

INTEGRATING GENDER IN VOLUNTARY MEDICAL MALE CIRCUMCISION PROGRAMS TO IMPROVE OUTCOMES

Background

Male circumcision is proven to reduce the risk of sexual transmission of HIV from women to men by 60% (Auvert et al., 2006; Gray et al., 2007; Bailey et al., 2007), and it is estimated that 80% coverage of HIV treatment by 2015 could reduce new HIV infections by 30-50% over 5-10 years (Williams et al., 2011). Voluntary medical male circumcision (VMMC) is recommended as part of a comprehensive HIV prevention package, which includes HIV testing and counseling, correct and consistent use of male and female condoms, screening and treatment of sexually transmitted infections, promotion of safer sex behaviors, and referral of HIV-positive clients to care and treatment (WHO-UNAIDS recommendations).

VMMC is a relatively new approach for HIV prevention, and there are limited data or reporting on VMMC programs. This offers an important opportunity to apply improvement methods, including gender integration, in the scale-up of VMMC in order to learn how to effectively implement the intervention.

Existing research and reports, while limited, concur that women play an important role in VMMC service adoption, men's adherence to the abstinence period, and outcomes and that negative consequences can occur as a result of lack of knowledge and engagement among female partners.

Male circumcision also reduces the risks of other sexually transmitted infections and cervical cancer in women and girls.



In Uganda, surgeons perform safe male circumcision under a tent on the lake's edge to reach one of the most at-risk populations, people living in fisher communities.

Photo by Kim Burns Case/JHUCCP, Courtesy of Photoshare

A study conducted in South Africa found that circumcised men were about half as likely to have the human papilloma virus as uncircumcised men, when controlling for other factors (Auvert et al., 2009). This translates to a lower rate of HPV and cervical cancer among their female partners.

Traditions surrounding circumcision vary by region, community, and generation. Many myths surround the procedure, some of which can lead to risky behaviors and negative social implications surrounding circumcision. Men and women may also have different perspectives and knowledge about the effects of male

Box 1. Gender issues for consideration in VMMC services

- Harmful gender-related myths and traditions
- Female partners' roles in VMMC decisions
- Female partners and post-operative care, adherence, and risk-reduction behaviors
- Negative consequences of excluding women
- Female providers
- The role of mothers and fathers in VMMC

circumcision on sexual experiences; a woman's opinion may motivate or deter her partner from undergoing circumcision. Misunderstandings about VMMC, particularly when not delivered as part of a comprehensive HIV program, may lead to distrust and violence in a relationship. Finally, leaving women out of this HIV-prevention activity misses an opportunity for couples' counseling and testing and linking women to other services.

Gender Issues in VMMC

Myths and traditions surrounding male circumcision

For many, male circumcision is an important tradition or rite accompanying meanings of status, manliness, sexuality, and religion. VMMC programs

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must respect local traditions while aiming to provide a safe alternative for the reduction of HIV risk. In many cultures in Sub-Saharan Africa, circumcision marks the transition into adulthood and the time to initiate sexual activity (WHO, 2009). However, WHO safety guidelines for VMMC state that clients must abstain from sexual intercourse for 6 weeks after the surgery to ensure proper healing. Men are more at risk of acquiring HIV and transmitting HIV if HIV-positive immediately following circumcision.

Men considering medical circumcision may face stigma. For example, some cultures oppose circumcision. Other groups consider those who do not participate in a traditional circumcision ceremony as weak or of lesser status, even if the traditional procedure is unsafe. Female partners who are not aware of the medical benefits of VMMC or who don't fully understand the procedure often harbor negative sentiments which can deter men from undergoing medical circumcision or can lead to adverse events after circumcision.

Focus group discussions in Uganda in April 2013 through the USAID ASSIST Project revealed that some beliefs and practices may lead to negative health consequences for men and women or lead to strains in intimate partnerships. These included the belief that a married man should have sex with a virgin after circumcision to promote healing, or to have sex with a woman other than one's wife or intimate partner after circumcision as a protective measure to avoid being "cursed." Such beliefs not only encourage risky behaviors, but also cause some female partners to dissuade their husband from seeking services or to become suspicious and angry with their partners after circumcision, which can itself lead to violence.

Female partners' roles in VMMC decisions

Educational programs must challenge traditional and harmful beliefs and reach both men and women. Women are frequently blamed for the spread of HIV, and this results in stigma and discrimination against women living with HIV, as well as the fear of disclosure (Nudelman, 2013). Because VMMC reduces female-to-male transmission of HIV, care must be taken in its promotion to avoid spreading the harmful misconception that women are the chief vectors of HIV.

Discussing circumcision with a female sexual partner was the greatest predictor of readiness to undergo VMMC in one study in Zambia

Box 2. USAID ASSIST Safe Male Circumcision (SMC) Gender Integration Strategy and Progress in Uganda

In Uganda, the USAID ASSIST Project is supporting facility-based improvement teams in 26 districts to improve the quality of SMC services. Steps taken by the URC Uganda team to integrate gender considerations in the SMC program included:

- Presented gender integration recommendations for the Ministry of Health's Quality Improvement Tool for Safe Male Circumcision to the National Task force which, in turn, adopted recommendations
- Trained facility staff in gender integration in SMC at learning and coaching sessions
- Supported facility teams to develop talking points and mobilization campaigns to encourage female involvement
- Female service packages were adopted at some SMC settings including cervical cancer testing, family planning, and ANC services
- Developed indicators to track partner participation in SMC
- Conducted research on the effects of female involvement in SMC programs

Teams identified engaging female partners to attend educational sessions and clinic visits with male clients as a change to test. From January to December 2013, the proportion of clients who attended educational sessions with partners increased from 0 to 30%.

Anecdotal evidence suggests that this had contributed to an increase in retention of follow-up visits and a decrease in adverse events. Couples who attend SMC visits as partners are offered HIV counseling and testing, and female partners are encouraged to access reproductive and other health services at visits. By December 2013, two health facilities reported an increase in uptake of others health services like family planning and immunization because of engaging female partners.

The USAID ASSIST Uganda team also identified barriers to female participation in SMC, including that the majority of clients who attend SMC services leave their partners to attend to their own duties while they're away, such as managing a store or taking care of the home. It therefore becomes difficult for female partners to attend SMC appointments and educational sessions. Finding transport for two people also poses an additional burden on couples. To address this, providers have organized SMC outreach camps to reduce transport costs. SMC teams also faced difficulties in convincing the community of the benefits to female partner participation in SMC. To address this challenge, the team developed a list of talking points with advantages of female participation to aid mobilization campaigns. The project is working to produce qualitative and quantitative evidence on the impact of gender integration.

(Jones, 2013). A survey conducted by the Women's HIV Prevention Tracking Project found that 74% of women would like to be involved in the decision-making for VMMC. Both men and women expressed fear that their partner would be unfaithful during the six weeks of medically-advised abstinence following circumcision (WHIPT, 2010). Multiple studies have found that women have significant influence over their partner's decision to be circumcised, whether openly or privately (Hatzold et al., 2014; Lanham et al., 2012). Female partners can help encourage men to get medical circumcision by assuring their partner of their support. In many households, women are responsible for health-related matters. By educating women on the benefits

of the VMMC service, they serve as the gatekeepers for access to services.

Female partners and post-operative care, adherence, and risk-reduction behaviors

After undergoing VMMC, men must abstain from sexual activity for six weeks in order to properly heal. During this period, they are susceptible to wound infection and are more likely to transmit or become infected with HIV. Both men and women express difficulty adhering to this requirement (Nieuwoudt et al., 2012; Evens et al., 2014). Discussing this requirement as a couple and approaching the issue together will improve adherence and

Box 3. Example of gender-related issues in SMC services

Jude Ssensamba, Quality Improvement Officer for the ASSIST Uganda SMC Program, shared this example of gender-related issues identified:

A client was circumcised without informing his wife. When the client returned home from the procedure, his wife assumed he received the circumcision in order to have multiple sexual partners. She became angry and threatened divorce. She packed her belongings and filed a complaint against her husband at the Local Counsel. The client returned to the health clinic late at night. Health workers counseled the client and reached out to the wife for counseling. A Regional Coordinator traveled to the couples' home to follow up and provided counseling on the benefits of SMC. Through counseling the couple resolved the conflict. The cost of activities with the Local Counsel and for the health workers and Regional Coordinator to follow up with counseling resulted in an expenditure of about \$145. This could have been avoided if the wife had been proactively included in the education process.

foster joint accountability. Men who receive this clinical guidance alone may not tell their female partners, or if they inform their partners, their partners may not believe them. Cases have been cited where women perceived their partners as lying in order to pursue someone else. At the same time, some men do not abstain because they fear their wives will seek to fulfill their sexual needs with someone else (RTI International et al., 2012). Including women in the process also offers an opportunity for couples' testing and counseling which will increase their knowledge about protection and can link both men and women to treatment and services as needed.

Most men who volunteer to undergo medical circumcision are nervous, and the pain of the procedure may further distract them from the post-operative cleaning and care procedures instructed by physicians. USAID ASSIST-supported facilities found that female partners accompanying men can help by learning how to dress and clean the wound. Involving a female partner can improve adherence to the WHO-recommended 48-hour and 7-day follow-up appointments and thus reduce adverse events. It's important to remember that medical circumcision does not offer complete protection; men still need to wear condoms as they can still transmit HIV to women and still acquire HIV from an infected woman. Women need to be aware of the limitations of male circumcision in order to negotiate condom use.

Negative consequences of excluding women

Research conducted in Swaziland found that the majority of women believed that male circumcision would lead to an increase in gender-based violence and intra-partner conflicts (WHIPT, 2010). Proper education, counseling, and joint decision-making can

decrease the likelihood of conflicts. Women who learn of their partner's circumcision without prior discussion may accuse them of accessing services in order to have multiple partners or of being HIV-positive.

Misunderstandings surrounding condom use may also lead to conflict if both partners are not knowledgeable and in agreement about protective behaviors after circumcision. Research conducted in the Kisumu municipality in Kenya indicates that men with inconsistent condom use and multiple sexual partners are more likely to decide to get circumcised (Westercamp, et al., 2010). Men should be educated about the fact that circumcision does not provide 100% protection, and female partners must be empowered with knowledge to protect themselves in these situations.

Female providers

Gender issues can also present themselves when male clients undergoing VMMC have preconceived notions about interacting with female nurses and doctors. Traditionally, male circumcision was a male-only affair; although now a medical procedure, there are objections among some male patients to involving female health providers. Qualitative research has found that men often feel uncomfortable going to a female physician or nurse due to their sex (Umar et al., 2013; Soul City Institute, 2010).

The role of mothers and fathers in VMMC

For VMMC projects which target adolescents and young boys, mothers and fathers are important actors in the decision for their sons to undergo the procedure and in the care and follow-up after the procedure. While youth are more likely to accept VMMC than adult men, as it is seen as modern and hygienic (Westercamp,

Box 4. How the WHO VMMC Toolkit addresses integrating female partners

Criterion 1.4: Specific efforts should be made to ensure that women are involved as partners and mothers

Criterion 2.1: HIV testing services routinely offered to clients' partners

Criterion 2.3: Risk reduction and safer sex counseling to men and messages to deliver to their partners (if partners are present, should be included in counseling)

- Counseling on the importance of both clients knowing their status, reducing number of partners, female and male condom use education, education on increased risk of HIV if engaging in intercourse before the wound is healed

Criterion 2.4: Male and female condoms available at the facility

Criterion 5.1: Partners provided printed materials: "Materials for women should specifically include information about the risks and benefits of MC for women, so that they are aware and can take steps to protect themselves and encourage MC among HIV-negative men in the population."

Criterion 5.2: Appropriate reinforcing and educational materials are provided, available in counseling rooms with information to clients and sexual partners

Source: World Health Organization. Male Circumcision Services: Quality Assessment Toolkit.

et al., 2010), it's important to educate mothers and fathers or other guardians about the benefits of VMMC and post-circumcision care and follow-up. Analyzing who makes health and financial decisions in the household is important when designing programs to engage parents in VMMC.

Considerations for Integrating Gender into VMMC Services

1. Educate men and women in the community on VMMC

- Counter myths and harmful traditional practices by working with community leaders

- Disseminate radio and media messages to the entire community about the importance of males who undergo VMMC informing and involving their female partners in the procedure
- Enlist community health workers as messengers

2. Encourage female partners to come to clinics

- When recruiting men, encourage them to bring partners, but allow male patients to decide whether or not to involve their partners
- Provide individual/couples counseling and testing
- Reach out to women's groups about VMMC and engage women to be involved in and educated about their partner's VMMC procedure

- Provide education sessions for couples, but also make sure men who come without a partner receive counseling and required information
- Always ensure both partners agree to counseling, testing, and sharing their status
- Protect the privacy and confidentiality of all clients

3. Create an inclusive environment

- Offer couples testing and counseling at VMMC appointments
- Link VMMC services to PMTCT, ART services, well-child visits, and other reproductive health services
- Train health care workers on gender issues surrounding VMMC
- If possible, ensure both male and female providers are available for counseling and testing.

Resources to learn more

World Health Organization. Male Circumcision Services: Quality Assessment Toolkit.

Accessed at: http://malecircumcision.org/programs/documents/WHO_QA_Toolkit_WEB.pdf

This toolkit is designed for facility staff and program managers and can be used as a guide to set up VMMC programs and to assess the quality of programs to ensure they meet the minimum standards of safety and quality. The tool identifies gender-related barriers to accessing care and discusses efforts which should be made to ensure that women are involved as partners or mothers. The toolkit also provides guidance regarding what type of material should be provided for and what should be communicated directly to women.

Call to Action on Voluntary Medical Male Circumcision, Implementing a Key Component of Combination HIV Prevention.

Accessed at: <http://www.avac.org/ht/a/GetDocumentAction/i/44846>

The report highlights the importance of VMMC as a tool to decrease the spread of HIV/AIDS and discusses the impact of counseling on sexual behaviors. It explains how programs should provide an education component that includes dialogue to address issues of gender roles. The report highlights the unique role that VMMC programs can play in fostering these conversations with men who might be hard to reach through the health services, and calls attention to the role of civil society partners in gender-related education about VMMC including gender equality and domestic violence.

References

Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, et al. 2006 "Correction: Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial." *PLoS Med* 3(5): e226. doi:10.1371/journal.pmed.0030226.

Auvert B, et al. 2009. "Effect of Male Circumcision on the prevalence of high-risk human-papilloma-virus in young men: results of a randomized control trial conducted in Orange Farm, South Africa." *J Infect dis*. 2009 Jan 1; 199(1): 14-9. doi: 10.1086/595566.

Bailey RC, et al. 2007. "Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial." *The Lancet* 369(9562).

Evens E, Lanham M, Hart C, Loolpait M, Oguma I, et al. 2014. "Identifying and Addressing Barriers to Uptake of Voluntary Medical Male Circumcision in Nyanza, Kenya among Men 18–35: A Qualitative Study." *PLoS ONE* 9(6): e98221. doi:10.1371/journal.pone.0098221.

Gray RH, et al. 2007. "Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial", *The Lancet* 369(9562).

Hatzold K, Mavhu W, et al. 2014. "Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: results from a mixed methods study." *US National Library of Medicine: National Institutes of Health*.

Jones D, et al. 2013. "Acceptability, Knowledge, Beliefs, and Partners as Determinants of Zambian Men's Readiness to Undergo Medical Male Circumcision." *AIDS Behav*. DOI 10.1007/s10461-013-0530-0.

Lanham M, L'Engle KL, Loolpait M, Oguma IO. 2012. "Women's Roles in Voluntary Medical Male Circumcision in Nyanza Province, Kenya."

Nieuwoudt S, Frade S, Rech D, Taljaard D. 2012. "Uncovering the dirt on demand creation for medical circumcision: a qualitative study of medical male circumcision demand creation in Gauteng province, South Africa in 2012."

Nudelman A. 2013. "Gender-Related Barriers to Services for Preventing New HIV Infections Among Children and Keeping Their Mothers Alive and Healthy in High- Burden Countries; Results from a Qualitative Rapid Assessment in the Democratic Republic of Congo, Ethiopia, India, Nigeria and Uganda." *UNAIDS Discussion Paper*.

RTI International, Population Services International. 2012. "Voluntary Medical Male Circumcision (VMMC) Demand Creation Toolkit." Available at: http://www.thehealthcompass.org/sites/default/files/strengthening_tools/VMMC_Demand%20Creation%20ToolkitFINAL%20PEPFAR%20APPROVED.pdf.

Soul City Institute: Health and Development Communication. 2010. "HIV prevention: Medical male circumcision in South Africa." Available at: <http://www.soulcity.org.za/projects/soul-city-series/soul-city-series-11/soul-city-11-research/Male%20circumcision%20TA%20research%20report%20%20JB%2022%2011%202011.pdf/view>.

Westercamp M, Bailey RC, Bukusi EA, Montandon M, Kwena Z, et al. 2010. "Male Circumcision in the General Population of Kisumu, Kenya: Beliefs about Protection, Risk Behaviors, HIV, and STIs." *PLoS ONE* 5(12): e15552. doi:10.1371/journal.pone.0015552.

Williams B, Lima V, Gouws E. 2011. Modelling the impact of antiretroviral therapy on the epidemic of HIV. *Curr HIV Res*; 9(6): 367–82.

Women's HIV Prevention Tracking Project (WHiPT). 2010. Making Medical Male Circumcision Work for Women. Available at: <http://www.avac.org/sites/default/files/resource-files/Making%20Medical%20Male%20Circumcision%20Work%20for%20Women.pdf>.

World Health Organization (WHO). 2009. Traditional Male Circumcision among young people: a public health perspective in the context of HIV prevention.

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