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TECHNICAL REPORT

Qualitative Research on Male Circumcision in Namibia

MAY 2009

This study report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID). It was authored by Katina A. Pappas-DeLuca, Frantz Simeon, and Friedrich Kustaa. The qualitative research was conducted under the Health Care Improvement Project, which is made possible by the support of the American people through USAID.

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Katina A. Pappas-DeLuca
Frantz Simeon
Friedrich Kustaa

DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
BCC	Behavior change communication
DHS	Demographic and Health Survey
DOH	Department of Health
FGD	Focus group discussion
FL	Free list
FMS	Finish Missionary Society
HCI	Health Care Improvement Project
HIV	Human immunodeficiency virus
MC	Male circumcision
M&E	Monitoring and evaluation
MoHSS	Ministry of Health and Social Services
N/A	Not available
NGO	Non-governmental organization
NT	National training
P#	Participant number
PS	Permanent Secretary
QA	Quality assurance
STD	Sexually transmitted disease
TCE	Total Control of the Epidemic
URC	University Research Co., LLC
USAID	U.S. Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Aim of the research study

This consultancy asked members of the general public, health care personnel, and other key stakeholders for their attitudes and perceptions toward male circumcision in Namibia. Conducted in the summer of 2008, the research sought to collect information on:

1. The perceived benefits and drawbacks of male circumcision,
2. Attitudes of individuals toward male circumcision,
3. Key influences on the decision to circumcise, and
4. Understanding of the relationship between HIV and male circumcision.

Methods

Data were collected in eight regions: Caprivi, Karas, Kavango, Khomas, Kunene, Ohangwena, Omaheke, and Oshana. Two methods were used for data collection: focus group discussions (FGDs) with the general public and key informant interviews with stakeholders.

Across the eight regions, 46 FGDs were conducted separately by sex (male/female), age (18–34/35+ years), and circumcision status (circumcised/uncircumcised). They were held in a language common among participants, using Afrikaans, Oshiwambo, Otjiherero, Damara/Nama, Rukwangali, Silozi, and English.

The key informant interviews were conducted with health personnel, traditional circumcisers and healers, business leaders, community leaders, HIV/AIDS activists, religious leaders, government officials, and political leaders.

Main Findings

Focus group participants were generally familiar with the practice of male circumcision, although their understanding of and experience with the practice varied. Regardless of whether or not male circumcision was typically done in the culture or area, participants had a general understanding that the moist and closed environment of foreskin contributes to the growth of bacteria and that this may be related to negative health consequences.

Advantages and disadvantages of male circumcision

Most of the findings on perceived advantages and disadvantages of male circumcision centred around four areas: health and hygiene, culture/tradition, sexual pleasure, and normative beliefs.

Health and hygiene: The main perceived advantage of male circumcision was for health and hygiene, including cleanliness and disease prevention. Circumcision was associated with cleanliness as foreskin was viewed as a trap and host for bacteria. Secondly, male circumcision was identified as a corrective medical measure for problems related to blockage and pain associated with urinating. With specific regard to HIV and other sexually transmitted diseases (STDs), many saw male circumcision as a way to reduce the risk of STDs (harbored by the foreskin), and some acknowledged the additional protection against HIV infection.

In contrast, many uncircumcised men perceived the removal of the foreskin as a possible health risk in that it meant the loss of a protective covering for the penis. Another key perceived disadvantage was the pain associated with the procedure and the risk of disfigurement or even death. Some respondents saw male circumcision as a risk for transmission of HIV infection, particularly when the same blade is used on several individuals. Another concern was that male circumcision may lead to disinhibition (increased sexual risk-taking) as people may think condoms are no longer necessary.

Culture/tradition: Many respondents also viewed male circumcision as a sign of a compliance with certain cultures and traditions.

For those belonging to circumcising cultures, having been circumcised was viewed as a symbol of cleanliness, a rite of passage into manhood, and a way to earn respect. They consider that compliance with this tradition was not only important to men individually, but also for parents of young boys and for sexually active women in their relationships with men.

In contrast, many participants from the cultures that did not traditionally circumcise saw having a circumcision as adopting a practice belonging to “other” cultures. In some cases, removal of the foreskin was seen as against God’s will.

Sexual pleasure: The perceived advantages and disadvantages regarding male circumcision and sexual pleasure were largely based on hearsay: Few participants had experienced sexual intercourse both with and without their foreskins.

Perceptions that circumcised men experienced and provided greater sexual pleasure was related to beliefs that penetration is easier without the foreskin and that the trauma experienced from difficult penetration is reduced. Similarly, others claimed that a circumcision left one less layer between the man and woman, regardless of condom use.

Some uncircumcised respondents perceived the loss of foreskin as a disadvantage, citing the sexual pleasure derived from the movement of foreskin. Others said there would be no difference between being circumcised and uncircumcised if a condom is worn.

Many respondents thought that sexual pleasure was related to the size of the penis. Some felt that circumcising increased the size of the penis and enhanced sexual pleasure. Others felt that circumcision inhibited the growth of the penis and decreased sexual pleasure.

Most women expressed a preference for circumcised men, although few actually reported sexual experience with both circumcised and uncircumcised men. Preference was based on the perception that sex was better with circumcised men (for reasons cited above) and that women feel safer from diseases when having sex with circumcised men, thus increasing their enjoyment.

Normative beliefs: Another perceived advantage of male circumcision was that it was seen as a way to fit in with a community and earn respect. This was particularly true for boys and men in areas where circumcision was more common/normative. Also, being or becoming circumcised was seen as a way to get girlfriends (i.e., have sex with them) and be accepted.

In both cases of uncircumcised men/boys living in areas where the majority of others were circumcised and of circumcised men/boys living in areas where circumcision was uncommon, feelings of embarrassment related to teasing were expressed.

Attitudes toward male circumcision: In general, respondents expressed positive attitudes toward male circumcision. This was particularly true for women who were primarily in favor of male circumcision because of the perceived health benefits. Men who were not in favor of circumcision felt “fine with how they are” and did not see any reason to change. Some older respondents felt they were too old to circumcise, but would encourage it for younger boys. The few women who said they would not circumcise their sons or encourage their partners to circumcise believed that it should be the boy’s right to decide when he is old enough. They also said that it would be difficult to discuss or negotiate circumcision with their partners.

Key influences on decision-making

The decision to circumcise or not was said to be influenced by two key areas: health and culture. When circumcision is done for health reasons, the key influences reported were parents (for small boys), doctors, individuals (for grown men), and partners (for sexual health reasons). When circumcision is

sought for cultural/traditional reasons, the influencing players were identified as family, community, cultural group, and partner.

Understanding of the relationship between HIV and male circumcision

Although many FDG participants had heard of the relationship between HIV and male circumcision and could cite the 60% protective rate, most did not believe that HIV was related to circumcision since HIV is transmitted through blood and semen. Many participants from areas with lower circumcision rates said that male circumcision could contribute to HIV infection when the procedure is performed by traditional circumcisers using one blade for many procedures.

Although participants generally recognized uncircumcised men as more susceptible to infections, a few lacked understanding of whether circumcision offered better health outcomes than careful washing under the foreskin, particularly after sexual intercourse.

Conclusions and Recommendations

Despite some perceived disadvantages, participants overall endorsed male circumcision, especially relative to health. Their main concerns related to the quality and safety of the procedure, accessibility, the coordination of efforts among providers (medical and traditional), the benefits to women, and the possible tendency toward disinhibition.

There was overwhelming support for the government to educate the public on male circumcision. Many respondents felt that a clear and comprehensive education program—one that would incorporate local authorities, door-to-door educators, and media sources, such as radio—would reduce misconceptions about and encourage uptake of male circumcision.

Respondents from areas where circumcision was not widespread expressed a preference for having services provided at hospitals, increasing training, and making circumcision services more available. Participants from areas where circumcision was less common expressed a mistrust of traditional circumcisers, while participants from cultures where male circumcision is a tradition expressed a preference for traditional circumcisers over medical doctors.

The findings underscore that issues around education, training and services, and policies need urgent attention. Based on the findings, the authors make the following recommendations to the MoHSS:

Education

- Widely broadcast information on the health benefits of male circumcision for men and women and the importance of condoms and partner fidelity.
- Tackle myths linked to male circumcision.

Training and services

- Offer training in male circumcision for traditional circumcisers and medical personnel.
- Provide certificates to legitimize traditional circumcisers and prevent circumcision by those unqualified to provide the service.
- Increase the level of collaboration between the medical community and traditional circumcisers.
- Increase forums for mutual learning and sharing of expertise and resources.
- Establish centers or mobile facilities for male circumcision.
- Increase integration of male circumcision services into existing health facilities.
- Reduce the costs of male circumcision.

Behavior change communication

- Communication campaigns for male circumcision should focus on health benefits and include role models for men and women.

I. INTRODUCTION

Recent studies in sub-Saharan Africa show that male circumcision can reduce the transmission of HIV/AIDS by 60%. Namibia's Ministry of Health and Social Services (MoHSS) is exploring how to include this intervention in its HIV/AIDS prevention strategy. The qualitative research reported here assessed the perception of male circumcision among Namibia's general population and key stakeholders. This study was part of a larger situation assessment of male circumcision in Namibia designed to provide appropriate information for decision-making regarding a national prevention strategy.

A. Background

HIV prevalence among pregnant women in Namibia is near 20% (MoHSS 2007), and national HIV prevalence is estimated to be among the highest in the world. Despite significant efforts and funding to slow HIV incidence, the annual number of new infections remains stable. A renewed focus on prevention is urgently needed to slow these infections. Any HIV prevention strategy requires a diverse mix of evidence-based interventions, and male circumcision is one such intervention that could be effective. Preliminary results from the 2006–2007 Namibia Demographic and Health Survey (NDHS) indicate that 21% of 15–49-year-old men there are circumcised, varying by region from 1% in Ohangwena to 57% in Omaheke.

Other than the NDHS data, little in-depth information is available on male circumcision in Namibia. This rapid situation assessment sought to explain the determinants of male circumcision in different regions, the acceptability of the practice, where male circumcision is practiced, the barriers to access, safety precautions, and whether health facilities could safely respond to greater demand for male circumcision.

B. Historical Context for Male Circumcision in Namibia

The relatively low prevalence of male circumcision in Namibia is related to a number of historical, social, and political factors.

The original inhabitants of this area, the Khoi-San people, such as Nama and San people¹, have not engaged to a significant degree in ritual circumcision as part of their cultural practices. However, for centuries male circumcision was an integral cultural practice among the Bantu-speaking people here (such as the Herero, Ovambo, and Kavango ethnic groups) who migrated from Central African regions and settled in this part of Africa.

Before the arrival of Europeans, some social developments, such as divine kingship, contributed to the decline of male circumcision in the Ovambo kingdoms, especially among members of the royal families in areas settled by Oshidonga and Oshikwanyama speakers². Before male circumcision was discontinued in these kingdoms, only circumcised men could become kings (Loeb, 1967)³.

Once the concept of divine kingship developed in the Donga and Kwanyama kingdoms, kings could no longer be circumcised because it was taboo for a divine person to lose blood, which was viewed as a bad omen⁴.

¹ For a discussion of the San people as the oldest inhabitants of Namibia and many other regions of Africa, see Lee (1979) and Angula (1988).

² For a discussion of divine kingship in the Kwanyama and Donga kingdoms, see Loeb (1967).

³ According to Patricia Hayes (undated), King Mweshipandeka of Ukwanyama Kingdom abolished male circumcision rituals, and this spread to other kingdoms.

⁴ On the history of divine or sacred kingship of the Ovambo people, see Loeb (1967) and Salokoski (2006). For a general discussion on the history of divine kingship, see Hadfield (1979).

During wars, some Ovambo Kings did not want their young men to be unavailable due to rites-of-passage ceremonies such as ritual circumcisions. Furthermore, missionaries opposed such ceremonies (Loeb, 1967; Hayes, undated).

Although these social, political, and historical factors led to the decline of male circumcision, the legacy of male circumcision among certain privileged members of society endured for a long time. Also, some kings (e.g., in Kwanyama Kingdom) didn't easily give into the missionaries' pressure to abandon the rites-of-passage ceremonies. Also, the colonialists and missionaries disagreed on the need to end circumcision. Ultimately, the practice of male circumcision ended in the most populated parts of northern Namibia and at present is mainly restricted to smaller ethnic groups, such as the Kavango and Herero communities.

II. METHODOLOGY

The study was conducted in eight regions: Caprivi, Karas, Kavango, Khomas, Kunene, Ohangwena, Omaheke, and Oshana. Focus group discussions (FGDs), conducted in each region, were stratified by age (younger = 18–34 yrs; older = 35+ yrs) and sex. Additional focus groups were conducted in selected regions based on the percentage circumcised and population size (see Table 1). In regions with circumcision rates of 25% or higher (Kavango, Khomas, Kunene, and Omaheke), male FGDs were stratified by circumcision status (circumcised and uncircumcised men were recruited for separate groups). In the Khomas region, given the large and diverse population, twice as many FGDs were conducted within each stratum. Table A-1, in Appendix A, presents the number and types of focus groups convened by region.

Approximately five key informant interviews were conducted per region. Key informants included health professionals and traditional circumcisers from each region where available. Additional key informants included government officials, medical aid personnel, religious leaders, community leaders, and HIV/AIDS activists.

A. Preparing for Data Collection

Data collectors were selected based on relevant experience, availability during the study timeframe, and fluency in selected regional languages and English: 24 data collectors were trained, including four University Research Co., LLC (URC) field coordinators who served as field data collection supervisors in each region.

The data collectors were trained in: 1) the purpose of the study and the relationship between HIV and male circumcision; 2) the intent of the interview guides; 3) facilitated discussion techniques, including strategies to encourage broad participation and discussion; and 4) the process for taking notes and oral translation. Training included multiple practice sessions with feedback loops and a minimum of one field pretest per language group (see Appendix B for the training report).

In coordination with the male circumcision task force, regional contacts, and the URC field coordinators, participants were selected according to pre-identified criteria of age, sex, and circumcision status (where appropriate). Participants were recruited from such gathering places as youth centers, churches, villages, schools, organized community groups, and health care facilities and by door-to-door approaches. Recruitment was intended to diversify group participants in an attempt to avoid recruiting too many participants from any one location. Facilitators and participants were matched by sex whenever possible. FGDs were scheduled in conveniently located community venues at varying times of day and days of the week to reduce barriers to participation. Participants received compensation for transport and refreshments.

Table 1: Selected Data from Census and Male Circumcision Report, by Study Region

Region	Caprivi	Karas	Kavango	Khomas	Kunene	Omaheke	Oshana	Ohanawena
FGD circum. Status	Mixed	Mixed	Separate	Separate	Separate	Separate	Mixed	Mixed
% of pop. circumcised (2006)	6.3	9.3	30.5	26.6	52.2	56.7	14.1	0.6
% who were circumcised < 13 years	70	63	71	84	92	97	82	n.d.
Total population (2001)	79,826	69,329	202,694	250,262	68,735	68,039	161,916	n.d.
% urban	28	54	28	93	25	28	31	n.d.
Population density (#/km ²)	5.5	0.4	4.2	6.8	0.6	0.8	18.7	n.d.
Largest urban area	Katima Mulilo	Keetmanshoop	Rundu	Windhoek	Outjo	Gobabis	Oshakati	n.d.
Total urban population	22,694	15,543	44,413	233,529	6,013	13,856	28,255	n.d.
Main language groups	88% Caprivi lang.	40% Afr kaans, 26% Damara/ Nama, 23% Oshiwambo	91% Kavango languages	37% Oshiwambo, 24% Afr kaans, 13% Nama/ Damara	42% Otjiherero, 36% Nama/ Damara	39% Otjiherero, 27% Nama/ Damara, 12% Afr kaans	93% Oshiwambo	n.d.
Other				Urban only	Rural only	Rural only		n.d.

Notes: 1) In regions with circumcision rates of 25% or higher (Kavango, Khomas, Kunene, and Omaheke), male FGDs were stratified by circumcision status: Circumcised and uncircumcised men were recruited for separate FGDs. 2) n.d. = no data

The research team used the draft key informant guide and focus group guide developed by the World Health Organization (WHO) as the starting point for the development of data collection tools. The supervisory team then reviewed and modified the draft guides to include items designed to elicit discussion of attitudes and perceptions towards male circumcision, decision-making processes, and barriers to and facilitators of undertaking male circumcision. Guides were updated to reflect input from task force members (Appendix C has data collection guides). During training, the field teams translated the guides into the predominant regional languages as indicated by the most recent census. Languages included Afrikaans, Damara/Nama, Oshiwambo, Otjiherero, Rukwangali, and Silozi. Translation decisions were based on consensus of field team members to ensure preservation of the intent of each question. Each guide was pre-tested at least once before data collection to ensure language clarity and give interviewers practice.

B. Data Collection

FGDs were held in mid-2008 with the different target groups identified above and ranged in length from one to three hours. Group size ranged from six to 12 participants (see Table A-1 in Appendix A). Two facilitators conducted the FGDs: one asking questions and one taking notes and managing the tape recorder. The note-taker was responsible for identifying the key words of each speaker to facilitate data interpretation. The FGDs were conducted in local languages, and participants were asked to indicate their participant number (P#) before commenting in an effort to distinguish among comments. Key demographic details were recorded for each participant and are summarized in Table A-2 in Appendix A.

Data collectors used the discussion guides to conduct key informant interviews, which lasted 45 to 90 minutes. The interviewer took notes and recorded the interview. Key demographic details were recorded for each informant and are summarized in Table A-3 in Appendix A.

C. Data Management

Upon completion of the FGDs and interviews, the data collectors listened to the audio tape and wrote a verbatim translation in English. Data collectors were instructed to listen to the recording of the discussion and write a verbatim English translation based on mutual agreement of the translation between the facilitators. These translations retained the participant numbers to enable researchers to distinguish among participants.

Facilitators also provided comments and a summary for each discussion that included information on the group's tone, challenges, and key points, as well as circumstances of data collection (number of participants, location, time of day, etc.). Upon completion of data collection within each region, the English audio tapes were given to typists who transcribed them into a word processing program.

Quality control of transcriptions was conducted by random comparative review of the English transcription and the English translation. Discrepancies were noted and corrected. Where transcripts did not reflect the translation, interviewers were asked to redo the translation.

Two different readers read each transcript in its entirety to identify themes and capture a full understanding of the data. Researchers also read summary forms. The transcripts were coded according to pre-identified themes, including barriers and facilitators, positive and negative attitudes, and key influences. Emergent themes were identified after initial coding and coded accordingly. Codes were discussed and agreed upon by all researchers.

D. Limitations

Focus groups are a useful research method to elicit perceptions from a target audience. As focus groups may not represent the larger population, generalizability of focus group findings is limited. In this study, generalizability was further limited by the small number of focus groups conducted in each population strata in each region and by selection bias caused by the need to recruit participants who could use a common language during each discussion. As a result, a region's diversity may not have been well represented among focus group participants. For example, with the exception of Khomas, all regions had only one group of young women of 18–34 years and one group of older women. In addition, participants in those focus groups had to be able to communicate in a common language.

An additional limitation involved recruitment procedures. Although facilitators were trained on the importance of recruiting from diverse venues for FGDs, logistics and timing influenced the operationalization of this approach. Recruitment was also complicated when regional stakeholders influenced recruitment areas and venues. Further, in many cases, many more people were invited to participate in the discussions than actually presented. Although lack of participation may have reflected

logistical conflicts, it may also suggest a differential willingness to participate by individuals with an interest in or awareness of male circumcision.

Recruitment procedures were further compromised by recruiting men based on circumcision status. For example, in the regions with percentage circumcised of 25% or higher, recruitment of men was to be stratified based on circumcision status. This required that men be asked whether or not they were circumcised at the time of recruitment, so they could be invited to the correct FGD. Although this was accepted in most cases, in Kavango the field team felt that this would not be acceptable, so the male FGDs were not exclusively circumcised or uncircumcised. This may reflect the culture of the Kavango region or characteristics of the field team there. Also in this region, local stakeholders advised that an elder be present at all FGDs.

In addition to limitations related to the methodology, the time available for content analysis of the transcripts was limited by a delay in receipt of the letter authorizing data collection.

Another limitation relates to the language and translation skills of the facilitators. Although all facilitators had a good knowledge of English and the local language of the regions they were assigned to, they were not professional translators. In many cases, translations into English included awkward wording and numerous grammatical errors, complicating analysis. In many cases the translated discussion guides required secondary translation to verify accuracy as well as substantial grammatical editing and cleaning for English comprehension. The difficulty with translation should be considered in the interpretation of the data.

III. RESULTS: FOCUS GROUP DISCUSSIONS

A. General Information

1. What is male circumcision?

Participants in most groups answered the question, “What is male circumcision?” by describing why it is done or indicating whether or not it was common in the area. Descriptions of male circumcision typically included reference to cutting off the foreskin on the tip of the penis. No participants had never heard of male circumcision. However, in areas where male circumcision is less common, some were unclear on exactly what it is, as illustrated by a young woman from Oshana, “Well, I’ve only heard about it but have never seen it and I don’t know what circumcision is exactly.”

Terminology related to male circumcision varied across regions. A list of local language terms is in Table A-4 in Appendix A.

2. What is the tradition of male circumcision in the area?

Traditions surrounding circumcision varied by region and were often associated with specific cultural groups. In many cases, descriptions of the tradition of male circumcision “in a specific area” included descriptions of the traditions of cultural groups in the area, as evident in the following from a circumcised man from Omaheke:

In this area, circumcision is more extensive among the Herero [-speaking] people. They have a tradition around this practice. A group of young boys partake in the ceremony, and at such ceremony there is a certain cost involved, perhaps a goat or a sheep.

Alternatively, descriptions referred to the respondent’s own cultural background, which may or may not have been related to the specific area. In particular, participants from Khomas typically referred to their own cultural backgrounds, rather than any tradition that could characterize the area. A young circumcised man from Khomas said:

P1: We can't say "tradition" for this area, because there are many traditions here. I would say in the black culture [circumcision is] not done nowadays as much as it was in the past. Only those who have heard about the advantages do it now.

Traditions surrounding male circumcision ranged from "no tradition" to detailed descriptions related to the practice, including preparation for the procedure itself and the healing process. The various reasons are summed up as: cultural (to show that you are a man), religious (to worship), and emotional (to express a passion about the practice). Even though it is part of the tradition for some ethnic groups, male circumcision is now practiced to prevent sickness.

No Tradition: Participants who characterized their region as having "no tradition" of circumcision frequently made references to "other" places or cultural groups where circumcision was perceived to be more common. They are mostly hearsay or vague observations and interpretations.

Some participants reporting no tradition of male circumcision in the area often went on to describe circumcision done for medical reasons only, circumcision as an historical tradition that is no longer practiced or widespread, and circumcision as an evolving tradition that is slowly becoming more popular.

Medical circumcisions only: Difficulty, pain, and blockage associated with urinating, typically associated with children, were the most common medical reasons cited for circumcising in areas with low male circumcision prevalence. In such cases, the doctor recommended circumcision based on his diagnosis.

In addition to urinary problems, several participants mentioned being born with a "long foreskin" as a reason necessitating medical circumcision.

Former tradition: In several areas where focus group participants indicated an absence of a current tradition regarding male circumcision (Karas, Oshana, Ohangwena, and Kavango), participants described traditions dating back generations when male circumcision was a part of their regional or ethnic culture. According to one young man from Oshana:

P2: [Circumcision has] been there for years and years of our ancestors. I think that some of the cultures, or maybe some of the people, don't know about it because it is not done in their time, in their culture. Only a few people in Namibia make use of it. I hope that everybody knows about it (laughing). They don't practice it around here anymore.

In some cases participants from the same area did not agree on whether or not male circumcision was historically associated with their culture. Participants variously believed that it is a personal decision ("It is the will of the man himself"), practiced in other countries ("It is done in our neighboring country, Angola"), based on specific locations in a region ("I think in some areas here they do it"), or practiced by some but not all people from other ethnic groups.

Evolving tradition: In some areas where the practice of circumcision was described as not (or no longer) traditional, participants indicated an acceptance, desire, and willingness to adopt the practice. This largely stemmed from a belief that male circumcision protects one's health, as illustrated through the opinions below:

A young woman from Karas reported that although male circumcision is a tradition, it has the potential to prevent HIV infections.

An older man from Oshana indicated an expectation that circumcisions would increase. He felt that Namibians were behind with the practice. He said that all his children are circumcised as soon as they are born: "They don't leave the hospital before they are circumcised."

A respondent from an uncircumcised older men's group in Omaheke said that he was not circumcised because it was not his tradition or his parents' way of doing things: "However, lately things have changed and there are a lot of new diseases, male circumcision is now very important."

Likewise a younger woman from Kunene said:

Yes, I heard from people in the community that when you are circumcised your risk of being infected with HIV is much less. And I've started seeing Damaras [-speaking people] from Sesfontein start to go to hospitals for circumcision."

Tradition of male circumcision: Several cultural groups were noted as having a tradition of male circumcision, including the Herero, Himba, Mbukushu, Ndonga, Angolans (Labule), and Zambians. While Angolans and Zambians were only mentioned by participants from northern regions, across geographic regions, the Herero-speaking people were most commonly associated with male circumcision, as noted by these participants from Kunene groups:

I heard that male circumcision is a tradition among Herero-speaking people; they cut off the foreskin of young boys. (Young, uncircumcised man)

(Male circumcision) is a Herero tradition, and that is our identification because we are the ones who are circumcised. (Young female)

Traditions surrounding circumcision included descriptions of preparation, the procedure itself, and the healing process.

In general, Herero-speaking participants expressed a preference of being circumcised by traditional circumcisers. Circumcisions in this cultural group are typically done when the child is a few months old, but the timing is largely tied to the availability of the traditional circumciser. Circumcisions were often planned around when the traditional circumciser would be in town.

Preference for the traditional circumciser was multi-fold: The procedure, control of hemorrhage (by traditional herbs), and subsequent healing were perceived to be better; it was the way to be fully compliant with culture (i.e., to be a "full Herero man"); and it gave the benefit of joining a peer group (Omakura) of individuals circumcised in the same time period.

Young, circumcised Herero-speaking men gave little credit to the medical approach. They said hospitals have fewer risks but that different regions believed it is common for the foreskin to grow back when circumcisions are performed at medical facilities, which was unheard of with the traditional approach. This appears to be related to a perception of differing efficacy of cutting techniques used by traditional and medical circumcisers.

These respondents said that traditional circumcisers are more skilled and motivated by tradition, while medical doctors have a lot to learn and are money- and task-oriented.

3. At what age is male circumcision typically done?

When asked at what age male circumcision is typically done, responses ranged from birth through to adulthood.

Infants and young children: Aside from circumcisions due to medical necessity, participants who favored circumcising boys for tradition or out of personal preference justified such attitude on the beliefs that: 1) the procedure would hurt less due to a lack of physical sensitivity in babies; 2) a baby's soft skin bleeds less and creates improved physical conditions that make the procedure and healing easier; 3) the child will grow up thinking it is normal to be circumcised and won't have to consider it later or be teased for being uncircumcised; and 4) it enables the parents to do something that will help their child in the future (e.g., keep him healthy). The following quotes illustrate these points:

P8: I think a baby can also be circumcised, because [he] will not feel pain. (Young woman, Kavango)

(Circumcise) while the child is one week (old) to prevent more pain. If a child is circumcised while he is young, he heals easily. (Older, uncircumcised man, Omaheke)

P6: At age two to three years, the foreskin is soft. Later, the foreskin gets harder and one has more blood that can be lost through male circumcision. With a baby, the wound will heal faster. For example, if I (had recently had a circumcision) and saw an attractive lady, I would get an erection, which would interrupt the healing. (Young, circumcised man, Khomas)

P1: If a child is circumcised, there are benefits in the future. He is protected from getting many bacteria, and the mother will really feel proud. But then, it doesn't mean he will never get bacteria. Of course he will, though the risk is low. (Young woman, Oshana)

Older children/teenagers: Other participants felt that it is best to wait until the child is a little older so that their growth is not inhibited and so he can make the decision for himself. A young woman from Kavango said, “*It is better to circumcise a man from eight years old. It is not good to circumcise a baby as it affects the baby's growth.*”

A young woman from Oshana said, “*It is not good to circumcise a child young because he needs to decide for himself. What if I get him circumcised while young and he blames me when he grows up?*”

In some traditions, circumcising at an older age was related to the symbolism of transitioning from boyhood to manhood.

Adults: Although several respondents supported the idea of circumcision for those old enough to make their own decisions and several men had been circumcised at older ages, many others indicated a lack of understanding of whether or not adults could become circumcised, as illustrated by a young woman from Oshana who said, “*I have a question: If a woman is getting married, can she tell her fiancé to get circumcised? Is there an age limit?*”

Questions regarding the feasibility of circumcising at older ages also reflected a belief that there was more potential for negative side effects for adult circumcisions, including longer healing times.

In addition to age preferences, several respondents mentioned a seasonal preference; winter is reportedly the best time to circumcise.

4. How much does male circumcision cost?

Costs associated with male circumcision varied depending on whether or not the procedure was performed by a traditional circumciser or in a medical facility.

Medical facilities: Costs reported for circumcisions performed at a medical facility were thought or known to be equal to the regular cost of admission to the local hospital. Reported costs ranged from N\$4–30. Some respondents speculated on the difference in cost between medically necessitated circumcisions, for which medical aid could be used, and those done for personal preference. The cost was seen as all inclusive, and no additional fees were noted for medications.

Traditional: Costs reported for circumcisions performed traditionally varied widely and appear to have changed significantly over time. Compensation for traditional circumcisions ranged from “none,” to a cow or goat, to set monetary compensation typically described between N\$100 and N\$200. The cost of medicine and a blade was also cited as an expense for a traditional circumcision. According to one older, uncircumcised man from Omaheke:

In the past it was very cheap, sometimes free, but now they are increasing the price because the cost of everything is increasing, even petrol. That's why everything is getting expensive. I think it is N\$150.

These young, circumcised men from Khomas reported:

P7: It is not that expensive. The people who can do it very well are not charging a lot, but some charlatans are over-charging.

P6: The cost depends on where the circumcision is done. The hospitals are charging for their services. The traditional circumcisers ask a little bit more.

5. Where do participants get health information?

In response to questions on where participants get their health information, responses included: from the health field, including hospitals, clinics, doctors, nurses, and home-based care; specific community organizations (such as Total Control of the Epidemic [TCE]); and New Start Centres. In addition, media outlets including radio, newspapers, and the Internet were mentioned. TCE was mentioned in northern regions only (Kavango, Oshana, Ohangwena) and the Internet was not mentioned outside of Khomas.

Many FGD responses to this question included where or how they had heard about male circumcision. Some said they had heard nothing on circumcision; some knew about it from other cultures or countries; some learned from peers; others learned from doctors due to medical necessity; and still others had heard about it through media: TV, radio, and newspaper.

References to hearing about male circumcision on television typically described a program broadcast some time ago that highlighted the risks from traditional circumcision, particularly from a practice where several boys were circumcised “in the bush” in succession, using the same blade. This program seemed to have contributed significantly to participants’ understanding of the risk of acquiring HIV through male circumcision.

References to radio and newspaper as sources of information on male circumcision described recent stories highlighting the health protective benefits of male circumcision, particularly for HIV. Several participants who heard the radio reports could cite the 60% protective effect of male circumcision on HIV. In each region some respondents reported learning something on male circumcision from the radio or newspaper.

B. Perceived Advantages and Disadvantages of Male Circumcision

In an effort to understand barriers and facilitators of male circumcision, the research team explored the perceived advantages and perceived disadvantages of male circumcision.

1. Perceived advantages

Health and hygiene advantages: Discussions of health and hygiene included themes of solutions to health problems and disease prevention. Regardless of whether or not male circumcision was typically done in the culture or area, participants had a general understanding that the moist and closed environment of the foreskin contributes to the growth of “bacteria” and that this may be related to negative health consequences.

Male circumcision was cited as the (only) solution to medical complications associated with urinating, including difficulty, pain, and blockage. It was also seen as a solution for children born with “a long foreskin.” These health issues were most typically associated with children, although uncircumcised men reportedly experienced pain and difficulty urinating that they attributed to the foreskin.

Other health problems that could be avoided by circumcision included trauma to the penis as a result of sexual intercourse. An older man from Oshana reported, “*Another benefit is in having sex with a woman with a small vagina. An uncircumcised person’s skin will tear when penetrating her. It will be better if your foreskin is removed to avoid such problems.*”

Another added, “*If you have sexual intercourse with someone who has a small vagina, your foreskin could be cut and bruised if you are uncircumcised. If you’re circumcised, the head of the penis is always dry, so there won’t be any bruises and cuts.*”

In general, but especially among circumcised participants and those from areas/cultural groups where male circumcision is more common, male circumcision is associated with cleanliness. In addition to comments about urine remaining under the foreskin, participants described the foreskin as a trap or place for bacteria to hide. Many participants, men and women alike, described a smell associated with uncircumcised men that they attributed to “dirtiness” beneath the foreskin. Many responded that all these adverse conditions are solved through circumcision. A young man from Kavango from saw the advantage of keeping the penis clean:

P13: One of the benefits is that when you are not circumcised, when you urinate, some of your urine will remain under the foreskin, and this dirt will produce a bad smell. When you are circumcised, the penis is always clean.

A young woman from Oshana appreciated that a circumcision would eliminate bacteria, saying “The benefit of circumcision is just that if [a man] gets some bacteria on his manhood, he can die easily. If he is circumcised, bacteria will die: We used to hear that bacteria die quickly in fresh air.”

Many participants also described “white stuff” forming on the uncircumcised penis and the importance of good hygiene to clean it off. In many cases, the consequences of not washing were perceived as contributing to infections, including STDs. A young, circumcised man from Khomas said:

P1: If a man is uncircumcised, he gets white things under the foreskin, and when this rots, it turns green. Such a man can get AIDS or any other STDs [sexually transmitted diseases] and then get totally sick.

Circumcised men were generally associated with cleanliness and good hygiene, although several participants noted that hygiene was associated with an individual’s habits, not the presence or absence of foreskin. Even so, participants generally acknowledged that a circumcised man could remain clean with less effort. For men with poor hygiene habits or in areas where water is scarce, male circumcision was seen as contributing to cleanliness. (See “Bathing” below.)

Reduced risk of STD/HIV: Related to other discussions of hygiene and cleanliness were discussions of how male circumcision helped reduce the risk of STDs. Again, the idea emerged that the moisture created by the covering of the foreskin contributes to the growth of bacteria. Two participants in Kunene noted:

I heard that scientists say that circumcised men don’t contract AIDS easily because . . . the head of the penis stays dry. (Young, uncircumcised man)

What is transmitting HIV is that wetness of the foreskin. If the wetness is not there, there will be no infections. So, people must go for circumcision. (Young woman)

A young, circumcised man from Omaheke noted the role male circumcision plays in reducing the risk of STDs:

Circumcision helps to keep STDs at bay because the foreskin that serves as host to germs and bacteria has been done away with, but it is not 100% accurate that you will not contract HIV viruses and other STDs.

The protection from infections that circumcision provides to men was also seen by many women as protective. According to these two young women from Oshana:

P7: As women, we must just encourage men to get circumcised. Because when he comes to you, he won’t infect you with his bacteria, which he picked up from other women.

P9: It will be nice to me to get married to a circumcised man because I am also somehow protected and so is he.

Advantages related to culture and tradition: Several advantages of male circumcision were described that related to culture or tradition. Aside from the belief that male circumcision fulfilled one’s

obligations to a cultural group where circumcision is the norm, other advantages noted were that male circumcision is a symbol of manhood and a way to earn respect. A young woman from Kunene said:

When you are circumcised you become a real man because when you still have the foreskin, you are called otjikave which means that you are still a woman or a moffie [homosexual] because when the boys are not circumcised they are treated like women at home and not allowed to eat food or meat, which is eaten by men, because they still have the foreskin.

The idea of respect that comes from undergoing manhood rituals was also mentioned in reference to some cultures where male circumcision is no longer normative (e.g., “Okupita Etanda” in Oshiwambo).

Discussions of gaining respect through circumcision and becoming a man were also related to the ability to have sex with a woman and marry. The influence of this is two-fold. First, circumcision means you are old enough (“a man”) to have sex with a woman, and second, women from cultures where circumcision is important or compulsory are taught not to (and are therefore often unwilling to) have sex with uncircumcised men. A man from Kavango said, “If you are Nyemba, the benefits will be great, because every Nyemba girl will think, ‘This guy is circumcised. I have to take him,’ or ‘It’s fine for me to go with him.’”

Circumcised older men from Omaheke observed:

P5: A Kavango lady will ask a sexual partner if he is circumcised and, if not, courting will be difficult.

P2: It is all in traditions. If I stand up now and court a Herero lady, she will ask me the same question.

Advantages related to normative beliefs: Many participants cited wanting to be, or being, circumcised due to a desire to “fit in.” Although these reasons were often related to culture (e.g., wanting to comply with their traditional culture or be able to get [have sex with] girlfriends from the culture), being accepted as “one of the guys” and not being teased for being uncircumcised were mentioned as benefits of male circumcision. A young, circumcised man from Khomas acknowledged several benefits to circumcision, including the “shyness” that may be felt if you are not circumcised:

P2: I will say male circumcision is a very good thing. For example, in our tradition, if you are uncircumcised, you will be shy to wash, bathe, swim, or shower with your friends. Also, I heard three months ago that the possibility of contracting HIV is lower if you are circumcised. I might be wrong. I don’t know.

Likewise, a young woman from Oshana said:

P2: Another benefit is to be considered important, a real man. Apparently some guys used to laugh at those who were not circumcised, and when he was circumcised, he felt good and important. In some cultures apparently you won’t even be in a group of circumcised men if you’re not circumcised.

Advantages related to sexual pleasure: Many examples were given regarding a difference in sexual experience and pleasure related to circumcision status. However, many participants appeared to be speaking hypothetically or based on hearsay. Very few male participants described having been circumcised after sexual initiation, which would make them sexually experienced both before and after being circumcised. Likewise, few female participants reported sexual experience with circumcised and uncircumcised men. The following quotes illustrate this point:

People believe hearsay, including some women, that a circumcised sex partner is better. (Young, circumcised man, Omaheke)

We feel that [a circumcised man] is real, and our men satisfy us. I don’t know about uncircumcised men. (Young woman, Kunene)

Despite lacking personal experience, many participants across demographic strata believed that a circumcised man could experience and give women greater sexual pleasure. Explanations for this belief were based on emotional, physical, and experiential reasons, as follows:

Emotional reasons: Noted emotional reasons to influence women's preference for sex with circumcised men were related to the fact that the woman felt safer from diseases with a circumcised man, and therefore, enjoyed it more. A young woman from Kunene said, "After having sex with an uncircumcised man, you think that all the dirt that was under the foreskin has been transferred to you, and you will get infections."

Because of the way a condom fits on an uncircumcised man, some women also expressed feeling "unprotected," even with a condom. One said, "We think that every man's foreskin should be removed because [with it] the condom doesn't sit right. . . . You are not safe when having sex with an uncircumcised man."

Physical reasons: Physical reasons supporting the idea that circumcised men provide greater pleasure for women included that the foreskin is out of the way, there is no noise from moving foreskin, and penetration is easier.

Our (circumcised) men are real, and they are hot when they enter you. You feel that something is getting into you, but the uncircumcised men are covered with the foreskin, and they are wet, so you don't feel any heat from them. (Young female, Kunene)

You don't feel anything when you have sex with an uncircumcised man. There is no goodness. You only do it to satisfy the other one while you will not get satisfied. (Young female, Kunene)

Participants in several focus groups perceived a relationship between circumcision and penis growth or size. These perceptions were inconsistent: Being circumcised while young can inhibit the penis growth and circumcised penises grow larger. This topic was raised and even debated during several discussion groups, suggesting that many people hold beliefs and misunderstandings regarding a relationship between penis size and circumcision. The following quote from a young woman from Kunene suggests both emotional and physical reasons for circumcision status related to sexual pleasure:

P12: After having sex [with an uncircumcised man], the foreskin is just hanging. . . . When you want to clean him, you don't even know what to do because the foreskin makes you afraid even to touch it. That is really not good.

Experiential reasons: Some respondents suggested that the traditional process of circumcision that was part of a manhood initiation ceremony included education on how to be good husbands and how to satisfy women sexually. Thus, those who were circumcised traditionally were believed to have received instruction on how to provide sexual pleasure.

2. Perceived disadvantages

Health disadvantages: Several health reasons were cited as disadvantages to male circumcision, including 1) the loss of the foreskin as a protective covering; 2) fear of death, pain, or disfigurement; and 3) perceptions of increased risk for HIV.

Foreskin as protection: Many uncircumcised men perceived the foreskin as protecting the penis. For these men, being circumcised would make one vulnerable to such injuries as insect bites. In response to a question on the benefits of being uncircumcised, a young man from Oshana said:

P6: I'm not circumcised, but to me, being circumcised provides you with a health advantage, especially in sexual intercourse, where you are safe. Generally, there are creepy-crawlies everywhere. The foreskin is there, meaning that even though the creepy-crawlies bite you, it doesn't bite something sensitive, because the skin under the foreskin is very sensitive.

Likewise, an older Caprivi male said, “[Circumcision] leaves the penis open: Even an ant can bite.”

Less frequently, foreskin was described as protecting a man from such harms as a kick, the wind, and the burning sensation from chili peppers. Although these risks were mentioned less frequently than insect bites, they support the general perception of protection from the foreskin.

Fear of death, pain, and disfigurement: Many respondents saw the possibility of death from male circumcision as a very real possibility, and fear would dissuade them from considering it. The following excerpts from young men in Caprivi illustrate this point:

P7: The negative effects of circumcising, just as some knowledgeable people have said, (is) that if someone does not know how to [circumcise correctly], death may occur or you may get sick.

P1: An incident happened in Rundu: Two kids were not [circumcised] properly and died, and that is the effect of it.

In response to a query for drawbacks to male circumcision, a young man from Kavango replied, “Death is one of the drawbacks.”

And an older woman from Kavango said, “Nowadays people are afraid, thinking that they might die when they go for circumcision.”

In addition to possible death, participants noted pain, disfigurement, and HIV infection as possible consequences of male circumcision. An uncircumcised, young man in Khomas said, “Yes, there are drawbacks. Especially if it is done traditionally, the skin can be cut off too far.”

Drawbacks related to fear of pain and to the healing process were described by a young man from Kavango as follows:

P6: People are afraid of the pain, and the suffering that you go through when the wound is healing... the way you walk, you won't be allowed to wear underwear, all that. Just say “no” to circumcision.

Young men from Caprivi described the need for abstinence during the healing process and complications that could result from an erection during healing as other drawbacks to circumcision:

P12: Another effect is that during the period of circumcision you cannot have sexual intercourse because you went for male circumcision or you are still sick.

P11: Let me finish on the disadvantages: What makes people sick longer is an erection.

This explanation of how an erection can compromise the healing process explains why, in many cultures, women have traditionally been separated from circumcised men until healing is complete. A young woman from Kavango said, “If a woman gets close to this place [where men are traditionally circumcised], the men think of sex and become erect, worsening the wound. That’s why they are separated from women.”

A young man from Ohangwena related a similar story of past traditions and how it could be dealt with now:

P4: If you think about it, it must be done in hospitals. It was also done to keep [circumcised men] away from women. So that you are far away and don't get an erection. If [circumcision is] done in hospitals, there should only be male nurses.

Increased risk of HIV: Possible infection with HIV was perceived as a drawback: Risk of infection was attributed to traditional circumcisions where one blade is used to perform multiple circumcisions. An uncircumcised man from Khomas said, “The same blade is used and you can become infected. You can be infected with HIV/AIDS.”

In addition, some participants worried that circumcised men believe they are immune to infection and may engage in more sexual risk-taking behaviors, such as having sex without condoms and having multiple partners.

P3: Some of these guys who are circumcised are just sleeping around: doing it without a condom. That's the disadvantage of [circumcision]. (Young man from Karas: Also see section below on disinhibition.)

Disadvantages related to culture: Culture as a barrier to circumcision primarily focused on two themes: Appearing to adopt the culture of another group by being circumcised and going against the will of God by altering your body.

Adopting the culture of others: Given the strong association of the practice of male circumcision with certain cultural groups, some respondents felt that being circumcised would give the appearance of adopting the culture of another group.

Altering your body: Several respondents considered being born or created with a foreskin to be a compelling reason to remain that way. The natural state of having the foreskin intact was an important deterrent to being circumcised.

A young woman from Oshana said, “*The benefit of not being circumcised is that the person must just stay as created by God. [The foreskin] must not be removed. Let [a man keep] all his body parts.*”

Similarly, a young man from Oshana said, “*The foreskin was there. You were born with it, meaning that it was created on you.*”

Some participants went further and suggested that God would wonder where the foreskin is when he with a deceased circumcised. A young woman from Kavango said, “*Other people do not do it because they fear that God will ask them about their foreskin.*”

Another participant from the young men’s group in Ohangwena said, “*We are Christian. What if God asks for his skin back when you die?*”

Several participants invoked the Bible, stating that it is against their religion to alter the body for physical pleasure or beautification. A man from Caprivi reported that the tradition of male circumcision was ended because it was found to be against God’s will, saying “*Why did they stop circumcision? Because of the Word of God. Because there are some who believe that to cut the body God gave you to beautify yourself is a thing the Bible forbids.*”

This argument was presented in Oshana, Kavango, Caprivi, and Ohangwena. (Note: In some FGDs, participants countered this argument stating that Jesus was circumcised, so circumcision is not forbidden by the Bible.)

Other perceived disadvantages: Other disadvantages included the cost of the procedure and medication, the uncertainty any increased sexual pleasure, and normative beliefs. Many respondents doubted that circumcision produces greater sexual pleasure for the man or woman. An older woman from Kavango said, “*I think there is no difference because when the penis penetrates the vagina, the skin pulls back. So, I think it’s the same as a circumcised man.*”

Peer pressure to remain uncircumcised was evident, as in the following comment from a young man from Kavango:

P13: Sometimes you find that not all your fellow males are circumcised. So if you go for circumcision, they will laugh at you. They will say, “This guy is circumcised” and so on. The peer group discourages us from going for male circumcision.

C. Attitudes toward Male Circumcision

Participants' attitudes toward becoming (or encouraging others to become) circumcised were positive, negative, and ambivalent.

Positive attitudes: Favorable attitudes toward circumcision were reflected in a desire to be circumcised or encourage others to do so and satisfaction with their circumcision status. Respondents who did not come from an area or tradition of circumcising felt the perceived health benefits were compelling. This was especially true for women. An older man from Oshana described this perspective well by saying, *"If you look at it, it's this information of spreading the diseases that makes one decide to be circumcised. And it's also something that will keep you healthy."*

Negative attitudes: Negative attitudes were expressed through opposition to getting a circumcision or encouraging others to do so. Some opposition stemmed from a belief that the drawbacks of becoming circumcised outweigh its benefits. In response to whether or not he would like to be circumcised, one young man from Ohangwena said, *"The thought has never come to me because I was with people who are circumcised and they wished they had not. . . . Wind, insects, and whatever will be able to enter."*

An uncircumcised, older man from Omaheke said, *"The benefit of circumcision is only experienced by those who are circumcised. I am not circumcised, but I am as good as I am. All of us are just the same. Being uncircumcised also has its benefits."*

In response to a question on how he feels about being uncircumcised, a young man from Ohangwena replied, *"I feel good. I can feel the satisfaction. If I get circumcised, maybe I won't get the same satisfaction, and I won't be able to reverse the process."*

In other cases, rather than feeling that it was *better* to remain uncircumcised, some respondents reported simply not being convinced that it would make any difference in their lives. This is illustrated by the following excerpts from a group of older, uncircumcised men from Khomas:

P5: I don't see the need to be circumcised. I'm 50 years of age. I won't take a wife anymore, but I am happy with being uncircumcised.

P4: I feel that I will stay this way. I'm happy. I just want to meet the right woman. Then I will stay with her until I die. So, there is no need now for me to be cut.

A young, uncircumcised man from Khomas said, *"I have absolutely no problems, so I will stay this way. There is no sufficient reason for me to be circumcised."*

Ambivalence: Ambivalent attitudes were those where participants indicated both a lack of interest in becoming, or encouraging others to become, circumcised and a lack of opposition to circumcision. When asked to discuss his feelings about his circumcision status, a young, uncircumcised man from Khomas indicated that he didn't care (P3).

Older, uncircumcised men from Khomas described being content with their current status but a willingness to become circumcised if compelled by a respected authority.

I haven't experienced any sickness thus far. If a doctor doesn't tell me that I must be circumcised, I will stay this way.

P6: If it is compulsory for my health and if it is compulsory in Christianity, I will do it, but only for those reasons.

D. Key Factors in the Decision of Whether to Circumcise

The influences on deciding whether or not to circumcise were often multi-faceted and seemed to reflect an informal weighing of the advantages and disadvantages related to tradition/culture, health and hygiene, and perceived norms. In response to a question on what would be the considerations in deciding to

circumcise, an older man from Khomas described multiple influences of health, partner preference, and normative beliefs, saying “First, if it gives me a health problem; second, if my lover or wife would encourage me to do it; and third, if it becomes fashion.”

For those who come from traditions or cultures where circumcision plays an important role, decision-making regarding circumcision tended to be conceptualized in two ways: The decision was compulsory and therefore not a decision at all, or it should be made at the community level and involve elders, traditional leaders, parents, and others who help in the preparation, procedure, and healing process. In the latter, involving the traditional circumciser was seen as critical.

Traditions varied by ethnic or cultural background and among sub-groups. Families with mixed backgrounds might reflect those backgrounds in their circumcision decisions or choose the tradition of one over the other.

A young woman from Oshana said:

I am involved in two cultures. My mom is an Mbalantu and my father is an Ndonga. At my fathers' side, all my brothers are circumcised, but not because they were sick or something. My father's family just believed that boys must be circumcised.

In some cases, the role of tradition in the decision to circumcise was geographically influenced. Those living in urban areas were influenced by recent trends in circumcision and age of respondent (younger respondents were more likely to express their independence in decision-making and individual choice). A young, uncircumcised man from Khomas characterized the urban influence by commenting, “Say, for instance, that I go to the village now. I have nothing in common with a village boy. They talk about cattle; we talk about cars.”

For respondents from cultural groups without a tradition to circumcise, influences were described as health-related and related to the influence of others. A young woman from Kunene described health as the major influence on the decision to circumcise beyond culture by noting, “What is influencing me is my culture. For the other people, I think [they are influenced by] the sexual infections they [could] get through sex.”

Likewise, a young man from Kavango said, “I think the decision is the man's only; especially among those of us who are not inclined to [traditional] culture.”

Many participants also described the influence of others, particularly their parents, communities, and sexual partners. While an older, uncircumcised man from Omaheke said parents had the most influence, older, uncircumcised men from Khomas noted:

P4: I think it varies from person to person. Some decide for themselves, some have no choice. In my case, my parents did not inform me about it. I also never heard much about it, and in the community where I grew up, nobody was circumcised.

P6: We did not know about it. We read about it in the Bible, but did not see it as compulsory because the pastors never preached about it. My parents also did not talk to us about it and never decided that we should be circumcised.

Many women were uncertain of their ability to influence their partner's decision to have a circumcision. Women from Ohangwena, when asked how they would feel discussing the subject of male circumcision with a partner, said:

P2: If you tell a man nowadays about that, he will ask you, “How you know about it?” and suspect that maybe you are cheating on him with a circumcised man.

P3: If you tell him to use a condom, he will ask you, “That for us to use a condom, what is the reason? What did you hear about me that I don't know?” Or, “Do you have a virus?” That is how it should be.

Whereas many women felt unable to influence their partner's decision to circumcise, many men mentioned their partners' preference as important. The following quotations from young men from Khomas illustrate this point.

P3: If my girlfriend says, "Have a circumcision; it makes sex better," then I will.

P8: My nieces nowadays only want men who are circumcised. I'm not joking!

Many respondents noted that recommendations from the government would weigh heavily on their decision of whether or not to circumcise. They believed that the government would not make recommendations that were not based on research, and in the best interest of Namibians.

E. Relationship between HIV and Male Circumcision

Although many participants recognized the role of male circumcision in the prevention of STDs, including HIV, most were unclear or unconvinced. Some misunderstood or disbelieved how the two are related. Others perceived that circumcision led to an increased risk for HIV.

Although many focus group participants had heard news items on the protective relationship between HIV and male circumcision and could even cite the 60% protective rate, some were either confused or did not believe that the change of HIV transmission was affected by circumcision. This disbelief seemed to involve: the difficulty in distinguishing between the concepts of reduced risk versus no risk, the lack of understanding of the mechanism of transmission, misconceptions regarding the role of bathing, the level of protection condoms provide, and a fatalistic attitude toward prevention in general.

1. Reduced risk versus no risk:

Broadcast messages on reduced risk and the relationship between male circumcision and HIV had confused many participants, who seemed to grapple with the distinction between "no risk" and "reduced risk." A young man from Kavango said:

P13: This research did not conclude that it's 100% [certain] that circumcised men are safe from diseases. The research concluded that 60% [are safe, leaving] 40%. So if you mess around, you contract the diseases. It's best to use a condom.

Two participants in a group of young, uncircumcised men from Khomas discussed the topic as follows:

P8: Let's take two men, one circumcised and the other not. Both practice unprotected sex with an infected partner. [There's a] 60% chance that the circumcised man won't be infected and 100% chance that the uncircumcised man will be infected. The foreskin is full of bacteria.

P5: But HIV is in the blood and bodily fluids.

P8: P5, we go to the root of the cause. If you have sexual intercourse, you use your penis. So, if you have a foreskin, and you have unprotected sex, it's dangerous. If you don't have the foreskin, it's also dangerous, but at least you can still escape.

Understanding the mechanics of transmission: Many participants were adamant that male circumcision offered no protection against HIV because transmission occurs through blood and semen, which are unrelated to foreskin. According to older women in Kavango:

P1: They need to use condoms because HIV is not found in the foreskin but inside the body. But STDs, like gonorrhoea, are found on the outer part of the skin.

P3: HIV is found in blood.

One young man from Ohangwena described it as follows:

P1: I have never heard of anyone who has died because they have foreskin. It's just like we have our mouths and they are covered by our lips. Will we now have to cut off our lips for our mouths not to get any infections?

In several cases, participants distinguished the protective effect of male circumcision from HIV versus other STDs, namely syphilis and gonorrhoea. This is possibly due to the different ways these infections are believed to be transmitted. A woman from Ohangwena noted, "AIDS cannot be prevented by circumcision, but maybe syphilis can be."

2. Bathing

Some participants think the relationship between male circumcision and HIV could be mitigated by bathing. According to a young female from Karas:

P9: It is necessary for circumcised men to use condoms, because sometimes you sleep with someone who is infected with STDs. The next day, without washing, you might get involved with your other girlfriend again. So it's needed.

Likewise, a young woman from Oshana said:

P6: Male circumcision can lower the risk of HIV infection because men don't like bathing like us women. He can go without bathing for two days, even though he sleeps with different women. But because he is circumcised, it can help him not to get infected because the bacteria on his manhood will die when exposed to air, given that the skin is no longer there.

An uncircumcised, young man from Khomas said, "You don't have to be infected with HIV the first time you have sex with a lady. I know a Vambo who says when he is finished with sex, he washes. We both went for HIV tests, and he was not infected."

Still another said, "I feel (that) if you wash there everyday, you don't need to be circumcised."

From these excerpts it is clear that some respondents view circumcision as an alternative or addition to bathing. Some participants described an increased benefit of circumcising over bathing in times or locations where water is scarce. An older, uncircumcised man from Khomas discussed the role of cleanliness as a protective strategy and how a lack of water may compromise that strategy:

P5: I strongly believe it just depends on you, how you take care of yourself.

P9: What you people should know is that we come from different backgrounds. Not all of us can get water and wash ourselves.

A young man from Ohangwena described the move away from a tradition of circumcising as a function of improved hygiene by saying, "The only benefits were there a long time ago, you see that people didn't wash back then. But because people wash regularly now, you can get to the tip of the penis and clean it properly."

Two young men from Oshana discussed the relationship between bathing, infection transmission, and circumcision.

P3: If I am uncircumcised and have sex and then go and wash, am I not protected, P2?

P2: Yes, you could be protected, but you are not always able to wash. By the time you go down to the toilet, you [may be infected] already.

3. Role of condoms

In addition to the perception that bathing prevented HIV transmission, participants similarly discussed the role of condoms. In general, participants expressed an acceptance of the continued need to use

condoms, despite circumcision status. In response to a question about whether circumcised men still need to use condoms as protection from HIV, a young man from Kavango said, “Yes, men who are circumcised will need to use a condom because the disease is carried by semen. Condoms are best.”

According to a young man from Karas, “Basically, whether you are circumcised or not, if you have penetrating sex and are unprotected, you’ll get HIV.”

Likewise, a young, circumcised man from Omaheke said, “Whether you are circumcised or not, you can’t not use a condom.”

In some cases, the continued need to use condoms furthered disbelief in the relationship between circumcision and HIV prevention. For others, circumcision was seen as an additional strategy for protection, including condom use. According to a young, uncircumcised man from Khomas:

P5: If you are circumcised or not, if you sleep with a person infected by HIV and you don’t use a condom, you will be infected. And if the condom tears or breaks, you will still be infected whether you are circumcised or not.

Another young, uncircumcised man from Khomas said, “If you look at the pack of condoms, it says ‘not 100% safe,’ so, being circumcised gives you that extra feeling of knowing you are safe.”

A young, circumcised man from Khomas saw condoms as the way to improve on the 60% protective effect of circumcision, saying, “It only says that the chance is lower, so it warns all people must use condoms.”

Problems with condoms: In Caprivi alone, some participants said that condoms should not be used at all, citing them as sources of HIV infection and adding that condoms are forbidden by the Bible because they inhibit conception. These participants saw male circumcision as the solution to the HIV/AIDS problem. This belief was related to the fact that circumcision did not interrupt pregnancy and was therefore consistent with religion. The following comments were made during a discussion with older men in Caprivi when the facilitator asked, What is the relationship between wearing condoms and male circumcision?

P1: There is no relationship. Condoms kill us because they have a worm. Circumcision is better. I have traveled in South Africa and asked about condoms. They said condoms are to prevent diseases. Until I accepted God, I believed them, but now, I see the good of circumcision, not condoms.

P2: I see the case for condoms, that we should wear them to prevent children, but it’s hard. When Judgment comes, God will ask about the children you killed. So I see the good in circumcision. It’s all I need.

P6: I see using condoms as a way to kill children.

The condoms are bringing too many deaths to Caprivi.

Fatalism: Some participants attached fatalism to HIV infection, stating that it is only bad luck if you get it and that circumcision status makes no difference. AIDS was identified as an unavoidable curse. A male respondent from Caprivi said, “It was important to be circumcised a long time ago, but no longer. Now, even if you are circumcised, AIDS can kill you.”

Belief that male circumcision increases the risk of HIV: When asked about the relationship between HIV and male circumcision, many respondents said that being circumcised increases the risk of infection. This belief appeared to be related to two main reasons: 1) infection that is caused by unsafe circumcising practices (i.e., re-using blades) and 2) that being circumcised leads to increased sexual risk taking (disinhibition) as a result of a sense of being protected.

Increased risk from unsafe circumcising practices: Many participants from areas with lower rates of circumcision reported that male circumcision contributed to HIV infection when it is performed by traditional circumcisers who use one blade for many procedures.

A young woman from Oshana said, “I agree that there is a relationship between male circumcision and HIV: I heard that traditional circumcisers only use one knife on different people and do not wash that knife. It is dangerous and spreading HIV easily.”

Disinhibition: For many participants, understanding and accepting the relationship between HIV and male circumcision reduced or eliminated the belief in the need for other protective strategies, such as condoms and partner fidelity. This was common among men, although some women suggested feeling less vigilant about the need to protect against disease with circumcised partners. Young women from Oshana discussed the question of how a man’s circumcision status affects his condom use and number of sexual partners:

P6: I believe [circumcision] plays a role in a decision to have sex because those who are circumcised will think that because they are circumcised they are free to have sex.

Pl: If a man is circumcised, does it mean he will have many sexual partners or have unprotected sex?

P6: That’s not what I said. But if a person is circumcised, he thinks he is somehow protected against diseases.

P8: That’s also how I understand it, that some people may not understand it very well. If circumcised, a man can have many partners and not get STDs.

Pl: If a person is circumcised, that doesn’t mean he is free to engage in unsafe sex with anyone. It is not that he won’t get bacteria. Of course he will, especially HIV, which one can get easily. They have to protect themselves like those who are not circumcised.

The following young women from Kunene said:

The men sleep around and give us the disease. In our culture, our Herero men don’t want to use condoms because they say that it prevents them from enjoying sex, and that is the first cause of spreading HIV.

I think that our (Herero) husbands sleep around. They started to have sex with women from other tribes who had had sex with uncircumcised men, and that is one thing that has brought HIV to our community.

In addition to the perception that those who are already circumcised may engage in higher-risk behaviors as a result of their belief that they are protected, some uncircumcised participants indicated that they found the option of circumcision compelling precisely because it would mean they would not have to use condoms. A young, uncircumcised man from Khomas said, “Okay, I will believe that I want to be circumcised because if it is less risky to me, I would love to take chances without a condom. I will love it.”

P7: Just for my own good. I have now heard it prevents the spread of sexually transmitted diseases. Because, honestly, we men are very naughty. Traditionally, they say Oshiwambo-speaking males can’t stay with one woman. If you leave your one woman at home, when you go to the next one, you won’t expect to use a condom with another lady.

Likewise, in response to whether or not he had ever thought of becoming circumcised, this older, uncircumcised man from Oshana replied:

P7: I have heard this information and want to find out more at the hospital to make my decision.

Pl: Why?

The following quote from an older man from Oshana reflects the complex relationship between lack of knowledge, disinhibition, and bathing with regards to circumcision and STDs:

P5: Circumcisions won't be done because, first, the people from here are scared of such things. Second, they accept [their fate]. Third, they don't know the reasons why someone should be circumcised. But [Angolans] do: to prevent STDs. I think, if you sleep with a woman without a condom who has an STD and you are not circumcised, you will be infected immediately. If you're circumcised, you won't be infected. . . . In developed countries, there are just a few people that are infected, but here, in Namibia, a lot of people are. In those countries, one person has about 80 women, and he sleeps with them all in one day. But if you have a lot of women and, say, two are infected, you won't leave without being infected.

F. Possible Government Promotion of Male Circumcision

1. Education

There was overwhelming support for the government to educate the public on male circumcision and clarify its role in improving health. Many participants felt that a clear and comprehensive education program, engaging local authorities, door-to-door educators, and the media, would go far in clearing up misconceptions and encouraging uptake.

According to a young woman from Kavango:

P8: People are willing to [be circumcised], but they don't have clear information of where to go. It is done at the hospital, but people fear that it is painful. In different homesteads people are doing it, but others are doing it wrongly. Thus, people become scared. People are confused, not knowing where to go for circumcision.

An older woman from Kavango said, "If they are to introduce [male circumcision], first they have to educate the nation on its importance. Then people will understand. After that they will be willing."

In response to another participant's statement that many people in Namibia are infected with HIV, an older man from Oshana said, "I think the MoHSS should educate people about circumcision. It's going to protect you, which means the nation won't be infected anymore."

A young, circumcised man in Omaheke said, "If the government recommends [male circumcision] services, it should inform communities and the nation why and explain the pros and cons."

Further, on the question of whether or not a relationship between male circumcision and HIV would influence their decision to circumcise, young men from Ohangwena said:

P4: This would only influence people if clear information were given to both adults and children. For example, when HIV came to this country, if people were well informed that it's a disease like any other, then a lot of people wouldn't be infected. Because people were misinformed and not informed, at first, they feared being tested. Now that information is more available, there is more confidence. The other thing is, especially when it comes from the government, people tend to listen.

P10: It would be good if the MoHSS would tell the people about the advantages of being circumcised because it will help reduce HIV.

Some participants indicated that as a result of what they learned by participating in the focus group, they would to consider circumcision. This is reflected through the following excerpt from a dialogue among older men in Omaheke:

P10: I am hearing only today that if you are uncircumcised you'll get diseases and also that to be circumcised is a good thing.

P9: This will go to our parents, because maybe they didn't know that today there would be diseases like this. They were only thinking that, in our tradition, we don't do male circumcision. Now, we realize that male circumcision is a good thing, so we will follow this.

P5: I used to be with circumcised people, so I feel very bad. I even went to my parents and asked and even on my father's side, they practice male circumcision, but not on my mother's side. Now I don't know what to do. So, because I don't feel good, I have to go for male circumcision, because of health.

Many focus group participants also described how they think information on male circumcision should be disseminated. They recommended pamphlets and using community leaders and radio. Several described their ideas for communication. A young woman from Kunene said, "In some areas there is no radio. So, the government must go out in the community and have meetings with the public and tell the people about the advantages of circumcision."

A young man from Ohangwena said:

P4: A good way would be to mobilize people. First give them information. In the villages, they should be the ones to give this information to us. Sometimes, when people just come from far and want to spread information, it's quite difficult to listen. The people from that village should be educated and give information to the community.

A young man from Oshana suggested that the youth training program be used: "I just want to advise our government to train some people from the national [group] that is training the youth: Train young people to come into the villages to provide information."

Comments from uncircumcised, young men in Khomas suggested the importance of information campaigns on people's willingness to be circumcised:

P8: If it is done or advertised through media, like radio and television, more boys will go for circumcision.

P1: It will benefit our country a great deal! The HIV rate is shockingly high!

P5: As long as they don't make it compulsory. Leave the decision to the men or boy himself. If they open a lot of places where it could be done, it would be a great benefit. But as P8 says, if you don't use the media, it will then be a great loss. Places would be opened, but no one would use the facilities.

2. Legislation versus recommendations

Many groups supported a law requiring male circumcision to improve health outcomes for Namibians. Others, while in favor of circumcision, disfavored a law, as illustrated by the following discussion between older, circumcised men in Khomas:

P3: Make it a law: From a certain year all boys born must be circumcised.

P6: I don't think it will work because we are in a free country. You can't pressure someone. You must just convince people. Indicate that it is safe, and give all the advantages. Don't make it compulsory. Advertise over the radio: Nama, Damara, Oshiwambo, all the radio stations. Call people together to hold seminars.

P2: I agree with the law, but they must talk to the traditional healers to hold seminars.

According to young men from Ohangwena:

P1: Before that decision is made, they must ask us, me, to democratically vote to see who wants it and who doesn't!

P9: Going forward with P1's ideas, even if the government makes it a law, I have the right myself if I don't want it! It's my body and I have the right to make my own decisions over it.

In fact, participants overwhelmingly expressed trust in the government and said that if the government would make recommendations, it would be in the best interest of their health and based on careful research. However, many also felt that, although they were in favor of male circumcision, it should *not* be compulsory and that an individual should retain the right to choose whether or not to be circumcised. An uncircumcised, older male from Omaheke said, “Now that HIV has spread throughout the nation, we the uncircumcised always are the scapegoats for the situation. So, let the government proceed with male circumcision so that we can see how it will be in the future.”

An older man from Oshana said, “I have the right myself on such authority. I have the right to decide. You can’t tell me to get circumcised or not.”

Despite reluctance for compulsory male circumcision, many felt that if male circumcision could improve the HIV rate and health of Namibians, recommendations should be taken as quickly as possible. This attitude was expressed in a group of older men from Karas, in response to the facilitator’s asking: Let’s assume the government wanted to increase the availability of male circumcision. How do you think about this?

P7: It’s fine. [The president] should make it quicker because we are dying here.

P6: The government should make it quicker. I’m concerned about our people.

3. Collaboration between Traditional Circumcisers and Medical Doctors

Participants from cultural groups where male circumcision is a tradition often recommended using traditional circumcisers. In many cases, participants from circumcising cultures believed that the traditional male circumcision offered a superior procedure with fewer complications than medical circumcisions. In contrast, participants from cultures or areas with no tradition of circumcision felt that traditional circumcisers were a source of risk, particularly due to lack of hygienic tools and healing medicines. These different attitudes also influenced how a person felt about the future role of traditional circumcisers in male circumcision in Namibia, as characterized by an exchange between older men from Oshana:

P8: This is not the olden days. One can just go to the hospital and be circumcised..

P9: I have one question: What do you mean “olden days”? Traditionally, we still do circumcisions. Does this mean we will be left out, because now the people only go to the hospitals? Maybe the traditional method should just be improved because to us traditions should be included.

P10: If you go and get circumcised traditionally, you will die. Just go to the hospital.

The following excerpts from discussion groups with younger circumcised men in Omaheke also suggest a preference for circumcision through modern doctors:

There is the manner how you get operated on if you are being circumcised by a traditional circumciser. Your health will be at risk.

Male circumcision is good, but get circumcised by a modern doctor.

Although many participants clearly preferred one over the other, several acknowledged the benefit of having the two groups of providers work together. A young man from Kavango said, “The people who are doing it traditionally should collaborate with the doctors in the Ministry of Health or private doctors. Doctors can help them with some medicine that is approved.”

A young woman from Kunene also said, “I think that the government must recruit traditional circumcisers to educate the medical doctors on how to perform circumcisions, because they have done it for a long time and have experience doing it.”

IV. RESULTS: KEY INFORMANT INTERVIEWS

Key informant interviews were conducted with various community stakeholders across the eight regions. No dramatic differences were noted between findings from the general public and stakeholders regarding attitudes toward or acceptability of male circumcision or the knowledge of the relationship between male circumcision and HIV prevention. To reduce redundancy, results from key informant interviews are limited to a summary of key points and discussion of differences with the general population.

A. Knowledge of Circumcision

Male circumcision is well known in Namibia. Every key informant could explain it in general and in detail. Although different words were used to describe it in different parts of the country, the explanations were quite similar. Male circumcision is practiced in all surveyed regions.

B. Relationship between Male Circumcision and HIV

Knowledge of the relationship between male circumcision and HIV varied. Understandably, key informants from the health field had a better understanding of the relationship between male circumcision and HIV and encouraged it as a strategy. Some participants were aware of the debate around the protective effect of male circumcision for HIV. A few believed male circumcision provides 100% protection and that condom use is not necessary for circumcised men. Others acknowledged only partial protection and strongly recommended the use of condoms even after circumcision.

An important proportion of key informants saw no link between male circumcision and protection against HIV transmission, but they believed circumcision protects against most other STDs. For them, the only way to prevent HIV is using condoms. Some referred to the idea of a protective effect of male circumcision on HIV infection as a “myth.” Absent formal information from the medical community or government leaders, these ideas seem fixed.

C. Level of Acceptability

Key informants revealed a high degree of acceptability of male circumcision, with reasons ranging from cultural, to medical (disease prevention, hygiene), to social (sexual pleasure, prerequisite to marriage, etc.) convictions. Regardless of the reason(s) held, almost all key informants agreed it should be promoted.

D. Key Factors in the Decision of Whether to Circumcise

Most key informants believed the decision of whether to circumcise is made by the parents (usually the mothers) in the case of children and by the adult in adult cases. Some key informants think that the community, mostly family members and local leaders, plays an important role in this decision.

Some healthcare providers felt that they should not interfere with the parents’ or patients’ decisions, providing information and letting others decide freely. Many key informants recognized their potential role in advocating for a policy of male circumcision. Many indicated they would feel comfortable in such role, after receiving proper guidance from the medical sector, if it is culturally sanctioned or a policy were approved by the National Assembly.

E. Perceived Next Steps

The Government of Namibia is perceived to be the natural umbrella for a program to scale up male circumcision countrywide. Most key informants suggested a progressive approach to scale up that is supported by widespread education.

Similar to the general public, most key informants view the government leadership as respectful of the fundamental rights of people. Most believed that male circumcision should not be compulsory.

Overall, the key informants favored male circumcision, with some expressing a willingness to play a positive role, if need be, in the implementation process.

F. Constraints

Key informants viewed barriers to improving circumcision services at health facilities as including a lack of: personnel, training, facilities, and financial resources.

In addition to the influence they, themselves, were perceived to be able to provide, many felt that giving the public broadly based information on male circumcision would be highly motivating and would enable them to make an informed decision.

V. DISCUSSION AND RECOMMENDATIONS

Our study results suggest an overall positive attitude toward circumcision due to its protection from HIV transmission. Nevertheless, many barriers to uptake were revealed; they can be summarized as:

- Many participants did not know that adults can be circumcised; others knew adults can be circumcised but were concerned about negative side effects, such as the length of time healing takes.
- Most participants knew that costs are associated with circumcision (and some believed that traditional circumcisers charge more than doctors).
- Many uncircumcised men were concerned that circumcision would reduce protection for the penis from insect bites and other injuries; they also feared pain, disfigurement, and death.
- Some participants believed that circumcision would impede penis growth.
- Some participants feared that circumcision would contribute to disinhibition.
- Some believed that circumcision could transmit HIV, especially in ceremonies where several people would be circumcised with one knife.
- The need for abstinence after circumcision was cited as a disadvantage.
- Cultural barriers included the need to give the appearance of adopting one's (non-circumcising) culture and fear of contravening a religious dictum.
- Some participants believed that circumcision would reduce sexual pleasure.
- Some could see no reason to be circumcised.
- Some indicated that they would not be circumcised without the involvement of elders, traditional leaders, parents, and other parties.

Our recommendations would address these barriers through a focus on education, training, and carefully designed behavior change communications programs.

A. Education

Substantial misunderstanding exists regarding the health benefits of male circumcision, particularly as it relates to HIV. An education and awareness campaign should address:

- How male circumcision reduces the risk of STDs, including HIV;
- That role of male circumcision can be one of several strategies for HIV prevention that include condoms and fidelity;
- The role of bathing in disease prevention: What it can and cannot do; and
- The evidence of negative consequences of male circumcision, especially rates of disfigurement and death and average length of time needed for healing (and abstinence).

The following quote from a young Kavango man underscores the importance of clarity in the information campaigns:

P8: It's a good idea to have all men circumcised. But, the . . . the research must not confuse people [into believing] that if you are circumcised, you will not contract HIV. The use of condoms should and must be practiced.

Educational campaigns should include mass media and local-level approaches. Government collaboration with local leaders in each region would provide the most effective program.

B. Training for Circumcisers and Increased Availability of Services

Training for and collaboration between traditional and medical circumcisers would increase the level of quality and quantity of services offered. Steps would include:

- Creating a certificate program for traditional circumcisers to legitimize those with experience and prevent those who should not be practicing from doing so,
- Fostering collaborative relationships between traditional circumcisers and health personnel,
- Expanding training for medical and traditional circumcisers,
- Establishing centers or mobile units for male circumcision,
- Increasing forums for mutual learning and sharing of expertise and resources,
- Increasing the integration of male circumcision services into existing health facilities, and
- Reducing the costs associated with male circumcision.

C. Behavior Change Communication Campaign

In addition to education campaigns and training for providers, a behavior change campaign should address barriers to male circumcision that exceed awareness limitations. A campaign that would offer role models for women and men could help to identify and inspire steps toward behavior change, illustrate that the advantages outweighing the disadvantages, and change normative perceptions of the prevalence of male circumcision in Namibia.

Behavioral role models for women, especially those from non-male circumcision cultures/areas, could model discussing male circumcision with their partners and preparing their sons for circumcision. Such models for men, especially regarding seeking circumcision as an adult, could exemplify positive outcome expectations, give evidence of normative behavior, and offer skills enhancement and increased self-efficacy. The following quotations from focus group participants from two northern regions with low prevalence of male circumcision describe the perceptions of the power of modeling behavior and changing normative perceptions of circumcision.

P5: If people realize that others have been circumcised, they will be circumcised themselves. (Young woman, Oshana)

P12: I saw that a lot of people were being circumcized, only then would I be. I wouldn't want to be the only one in the village not circumcised. (Young man, Ohangwena)

Given the very strong association between male circumcision and culture, and the reference to male circumcision as an activity of "others," programs to increase male circumcision uptake in Namibia must transcend cultural boundaries to create a more inclusive health policy targeting all Namibians. During a discussion group with young men from Oshana, participants discussed the role of culture and how it may deter some from being circumcised if it is not historically or currently a part of their culture. One young man suggested the following as a solution:

P6: In fact, let's just make it a Namibian culture, and not a tribal culture.

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APPENDICES

Appendix A: Data Tables

Table A-1: Number and Type of Focus Group, by Study Region

Region	Discussion group languages	Number and ages of focus group: women	Number, ages, and circumcision status of focus group: men
Omaheke	Otjiherero, Afrikaans	1 group: 18–34 yrs 1 group: 35 yrs+	1 group: 18–34 yrs, uncircumcised 1 group: 18–34 yrs, circumcised 1 group: 35 yrs+, uncircumcised 1 group: 35 yrs+, circumcised
Kunene	Otjiherero, Afrikaans	1 group: 18–34 yrs 1 group: 35 yrs+	1: 18–34 yrs, uncircumcised 1: 18–34 yrs, circumcised 1: 35 yrs+, uncircumcised 1: 35 yrs+, circumcised
Khomas	Afrikaans, Oshivambo, Otjiherero, Nama/Damara	2 groups: 18–34 yrs 2 groups: 35 yrs+	2 groups: 18–34 yrs, uncircumcised 2 groups: 18–34 yrs, circumcised 2 groups: 35 yrs+, uncircumcised 2 groups: 35 yrs+, circumcised
Karas	Afrikaans, Nama/Damara	1 group: 18–34 yrs 1 group: 35 yrs+	1 group: 18–34 yrs, mixed 1 group: 35 yrs+, mixed
Oshana	Oshivambo	1 group: 18–34 yrs 1 group: 35 yrs+	1: 18–34 yrs, mixed 1: 35 yrs+, mixed
Ohangwena	Oshivambo	1 group: 18–34 yrs 1 group: 35 yrs+	1: 18–34 yrs, mixed 1: 35 yrs+, mixed
Caprivi	Silozi	1 group: 18–34 yrs 1 group: 35 yrs+	1: 18–34 yrs mixed 1: 35 yrs+ mixed
Kavango	Rukwangali	1 group: 18–34 yrs 1 group: 35 yrs+	1 group: 18–34 yrs, uncircumcised 1 group: 18–34 yrs, circumcised 1 group: 35 yrs+, uncircumcised 1 group: 35 yrs+, circumcised

Table A-2: Demographics of Focus Group Participants, by Region

Region	Gender	Age (mean)	#	Home language (number of speakers)	Education	Employment status	Marital status	Circumcision status
Khomas (3 groups)	Male	35–58 (44)	26	Afrikaans (3) Damara>Nama (2) Otjiherero (19) Tswana (1)	100% secondary	24% employed 64% unemployed 12% self-employed	72% single 24% married 0.4% co-habiting	100% circumcised
Khomas (2 groups)	Male	36– 85 (49)	16	Afrikaans (37) Afrikaans>Nama (1) Afrikaans/ Oshiwambo (1) Damara>Nama (3) Oshiwambo (3) Otjiherero (1)	87.5% secondary 12.5% above secondary	56.2% employed 6.2% unemployed 37.5% pensioners	50% single 31.2% married 18.7% widowed	100% uncircumcised
Khomas (2 groups)	Male	18–32 (23)	17	Afrikaans (13) English (1) Oshiwambo (1) Otjiherero (11) Xhosa (1)	88.2% secondary 11.7% above secondary	47% employed 23.5% unemployed 29.4% students	100% single	100% circumcised
Khomas (2 groups)	Male	18–28 (22)	14	Afrikaans (7) Damara (1) Oshiwambo (6)	71.4% secondary 28.5% above secondary	42.8% employed 57.1% students	100% single	100% uncircumcised
Khomas (2 groups)	Female	18–34 (23)	21	Afrikaans (4) Damara (2) Damara/nama (2) Oshiwambo (8) Otjiherero (4) Tswana (1)	90.4% secondary 9.5% above secondary	23.8% employed 47.6% unemployed 28.5% students	80.9% single 9.5% married 9.5% co-habiting	N/A

Region	Gender	Age (mean)	#	Home language (number of speakers)	Education	Employment status	Marital status	Circumcision status
Khomas (2 groups)	Female	35–59 (41)	18	Afrikaans (5) Damara(1) Damara/Nama(2) nama (1) Oshiwambo (3) Otjiherero (2) Tswana (3) Coloured (1)	5.5% uneducated 16.6% primary 77.7% secondary	72.2% employed 27.7% unemployed	44.4% single 16.6% married 16.6% co-habiting 11.1% divorced	N/A
Kunene	Male	22–34 (25)	7	Otjiherero (7)	100% secondary	57.1% employed 14.2% unemployed 14.2% self-employed 14.2% students	85.7% single 14.2% married	100% circumcised
Kunene	Male	19–28 (23)	6	Damara/Nama (6)	33.3% uneducated 66.6% secondary	33.3% employed 66.6% unemployed	100%single	100% uncircumcised
Kunene	Male	35–65 (46)	10	Otjiherero (10)	30% uneducated 50% primary 20% secondary	10% employed 90% self-employed	50% single 50% married	100% circumcised
Kunene	Male	35–19 (39)	10	Afrikaans (1) Damara/Nama (9)	20% uneducated 30% primary 50% secondary	40% employed 60% unemployed	100% single	100% uncircumcised
Kunene	Female	35–65 (43)	12	Otjiherero (12)	58.3% uneducated 33.3% secondary	9% employed 91% unemployed	41.6% single 58.3% married	N/A

Region	Gender	Age (mean)	#	Home language (number of speakers)	Education	Employment status	Marital status	Circumcision status
Kunene	Female	18–34 (25)	12	Otjiherero (12)	41.7% uneducated 58.3% secondary	8.3% employed 83% unemployed 8.3% student	58.3% single 41.6% married	N/A
Ohangwena	Male	18–34 (22)	12	Kwanyamas (12) Oshiwambo	8.3% uneducated 91.6% secondary	25% employed 75% unemployed	100% single	100% uncircumcised
Ohangwena	Female	19–29 (23)	11	Oshiwambo (11) Oshilwanyama	100% Secondary	100% unemployed	100% single	N/A
Ohangwena	Female	35–42 (40)	7	Oshilwanyama (7) Oshiwambo	100% Secondary	14.2% employed 71.4% unemployed 14.2% no occupation	42.8% single 57.1% married	N/A
Oshana	Female	24–33 (25)	11	Oshikwambi (1) Oshikwanyama (4) Oshindonga (6)	18.1% primary 81.8% secondary	18.1% employed 54.5% unemployed 27.2% volunteers	100% single	N/A
Oshana	Female	35–57 (45)	7	Oshikwambi (2) Oshikwanyama(2) Oshindonga (2) Oshingandjera (1)	42.8% primary 57.1% secondary	14.2% employed 28.5% unemployed 57.1% self-employed	42.8% single 14.2% married 42.8% widowed	N/A
Omaheke	Male	19–34 (26)	9	Afrikaans (1) Damara (1) Mbanderu (1) Oshiwambo (1) Otjiherero (5)	100% secondary	11.1% employed 88.8% unemployed	77.7% single 22.2% married	100% circumcised

Region	Gender	Age (mean)	#	Home language (number of speakers)	Education	Employment status	Marital status	Circumcision status
Omaheke	Male	36–59 (43)	6	Himba (1) Ju-watsi(San) (1) Mbandja (1) Oshilkwanyama (2) Otjizemba (1)	100% Primary	100% unemployed	66.6% single 33.3% married	100% uncircumcised
Omaheke	Male	38–59 (48)	6	Afrikaans (1) Damara>Nama (1) Kavango (1) Nama (2) Oshiwambo (1)	83.3% primary 16.6% secondary	8.3% employed 16.6% pensioners	16.6% single 5% married 16.6% widowed 16.6% divorced	100% circumcised
Omaheke	Female	35–53 (44)	10	Afrikaans(1) Damara>Nama(1) Otjiherero (6) Tswana(2)	10% primary 30% secondary 60% above secondary	70% employed 30% unemployed	70% single 30% married	N/A
Omaheke	Female	19–34 (24)	7	Otjiherero (7)	100% secondary	100% unemployed	100% single	N/A
Caprivi*	Male	24–24 (29)	12	Lozi (4) Matjwe(3) Subia (5)	8.3% primary 66.6% secondary 25% above secondary	41.6% employed 50% unemployed 8.3% student	58.3% single 41.6% married	17% circumcised 83% uncircumcised
Caprivi	Male	35–72 (48)	10	Matwe (3) Mayeyi (7)	20% uneducated 30% primary 50% secondary	30 % employed 50% unemployed 20% retired	20% single 80% married	100% uncircumcised
Kavango	Male	34–59 (41)	11	Lozi Rulwangali Thimbukushu Zulu	18.1% uneducated 36.3% secondary 45.4% above secondary	100% employed	100% married	9% circumcised 91% uncircumcised

Region	Gender	Age (mean)	#	Home language (number of speakers)	Education	Employment status	Marital status	Circumcision status
Kavango	Male	22–34 (26)	12	Matjwe (1) Nyamba (3) Rukwangali (3) Thimbukushu (5)	25% secondary 75% above secondary	75% employed 25% students	91.6% single 8.3% married	33% circumcised 66% uncircumcised
Kavango	Male	19–33 (26)	10	Nyemba (1) Rugisiku (3) Rukwangali (2) Thimbukushu (3) Tjokwe (1)	100% above secondary	70% employed 30% unemployed	70% single 30% married	60% circumcised 40% uncircumcised
Kavango	Male	35–62 (43)	6	Rushambyu (4) Rykwangali (2)	16.6% uneducated 83.3% secondary	50% employed 33.3% unemployed 16.6% retired	100% Married	100% circumcised
Kavango	Female	35–48 (41)	9	Oshiwambo (1) Thimkukushu (8)	55.5% primary 44.4% secondary	100% employed	44.6% single 55.5% married	N/A
Kavango	Female	20–32 (12)	12	Rugiriku (5) Rykwangali (7)	50% uneducated 50% educated	25% employed 8.3% unemployed 41.6% self-employed 25% students	66.6% single 33.3% married	N/A
Karas	Male	33–55 (42)	8	Nama (2) Nama/Afrikaans (6)	50% primary 50% secondary	12.5% employed 87.5% unemployed	75% single 25% married	25% circumcised 75% uncircumcised
Karas	Female	23–35 (27)	9	Nama (9)	Secondary	Employed	Single	N/A
Karas	Female	64–89 (77)	13	Afrikaans (13)	Secondary	Pensioners	Married	N/A

*Demographic data forms missing for Caprivi female groups

Table A-3. Demographics of Key Informant Interviews, by Region

Region	Sex	Age	#*	Home language	Occupation
KHOMAS	Female	28–47	4	Damara>Nama Oshiwambo Shona Tswana	Teacher Control officer Medical doctor Officer - New Start Centre
KHOMAS	Male		2	English	Pastor Medical doctor
KUNENE	Male	38–42	2	English Otjiherero	Medical doctor Traditional circumciser
KUNENE	Female	49	1	Afrikaans, English	Nurse, HIV officer
KUNENE	Female	29	1	English, Otjiherero	Data typist
KUNENE	Female	26	1	English, Lozi	HIV activist
OHANGWENA	Male	49–51	2	English Oshiwambo	Medical doctor Nurse
OHANGWENA	Female	46–86	2	Oshikwanyama (2), Oshiwambo	Pensioner, School principal
OHANGWENA	Male	51	1	Oshikwanyama, Oshiwambo	Nurse
OSHANA	Male	48	1	Arabic/English	Medical doctor
OSHANA	Female	44–71	3	Oshikwambi (2) Oshikwanyama(1)	Businessman
OMAHEKE	Male	32–36	3	Otjiherero(1) Shona (2)	Medical doctor Mayor, pastor
OMAHEKE	Male	43	1	Otjiherero	Chief executive officer
OMAHEKE	Female	25	1	Otjiherero	Artist
CAPRIVI**	Male	54	1	Matwe	n.d.
CAPRIVI	Male	NA	1	Subia	n.d.
KAVANGO	Female	43	1	Rukwangali	Clerk
KAVANGO	Female	53	1	Thimbukushu	Counselor
KAVANGO	Male	42–67	2	French Rushambyu	Medical doctor Traditional healer
KARAS	Male	29–70	3	Arabic English English/Afrikaans	Medical doctor Medical doctor Mayor
KARAS	Female	46–71	2	Afrikaans Nama	

Notes: * # is number interviewed; **demographic forms from Caprivi females are missing; n.d. is no data available.

Table A-4. Local Language Terms Related to Male Circumcision

Term	Meaning	Language	Region	Discussion Group (Respondent Number)
Besnyding	Circumcision	Afrikaans	Karas	F, Y (1) M (2)
Tabiera	Sterilize (animal)	Damara>Nama	Karas	F, Y (1)
Tsuri (tsuries)	Circumcision	Damara>Nama	Karas	F, Y (1)
//na//nas	Baptism	Damara>Nama	Karas	M, O (1)
!gao	Circumcise	Damara>Nama	Karas	M, O (1,2)
/hau/ha	Numb from pain	Damara>Nama	Karas	M, O (2)
Gewerk	Circumcised	Afrikaans	Karas	M, O (3)
Manstonde	Period, menstruation	Afrikaans	Karas	M, O (5)
/hubu/hubusen	n.d.	Damara>Nama	Karas	M, O (5)
Zoet (gezoet)	“Cut”/circumcised	Afrikaans slang	Karas	M, Y (2)
Gesoenat			Khomas	M, Y (2)
Ofiko(a)	Circumcision	Oshiwambo?	Karas	M, Y (2)
Omkewa	Circumcision	Oshiwambo	Karas	M, Y (2)
Dapie (Dappie)	Circumcised	Damara>Nama	Karas	M, Y (2)
Half kapater	Circumcised	Afrikaans	Karas	M, Y (2)
Okukenghwa	Circumcision	Oshiwambo	Karas Oshana Khomas	M, Y (4) M, Y (1) M, O (3)
Okupita Etanda, Oku pitu etanda, Epito letanda	Coming of age ritual, symbolizing becoming an adult (“real man”)	Oshiwambo	Karas Ohangwena Oshana	M, Y (4) M, Y (1) M, Y (8-9) M, O (2) F, O (2)
Yka (sonyako)	Traditional healer	n.d.	Karas	M, Y (5)
Okujenda ko tjitiro	To go to the circumcision place	Herero	Karas	M, Y (5)
Ekura Omakura	Cohort “mates” (circumcised during same time frame)	Otjiherero	Karas Khomas	M, Y (5) F, O (4) M, Y (8) M, O (2)
Okurira omurumendu	Recognized as a “man”	Otjiherero	Karas	M, Y (5)
Shembiro	Circumcision	n.d.	Caprivi	F (1)
Mupato	Becoming a man	n.d.	Caprivi	F (1)
Sikenge	Place where girls become women	n.d.	Caprivi	M (1)
Kukena (kukenna)	Circumcision	Thimbukushu	Kavango	M (1) F, O
Mukunda Mukanda	Place for male circumcision	Mbukushu (Nyemba)	Kavango	M (1); F, Y (1); F, O (1)
Kukeria	Circumcision		Kavango	F, O (1)
Ekengho	Circumcision (younger)	Oshiwambo	Ohangwena Oshana	F (2) F, O (3); M, Y (1); M, O (2)
Oshivatu	Contact with those uncircumcised	n.d.	Ohangwena	F (4)
Omalenga	Headman	Oshiwambo	Ohangwena	F (20)
Eehamba	Chiefs		Ohangwena	F (20)

Term	Meaning	Language	Region	Discussion Group (Respondent Number)
Uulumenhu uili kowala	Naked penis	Oshiwambo	Oshana	F, O (2)
Ekelo loshipa	Cutting off skin	Oshiwambo	Oshana	F, O (2)
Oshipa tashi tetwa	Cutting skin	Oshiwambo	Oshana	F, O (2)
Kandongow Ohinena	Sexually transmitted disease		Oshana	M, Y (4)
Ngenge owa kenghwa?	Are you circumcised?	Oshiwambo	Oshana	M, Y (6)
Okuthukara Okusukara	Circumcision	Otjiherero	Khomas	F, Y (3) M, Y (2) M, O (3)
Okukutulwa	Circumcision	Oshiwambo	Khomas	F, Y (3)
Omushite	Type of tree used in circumcision tradition		Khomas	F, Y (11)
Gomasam	Type of fat like Vaseline used to heal wound	Damara>Nama	Khomas	F, Y (11)
Omaze uozongombe	Traditional mixture to heal circumcision wound	Otjiherero	Khomas	F, Y (11)
Uakondua	Are you circumcised?	Otjiherero	Khomas	F, Y (13)
Omasukarero	Cut off of the foreskin	Otjiherero	Khomas	F, O (1)
Okujenda Kotjivetero	Cutting of the foreskin	Otjiherero	Khomas	F, O (1)
Okujenda mokuti	Cutting foreskin	Otjiherero	Khomas	F, O (1)
Gurupa	Circumcision	Tswana	Khomas	F, O (1)
Omupotu	"Blind" meaning the hole in the child's penis is not opened	Otjiherero	Khomas	F, O (2)
Omutue	Ash: to be used on circumcision wound	Otjiherero	Khomas	F, O (3)
Ekara	Charcoal: to be used on circumcision wound	Otjiherero	Khomas	F, O (3)
Omukova	Skin, foreskin	Otjiherero	Khomas	F, O (6)
Ozombuka	"Ants" to signify itching of penis done by uncircumcised men	Otjiherero	Khomas	F, O (6) M, O (2)
Okupindua	Used for castration of animals and wrongly used to refer to male circumcision	Otjiherero	Khomas	M, Y (2)
Ondomo	Herb to stop bleeding from circumcision	Otjiherero	Khomas	M, Y (7) M, O (4) M, O (9)
Otjuondo	Cohort or "mates" that were traditionally circumcised during same time period	Otjiherero	Khomas	M, Y (8) M, O (6)

Term	Meaning	Language	Region	Discussion Group (Respondent Number)
Otjna otjiua katji tirue okutanaurua	If something is good, accept it and do not change the culture	Otjiherero	Khomas	M, Y (9)
Tsongura	Circumcision	Damara	Khomas	M, O (3)
Quedine	Uncut (not circumcised)	Xhosa and Zulu	Khomas	M, O (3)
Otjivetero	Circumcision (respectful word)	Otjiherero	Khomas	M, O (1) M, O (4)
Okusukarisiua	To be circumcised	Otjiherero	Khomas	M, O (1) M, O (4)
Okunjua	Itching in male parts	Otjiherero	Khomas	M, O (2)
Uapindua	Refers to castrating animals	Otjiherero	Khomas	M, O (5)
Ezuko	Fire	Otjiherero	Khomas	M, O (4)
Okujenda ko tjivetero	n.d.	Otjiherero	Khomas	M, O (4)
Uasukara?	Are you circumcised?	Otjiherero	Khomas	M, O (4)
Keja sukara	Not circumcised	Otjiherero	Khomas	M, O (5)
Uno zondjo za Tjitambi	You owe " <i>tjitambi</i> ," the traditional circumciser, meaning you are not yet circumcised	Otjiherero	Khomas	M, O (5)
Omusiasetu (Otjatu)	Tree	Otjiherero	Khomas	M, O (5)

Notes: F is female; M is male; Y is young (18-34 years); O is older (35 years or older); n.d. is no data available.

Appendix B: Training Report

Qualitative Research on Male Circumcision in Namibia

Training Report

Prepared by: Katina A. Pappas-DeLuca, Ph.D.

Date: 20 July 2008

Qualitative Research on Male Circumcision in Namibia

Training Report

Dates: 13-22 May 2008 (formal training 13-16 May, pilot testing 17-22 May)

Venue: URC Conference Room, Channel Life Building, Windhoek, Namibia

Trainers: Friedrich Kustaa, PhD
Katina A. Pappas-DeLuca, PhD
Frantz Simeon, MD

Overview

24 field researchers and 4 URC field coordinators were trained on the topic of male circumcision, the purpose of the proposed study, qualitative research techniques, and data collection instruments and protocols (see list of participants). All field instruments were translated during training into the following languages: Otjiherero, Afrikaans, Silozi, Rukavango, Damara/Nama, and Oshiwambo. Upon completion of the formal training, male and female field teams were identified for each language group and region. Pilot testing was carried out in each language giving all field teams an opportunity to practice conducting a group. Pilot tests were reviewed and debriefed in group format to continue to enforce interviewing skills.

Training Objectives

The training was designed so that upon completion the participants would:

- Understand the objectives of the study
- Understand what makes for a good qualitative interview
- Have practiced the skills needed for a qualitative interview
- Understand the difference between individual and focus group interviews
- Practice the skills needed for individual and group facilitation
- Understand thoroughly the interview guides
- Understand and practice the skills necessary for transcription and translation
- Understand thoroughly the research protocols
- Have translated the interview guides into selected languages
- Conduct and debrief on pilot test interviews.

Summary of Key Activities

- Background on male circumcision and the relationship with HIV prevention: The practice of male circumcision was described as well as the range of health benefits and side effects. Data on the relationship between male circumcision and HIV prevention was also provided.
- Background of the study: The background and purpose of the study were described. Participants were briefed on the research questions, what the study was intended (and *not* intended) to do, the research audience, and the reasons behind and details of the research design, including selection of regions, stratification by gender, age, and circumcision status (in selected regions).
- Roles and responsibilities: Rules of proper conduct and responsibilities of interviewers and note-takers were discussed.

- Good qualitative interviewing techniques: Qualitative and quantitative approaches were distinguished. Strategies for facilitating discussion were discussed. The importance of rapport building was emphasized. The group reviewed examples of possible probes and discussed how to make them more culturally appropriate to Namibia. The group practiced using probing techniques.
- Review of instrument guides: Each item in the focus group and key informant interview guides was reviewed by participants in a group setting. Participants discussed wording and intent of the items to ensure a full understanding.
- Strategies for recruitment: We discussed the importance of recruiting a diverse group of participants for the focus groups to ensure that as many different voices could be heard through this research.
- Translation of instrument guides: Based on census information of predominant cultural groups in the selected regions, discussion guides were translated into the following languages: Otjiherero, Afrikaans, Silozi, Rukavango, Damara/Nama, and Oshiwambo. Participants were divided into small groups based on language capabilities and translation of guides occurred through discussion and consensus.
- Practice and pilot testing: Each trainee had an opportunity to practice interviewing techniques through role plays and paired practice during the training. After guides were translated into selected language groups, trainees conducted mock focus groups within language groups. Each language group had opportunity to practice male and female instruments and debrief in group setting. Participants were asked to provide comments and feedback to one another and then trainers provided additional feedback and discussion of strategies for improved data collection techniques. Upon completion of in-office practice, each language team recruited for and conducted pilot test discussions. Summary and debriefing of pilot tests were done in a group format to elicit feedback and discussion around what worked well and opportunities for improvement.
- Field research protocol: Data collection and transcription protocols were developed, and each field team met to review protocols and plan for field work prior to commencing data collection.

Documents Provided

- Background information on male circumcision
- Tips and suggestions for good focus group/interview techniques
- English focus group and key informant interview guides
- Demographic and summary sheets
- Overview of the study (including study purpose, research questions, research design, interviewer roles)
- Field work protocols (including review and guidance for preparation, recruitment, focus group/interview conduct, translation and summary of discussion, and regional contact information)
- Protocol for transcription of discussion (for typists)

Unanticipated Problems

Some pilot focus group participants were recruited by staff at a church where some groups were held. Participants in these groups were often unclear on the purpose of the group and their participation. At the start of each group, facilitators needed to clarify and, in some cases, correct misinformation regarding the focus group purpose and compensation. This served as a good opportunity to emphasize the importance of clear and honest recruitment techniques.

The letter of approval from the Permanent Secretary was not ready until 28 May. Therefore, data collection was delayed. As a result, some trained interviewers accepted other jobs prior to commencing field work.

In order to hear from as many different cultural groups within each of the 8 study regions, field researchers were instructed to recruit culturally diverse group of participants for focus groups discussions. Attempting to include representatives from many different cultural groups posed a challenge of identifying a common language in which to facilitate discussions.

Lessons Learned

In order to produce a verbatim translation of the discussions, the interviewers felt they needed to first write down the translation in English. Therefore, the research team decided not to have interviewers produce an oral translation of the discussions. Rather, the written translations could be passed to the typist for transcription. In the event that discussions occurred in English, the tapes could be passed directly to the typist.

There was some confusion regarding logistics of payment and compensation for the field teams. This may have been avoided if written contracts outlining payment details were prepared for signature upon completion of the training.

Appendix C: Focus Group Data Collection Guides (English)

Focus Group Guide – Men (Circumcised)

Reminder to facilitators:

The purpose of this focus group is to understand the following:

- What are the attitudes of people towards circumcision?
- What are the key influences on the decision of whether or not to circumcise?
- What are the perceived pros and cons of male circumcision?
- What is understood about the relationship between HIV and male circumcision?

I. Introduction [5 min.]

Hello. My name is _____, this is _____ and we are here representing University Research Center in Windhoek. We want to thank you all for taking the time to meet with us.

We are conducting discussion groups in many regions of Namibia to try to learn more about how people in Namibia feel about male circumcision, and what things are considered when deciding whether or not for men and boys to be circumcised. We will be discussing your thoughts and ideas about male circumcision. Our discussion will provide us with information that will help policymakers in Namibia to educate people about circumcision.

We are interested in hearing what you think and feel. There are no right or wrong answers. We expect that you will have different points of view.

Our discussion will be about one and a half hours. We'd like the discussion to be informal, so there's no need to wait to be called on to respond. You may respond directly to the comments other people make. If you don't understand a question, please let me know. We are here to ask questions, listen, and make sure everyone has a chance to share. We're interested in hearing from each of you, so if you are talking a lot we may interrupt you and if you aren't saying much, we may call on you. If we do, please don't feel bad about it, it's just our way of making sure we get through all of the questions and everyone has a chance to talk.

We will be tape recording the discussion, because we don't want to miss any of your comments. No names will be included in any reports. In fact, we will be referring to each of you by the "P#" that is on the sign in front of you. That is so your comments are confidential. If you would like to address each other, or follow up on what someone else has said, please use the person's "P#", instead of their name. Finally, we are requesting that you make sure any personal comments discussed here, are not discussed with others who are not here. This is because it is important to us that you feel free to speak openly and honestly.

Are there any questions before we begin?

[consider icebreaker]

II. Opening questions – pros/cons and decision making (FL= free list) [estimated time= 40 minutes]

- [FL]Let's start with a general question: what is male circumcision? (*explain correct definition as per guide once people have responded*)
- [FL]What is it typically called in this area? (*mutually decide on what you will call it during session*)
- What is the tradition in this area around male circumcision? [are they typically done?] If so: How are male circumcisions typically done here? [FL: At what age is it typically done? Who does it? How much does it cost (monetary/non-monetary)?]
- What are the **reasons** male circumcision is done (or not done)?

- What do you think are the benefits of male circumcision? [prompt for short and long term benefits, prompt for health, sexual, behavioural, other.]
- What are any drawbacks of male circumcision?[prompt for short and long term drawbacks, health, sexual, behavioural, other]
- What do you think are the benefits of not circumcising? [prompt for short and long term drawbacks, health, sexual, behavioural, other]
- What are any drawbacks of not circumcising? [prompt for short and long term drawbacks, health, sexual, behavioural, other]
- What do you think that women feel about having sex with man who is circumcised vs. uncircumcised? [Prompt for: any benefits or drawbacks for women]
- How is the decision made of whether or not a male is to be circumcised? [at family level, at community level] What are some of the considerations? Who is a part of that decision? How does it differ for baby/child/adult?

III. Questions for circumcised men (estimated time=30 minutes)

- How do you feel about being circumcised?
- How many of you were circumcised at a health clinic? How many of you were circumcised by a traditional circumciser? Others? *(use this information to direct the next set of questions to the appropriate groups)*

Questions to men in the group who were circumcised by a traditional circumciser

- These next few questions are for those of you who were circumcised by traditional ways. Tell me about what happens before, during and after male circumcision when it takes place in a traditional way that is not in a health facility? [prompt for preparation process and recuperation process. Who is involved in these processes?]
- What do you think are the benefits of having a circumcision with a *traditional* circumciser (traditional method)? [note: these should be specific to the traditional method, not circumcision in general]
- What do you think are any drawbacks or risks of having a circumcision with a *traditional* circumciser (traditional method)? *(note: these should be specific to the traditional method, not circumcision in general)* Have you heard of any of these things ever happening?
- Based on your experience, what suggestions might you have for improving the way male circumcision is done by a traditional circumciser?

Questions to men in the group who were circumcised at a health facility

- These next few questions are for those of you who were circumcised in a health clinic. Tell me about what happens before, during, and after a male circumcision when it takes place in a health facility. [prompt for preparation process and recuperation process. Who is involved in these processes?]
- What do you think are the benefits of having a circumcision in a health facility? [note: these should be specific to having it in health facility, not male circumcision in general]
- What do you think are any drawbacks or risks of having a circumcision in a health facility? *(note: these should be specific to having it in health facility, not male circumcision in general)* Have you ever heard of these things ever happening?
- Are there any barriers to having male circumcision done in a health facility? Cost? Accessibility? Safety?
- Based on your experience, what suggestions might you have for improving the way male circumcision is done in a health facility?

IV. Health related questions (estimated time=10 minutes)

- What do you think is the relationship between male circumcision and sexually transmitted infections like HIV?
- Have you heard that male circumcision can reduce the chance of being infected with HIV or passing it on to another? (count) Do you believe this to be true? If not, why not?
- What is the relationship between wearing condoms and male circumcision? [prompt: do circumcised men still need to use condoms to protect themselves from HIV/AIDS?]

V. Closing questions (estimated time=15 minutes)

- What (or who) do you think has had the biggest influence on your opinion of male circumcision? What was that influence?
- What would you say to someone who was considering getting a male circumcision? What do you think would influence a person nowadays on whether or not to get a male circumcision (as adult or to circumcise child)?
- Who do you usually go to/where do you prefer to get your information on health?
- Let's assume the government wanted to increase the availability of male circumcision services. What would you feel about that? What would you think would be good, or bad, ways to do this?

Thank you very much for coming here and speaking with us. Do you have any questions before we end?

Focus Group Guide – Male (Uncircumcised)

Reminder to facilitators:

The purpose of this focus group is to understand the following:

- What are the attitudes of people towards circumcision?
- What are the key influences on the decision of whether or not to circumcise?
- What are the perceived pros and cons of male circumcision?
- What is understood about the relationship between HIV and male circumcision?

I. Introduction [5 min.]

Hello. My name is _____, this is _____ and we are here representing the University Research Center in Windhoek. We want to thank you all for taking the time to meet with us.

We are conducting discussion groups in many regions of Namibia to try to learn more about how people in Namibia feel about male circumcision, and what things are considered when deciding whether or not for men and boys to be circumcised. We will be discussing your thoughts and ideas about male circumcision. Our discussion will provide us with information that will help policymakers in Namibia to educate people about circumcision.

We are interested in hearing what you think and feel. There are no right or wrong answers. We expect that you will have different points of view.

Our discussion will be about one and a half hours. We'd like the discussion to be informal, so there's no need to wait to be called on to respond. You may respond directly to the comments other people make. If you don't understand a question, please let me know. We are here to ask questions, listen, and make sure everyone has a chance to share. We're interested in hearing from each of you, so if you are talking a lot we may interrupt you and if you aren't saying much, we may call on you. If we do, please don't feel bad about it, it's just our way of making sure we get through all of the questions and everyone has a chance to talk.

We will be tape recording the discussion, because we don't want to miss any of your comments. No names will be included in any reports. In fact, we will be referring to each of you by the "P#" that is on the sign in front of you. That is so your comments are confidential. If you would like to address each other, or follow up on what someone else has said, please use the person's "P#", instead of their name. Finally, we are requesting that you make sure any personal comments discussed here, are not discussed with others who are not here. This is because it is important to us that you feel free to speak openly and honestly.

Are there any questions before we begin?

II. Opening questions – pros/cons and decision making (FL= free list) [estimated time= 40 minutes]

- [FL]Let's start with a general question: what is male circumcision? (*explain correct definition as per guide once people have responded*)
- [FL]What is it typically called in this area? (*mutually decide on what you will call it during session*)
- What is the tradition in this area around male circumcision? [are they typically done?] If so: How are male circumcisions typically done here? [FL: At what age is it typically done? Who does it? How much does it cost (monetary/non-monetary)?]
- What are the **reasons** male circumcision is done (or not done)?
- What do you think are the benefits of not circumcising? [prompt for short and long term drawbacks, health, sexual, behavioural, other]
- What are any drawbacks of not circumcising? [prompt for short and long term drawbacks, health, sexual, behavioural, other]

- What do you think are the benefits of getting circumcised? [prompt for short and long term benefits, prompt for health, sexual, behavioural, other.]
- What are any drawbacks of getting circumcised? [prompt for short and long term drawbacks, health, sexual, behavioural, other]
- What do you think that women feel about having sex with man who is circumcised vs. uncircumcised? [Prompt for: any benefits or drawbacks for women]
- How is the decision made of whether or not a male is to be circumcised? [at family level, at community level] What are some of the considerations? Who is a part of that decision? How does it differ for baby/child/adult?

III. Questions to uncircumcised men (estimated time= 25 minutes)

- How do you feel about being uncircumcised?
- Why do you think you are not circumcised?
- Have you ever thought of getting circumcised? If so, why? If not, why not?
- What would be some of the considerations for you in deciding whether or not to get circumcised?
- If you were to decide to get circumcised, would you prefer to get circumcised by a traditional circumciser or in a health facility? Why?
- What would be some of the considerations for you in deciding whether or not to get your son circumcised?

IV. Health related questions (estimated time=10 minutes)

- What do you think is the relationship between male circumcision and sexually transmitted infections like HIV?
- Have you heard that male circumcision can reduce the chance of being infected with HIV or passing it on to another? (count) Do you believe this to be true?
- How would this information influence your interest in becoming circumcised?
- What is the relationship between wearing condoms and male circumcision? [prompt: do circumcised men still need to use condoms to protect themselves from HIV/AIDS?]

V. Closing questions (estimated time=15 minutes)

- What (or who) do you think has had the biggest influence on your opinion of male circumcision? What was that influence?
- What would you say to someone who was considering getting a male circumcision? What do you think would influence a person nowadays on whether or not to get a male circumcision (as adult or to circumcise child)?
- Who do you usually go to/where do you prefer to get your information on health?
- Let's assume the government wanted to increase the availability of male circumcision services & the number of men who get circumcised. How would you feel about that? Is it a good idea? What would you think would be good, or bad, ways to do this?

Thank you very much for coming here and speaking with us. Do you have any questions before we end?

Focus Group Guide – Women (Largely Circumcised Area)

Reminder to facilitators:

The purpose of this focus group is to understand the following:

- What are the attitudes of people towards circumcision?
- What are the key influences on the decision of whether or not to circumcise?
- What are the perceived pros and cons of male circumcision?
- What is understood about the relationship between HIV and male circumcision?

I. Introduction [5 min.]

Hello. My name is _____, this is _____ and we are here representing the University Research Center in Windhoek. We want to thank you all for taking the time to meet with us.

We are conducting discussion groups in many regions of Namibia to try to learn more about how people in Namibia feel about male circumcision, and what things are considered when deciding whether or not for men and boys to be circumcised. We will be discussing your thoughts and ideas about male circumcision. Our discussion will provide us with information that will help policymakers in Namibia to educate people about circumcision.

We are interested in hearing what you think and feel. There are no right or wrong answers. We expect that you will have different points of view.

Our discussion will be about one and a half hours. We'd like the discussion to be informal, so there's no need to wait to be called on to respond. You may respond directly to the comments other people make. If you don't understand a question, please let me know. We are here to ask questions, listen, and make sure everyone has a chance to share. We're interested in hearing from each of you, so if you are talking a lot we may interrupt you and if you aren't saying much, we may call on you. If we do, please don't feel bad about it, it's just our way of making sure we get through all of the questions and everyone has a chance to talk.

We will be tape recording the discussion, because we don't want to miss any of your comments. No names will be included in any reports. In fact, we will be referring to each of you by the "P#" that is on the sign in front of you. That is so your comments are confidential. If you would like to address each other, or follow up on what someone else has said, please use the person's "P#", instead of their name. Finally, we are requesting that you make sure any personal comments discussed here, are not discussed with others who are not here. This is because it is important to us that you feel free to speak openly and honestly.

Are there any questions before we begin?

II. Opening questions – pros/cons and decision making (FL= free list) [estimated time= 40 minutes]

- [FL]Let's start with a general question: what is male circumcision? (*explain correct definition as per guide once people have responded*)
- [FL]What is it typically called in this area? (*mutually decide on what you will call it during session*)
- What is the tradition in this area around male circumcision? [are they typically done?] If so: How are male circumcisions typically done here? [FL: At what age is it typically done? Who does it? How much does it cost (monetary/non-monetary)?]
- What are the **reasons** male circumcision is done (or not done)?
- What do you think are the benefits of male circumcision? [prompt for short and long term benefits, prompt for health, sexual, behavioural, other.]
- What are any drawbacks of male circumcision? [prompt for short and long term drawbacks, health, sexual, behavioural, other]

- What do you think are the benefits of not circumcising? [prompt for short and long term drawbacks, health, sexual, behavioural, other]
- What are any drawbacks of not circumcising? [prompt for short and long term drawbacks, health, sexual, behavioural, other]
- How is the decision made of whether or not a male is to be circumcised? [at family level, at community level] What are some of the considerations? Who is a part of that decision? How does it differ for baby/child/adult?

III. Questions to women in communities where men are normally circumcised (estimated time=25 minutes)

- What role do women play in the decision and process of male circumcision?
- As women, what does a man being circumcised mean to you? What role does circumcision play in a decision to marry?
- When you become mothers, or as mothers, what will your son's circumcision mean to you?
- What role does circumcision play in decision to have sex or the act of sex? What do you think that women feel about having sex with man who is circumcised vs. uncircumcised? [Prompt for: any benefits or drawbacks for women including pleasure, health protection, condom use, other]

IV. Health related questions (estimated time=10 minutes)

- What do you think is the relationship between male circumcision and sexually transmitted infections like HIV?
- Have you heard that male circumcision can reduce the chance of being infected with HIV or passing it on to another? (count) Do you believe this to be true? If not, why not?
- What is the relationship between wearing condoms and male circumcision? [prompt: do circumcised men still need to use condoms to protect themselves from HIV/AIDS?]

V. Closing questions (estimated time=15 minutes)

- What (or who) do you think has had the biggest influence on your opinion of male circumcision? What was that influence?
- What would you say to someone who was considering getting a male circumcision? What do you think would influence a person nowadays on whether or not to get a male circumcision (as adult or to circumcise child)?
- Who do you usually go to/where do you prefer to get your information on health?
- Let's assume the government wanted to increase the availability of male circumcision services. How would you feel about that? What would you think would be good, or bad, ways to do this?

Thank you very much for coming here and speaking with us. Do you have any questions before we end?

Focus Group Guide – Women (Largely Uncircumcised Area)

Reminder to facilitators:

The purpose of this focus group is to understand the following:

- What are the attitudes of people towards circumcision?
- What are the key influences on the decision of whether or not to circumcise?
- What are the perceived pros and cons of male circumcision?
- What is understood about the relationship between HIV and male circumcision?

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- What do you think that women feel about having sex with man who is circumcised vs. uncircumcised? [Prompt for: any benefits or drawbacks for women]
- How is the decision made of whether or not a male is to be circumcised? [at family level, at community level] What are some of the considerations? Who is a part of that decision? How does it differ for baby/child/adult?

III. Questions to women in communities where men are normally not circumcised (estimated time=25 minutes)

- What role do women play in the decision and process of male circumcision?
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- When you become mothers, or as mothers, what will your son's circumcision mean to you?
- What role does circumcision play in decision to have sex or the act of sex? How do you feel about having sex with man who is circumcised vs. uncircumcised? [Prompt for: any benefits or drawbacks for women including pleasure, health protection, condom use, other]

IV. Health related questions (estimated time=15 minutes)

- What do you think is the relationship between male circumcision and sexually transmitted infections like HIV?
- Have you heard that male circumcision can reduce the chance of being infected with HIV or passing it on to another? (count) Do you believe this to be true?
- How would this information influence your feelings towards having sex partners who are not circumcised? How about in your decision to circumcise your sons?
- What is the relationship between wearing condoms and male circumcision? [prompt: do circumcised men still need to use condoms to protect themselves from HIV/AIDS?]

IV. Closing questions (estimated time=15 minutes)

- What (or who) do you think has had the biggest influence on your opinion of male circumcision? What was that influence?
- What would you say to someone who was considering getting a male circumcision? What do you think would influence a person nowadays on whether or not to get a male circumcision (as adult or to circumcise child)?
- Who do you usually go to/where do you prefer to get your information on health?
- Let's assume the government wanted to increase the availability of male circumcision services. How would you feel about that? What would you think would be good, or bad, ways to do this?

Thank you very much for coming here and speaking with us. Do you have any questions before we end?

USAID HEALTH CARE IMPROVEMENT PROJECT

University Research Co., LLC
7200 Wisconsin Avenue, Suite 600
Bethesda, MD 20814

Tel: (301) 654-8338

Fax: (301) 941-8427

www.hciproject.org