will happen."

When asked whether older men might be persuaded, the younger healer believed that "if they understand about it, lots of them may respond positively… this is because the disease is affecting all the areas and everybody." The other was not convinced that older men would come forward so easily, especially those from the rural areas. According to him, the best chances in mobilizing them would involve

> […] working together as a team, with seminars on the subjects to start before the information is taken to the community. This means seminars for leaders to allow easier response to male circumcision by the community. (Traditional Healer, male, age 70)

Public health officials

During the interviews, area public health officials were eager for more information about the planned expansion of VMMC services. They seemed convinced that with effective education and community mobilization the VMMC program would be successful in Turkana County, even among older men. One had had close experience with the previous attempt to implement a VMMC program in the area. He spoke of the lack of social mobilization and advocacy as the program's key failure.

> […] the Nyanza Reproductive Health Team that came from Nyanza and they camped at our Youth Resource Center called Multipurpose. The only problem was that these people came and continued with the exercise without a good entry point. They didn't do any kind of social mobilization, advocacy to the leaders. (Public health official, Turkana North, 50 years)

All the public health officials had in fact been involved in the earlier, unsuccessful launch of VMMC. As a result of this experience, several made comments indicating that it's the "approach that matters." Their value of behavior change and mobilization strategy was evident when asked to evaluate the prospect of widespread adoption of VMMC services among Turkana men.

> When we were discussing […] why NRHS did not succeed, everyone said "we welcome male circumcision" and somebody was saying "even if we agree now, let them come and start with me" and this was an old man of over 50 years addressing the Ministry of Health of Turkana Central. When they come, they should follow the right channel. I think the prospects are very high. We shall succeed once the project starts. (Public health official, Turkana North, 50 years)

Another said:

> We are not anticipating any problems at all for those to circumcise. This is a very changing world and the society is rapidly changing and I know they will buy the idea so much if given correctly and professionally. There is no worry that it might impact negatively. No. (Public health official, Turkana South, age 37)

Public health officials on the county and sub-district levels expressed similar views. All regarded older men in urban areas as much more likely to agree to circumcision, but that education and sensitization of stakeholders and the community could result in successful programs even to older men in the rural areas. This tactic could be especially effective when involving village chiefs and elders, as one key informant pointed out.

> I don't think it is difficult to reach them (rural men) because the Provincial Administration can reach even deep in the interior. [It] has structures like the Chief, Assistant Chief and village elders who represent that community […]. And you know the Chiefs are very powerful and they can call a *b*araza (meeting) at any time. Even the Church has penetrated deep. I think if we use those avenues, we can reach them. (Public health official, Central Turkana, age 39)

Similarly, another respondent agreed that while culture might be a hurdle, it could be tactfully surmounted.

> We need to approach them (older rural men) cautiously by first trying to understand and respecting the culture of Turkana but slowly and tactfully trying to bring in the idea of male circumcision because it is something new to them. But if they get the concept, I believe they will change. (Public health official, Central Turkana, age 39)

Health system and supply barriers often overshadowed demand creation in discussions with some administrators. For example, one respondent began by expressing his general enthusiasm for VMMC:

> I am actually an advocate of VMMC in every social place that I go to. At every junction I meet with the community, I tell them about VMMC. It is one of my never changing agendas. (Public health official, Central Turkana, age 39)

While later, he expressed his concern about access barriers and lack of personnel:

> Access to these services is one of the hindrances because most of these facilities are 50-55 kilometers apart. So obviously access here is a problem [….]. And lack of personnel because circumcision as it is now is a package. So we need people (local personnel) who can interact with that person effectively. People who can interact on a one-on-one basis and understand each other and one who will convince that person to embrace male circumcision. (Public health official, Central Turkana, age 39)

The reference to local personnel alludes to the need for Turkana-speaking personnel, such as counselors and managers, and ideally, clinicians, to implement the program. One senior public health official confirmed this concern about human resources, adding the need for better education of personnel.

> […] human resources are a big issue here although I think the gap is closing. But even going back to the advocacy and information gap – many health workers don't even know the basics about VMMC and HIV – this needs to change. (Public health official)

In general, it was these health care service delivery issues, not the community demand creation, that most concerned the HIV service coordinators about the success of the VMMC expansion in Turkana.

Discussion

Many respondents predicted circumcision would become an accepted norm among men in Turkana when services become more available. Results suggest that there is already some demand for VMMC, mainly in urban areas among men under 35 who are more likely to equate circumcision with reduction in HIV risk. Even many older men and traditional leaders considered the practice valuable in disease prevention, though many were reluctant to seek the service for themselves.

Despite optimistic reactions and potential impact of the expanding VMMC services in Turkana, the data from this study revealed many barriers for older men that, if not addressed, may impede their uptake of Turkana's growing VMMC services. Older men, especially in the rural areas, may be hardest to mobilize considering their lower perceived susceptibility to HIV and greater adherence to the Turkana cultural tradition. Other barriers included the cultural stigma of "nakedness" for uncircumcised men and especially concerns about service quality and accessibility. Facilitators to demand included an emerging view that circumcision equaled health, protection and cleanliness, and the potential influence of community leaders. Social influences also appear to facilitate the adoption of the behavior, as some men said they would act according to their perceived social norm of circumcision among their peers.

Findings in the context of previous literature

Compared to the reviews of the acceptability studies noted in the introduction of this report, cultural considerations were much more salient among respondents of the present study. The most common facilitators of VMMC uptake revealed in the literature review were improved hygiene, protection from STIs and HIV, improved sexual pleasure and performance, and social acceptance (Westercamp & Bailey, 2007; Westercamp et al., 2012). In the present study among older men, improved hygiene was mentioned by a few of the women and only one or two men, while HIV prevention was mentioned by nearly every respondent. Improved sexual performance or pleasure was mentioned by only a few women, and social acceptance for being circumcised was mentioned only in the FGDs in urban Lodwar.

Compared to the perceived barriers mentioned in the studies of Nyanza, Rwanda, Botswana and South Africa, the fear of pain did not emerge among the respondents in this study, though fear of adverse events and poor quality care were mentioned (Albert et al., 2011, Gasasira et al., 2012, Westercamp, et al., 2012, Bridges et al., 2011). Some Turkana mentioned the economic barrier of cost, which was commonly reported in other studies. Though the services offered in Turkana will be free of charge, concern remained about costs related to transportation and lost work during the recovery period. Some studies revealed that serving older men alongside young boys may deter uncomfortable older men from seeking services in VMMC facilities; but this did not come up as a barrier in this study (Albert et al., 2011; Herman-Roloff et al., 2011b). This is likely due to the fact that the VMMC program has not yet developed and few have had the experience of being served alongside young boys. However, the issue of age and cultural initiation was so salient that segregating services for men of different ages should be considered in VMMC scale up. Poor knowledge of VMMC procedures may also explain why the post-operational abstinence period was not discussed as a barrier for men.

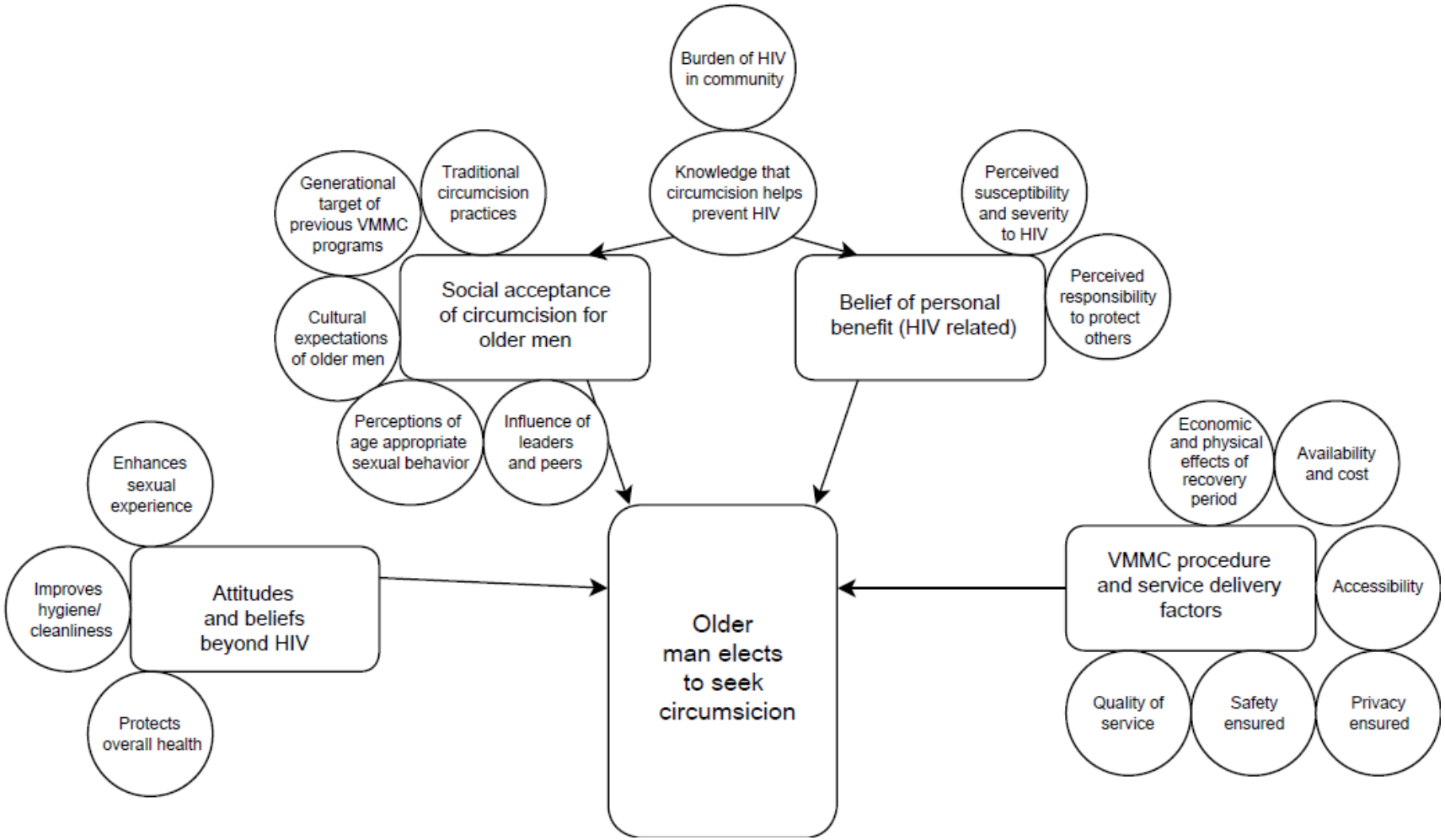
Contrary to findings in other areas of sub-Saharan Africa (Sawires et al., 2007), at no point did respondents cite the stigma of being associated with HIV as a barrier to seeking VMMC. This may be due to the lack of awareness about the HIV counseling and testing component of the planned VMMC program, or simply because the discussion guides did not specifically ask about HIV-related stigma.

Conceptual Framework

In comparing the findings from the respondents in Turkana to previous findings in the literature, it is evident that no single model for VMMC demand creation among older men can be applied to all settings. The variations in social, behavioral, and historical factors from setting to setting require a thorough examination before VMMC programs can effectively target older men. Though the results from Turkana cannot be generalized to other populations, the elements of demand creation revealed in this study can be valuable in directing future research and program development in other locations.

In the following model, we have integrated results from the present study with other common findings from previous literature in sub-Saharan Africa to provide a framework for conceptualizing the influences on VMMC demand in older men. It is important to note that in various contexts and locations, each factor depicted in this model may carry more or less influence on demand creation relative to others. In the case of older men in Turkana, we believe that heavy emphasis among respondents on service quality and the cynicism of governmental programs in the region renders “acceptability of procedure and service delivery” particularly influential in the model. We also note that the association of circumcision with the initiation rite of passage for young men as practiced by Turkana’s neighbors and enemies may also be a paramount barrier amongst older men.

Figure 1: Conceptual framework for demand for medical male circumcision among older men in sub-Saharan Africa



Recommendations for Turkana

Overall, respondents welcomed the idea of a VMMC program expansion; though the cynicism related to the historical lack of government involvement in the region added a sense of caution to this welcoming attitude. Interest in a new service being offered by the government may mobilize older men and overcome barriers. Program planners should not underestimate the effect of isolation and perceived governmental neglect or abandonment in many regions of Turkana. If executed tactfully, the VMMC program presents an important opportunity for the government and its partners to demonstrate and strengthen a working administrative relationship. An overall well-conceived and well-executed VMMC program can serve as both a vital public health intervention and as a mechanism to build local confidence in government and health services. Yet maximizing the potential reach and success of the VMMC program first requires targeted efforts in demand creation, including action specific to older men.

Based on the data from this study, the following actions are recommended for creating demand for VMMC services among older men in Turkana County:

1. Focus social and behavior change communication on the biomedical benefits and social acceptability (and ultimately, desirability) of circumcision.
2. Employ separate communication strategies designed specifically for urban or rural areas, ensuring adequate HIV education as a prerequisite for promoting VMMC in a particular community.
3. Address the distance-to-service barrier for older men in rural areas by increasing outreach and mobile sites or offering transportation assistance.
4. Target the lower end of the age range for older men.
5. Utilize and educate local traditional leaders to mobilize communities.

Social and behavior change communication

Marketing VMMC as a biomedical intervention, as opposed to more directly addressing cultural connotations, may be the most effective way of framing behavior change messages. One possible approach would be to use street theater, as well as visual aids to help individuals differentiate between the traditional knife-cutting circumcision ceremonies of their enemies and the new, biomedical and culturally neutral VMMC.

Social and family influences in Turkana society have the potential to be powerful facilitators for VMMC demand creation. Messages can address stigma against circumcision by promoting the acceptance of the older circumcised man—as someone not to be ridiculed, but rather as someone to be respected for what he has done to protect himself and his family against HIV and other sexually transmitted infections. Messaging should aim to influence perceived social norms, as the findings from this study suggest that men may be more likely to get circumcised if they believe their peers have sought or intend to seek VMMC. Social and behavior change communication should explore ways to tactfully use peer and family influences while still respecting the fact that the many men may want to keep their decision to get circumcised private. Programs should also consider conducting further research on peer and individual influences on men's decision to get circumcised, in order to better explain the social-cognitive pathways through which these decisions are made.

Regional specificity

The program may benefit from dividing into urban/peri-urban and rural phases, in both social and behavior change communication and actual service rollout. Older men from urban or peri-urban areas should be the first targets of the intervention, not only because they are thought to be at greater risk of HIV infection and transmission, but also because the program can more easily test messaging materials and service delivery in these more accessible areas. By piloting messaging and procedures in these areas the program can take advantage of the notion that older men in urban areas may have had more exposure to HIV education in the past and may be more accepting of VMMC as a modern medical procedure.

While services and mobilization efforts are initially being expanded in the urban/peri-urban areas, education efforts should be simultaneously implemented in the rural areas in order to address the HIV knowledge gap. Ensuring a basic level of knowledge of HIV prevention, transmission, and treatment in each community is an essential first step that must precede any messaging that justifies the medical benefits of VMMC. This type of communication should also be designed around the possible barrier of limited media infrastructure, and program planners should consider focusing on radio and community leaders to deliver educational messages to older men in rural areas.

In subsequent phases, after messaging and service delivery have been improved through the initial phases in the urban/peri-urban areas, rural men primed with HIV education can be effectively targeted with the specific aim of creating demand for VMMC services.

Travel assistance

The distance to facilities was also a common concern for older men in rural areas, and needs to be addressed by program planners. Older men who would have to walk significant distances to reach health centers may be more likely to access VMMC if transportation were available to relieve them of travel costs or the prospect of walking home with a serious wound. Mobile services for VMMC have already been considered for Turkana, but will need to overcome challenging logistics and the funding needed to effectively reach men living in remote rural areas. Assistance with travel costs and arrangements may prove to be the best option, and could enable men from more remote areas to travel to VMMC service sites and remain there for the initial healing period.

Target age

Among the group examined (men ages 25-49), those 25-35 years old may be the most promising initial focus of the program. These men may not only be more sexually active, but may also be more apt to forgo deep-rooted cultural traditions for a more “modern” procedure. Though this research focuses on demand among older men, it does not necessarily recommend a drastic shift in the programmatic focus. Continued efforts should also build on the success of reaching boys, teenagers and young men through mobilizing and education through schools, parents, and mass communication.

Local Leadership

Ensuring the success of the VMMC program requires the use of respected local leaders for community sensitization and support. VMMC scale-up should carefully build up community confidence before the program opens by holding community-level meetings and seeking input from local leaders. Inclusion of local leaders and traditional healers in the early planning phases should also include training in VMMC

communication in order to help these already respected figures mobilize their communities and effectively address barriers to demand. The two traditional healers in this study already appear to support the new circumcision program as a means of decreasing the burden of HIV in the community; however, their knowledge of the surgical procedure was limited. Building off of the potential social leverage of these healers, as well as administrative and religions leaders is a great opportunity, but must be linked to guidance and education that can enable them to lead mobilization efforts effectively.

Limitations

On the whole, respondents were welcoming and receptive to the topic of circumcision, though its sensitive nature deterred a handful of individuals from participating. However, since respondents were recommended via community contacts for participation (e.g., chiefs, teachers, other leaders), many may have been purposely selected for being open, talkative and opinionated individuals not likely to be embarrassed by talking about circumcision. Due to this sampling, it is possible that there were different views among less outspoken individuals who may not have been recruited because of their sensitivity to the topic. Indeed, though the majority of the responses to VMMC were positive, there were some respondents who were relatively silent during focus group discussions. Program designers should consider the likelihood that this sample selected in this study likely emphasizes the more positive end of a possible spectrum of views toward circumcision, and that results cannot be generalized to the whole Turkana population.

Additionally, the interpretation or translation of the phrase “older men” may have been a limitation in this study. Despite training the interviewers to ask all questions about men aged 25 – 49 (middle aged men), they reported that respondents tended to interpret the word “old or older” to mean “very old,” even after being asked to think about the middle-aged instead of the elderly. This is most likely due to language barrier: there is a word for “old man” in Turkana but no term for the “middle aged,” creating challenges for translation. This misinterpretation is particularly noticeable in the reports that older men are not very sexually active. Perhaps most of these comments were made in reference to men over 65 years for whom sexual inactivity is more likely. These results are especially misleading considering past research suggesting that concurrent partnerships are most frequently practiced by men in their 30s and 40s (individuals within the actual age range of interest of this study) (Macintyre et al., 2011). Fortunately, the misinterpretation of the target age was not a consistent problem, and some interviewers were better than others at keeping the conversation focused on the middle-aged.

Finally, though barriers and facilitators were revealed in this study, the relative weight of each factor in a man’s decision to get circumcised is still unknown. Further research is necessary to describe the pathway and mechanisms of this type of multi-faceted decision-making, and to determine the relationships between these variables and the desired outcome (i.e. the uptake of VMMC). Survey research that takes into account the results of this qualitative study can help quantify the effects of these factors and help focus messaging where it will have the most influence on decision-making.

Conclusion

The maximum population level effectiveness of male circumcision for reducing HIV transmission cannot be achieved without expanding services to older men ages 25-49. Expanding VMMC services to older

men in Turkana County is a potentially pivotal action in reducing HIV in the region. Men and women were generally supportive of the idea of expanding VMMC services in Turkana. However, because cultural traditions do not align with the practice of circumcision, promoting the uptake of these services in the region may be particularly difficult, especially among older men. Using messages focusing on the biomedical benefits of circumcision—and disseminating them with the support of established local leaders—can help create the demand necessary for a successful rollout of VMMC services in Turkana and can offer lessons learned for similar sociocultural settings.

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