

**FACTORS CONTRIBUTING TO THE LOW UPTAKE OF MEDICAL MALE  
CIRCUMCISION IN BAMBAZONGE VILLAGE WITHIN MUTARE RURAL  
DISTRICT, ZIMBABWE**

BY

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Master in Public Health (MPH), School of Health Sciences**

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**Declaration**

I, Irene Onicah Chiringa, declare that the mini-dissertation on “**Factors contributing to the low uptake of medical male circumcision in Bambazonge village within Mutare rural district, Zimbabwe**” hereby submitted for the degree of Masters in Public Health Management (MPH) at the University of Venda has not been submitted previously by me at this or any other university. It is my own work in design and in execution. The sources that I have quoted have been indicated and acknowledged by means of complete references.

**Signature**

*Irene Onicah Chiringa*  
.....

**Date**

*27/03/15*  
.....

Chiringa I.O

### **Dedication**

I dedicate this research to my parents Shirley and Cosmas Chiringa who have shown me the importance of education. To my little brothers Nkossanah and Schneider who I have set a trail before them to follow. A special dedication to my older sister Kudakwashe and her husband Donald Makasi for their motivation and constant support.

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## Abstract

Male circumcision is one of the oldest and most common surgical procedures worldwide, and is undertaken for many reasons. These include religious, cultural, social and medical reasons. Medical male circumcision (MMC) has become a significant dimension of HIV prevention interventions after the results of three randomized controlled trials (RCTs) in Uganda, South Africa and Kenya demonstrated that circumcision has a protective effect against contracting HIV of up to 60 percent. In 2009, following recommendations by the World Health Organisation (WHO), Zimbabwe adopted Voluntary Medical Male Circumcision (VMMC) as an additional HIV prevention strategy to the existing ABC behavior change model. The purpose of this study was to investigate the factors contributing to the low uptake of MMC in Bambazongwe village in Mutare Rural District. The study adopted a quantitative approach using a descriptive cross sectional survey. Self-reported questionnaires with close-ended questions were administered to the eligible respondents. The targeted population was all males aged 18-49 who met the inclusion criteria. The households were systematically selected and a sample size of 234 was used. The Statistical Package for Social Sciences (SPSS) was used to analyse data. The study results indicated that religious affiliation has an influence on one's decision to be circumcised. Fear of surgical operation, long wound healing time, diminished sexual pleasure and costs that may incur before and after circumcision were identified as the major barriers leading to the low uptake of MMC. The study recommended the Ministry of health and child welfare to come up with more campaign strategies to increase its adoption and reduce misconceptions associated with it.

**Key words;** Factors, low uptake, medical male circumcision(MMC), Bambazongwe village

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UNICEF- United Nations Children's Fund

USAID- United States Agency for International Development

VMMC- Voluntary Medical Male Circumcision

WHO- World Health Organisation

## **Abbreviations and Acronyms**

- AIDS-** Acquired Immunodeficiency Syndrome
- BMSFI-** Brief Male Sexual Function Inventory
- HBM-** Health Belief Model
- HIV-** Human Immunodeficiency Virus
- MC-** Male Circumcision
- MMC-** Medical Male Circumcision
- SPSS-** Statistical Package for Social Sciences
- STI's-** Sexually Transmitted Infections
- UNAIDS-** United Nations HIV/AIDS Programme
- UNICEF-** United Nations Children's Fund
- USAID-** United States Agency for International Development
- VMMC-** Voluntary Medical Male Circumcision
- WHO-** World Health Organisation.

## CHAPTER 1: INTRODUCTION

### 1.1 Introduction

Male circumcision (MC) is one of the oldest and most common surgical procedures worldwide, and is undertaken for such reasons as religious, cultural, social and medical among others. MC is common in many African countries and is almost everywhere in North Africa and most of West Africa. In contrast, it is less common in Southern Africa where self-reported prevalence is around 15% in several countries such as Botswana, Namibia, Swaziland, Zambia and Zimbabwe (WHO, 2007). In Zimbabwe, MC has been a practice for traditional purposes among the Tsonga in Chiredzi and Mwenenzi districts, the Varembe in Gutu district and Mberengwa district. It has also been predominantly practiced by the Chewa and Muslim people for religious purposes (Government of Zimbabwe, 2009).

### 1.2 Background to the Study

Historically, the earliest records depicting circumcision date is around 2300 BC amongst the ancient Semitic people including Egyptians and those of the Jewish faith (Salem 2012). According to Salem (2012) circumcision is one of the oldest operations in history and the first unequivocal description of circumcision was found in the fourth dynasty Egyptian tombs around 3000 BC. It was practiced at puberty and is carved on portraits in the Karnak temple of Mount Sinai statues of Pharaohs. However, whether it had a religious or hygienic purpose in ancient Egypt is unknown. According to Salem (2012), the Egyptians taught the procedure to the Jews, Syrians and Phoenicians and later, the custom spread to Ethiopians.

The advancement in surgery and increased mobility in the 19<sup>th</sup> and 20<sup>th</sup> century led to the procedure being introduced into some previously non-circumcising cultures for both health-related and social reasons (WHO, 2012). According to UNAIDS (2012), approximately 30% of all males across the world, which is a total of approximately 670 million men, are circumcised. The representation of those circumcised are as follows; 68% are of Islamic faith, and 13% are non-Muslim, less than 1% of Jewish faith non-Jewish Americans. In the Jewish religion, male infants are traditionally circumcised on their eighth day of life, provided there is no medical contraindication. The justification behind it is that a covenant was made between Abraham and God, the outward sign of which is circumcision for all Jewish males (Dick, Keil & Wilcken.,

2010). Islam is the largest religious group to practice male circumcision. Furthermore, as an Abrahamic faith, Islamic people practice circumcision as a confirmation of their relationship with God, and the practice is also known as 'tahera', meaning purification. Salem (2012) postulates that with the global spread of Islam from the 7th century AD, MC was widely adopted among previously non-circumcising people. There is no clearly prescribed age for circumcision in Islam, although the prophet Muhammad recommended it be carried out at an early age and reportedly circumcised his sons on the seventh day after birth. Many Muslims perform the rite on this day, although a Muslim may be circumcised at any age between birth and puberty.

The Coptic Christians in Egypt and the Ethiopian Orthodox Christians retain many of the features of early Christianity, including male circumcision (Salem, 2012). Furthermore, the bases of their beliefs of MC is based on the scripture by St Paul in (Galations 5:6) "in Christ Jesus neither circumcision nor uncircumcision count for anything" and a Papal Bull issued in 1442 by the Roman Catholic Church stated that male circumcision was unnecessary. In contrast, focus group discussions on MC in sub-Saharan Africa found no clear consensus on compatibility of male circumcision with Christian beliefs (UNAIDS, 2012).

For many thousands of years in sub-Saharan Africa, circumcision has been practiced for non-religious reasons as well. Traditionally, MC is usually performed in a non-clinical setting by a traditional practitioner with no formal medical training (Dick, Keil & Wilcken., 2010). It has been a practice among the aboriginal Australasians, the Aztecs and Mayans in the Americas, inhabitants of the Philippines and Eastern Indonesia and of various Pacific Islands, including Fiji and the Polynesian islands. Tradition plays a major part for many ethnic groups. In Bendel State in Southern Nigeria, 43% of men stated that their motivation for circumcision was to maintain their tradition. In some settings where circumcision is the norm, there is discrimination against non-circumcised men (Dick, Keil & Wilcken, 2010).

When carried out as a rite of passage into manhood, traditional male circumcision is mainly performed on adolescents or young men. According to Dick, Keil and Wilcken (2010) in the majority of these cultures, circumcision is an integral part of a rite-of-passage to manhood, although originally it may have been a test of bravery and endurance. Salem (2012) associates MC with factors such as masculinity, social cohesion with boys of the same age who become circumcised at the same time, self-identity and spirituality. Moreover, the rites of passage

describe various initiation rites which are present in many circumcision rituals which include a three stage process: separation from normal society; a period during which the neophyte undergoes transformation; and finally reintegration into society in a new social role.

Social reasons behind MC are becoming ever more common. The desire to conform is an important motivation for circumcision in places where the majority of boys are circumcised. In the Philippines, where circumcision is practiced by almost everyone and typically occurs at age 10-14 years, a survey of boys found two-thirds of those surveyed choosing to be circumcised simply 'to avoid being uncircumcised', and 41% stating that it was 'part of the tradition' (UNAIDS, 2010). Furthermore, social concerns were also the primary reasons for circumcision in South Korea with 61% of respondents in one study believing they would be ridiculed by their peer group unless they were circumcised. The desire to 'belong' is also likely to be the main factor behind the high rate of adult male circumcisions among immigrants to Israel from non-circumcising countries (Salem, 2012).

In South Africa, some Christian churches oppose the practice of male circumcision as they view it as a pagan ritual while others including the Nomiya church in Kenya, require circumcision for membership (Hitji, Charlton & Samah, 2005). Similarly, participants in focus group discussions held in Zambia and Malawi mentioned similar beliefs that Christians should practice circumcision since Jesus was circumcised and the Bible teaches the practice (Dick, Keil & Wilcken, 2010). For the Lunda and Luvale tribes in Zambia, or the Bagisu in Uganda, it is unacceptable to remain uncircumcised, to the extent that forced circumcisions of older boys are not uncommon. Hitji, Charlton and Samah, (2005) further state that among the Xhosa in South Africa, men who have not been circumcised can suffer extreme forms of punishment, including bullying and beatings.

In Zimbabwe, MC has also been a practice for both traditional and religious purposes amongst a few groups (Government of Zimbabwe, 2009). The recent findings that Medical Male Circumcision (MMC) significantly reduces a man's risk of acquiring HIV has led to the practice receiving renewed interest as the world looks to understand what this will mean for HIV prevention. According to the Global AIDS Response Progress Report (2012), various prevention methods such as abstinence, condoms, and fewer sexual partners and Prevention of Mother to

Child Transmission (PMTCT) are being used to lower the number of people infected by HIV but these efforts have not been enough. MC is a newly found intervention method which may provide an extra prevention method from acquiring HIV. A correlation between MC and HIV transmission was first discovered in Western and Northern Africa where the male circumcision prevalence rates tend to be high and HIV prevalence tends to be low (WHO, 2013). Due to this, studies have been conducted to see whether MC has an impact on HIV transmission or not.

According to WHO (2012), in 2007, WHO and UNAIDS (2011) issued recommendations on MMC as an additional HIV prevention strategy based on strong and consistent scientific evidence after three randomized controlled trials undertaken in Kisumu, Kenya, Rakai District, Uganda, and Orange Farm, South Africa showed that MMC reduces the risk of sexual transmission of HIV from women to men by approximately 60%. Data from Uganda show that in the five years since the Uganda trial was completed; high effectiveness has been maintained among the men who were circumcised, with a 73% protective effect against HIV infection (UNAIDS, 2011).

Furthermore, WHO and UNAIDS (2012) recommended that the intervention should be added in countries with high HIV prevalence, generalized heterosexual HIV epidemics, and low levels of MC where the intervention is likely to have the greatest public health impact. Fourteen priority countries with this profile are striving to scale up Voluntary Medical Male Circumcision (VMMC): Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Following the recommendations of WHO, Zimbabwe introduced the MMC programme in November 2009 as an additional HIV prevention strategy to the existing ABC behavior change model. The ABC model approach integrates the following components: A- abstinence B- faithfulness to one uninfected partner, and C- consistent use of condoms. The ABC approach has received considerable attention from scholars with some questioning its effectiveness on behaviour change. The major criticism of the ABC model is that it assumes that individuals are autonomous and have power to change their behaviour. The ABC model, like the Health Belief Model and the other theories of behaviour modification from which it is derived, makes a linear

assumption about human behaviour thus overlooking the power of structural forces such as culture that influence individual decision-making processes (Stretcher & Rovenstock, 1997).

A national MMC policy was developed and launched in November 2009 and a pilot roll out of the programme to five learning sites was carried out in Zimbabwe. The strategy aims to reduce HIV incidence through MC by between 25% and 35% by circumcising at least 80% of people aged 15 to 29 years by 2015. This group bears the highest incidence of new HIV infections (Government of Zimbabwe, 2009). In 2009, the pilot MMC programme managed to circumcise 2801 males. According to the Ministry of Health department (2011), the Zimbabwean government plans to circumcise about 3-million men by the end of 2015. However, the target may be overly ambitious, as less than 10% of the targeted population has been circumcised so far. A huge challenge in the promotion of male circumcision is that Zimbabwe is traditionally not a circumcising country.

### 1.3 Statement of the Problem

WHO has recommended that nations with high HIV prevalence rates should consider circumcision as part of a comprehensive HIV control programme (WHO, 2012). Following these recommendations, Zimbabwe adopted MMC. The procedure is offered free of charge at designated public hospitals and health centers throughout the country funded by Zimbabwe Ministry of Health as part of an HIV prevention package. Despite all the efforts to promote MMC, the uptake is very low in some areas. This is particularly so in most rural areas as illustrated in table 1 below.

**Table 1 Number of MCs performed among all age groups since its inception in Mutare rural district**

Year	2 009	2 010	2 011	2 012	2 013	Total population circumcised	Total males
Mutare rural district	38	47	35	54	46	220	104 887

Source: Mutare Health Department database

The overall Zimbabwean target is 1.3 million male circumcisions by 2015, representing 80% of adult men by 2015 (Ministry of Health and Child Welfare, 2012). However, statistics of the local clinics in Mutare rural district show that 5% of its population has been circumcised since the MMC program was started in 2009 and the reasons for this low uptake is unclear. Evidently with the lower uptake of males coming up for MMC it may prove impossible to meet the overall target. Furthermore, MMC being a prevention measure, it is disheartening if a few men are coming up for circumcision as this will leave the nation prone to more infections which may have been prevented if many were circumcised. The high uptake of MMC would mean a safer environment as it reduces the chances of acquiring HIV through vaginal sexual intercourse by 60%. It is not known why men in Mutare Rural District are not volunteering for circumcision. This study therefore seeks to examine factors that may inhibit men from being circumcised in Mutare Rural District.

#### **1.4 Rationale for the study**

Zimbabwe carries the third largest burden of HIV cases in Southern Africa after South Africa, with the largest burden globally of 5.6 million people living with HIV in 2010 followed by Mozambique with 1.4 million people in 2010 (USAID, 2011). There is need, therefore, to scale up efforts in providing prevention interventions to reduce the occurrence of new infections. Though the following methods are being implemented; abstaining, condom use, and early anti-retroviral therapy, voluntary testing and counseling, reducing sexual partners, delaying sexual activities and treatment of sexually transmitted infections, the recent approach of MMC could be of use in trying to reduce HIV transmission. It is thus vital to increase adoption of this HIV prevention strategy which is supported by scientific evidence. To increase the uptake of MMC the researcher found it critical to look at the factors that are causing resistance to this prevention measure in order for strategies to be developed to curb them. To date no known study has been conducted in Mutare rural district investigating factors leading to low uptake of MMC.

#### **1.5 Significance of the study**

It is of paramount importance to conduct an investigation on the factors that are leading to the low uptake of MMC in Zimbabwe in order to look for strategies to mitigate this problem. The results from this study may provide the nation with information as to why men in rural areas are reluctant to engage and partake in this program despite its protective effect. Particularly, the

information acquired may be of use to the National AIDS Council (NAC) and the Ministry of Health and Child Welfare by helping to develop an awareness programme. Furthermore, the results of the study may provide baseline information that will assist health planners to design effective strategies directed towards dealing with factors that are hindering uptake of MMC in rural areas.

### 1.6 Aim of the study

To investigate the factors contributing to the low uptake of MMC in Mutare Rural District.

### Objectives

The objectives of this study were to:

- assess the psychological factors contributing to the low uptake of MMC.
- determine the socio-cultural factors contributing to the low uptake of MMC.
- identify the socio economic factors contributing to the low uptake of MMC.

### 1.7 Definition of Key terms

**1.7.1 Factors-** According to the oxford dictionary (2012) it refers to one of the elements contributing to a particular result or situation. For the purpose of this study, it refers to the aspects influencing the low uptake of MMC.

**1.7.3 Low uptake-** It is the action of taking up or making use of something that is available minimally (Oxford Dictionary, 2012). For the purpose of this study, it refers to a reduced amount of males coming to hospitals for medical circumcision.

**1.7.5 Medical Male Circumcision (MMC)** - Medical male circumcision is male circumcision that is performed by trained personnel for medical reasons; such as infection and phimosis, where the foreskin is contracted in such a way that it can no longer retract over the shaft of the penis (WHO 2009). In this study, **MMC** refers to the full removal of the foreskin by a trained professional.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 Introduction

Literature review is a systematic explicit and reproducible method of identifying, evaluating and synthesising the existing body of completed and recorded work produced by researchers, scholars and practitioners (Fink, 2009). The sections below review literature by different authors on the various factors that can lead to the low uptake of MMC. To be reviewed also is the literature on the burden of HIV/AIDS in Africa, benefits of circumcision/risks of uncircumcised partner, psychological factors, socio-cultural factors and socio-economic factors contributing to the low uptake of MMC. The literature review is divided into two parts: data based literature and theoretical based literature.

### 2.2 The burden of HIV/AIDS in Africa

HIV and AIDS is one of the greatest contemporary health challenges that Africa is facing. The adverse effects of HIV and AIDS on some sub-Saharan African countries such as Botswana, South Africa and Zimbabwe continue to justify the often repeated comment that Africa is a continent in crisis. According to Sibanda (2010), research has shown that the sub-Saharan African region is a home to a mere 10% of the world's population but yet it harbours over 70% of those who are infected and affected by HIV and AIDS. Boyle and Hill (2011) and Darby and Van Howe (2011) oppose MMC saying that it does not prevent HIV. In this, they are joining other researchers in sub-Saharan Africa who claim that MMC can result in premature ejaculation or intra vaginal ejaculatory latency time in men. Though HIV is passed through many channels, it has been suggested that most HIV infections (92 percent) in Zimbabwe occur through heterosexual contact, followed by mother-to-child transmission (Zimbabwe National AIDS Council, 2005).

### 2.3 Psychological factors contributing to the low uptake of MMC

The current knowledge pertaining to how male feel about their circumcision has been based generally on surveys published in medical journals, clinical experience, and reports from men who have contacted circumcision information organizations. Circumcision advocates dismiss these surveys and reports as anecdotal. According to Goldman (1997) in a medical journal survey of 546 self-selected men between the ages of 20 and 60 who reported circumcision harm, the following effects and feelings were noted:

- anger, rage, sense of loss, shame, sense of having been victimized and mutilated
- low self-esteem, fear, distrust, and grief
- relationship difficulties, sexual anxieties, and depression
- reduced emotional expression, avoidance of intimacy

During the survey, one of the respondents said after they got circumcised they felt rage in themselves and felt a low sense of selfworth. However, not all men who have been circumcised undergo this negative experience. Paix (2011) claims that MMC is highly mutilating and seriously impairs penile function and amputates healthy functioning of protective and erogenous tissues. Boyle and Hill (2011) postulate that this has led vulnerable men to falsely believe their sexual problems stem from their infant circumcision, leading them to feel angry and mutilated, even to the point of psychological disturbance, resorting to mutilating foreskin restoration.

Since research is limited, speculations have been rife about the potential negative psychological effects of circumcision on men. It has been claimed that circumcision can inhibit men's sexual relationships with women (Paix, 2011). Goldman (1997) postulates that low male self-esteem, shame, fear, distrust, and sexual anxiety can adversely affect communication and limit the degree of intimacy. In addition, sexual intimacy is a major component of male-female bonding, and research has shown that male sexual activity increases when self-esteem is higher. Boyle and Hill (2011) state that if circumcision lowers both male self-esteem and sexual sensitivity, it would tend to reduce male sexual activity and consequently weaken the pair bond.

Male-female relationships could also be restricted because some circumcised men may feel a nagging sense of loss and feel that passion, excitement, or sexual fulfillment is missing. Men may withhold commitment and continually seek new women to give them hope, if they believe they cannot experience what they are missing with women (Boyle & Hill, 2011). In addition, women's feelings are dampened due to the reduction of emotional expression of circumcised men. As a result, both men and women may feel that something is missing from their relationships. From a larger perspective, it would not be surprising if circumcision were found to have a negative effect on interpersonal relationships, since circumcision is a trauma, and trauma commonly impairs a person's relations with others.

Goldman (1997) explains how the foreskin impairs sexual relationship when one gets circumcised. He postulates that the foreskin protects the head of the penis throughout life from contamination, friction, drying, and injury. It is an integral, natural part of the penis, not 'extra.' On the average adult male, it is about twelve square inches (some circumcised men are less than one square inch), and it consists of a movable, double-layered sleeve. The foreskin enhances sexual pleasure through the unique zones with several kinds of specialized nerves that are important to natural sexual function which leads one to experience the full range of sexual sensations (Goldman, 1997). Due to some of these stated reasons, some men have been worrying on whether after circumcision they would be able to fully satisfy their women. This may lead to reluctance to being circumcised.

According to Goldman (1997), MC may result in having a lot of emotionally and sexually injured males resulting in undesirable social effects. He further argues that men who were circumcised would be more likely to suffer from low self-esteem, avoid intimacy in relationships and lead to higher incidence of divorce. Moreover, he says circumcision may cause a higher incidence of unnecessary surgery and of adult violence, including suicide, rape, and murder. Baker (1996) argues that men harbor rage toward their mothers for neonatal circumcision and their wives for circumcision which occurred in adulthood. She also identifies a connection between sexual violence, rape and medical male circumcision. DeMause (1996) also concurs with the above notion as he connects perinatal circumcision trauma with increases in teenage suicide and social violence.

#### **2.4 Socio-cultural factors that may contribute to the low uptake of MMC**

Attitudes, beliefs, practices and socio-cultural practices of a community are an important facet that should be looked at when scaling up MMC. Included is the perception of acceptability of male circumcision by different groups, including potential clients, family members, partners, spouses, parents, service providers and other influential people. It is important to know people's beliefs and understanding about circumcision and to be aware of potential stigmatization associated with the procedure (WHO, 2012). Differences of opinion and practice regarding the age at which circumcision is performed (neonate, young child, adolescent or adult), and these matters should be carefully examined. In addition, the socio-cultural aspects of male

circumcision, particularly those relating to any current or historical traditional circumcision practices, are important in shaping effective strategies for either attempting to modify the practices or for taking advantage of them (WHO, 2012).

According to the observations by Westercamp and Bailey (2007), high levels of acceptability for male circumcision were found amongst non-circumcising communities. Communities that practice MC for cultural or religious reasons must not be overlooked as there is a frequently high social significance attached to the rituals associated with male circumcision. However, in a circumcising community, MMC may not be viewed as acceptable and may be resisted.

Circumcision has diverse meanings in different settings (Madhivanan, Krupp & Chandrasekaran, 2008). In some tribal groups who are traditionally circumcised and dominant, circumcision may be a symbol of "oppression". On the other hand, in the least dominant tribes it may be seen as a mark of inferiority (Madhivanan, Krupp & Chandrasekaran, 2008). Those rolling out circumcision programs will need to be sensitive to such issues and design suitable communication campaigns.

Kroon (2009) argues that MMC in cultures that practice traditional circumcision may have unseen consequences and be different. For example, amongst the Xhosa people in South Africa, men who have not undergone the traditional initiation ritual associated with male circumcision as a passage to manhood are shunned by both men and women and are not considered to be "real man" (Meissner & Buso, 2007). The Xhosa speaking people are inclined to attend traditional male circumcision due to fear of being ridiculed by peers or being called "small boys" if they remain uncircumcised or if they are not circumcised according to traditional norms. MMC is considered to be culturally inadequate and meaningless amongst Xhosa-speaking people. For one to be complete one should have underwent traditional circumcision. Such deeply rooted social reasons for traditional male circumcision suggest the need to adequately consider whether the means by which men become circumcised (i.e. medically) may have a negative social impact or other unforeseen consequences (Kroon, 2009).

The foregoing discussion suggests that for health policies to be successful, promotions must go beyond the narrow domain of biomedical paradigms (Peltzer et al., 2007) and should be consistent with socio-cultural norms. This is so, as MC in some African communities is a holistic

concept that brings together numerous and interlocked dimensions such as religion, spirituality and culture, plus social, biomedical and aesthetic aspects ( Peltzer, K. Niang, C.I. Muula, A.S. Bowa, K, Okeke, I, Boiro, H & Chimbwete, C., 2007).

### 2.5 Socio-economic factors contributing to the low uptake of MMC

A study in Uganda found that among youth (both males and females) aged 18-24 in rural areas; those with higher educational attainment (completed primary education vs. completed secondary education) had lower awareness of MMC role in preventing HIV (Wilcken, A. Miiro-Nakayima, F. Hizaamu, R. Keil, T. & Balaba-Byansi, D., 2010). The study found marginal evidence that educational attainment was the main explanatory variable for this difference suggesting a possible negative relationship between educational attainment and awareness of MMC for HIV prevention among youth in rural areas (Wilcken et al., 2010). In addition, since awareness of MMC benefits is likely to lead to uptake of the procedure, these results suggest that more educated youth might be less willing to undergo MMC. In a number of countries, socio-economic factors also influence circumcision prevalence, especially in countries with more recent uptake of the practice such as English-speaking industrialised countries. When male circumcision was first practised in the United Kingdom in the late 19th and early 20th century, it was most prevalent among the upper classes. In the US, a review of 4.7 million newborn male circumcisions nationwide between 1988 and 2000 also found a significant association with private insurance and higher socioeconomic status.

Religion, ethnicity, social desirability (cultural reasons), knowledge of MMC benefits and socio-economic factors (income and education) are described as important determinants of MMC prevalence in the WHO review (WHO, 2007). The influence of socio economic status on MMC is also fully documented, with consistent trends observed in developed countries; there is a positive relationship between MMC prevalence and higher socioeconomic status.

## **2.6 Benefits of circumcision/risks of uncircumcised partner**

### **2.6.1 Cervical carcinoma**

Cervical cancer is almost certainly a sexually transmitted disease, caused by oncogenic strains of the human papillomavirus. According to Moses, Bailey and Ronald (2013) evidence linking risk for cervical cancer with uncircumcised male partners is largely ecological. This draws on the observation that cervical carcinoma is relatively uncommon in certain populations where men are generally circumcised. In addition, a case-control study from India has reported that among women with one lifetime sexual partner, cervical cancer is significantly associated with having a husband who was not circumcised during the first year of life (risk ratio 4.1). Although cervical and penile carcinoma are likely caused by the same agent, and penile carcinoma is strongly linked to the presence of the foreskin, a protective effect of circumcision of male partners with respect to the occurrence of cervical carcinoma remains to be demonstrated (Moses et al., 2013).

### **2.6.2 Urinary tract infections**

According to Moses, Bailey and Ronald (2013), in 1993, Wiswell and Hachey conducted a meta-analysis of studies reported in the literature which had investigated the association between lack of male circumcision and risk for urinary tract infection among male infants. Nine studies were identified, six retrospective and three prospective. In all of the studies, uncircumcised infants were more likely to develop urinary tract infections than circumcised ones.

Similar findings have been reported in older children and adults. Bacterial adherence to the prepuce may explain the increased risk. Although these infections can be readily treated, they are associated with expensive and at times invasive investigations, and occasionally lead to renal injury. According to Salem (2012) in 1982 a case series of 109 infants in whom Urinary Tract Infection (UTI) developed between 5 days and 8 months of age was reported. Male infants predominated in the series; of these, 95% were uncircumcised. Furthermore, a review of a cohort of 5261 infants born at an army hospital found a higher incidence rate of UTI among the uncircumcised male infants (4.12%) than among those who were circumcised (0.21%).

### **2.6.3 Sexually transmitted diseases**

The relationship between the presence of the foreskin and sexually transmitted diseases other than HIV is complex and varies with the individual. There is strong evidence for an association

between ulcerative STDs (particularly chancroid and syphilis) and lack of circumcision in at least 11 studies (Moses et al., 2013). Hirji, Charlton and Sarmah, (2005) also assert that the following STDs chancroid, syphilis, genital herpes and gonorrhoea show lower susceptibility in circumcised men. Donovan et al.(1994) postulates that the uncircumcised penis is hypothetically at increased risk of STDs especially-genital herpes, gonorrhoea, syphilis, immunodeficiency virus type 1 (HIV-1) infection, candidiasis and chancroid due to larger surface area, thinner epidermal barrier, more liability for epithelial micro-trauma and the moist warm neck under the foreskin.

However, six studies by three different teams working in Rwanda, Uganda, Kenya and Tanzania and the USA found no relation between male circumcision and HIV status. The risk of contracting HIV was lower among circumcised men in the developing world, but this was not the case in developed countries (Hirji , Charlton & Sarmah , 2005). However, a subsequent meta-analysis revealed inconclusive findings in many trials. This analysis suggest it was protective in high-risk individuals particularly in developing countries and its benefits in the developed world is less well established (Moses et al., 2013).

Only anecdotal accounts of long term psychological, emotional and sexual adverse effects of male circumcision have been made. However, scientific evidence is lacking. In a study conducted in America examining female attitudes to male circumcision, 87% of college aged women expressed preference for pictures of circumcised penises over uncircumcised ones. When asked why they preferred to have sex with a circumcised man, 90% of a sample of predominantly white US women responded that it “looked sexier” (Goldman, 1997). Furthermore, over 50% of women who have uncircumcised partners expressed preference for vaginal sex with a circumcised man, and this proportion was much higher if oral sex was considered.

In Uganda, a generally uncircumcising nation, women indicated that they derive greater sexual pleasure from circumcised men (UNAIDS, 2012). A survey done in America of 1 400 men demonstrated that circumcised men have a more highly elaborated set of sexual practices, and were less likely than uncircumcised men to experience various sexual difficulties (Laumann, E.O. Masi, C.M & Zuckerman, E.W, 2010). Furthermore, there is indirect evidence suggesting

that the foreskin may have an important sensory function, although aside from anecdotal reports, it has not been demonstrated that this is associated with increased male sexual pleasure.

The effect on the sexual enjoyment of the circumcised male's partner has also been claimed to be reduced with less women achieving an orgasm with a circumcised partner (Hirji et al., 2005). Women also found it harder to manually stimulate circumcised partners during sex (Goldman, 2007).

On the other hand, a study held in Turkey assessing volunteers using the Brief Male Sexual Function Inventory (BMSFI) found no significant deficit in sexual function compared with control subjects, but a longer ejaculatory latency time which some considered beneficial (Meissner & Busso, 2007). Another study found a slight increase in sexual dysfunction in men who had not been circumcised, particularly later in life (odds ratio 0.66) and that circumcised men engaged in a wider range of sexual practices (Hirji et al., 2005).

### **2.7 Infant Male Circumcision (IMC)**

A study done in western Kenya on the factors associated with uptake of IMC for HIV prevention indicated that pain and perceived health risks to the infant, including bleeding, swelling, infection, and penile damage, are the major barriers reported by those declining IMC services (Nordstrom, Irwin, Ongong'a, Ochomo, Agot & Bailey, 2012). Even among those accepting IMC, 25% report pain as the primary reason not to circumcise an infant boy. Educational campaigns and counseling are recommended on pre and postoperative pain control and the low risk of complications in IMC programs.

### **2.8 Cost and risk versus benefit**

Travis, J.W. Buckley, S.J. Mason, P. McGrath, K. Van Howe, R.S and Williams, G. (2011) postulates that MMC costs more than it saves, whilst Forbes (2011) claims, without data, that the benefits and risks are evenly balanced. MMC is cost-effective in developing countries and in the USA a cost benefit analysis by the CDC found IMC would reduce lifetime HIV risk by 16%, making it cost saving for HIV prevention (Sansom, S.L. Prabhu, V.S. Hutchinson, A.B. Hall, H.I. Shrestha, R.K & Taylor, A.W, 2010). Furthermore, over their lifetime one in three uncircumcised males will be affected by at least one medical condition that MMC protects against. Benefits exceed risks by well over 100 and cost-benefit should be substantial, especially

given the high cost of treating genital cancers and AIDS, each more prevalent when MMC is not performed.

## 2.9. Theoretical Framework

The Health Belief Model (HBM) is an intrapersonal (within the individual, knowledge and beliefs) theory used in health promotion to design intervention and prevention programs. It was developed in the 1950s as an approach to explain why medical screening programs offered by the United States in Public Health service, particularly for tuberculosis, was not very effective. The focus of the HBM is to assess health behavior of individuals through examination of perceptions and attitudes someone may have towards disease and negative outcomes of certain actions. HBM is a simultaneous process used to encourage healthy behavior among individuals who put themselves at risk of developing negative health outcomes (Burke, 2012).

Burke (2012) postulates that HBM assumes that behavior change occurs with the simultaneous existence of three ideas:

1. An individual recognizes that there is enough reason to make a health concern relevant (perceived susceptibility and severity)
2. That person understands he or she may be vulnerable to a disease or negative health outcome. (perceived threat)
3. Lastly the individual must realize that behavior change can be beneficial and the benefits of that change will outweigh any costs of doing so (perceived benefits and barriers)

## THEORETICAL PROPOSITION OF THE HEALTH BELIEF MODEL

### Individual Perceptions

Individual perceptions speak directly to the knowledge and beliefs that a person has about his behaviors and the outcomes they could have. Individual perceptions are divided into two: Perceived Susceptibility and Perceived Severity. Within the context of the HBM, perceived susceptibility examines the individual's opinions about how likely the behaviors he/she partakes in are going to lead to a negative health outcome. HBM perceived severity addresses how serious

the diseases that a person is susceptible to can be. The HBM seeks to increase awareness of how serious the outcomes of behaviors can be in order to increase the quality of one's life (Burke, 2012)

### **Modifying Factors**

While Individual Perceptions were internalized, in the HBM, modifying factors step outside the body to examine and use outside influences to affect how threatened a person feels by the outcomes of continuing the same behaviors that put him at risk (Burke, 2012). Environmental factors can add to the threat of disease. Demographic background can cause one to be more at risk such as race, ethnicity and socio-economic status. Someone living in poverty would be more threatened by a disease if they could not afford health care. Also peers and other influential people can have an influence.

### **Likelihood of Action**

After becoming aware of the potential for developing a disease if behavior does not change, it is important to weigh out the benefits and the barriers to taking action and determine if it is worth it. Benefits to changing one's behavior should be examined. According to Burke (2012) the goal of the HBM is greater quality of life for an individual both mentally and physically. The individual often asks himself/herself about reasons why he/she cannot change his/her behavior. Barriers could be anything from losing friends to not having enough money or even self-efficacy problems such as not believing in one's self. For change to take place the benefits must be stronger than the barriers.

Due to its suitability, the HBM will be used as the framework for this study to examine factors that lead to the low uptake of MMC in Mutare Rural District. The three main categories addressed by Burke (2012), that is; individual perceptions, modifying factors and likelihood of action result in unfavourable attitudes which may lead to negative outcomes. The model may assist the researcher in guiding the search on how they perceive MMC and identifying points for change. If one perceives low risk perception of HIV one may see it unnecessary to be circumcised unlike when one has a high risk perception of HIV it becomes a main motivator for MMC. This study explores the above factors as having a possible influence in scaling up of MMC.

## Summary

The chapter was divided into two parts; data based literature and theoretical based literature. The data based literature reviewed the burden of HIV/AIDS in Africa, benefits of circumcision/risks of uncircumcised partner, psychological factors, socio-cultural factors and socio-economic factors contributing to the low uptake of MMC. The theoretical framework used was the Health Belief Model (HBM) which has three underlying components; individual perceptions, modifying factors and likelihood of action.

## CHAPTER 3: RESEARCH METHODOLOGY

### 3.1 Introduction

This section discusses the nature of the study, research design, purpose of the study, ethics, population and location of the study, sampling, data collection method and instrument, data management and analysis, pilot testing, study limitations and summary.

### 3.2 Research design

The study used a descriptive cross sectional survey which describes a phenomenon at one point in time. A quantitative approach was used as it provides high level of measurement as well as high degree of reliability. It also minimizes the researchers' bias as compared to a qualitative approach wherein there is interaction with the participants in the process of collecting non-numerical data. Therefore, by describing the response of participants in proportions, frequencies or percentages, it helped to bring out the factors contributing to the low uptake of MMC.

### 3.3 Study Location

The study was conducted in Bambazonge village located in Mutare Rural District which is divided into two parts namely; east (Zimunya) and west (Marange). Zimunya stretches from the Eastern Highlands (Bvumba) to the Odzi river and stretches westwards up to the Save river which borders with Buhera district. Bambazonge is under the leadership of traditional chiefs and headmen. It has a total population of 219 882 made up of 104 887 males and 114 995 females (Zimstats, 2012).

The major source of livelihood is subsistence farming and market gardening. The district is also home to the country's largest diamond deposits in Chiadzwa. The 2002 census report established that of the school going population, Mutare rural district had 65% children attending primary school, 23% attending secondary school and 35% students attending tertiary institutions. It has 6 health facilities which comprises of 5 clinics and 1 hospital. Amongst the villages in Mutare Rural District, Bambazonge is closest to the main hospital which is in a radius of 8 km. However, it is very far from the available clinics.

### 3.4. Study Population

The target population were all males aged 18-49 in Bambazonge village. The research focused on this age group because it is the most sexually active group with high infection rates. Bambazonge village consists of 452 households and 2 431 residents. The households are further arranged in blocks as illustrated in table 3.1.

**Table 2 Distribution of residents within Bambazonge Village**

Name of Section	No of household	Number of residents
1.Mudopa	106	543
2.Mawire	138	645
3.Ngeza	144	867
4.Nyandera	64	376
TOTAL	452	2 431

### 3.5. Sampling method

Mutare Rural district has 96 villages. The researcher purposively selected Bambazonge village because it is closest to the main hospital and campaigns on circumcision have been done in this area. The researcher hence will see whether exposure and accessibility have an influence on the decisions that individuals make about circumcision. Systematic sampling was used to select households in this study. The sample size was proportionally divided according to the population of each subsection (blocks) in the village.

### Inclusion Criteria

The following criterion was used for inclusion in this study:

- All males aged 18-49 years.
- All males who were willing and have signed the consent form.
- The ability to communicate in English or Shona

The sample size was calculated and found to be 234. The total household number of each village was divided by the sample size to find K value (sample interval) =  $452/234$ . Every 2nd household was included in the study on the grounds that they meet the inclusion criteria. The

first household was randomly selected, and when a chosen household failed to meet the inclusion criteria the researcher moved to the next household.

**Table 3 Sample frame**

Name of block	No of household	No of respondents	Percentage
1.Mudopa	106	55	23.5%
2.Mawire	138	71	30.5%
3.Ngeza	144	75	31.9%
4.Nyandera	64	33	14.2%
<b>TOTAL</b>	<b>452</b>	<b>234</b>	<b>100 %</b>

The sample size was calculated using the formula below where;

$n$  = sample size of the adjusted population.

$N$  = population size

$e$  = accepted level of error set at 0.05.

$$n = \frac{N}{1 + N(e)^2}$$

452

$$n = \frac{452}{1 + 452 \times (0.05)^2}$$

$$n = 452 / (1 + 452 \times (0.05)^2)$$

$$= 452 / (1 + 1.13)$$

452/2.13

Sample size ( $n$ ) = 212

The sample size was however increased to 10 % in order to leave room for non-response, giving us a sample size of 234. The researcher managed to distribute the questionnaires to 234 respondents as targeted and attained the data needed.

### **3.6 Data collection tool (Instrument)**

Self-reported questionnaire for collecting data was used. The questionnaire was modified from a previous study. General instructions on completing the questionnaire and the importance of completing all questions were included. The questionnaire was divided into four segments: biographical data, socio-economic factors, socio-cultural factors and psychological factors (see appendix 3). The questions focused on the psychological, socio-cultural and socio-economic factors contributing to the low uptake of medical male circumcision as well as the biographical data of the respondents.

The respondents chose the language they were comfortable using when giving feedback. The questionnaire was translated into Shona and translated back into English by a translator to ensure quality translation and correct comprehension.

### **3.7 Reliability and Validity**

#### **3.7.1 Validity**

Validity and content validity was assessed to ensure trustworthiness and truthfulness of the study through:

##### **3.7.1.1 Face Validity**

The staff from the University of Venda Department of Public Health and members of the Higher Degrees Committee (HDC) of the School of Health Sciences examined the questionnaire to see its eligibility and assisted in improving it.

##### **3.7.1.2 Content Validity**

According to Cresswell (2009), this type of validity ensures that the content of the instrument covers the content intended to be measured by the questionnaire. To ensure validity in this context, the questionnaire was assessed by people with indigenous knowledge. In the domain of the researcher were the supervisors of this research project with expertise in assessing the

representativeness of the questions on the variables being studied. The questionnaire was therefore re adjusted so as to ensure that it covers the content to be measured.

### **3.7.2 Reliability**

To ensure consistency and precision of results, a structured questionnaire was used to collect data from respondents by the researcher. Consistency in answering of the questions was assessed using test-retest technique whereby the same set of questions were administered on different occasions to a small sample of 25 males who were not included in the study.

The results of the first responses by each person were compared to the responses they gave on the second occasion after a period of a week and checked whether there would be consistency. The results of the test-retest technique showed a correlation-coefficient of close to 1 showing that the reliability of the statement was high. Testing of reliability assisted the researcher in adjusting the instrument to ensure consistency of the results.

### **3.8 Pretesting the instrument**

Pre-testing of the research instrument was done in Zvipiripiri, another village in Mutare Rural District, prior to actual data collection. The prepared questionnaire was randomly given to 25 males who are between the age group of 18 and 49. The questionnaire was administered either in English or Shona depending on the language preferred by the respondent. The necessary adjustments/corrections of the research instrument were done on the questions pertaining to the factors leading to the low uptake of MMC.

### **3.9 Data collection procedure**

A self-administered questionnaire with close-ended questions was hand-given to the eligible people. After explaining the purpose and the ethical principles, the researcher with the help of research assistants gave questionnaires to those who met the inclusion criteria in the chosen village. The researcher moved from one household to another and in a household where many met the inclusion criteria at least two were chosen. Two hundred and thirty four questionnaires were completed and none were spoilt. According to Cohen, Manion and Morrison (2007), making the respondents fill in the questionnaires as one gives them is helpful in that it enables any queries or uncertainties to be addressed immediately. It also reduces the rate of non-response. Therefore, respondents freely and privately completed the questionnaire in the

presence of the researcher. The presence of the researcher reduces information bias through sharing of information if the respondents complete and return the questionnaire immediately. Where clarity was needed the researcher and her two assistants were there to clarify as well as assist those who could not read and write.

### **3.10 Data Analysis**

The Statistical Package for Social Sciences (SPSS) Version 22.0 software was used to analyze data. Mouton (2009) states that data is analysed by using appropriate statistical techniques for the appropriate level measurement and drawing inferences according to the principles of statistical inference. Results emanating from the analysis are represented in the form of tables, graphs and charts.

### **3.11 Ethical considerations**

Ethical norms promote the aims of research such as knowledge, truth and avoidance of error. Prohibitions against fabricating, falsifying or misrepresenting research data, promote the truth and avoid error (Shamoo & Resnick, 2009). Ethical considerations come into play when the respondents are selected, during the intervention and in the release of the results obtained. This research integrates ethics in order to avoid harm to the participants as well as to ensure that the respondents take part in the research with full awareness of the purpose, risks and benefits of the research. The study investigates barriers against the low uptake of MMC. Throughout the research process informed consent, confidentiality, avoidance of harm and voluntary participation were observed.

#### **3.11.1 Permission to conduct the research**

The researcher sought permission to conduct this study from the University of Venda's Research Committee. The research proposal was presented to the Higher Degrees Committee for the School of Health Sciences at the University of Venda for quality control. Ethical clearance was obtained from the University of Venda Research and Ethics committee. Permission was requested from local leaders of Mutare rural District and the respective ward and village leaders (head men and councillors) in the area of research before the research commenced.

#### **3.11.2 Informed Consent**

A formal written letter of informed consent was issued to research participants before the commencement of the study to ensure that participants engage in the study without coercion.

The researcher ensured that the respondents were aware of the type of information needed, why the information was being sought, what purpose it would be put to, how they were expected to participate in the study and how it would directly or indirectly affect them. After thoroughly and truthfully informing them on the research process in one's preferred language, the researcher gave them the informed consent papers for signing indicating that they agree to participate in the study.

### **3.11.3 Voluntary participation**

The researcher ensured that participants know that participation is as a result of their own free will and that they have a right to withdraw at any time should they feel uncomfortable or threatened in the research process.

### **3.11.4 Confidentiality**

To ensure confidentiality, the names or identifications of the respondents were not published or linked to the specific participants who were part of the research. The researcher numbered the questionnaires from 1 to 234 to avoid attaching any name to the responses. Information acquired from them was not divulged or made available to any other party unless the respondent had given permission to it. Research assistants were also notified of the need to keep participants responses confidential. The topic at hand being a very sensitive issue the researcher ensured that the participants are completely aware that information will not be divulged or linked to them in any way. This enabled them to participate freely in the best possible way.

### **3.11.5 No Harm to Participants**

Shamoo and Resnick (2009) state that when conducting research on human subjects, harm and risks should be minimised whilst benefits are maximized. Furthermore, any cultural, religious, political, social, gender or other differences in a research population should be sensitively and appropriately handled by researchers at all stages of the research. The researcher ensured that no physical, psychological or emotional harm was inflicted. The researcher constructed questions in an appropriate manner to avoid being judgmental, inflicting anxiety and psychological discomfort during the process of responding to the questionnaire. Furthermore, in case the participant were harmed the researcher would do follow ups and refer the participant for counseling.

## Summary

This chapter focused on discussing the following: research design, study location, study population and sampling technique. Furthermore the chapter focused on the instrument used and the method that the researcher used to collect data as well as the measures taken to ensure the validity and reliability of the data collection instrument. Data analysis and ethical considerations were observed to ensure the safety of the respondents.

## CHAPTER 4: RESULTS OF THE FINDINGS

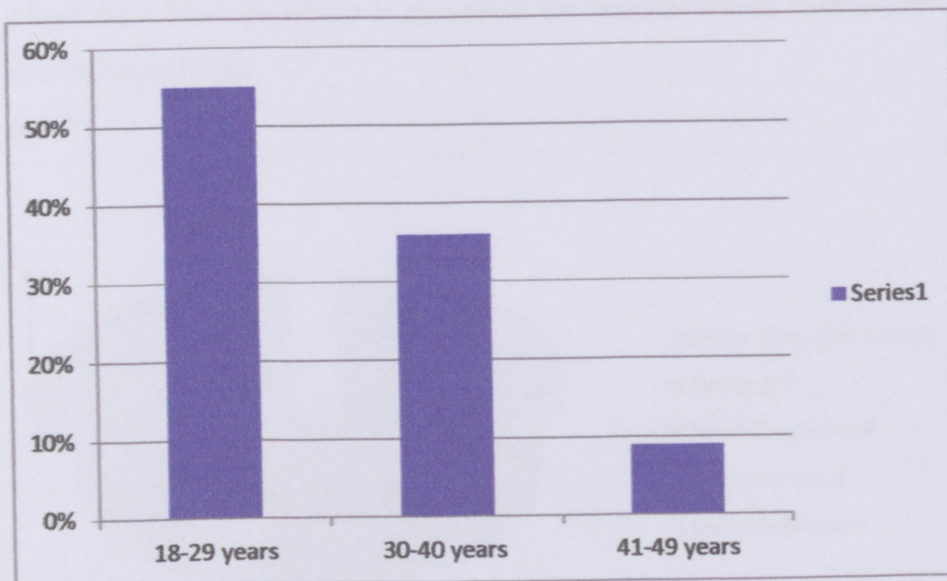
### 4.1 Introduction

This chapter presents the study findings based on the data that was collected from the males in Bambazonge village who responded by completing the questionnaire. The purpose of the study was to investigate the factors leading to the low uptake of MMC in Bambazonge village within Mutare Rural District, Zimbabwe. The findings of the study are presented and discussed according to the following sections; demographic information, socio cultural, psychological and socio economic factors leading to the low uptake of MMC. The findings are presented as descriptive summaries in the form of frequencies and percentages. Where appropriate cross tabulations between responses and respondent characteristics are presented.

### 4.2 Demographic Information of Respondents

Age, education qualifications, employment status, marital status, religious affiliation, ethnic group were identified as the ones that could affect one in making decision pertaining to MMC. Below each table is a brief interpretation of the table contents.

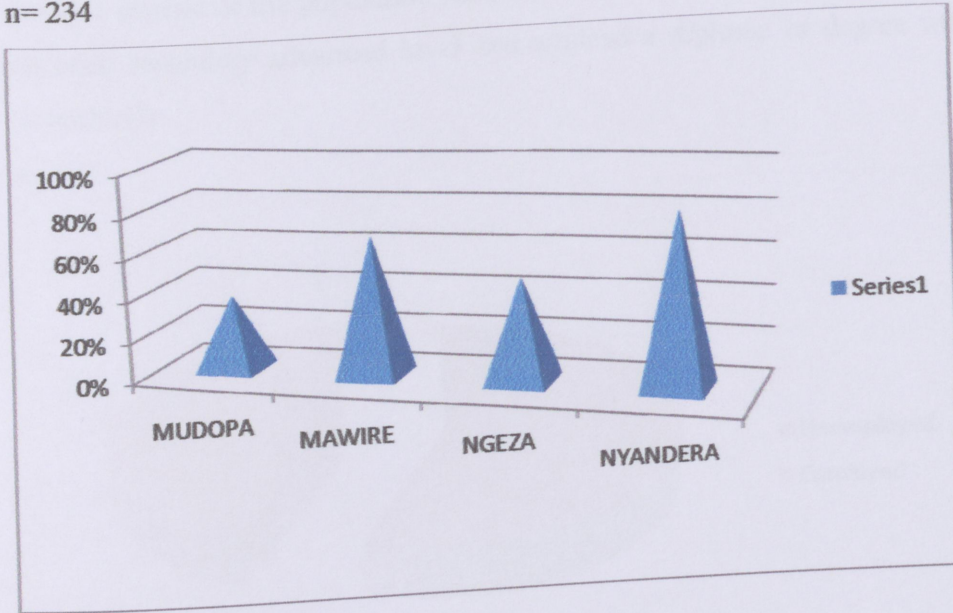
n=234



**Figure 4.1 Age profile of respondents**

The distribution of respondents by age group shows that there are fewer respondents in the older generation which is 41-49 years with 9% and the highest being the youngest category with 55%. The age category 30-40 years constituted 36% of the population.

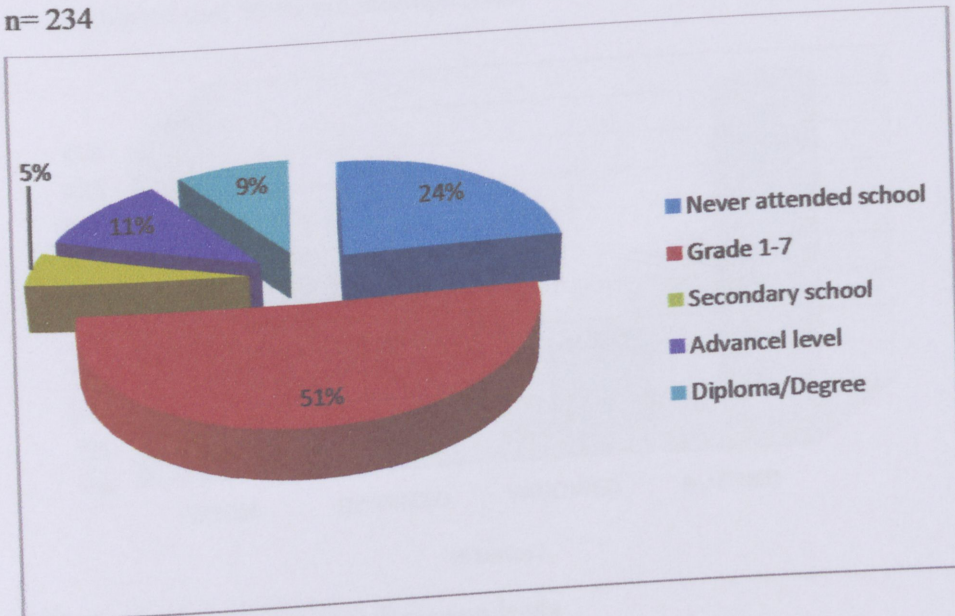
n= 234



**Figure 4.2 Section of respondents**

The study area was divided into 4 sections and as shown in figure 4.2, most respondents were from Nyandera with 82 (35%) followed by Mawire with 67 (29%), Ngeza 49 (21%) and the least were from Mudopa which is closest to the hospital where circumcision is done with only 36 respondents (15%).

n= 234



**Figure 4.2 Section of respondents**

The table shows the diverse level of education. Most of the respondents (51%) indicated that they have basic education as half of the population have attended grade 1-7. However, 24% have never attended school.

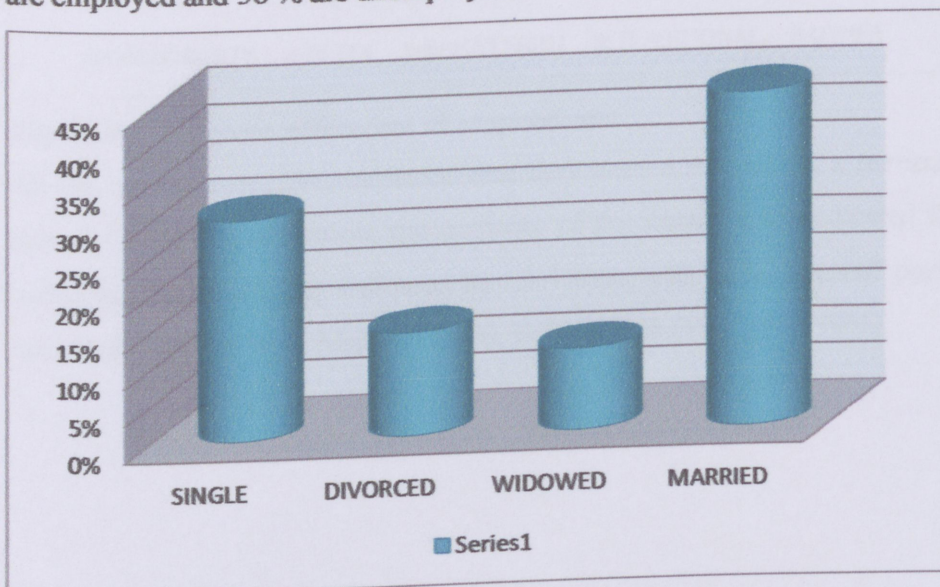
nearly a quarter of the population have not attended school, and even less of the population have attended secondary advanced level and attained a diploma or degree with 5%, 11% and 9 % respectively.

n= 234



**Figure 4.4. Employment status of respondents**

A small margin amongst employed and unemployed is evident as out of 234 respondents 44 % are employed and 56 % are unemployed.



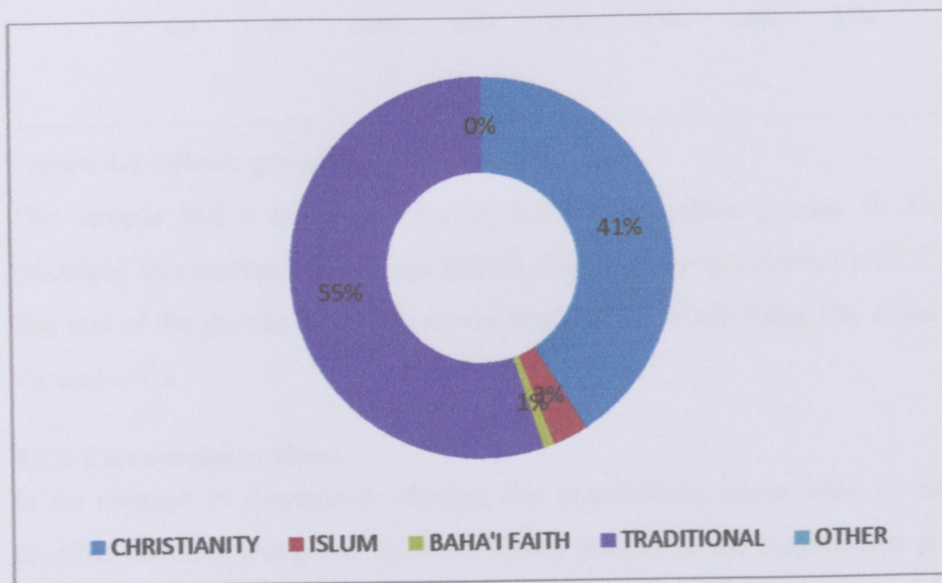
**Figure 4.5 Marital status of respondents**

The distribution of respondents according to marital status is mainly between those who are married and single with 45% and 30% respectively, whilst the divorced and widowed constitute only 14% and 11% respectively.

### 4.3 Socio cultural factors

#### 4.3.1 Socio cultural determinants

To determine the socio cultural factors, the respondents were asked if they were members of any faith or religion, and if yes which religion, as well as the ethnic group they belonged to.



**Figure 4.6 Religious affiliation of respondents**

All the respondents (234) indicated that they were a member of a particular faith or religion. In terms of religious affiliation, the majority of the respondents indicated that they followed their traditional beliefs (55%), followed by Christians with 41%. A small portion of the respondents indicated that they were Muslims (3%), Baha'I faith (1%), other (0%).



**Figure 4.7 Ethnic group profile of respondents**

The sample had a representation of the diverse ethnic groups in Zimbabwe. The majority described themselves as Karanga (35%), followed by the Zezuru with 27% and Shangani 14%. The rest of the groups have low representation with Kore Kore 7%, Alien 7 %, Ndebele 6 % and Varembe 4%.

#### 4.3.2 Circumcision views

In an attempt to determine whether the respondents knew what circumcision was, a list of possible answers was given to them. Thirty percent of the respondents postulated that it was the removal of the penis head, whilst 26% had accurate knowledge as they indicated it was the removal of the foreskin of the head of the penis. Twenty nine percent viewed it as preparation to manhood whilst 15 % had no idea what circumcision is as will be indicated in table 4.1 below.

**Table 4 Definition of circumcision**

WHAT IS CIRCUMCISION?	Percent (%)
REMOVAL OF THE PENIS FORE SKIN	26
REMOVAL OF THE PENIS HEAD	30
PREPARATION FOR MANHOOD	29
I HAVE NO IDEA	15
Total	100

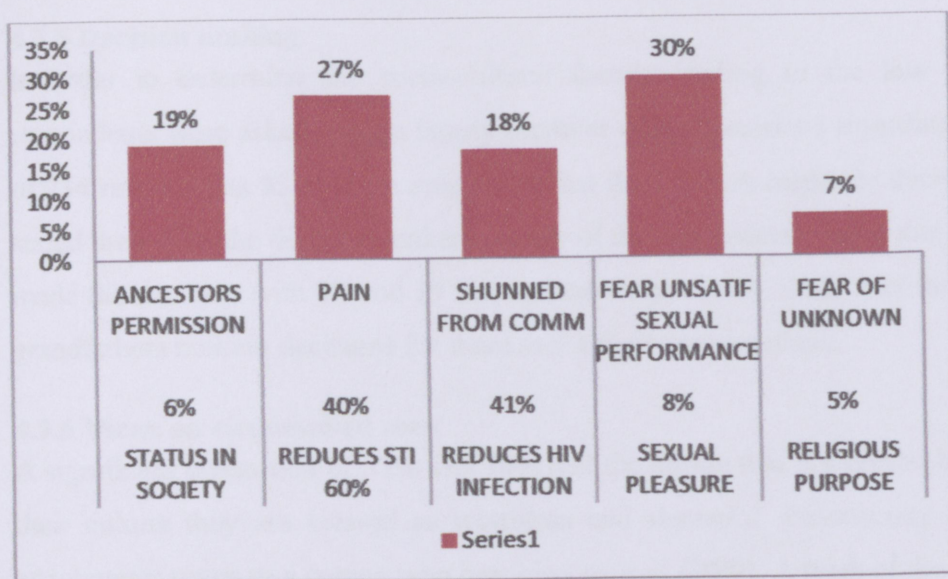
Furthermore the researcher wanted to know if the respondents were circumcised or not. The majority of the respondents are not circumcised at high rate of 78%, followed by a quarter of the population 17% circumcised and 5% who were unsure whether they were circumcised or not as shown in (table 4.2) below.

**Table 5 Are you circumcised**

ARE YOU CIRCUMCISED?	Frequency	Percent (%)
YES	18	17
NO	204	78
Valid		
DON'T KNOW	12	5
Total	234	100

#### 4.3.3 Reasons for getting or not getting circumcised

Those who indicated they had been circumcised were asked to give reasons for undergoing circumcision. The majority of the respondents had knowledge on the benefits of circumcision as 48% stated that it reduces sexual transmitted infections by 60% and that it reduces the risk of HIV infection (41%). The minority gave reasons of status in society, sexual pleasure and religious purposes with 6%, 8% and 5% respectively as indicated in the table below. To those that had not been circumcised, 30% feared unsatisfactory sexual performance and 27 % feared pain as the highest reasons. Ancestor's permission, being shunned from the community and fear of the unknown also had an influence on the respondents with 19%, 18% and 7 % respectively as illustrated in figure 4.8 below.



**Figure 4.8 Reasons for undergoing circumcision or not**

#### 4.3.4 Personal views on circumcision

The respondents who had undergone circumcision were asked the type of circumcision administered on them; 59% said traditional, 21% medical, 14% religious and 6% stated none of the above. When asked the best place for circumcision, the majority of the respondents opined that it was not acceptable (30%), 24% viewed a traditional setting as the best place followed by the church, clinic and home with 20%, 16% and 10% respectively. Pertaining to the best age for circumcision most of them disagreed with the category of 7-13 years as the best with 4% only, whilst 37% agreed that the most appropriate age would be at birth. Twenty four percent viewed the best age in the category of above 20 years and 23% were unsure of the best age for circumcision.

**Table 6 Type of circumcision undertaken and the best place and age for circumcision**

Type of circumcision	%	Best place for circumcision	%	Best age for circumcision	%
Medical	21	Clinic/hospital	16	New born baby	37
Traditional	59	Home	10	2-6 years	12
Religious	14	Traditional setting	24	7-13 years	4
None of the above	6	Church	20	Above 20 years	24
		Not acceptable	30	Unsure	23

### 4.3.5 Decision making

In order to determine the socio-cultural factors leading to the low uptake of MMC, the respondents were asked, which family member makes decisions regarding MC. Out of a sample of 234 respondents 95 of them articulated that their fathers made the decision, whilst 86 of them stated they were the decision makers. A few of the respondents stated that their mother and uncle made the decision with 23 and 19 respondents respectively. Only 8 of the respondents had their grandfathers making decisions for them and 3 their grandmothers.

### 4.3.6 Views on circumcised men

A significant proportion of 37% and 30% had the notion that if a person becomes circumcised in their culture they are viewed as worthless and shameful. Promiscuity was also stated as the attachments given to a person who gets circumcised (20%). A tenth of the respondents believed a man is viewed as honourable when circumcised and 3% of the respondents opined that a man who gets circumcised is defied by the gods as indicated in figure 4.9 below.



Figure 4.9 How men are viewed in their culture if circumcised

### 4.4 Psychological factors

In an attempt to investigate the psychological factors and socio economic factors respondents were asked to complete a structured questionnaire by indicating their preference or degree of agreement with a set of statements. The level of agreement statements of the Likert scale

questions were assigned a numerical value, 1 for “strongly disagree”, 2 for “disagree”, 3 for “unsure”, 4 for “agree”, and 5 for “strongly agree”. For analysis purposes similar responses from the likert scale responses were merged together (strongly agree and agree) (strongly disagree and disagree). However some of the data will be presented as it is to show the degree of agreement.

**Table 7 Levels of agreement on psychological factors**

PSYCHOLOGICAL FACTORS	Level of Agreement (%)				
	SD	D	U	A	SA
18. I fear surgical operation, pain, bleeding and other complications	9.4	10.7	9.0	46.6	24.4
19. I fear that circumcision would lead to infection and wound will take too long to heal	9.4	8.5	7.7	35.5	38.9
20. I feel ashamed and dehumanised due to circumcision	3.0	6.8	22.6	9.4	58.1
21. I fear being stigmatised and discriminated against	6.0	4.7	20.9	28.2	40.2
22. Circumcision gives me a false sense of security	1.3	63.2	31.2	0	4.3
23. HIV testing before the procedure prevents me from get circumcised	13.7	6.8	30.8	9.0	39.7
24. I heard women do not like circumcised men	38.5	27.8	25.2	5.1	3.4
25. Circumcision reduces penis size	17.1	10.3	0	52.5	20.1
26. I fear losing my partner or wife during the waiting period	32.9	8.5	0	47.0	11.5
27. I may lose the capability of having an erection and I am scared of having an erection during waiting period	5.6	0	0	4.7	89.7
28. Sexual pleasure is diminished when a person is circumcised and I might end up losing my partner	2.1	11.1	0	85.1	1.7
29. Women prefer to have sex with men who are circumcised	29.5	36.8	4.3	18.8	10.7

#### 4.4.1 Fear of surgical complications

The majority of the respondents (71%) stated fear of surgical operation, pain, bleeding and other complications as the reasons for not undergoing MMC, with only 20% in disagreement with it. Nine percent of the respondents were unsure of whether it influenced them or not.

#### **4.4.2 Fear of long wound healing time**

Fear of long wound healing time was reported by 18% of the respondents being the cause for not undergoing circumcision, whilst three quarters of the respondents (74%) had fears that MMC would lead to infection and long wound healing time.

#### **4.4.3 Ashamed and dehumanized**

Sixty seven percent of the population said that MMC would bring feelings of shame and make them feel dehumanized whilst 23% were unsure whether it would be shameful to them or dehumanising. A tenth of the population felt that MMC did not make them feel ashamed or dehumanised.

#### **4.4.4 Fear of stigma and discrimination**

The majority of the respondents were with the notion that MMC would lead to stigma and discrimination (68%), a minority (11%) had no fear of stigma and discrimination. However about 21% were not sure whether fear of stigma and discrimination had an impact on them undergoing MMC or not.

#### **4.4.5 Enhancing a false sense of security**

The respondents were in disagreement (64%) with the statement that circumcision gives a false sense of security whilst only 4% felt that it would bring a false sense of security and 31 % were not sure whether this factor had influence on their decision of getting circumcised or not.

#### **4.4.6 HIV testing prior to the procedure as a hindrance**

Nearly half of the respondents (121) articulated that HIV testing before the procedure prevented them from getting circumcised whilst 72 were unsure whether that was their cause for not undergoing circumcision. Thirty two and 16 of the respondents strongly disagreed and disagreed respectively that HIV testing before the procedure prevented them from getting circumcised.

#### **4.4.7 Women do not like circumcised men**

Regarding the notion that women do not like circumcised men, 67% of the respondents were in disagreement with it. Only 8% were in agreement with the notion that women do not like circumcised men, 25% stated that they were unsure pertaining to women's preference.

#### 4.4.8 Circumcision reduces penis size

Pertaining to whether circumcision reduces penis size, nearly three quarters of the respondents (72%) said that it would reduce their penis size. However 27% of the respondents did not agree with the notion that circumcision reduces penis size.

#### 4.4.9 Fear of losing partner during waiting period

Fear of losing a partner or wife during the waiting period was articulated by 58 % of the respondents whilst 42 % of the respondents indicated that fear of losing a partner or wife was not the reason for them withholding against circumcision.

#### 4.4.10 Fear of loss of the capability of having an erection and having an erection during waiting period

The respondents concurred that they feared loss of capability of having an erection after circumcision as well as having an erection during waiting period. Ninety five percent of the respondents shared these feelings constituting 90% in strong agreement and 5% in agreement. 6% of the respondents articulated that they did not fear loss of capability of having an erection and having an erection during waiting period.

#### 4.4.11 Sexual pleasure is diminished and may lose my partner

Diminishing of sexual pleasure and losing a partner due to it was mentioned by the respondents as factors that make them dread going for circumcision. Eighty seven percent of the respondents were in agreement that circumcision diminished sexual pleasure and this would lead them to losing their partner. Thirteen percent of the respondents did not think it would diminish their sexual pleasure or lead them to losing their partner.

#### 4.4.12 Women prefer to have sex with men who are circumcised

The majority of the respondents (66%) were in dissention that women prefer to have sex with men who are circumcised. Four percent were unsure of women's preference whilst (30%) opined that women prefer to have sex with men who are circumcised.

#### 4.5 Socio-economic factors

**Table 8 Levels of agreement on socio economic factors**

SOCIO-ECONOMIC FACTORS	Level of Agreement (%)				
	SD	D	U	A	SA
30. I don't have time to go to a centre for circumcision	3.8	7.7	16.7	13.7	58.1
31. It takes time away from work	4.7	1.3	0	49.1	44.9
32. I might lose my job if the pain persist for a long time	7.3	21.8	65.8	0	5.1
33. Complications may arise and may end up spending money on treatment	1.3	2.1	1.3	11.5	83.8
34. I don't have money for transport to the health centres	89.7	2.0	3.8	1.7	2.1

##### 4.5.1 No time to go to centre for circumcision

The majority of the respondents (72%) concurred that they had no time to go to a centre for circumcision. Some of the respondents (16%) were unsure whether time factor would be a barrier for them undergoing circumcision. Twelve percent of the respondents were in disagreement with the statement "I don't have time to go to any centre for circumcision".

##### 4.5.2 Takes time away from work

The respondents strongly felt that undergoing circumcision would lead them to be absent from work (95%). However, 5% of the respondents did not think that going for circumcision would take their time away from work.

##### 4.5.3 Loss of job if the pain persists for a long time

Losing a job if the pain persists for a long time seems to be a hindrance for circumcision as indicated by low numbers of respondents in agreement (5%). Twenty nine percent of the respondents disagreed that loss of job may occur if the pain persists for a long time. However, a significant amount of the respondents indicated uncertainty with persistence of pain for a long time leading to job loss (49%).

#### 4.5.4 Complications arising leading to use of money in treatment

A minority of the respondents (3%) were in dissent that complications may arise during circumcision leading to more money being spent on treatment. The majority (96%) held the notion that if complications arose during circumcision it means more money will be spent on treatment thus a reason for not undergoing circumcision. Of the 96%, 84% were in strong agreement to the statement.

#### 4.5.5 Lack of transport money to a health centre

Ninety percent of the respondents strongly disagreed that transport money would hinder them from going to a health centre to undergo circumcision. Few of the respondents (4%) enunciated that lack of transport money was a barrier for circumcision, with also 4% being unsure whether transport money had effect on one's decision to undergo circumcision.

#### 4.6 Cross tabulation of demographic characteristics and responses

##### 4.6.1 Age of respondents and reasons for undergoing circumcision

**Table 9 Cross tabulation of age of respondents and reasons for undergoing circumcision**

AGE OF RESPONDENTS (YEARS)	IF YES					Total
	STATUS IN SOCIETY	REDUCES STI 60%	REDUCES HIV INFECTION	SEXUAL PLEASURE	RELIGIOUS PURPOSE	
18-29	3	31	76	8	11	129
30-40	11	16	46	11	0	84
41-49	3	0	18	0	0	21
Total	17	92	95	19	11	234

n= 234

The table above showcases a cross tabulation of three age categories (18-29 years); (30-40 years), (41-49 years) and their responses about their reasons for undergoing circumcision. A high response rate is seen in all three categories stating that their reason for undergoing circumcision was due to the fact that it reduces HIV infection. The age category (18-29 years) had the highest number of respondents (76) stating their reason as reducing HIV infection followed by the 30-40 year category with 46 respondents and the 41-49 year category with 18 respondents.

#### 4.6.2 Educational level and the definition of circumcision

**Table 10 Cross tabulation of highest standard passed and what circumcision is**

HIGHEST STANDARD PASSED	WHAT IS CIRCUMCISION				Total
	REMOVAL OF PENILE FORES SKIN	REMOVAL OF PENIS HEAD	PREP FOR MANHOOD	I HAVE NO IDEA	
NEVER ATTENDED SCHOOL	6	4	45	0	55
GRADE 1-7	27	2	16	76	121
GRADE 8-11	7	1	4	0	12
GRADE 12 AND ABOVE	8	3	3	11	25
DIPLOMA/DEGREE	7	0	0	14	21
<b>Total</b>	<b>55</b>	<b>10</b>	<b>68</b>	<b>101</b>	<b>234</b>

n= 234

Five levels of education were used in the study; never attended school, grade 1-7, grade 8-11, grade 12 and above, and diploma/ degree. The majority (45 out of 55) of those who never attended school articulated that circumcision is preparation for manhood, whilst 76 out of 121 respondents in the category grade 1-7 stated they had no idea what circumcision is. Out of the 21 respondents with diplomas/ degrees, 7 of them stated it was the removal of the foreskin of the penis whilst a majority of them (14) stated they had no idea what circumcision is.

#### 4.6.3 Employment status and lack of time to go to the centre for circumcision

**Table 11 Cross tabulation of employment status and I don't have time to go to the clinic**

EMPLOYMENT	DON'T HAVE TIME TO GO TO THE CLINIC					Total
	SD	D	U	A	SA	
UNEMPLOYED	0	0	31	32	69	132
EMPLOYED	9	18	8	0	67	102
<b>Total</b>	<b>9</b>	<b>18</b>	<b>39</b>	<b>32</b>	<b>136</b>	<b>234</b>

n = 234

Two hundred and thirty four respondents was the sample size, 132 of them were unemployed and 102 employed. The majority of the unemployed respondents concurred that they did not have time to go to the clinic for circumcision shown by 101 respondents out of 132. Sixty seven of the employed respondents also stated that they did not have time to go and get circumcised and 37 of them stated that the issue of time was not a reason for them not getting circumcised.

#### 4.6.4 Employment status and fear of complications that may arise and lead to spending money on treatment.

**Table 12 Cross tabulation of employment status and complications that may arise**

EMPLOYMENT STATUS	COMPLICATIONS					Total
	SD	D	U	A	SA	
UNEMPLOYMENT	0	0	0	0	132	132
EMPLOYED	3	5	3	27	64	102
Total	3	5	3	27	196	234

n= 234

The unemployed respondents constitute 132 out of a sample size of 234 respondents. Of the 132 unemployed respondents all of them (132) had strong fears about complications that may arise if circumcision lead them to spend money on treatment. Ninety one employed of the respondents also had fear that complications may occur during circumcision leading them to spend money on treatment. Only 8 of the employed did not fear complications during circumcision which may lead to high financial expenditures.

#### Summary

The above chapter presented analysis data obtained from the questionnaires including descriptive, relationships between variables, tables and graphs. Two hundred and thirty four questionnaires were issued and the response rate was 100%. The findings were divided into the following: personal, demographic information, socio-cultural, psychological and socio-economic factors. Chapter five discusses the results, recommendations and concludes.

#### 4.6.5 Marital status and fear of loss of erection capability and scared of an erection during waiting period

**Table 13 Cross tabulation of marital status and fear of loss of erection capability and erection during waiting period**

MARITAL STATUS	ERECTION CAPABILITY			Total
	SD	A	SA	
SINGLE	13	11	45	69
DIVORCED	0	0	33	33
WIDOWED	0	0	26	26
MARRIED	0	0	106	106
Total	13	11	210	234

n= 234

A cross tabulation of marital status and the fear of loss of erection capability and erection during waiting period was made. Four categories were used to define marital status, single, divorced, widowed and married. All the married respondents who took part in the study (106) out of 234 strongly feared loss of erection capability and an erection during waiting period. The single category had 13 out of the 69 respondents displaying no fear of loss of erection capability and erection during waiting period and 56 of them stating the opposite. All the respondents who were either divorced or widowed (33 and 26) articulated that they feared loss of erection capability and erection during waiting period.

#### Summary

The above chapter presented analysed data obtained from the questionnaires, including descriptions, relationships between variables, tables and graphs. Two hundred and thirty four questionnaires were issued and the response rate was 100%. The findings were divided into the following categories, demographic information, socio-cultural, psychological and socio-economic factors. Chapter five discusses the results, recommendations and concludes.

## CHAPTER 5: DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

### 5.1 Introduction

This chapter discusses the research findings on the factors leading to the low uptake of MMC in Bambazonge village in Mutare rural district, Zimbabwe. The discussion is anchored on the findings presented in the previous chapter. The researcher describes the findings and also links it with the reviewed literature. Demographic information, socio cultural factors, psychological factors and socio-economic factors are discussed. The conclusions and lastly recommendations based on the findings are also presented.

### 5.2 Demographic information

**Age profile of respondents:** The age category 18-29 years had the highest rate of participants with 55%, followed by the middle aged at 36%, and lastly the 41-49 year category at 9%. The analysis by the Ministry of Health and Child Welfare National Aids council (2004) indicated that 24.6% of the entire adult population aged 15-49 is currently infected with HIV and AIDS, making Zimbabwe one of the most seriously affected countries by HIV and AIDS in the entire world. This is in correlation with the age categories which showed highest number of respondents.

**Section of respondents:** A fair distribution of respondents from the four sections is shown. The highest area with respondents constitutes 35% and the least with 15%. As not much difference is shown from each section, this enables representativeness.

**Education profile of respondents:** The study findings reflect that a small magnitude (5%) of the population have attended secondary school, advanced level or attained a degree or diploma. However, nearly half (52%) that is 121 of the respondents have attained basic education. The education level of participants is amongst the important characteristics as it is associated with many factors that have a significant impact on health seeking behaviours. The results of this study therefore coincide with the Zimbabwe National Statistics Agency (2012) which reflects a 96% literacy rate, a literate person having been defined as a person at least 15 years who has attended at least grade 3.

**Employment status:** Looking at the higher levels of unemployment in Zimbabwe, the study area has 56% unemployed and 44% employed respondents. The higher rate of unemployment could be attributed to the fact that in this study most respondents are in the age category 18-29 and

most likely to be currently unemployed than their counterparts in older age groups as they are still pursuing their education.

**Marital status:** The sample reflected that there are fewer divorced and widowed people whilst the married constitute the highest population. Few respondents are divorced thus indicating how the population still holds on to the cultural values of marriage.

### 5.3 Socio cultural factors

#### Religious affiliation

The results of the study confirm the assertion that Zimbabwe is mainly constituted of people with traditional beliefs and Christians as reflected by 55% and 41% respectively. The Islam, Baha'I faith constitute a small fraction of the population. Religious affiliation has influence on one's decision to undergo circumcision or not. A study on the acceptability of MMC within the Apostolic Sect in Zimbabwe (2014) concurred with this as the respondents indicated that in the Bible the Israelites were the only group that was circumcised but the practice ended with Jesus' baptism implying that the practice should no longer be done and also ended when Jesus died for peoples sins.

Other members of the Apostolic Sect in Zimbabwe (2014) viewed the removal of the foreskin as permanent disability to someone and perceived it as a sinful act and due to the fact that no person must have power to change what God has created. Bailey et al., (2007) concurs with the above as he asserts that low acceptability of MC amongst Christians due to the belief that it was a sin to change the way one was created. Furthermore a study by Kelly, Kupul, Fitzgerald, Aeno, Neo, Naketrumb, Siba, Kaldor and Valley (2012) shed the same light with the above as amongst Christians in Papua New Ginea, MC was considered unacceptable since they believed that HIV prevention was found in God from being faithful.

#### Ethnic group

The ethnic groups and their representation showed how these groups are no longer confined to a particular province for instance the Karanga are no longer found only in Masvingo province. Diversity is shown in the study sample as most ethnic groups are represented (Karanga, Zezuru, Shangani, Korekore, Ndebele) which acts as a source of information on different cultures/traditions and practices of the Zimbabwean populace. In a way, this study is similar to the study

conducted by Shapiro et al., (2001) in which 605 respondents from various geographic locations and ethnic groups were representative of Botswana. (Ntigi et al., 2012)

### **Circumcision Views**

Almost three quarters of the study population defined circumcision wrongly and some indicated that they did not know what it is. The results of the study of Mbusa and Nkala (2014) also indicated lack of in-depth knowledge about the benefits and limitations of MMC and without knowledge people become reluctant and skeptical. Furthermore, 78% of the respondents indicated they were not circumcised, leaving nearly a quarter of them saying they are circumcised. This study concurs with Fritz et al., (2000) study in terms of high rate of uncircumcision which was 86%. The results may be attributed to lack of knowledge or limited knowledge of medical benefits of male circumcision. In addition, statistics have shown higher low uptake of MMC in rural areas than in urban areas which coincides with the present study.

### **Reasons for getting or not getting circumcised**

A comparison of the reasons for getting circumcised and not getting circumcised was made. The findings reflect that those who are circumcised had knowledge of the benefits that circumcision has as most of them stated it reduces HIV transmission by 60% and that it reduces the risk of HIV infection. This is supported by the study findings of Mhangara (2011) which affirms that knowledge of the benefits of male circumcision is paramount in building a positive perception of the procedure as those who were circumcised or knew of its benefits had a positive view of the procedure.

Those who had not been circumcised opined that circumcision will lead to unsatisfactory sexual performance and pain thus preferred to avoid it. Hargreave (2010) enunciates the same concern that both male and female sexual enjoyment is compromised by MMC. A different school of thought argues that MMC leads to prolongation of ejaculation, latency time, which may be an added advantage in young men where quick ejaculation is very frequent. Noel (2006) concluded overall satisfaction rates despite slightly reduced erectile function and decreased penile sensitivity. Ancestor's permission, being shunned from the community and fear of the unknown were some of the highlighted reasons hindering circumcision. Circumcision has been described as a sign of social inclusion. The absence of circumcision for a male within a community in

which the practice is common can cause social stigma. On the other hand, being circumcised in a non-circumcising community leads to social stigma (Hirji et al., 2012).

### **Personal views on circumcision**

The study sample reflected that those who had undergone circumcision had done so traditionally (59%) and only (21%) medically. This is also in correlation with the religious affiliation of the study sample as most of them reflected that they had traditional beliefs as their religion. When asked the best place for circumcision, most respondents indicated a traditional setting. In conjunction with the above findings, other studies conducted among different ethnic groups in Africa have found that MC is carried out for traditional reasons, as an initiation ritual and a rite of passage from childhood into manhood (Bottoman et al., 2009; Grant et al., 2004). This therefore indicates how tradition or culture has an influence on MMC.

Regarding the best age for circumcision, most of the respondents viewed at birth as the most convenient. Tarimo, Francis, Kakoko, Munseri, Muhammed and Sandstrom (2012) corroborate with the present study as they postulate that in their study, men would prefer circumcision at early childhood because young boys express less pain than adult men and reasoned that men have matured vessels which may cause more pain to them. In addition, unlike young boys, men experience sexual desires that lead to erection; the erection may impair the healing process of a circumcised penis. Boyle and Hill (2011) argue that circumcision at birth is traumatic for boys as this is usually performed in the first weeks of life (the perinatal period). Many males, who were circumcised as infants, grow up to become circumcisers themselves and have an unending repetitive pattern of abuse.

Twenty four percent asserted that above 20 years would be appropriate and disagreed with age category of 7-13 years as reflected by a small percent (4%) stating so. Furthermore, practitioners interviewed in Kenya and Malawi preferred not to perform neonatal circumcision due to the small size of the penis and foreskin, potentially leading to higher rates of errors and complications. However in a study done by Plotkin et al., (2013) male and female participants almost unanimously articulated that it was best to perform MMC before puberty. Most respondents believed that MMC clients in their 20s or 30s would be ridiculed or thought to be unusual and shameful.

## Decision making

The majority of the respondents had their fathers making decisions for them with regards to circumcision, followed by those who made the decision on their own. Fewer of the respondents highlighted that their mothers and uncles made this decision for them. The study findings highlight the importance of the father in the decision making process. A qualitative study by Mavhu et al., (2012) which looked at the acceptability of early infant MC as an HIV prevention intervention in Zimbabwe also revealed that the father was the decision maker. The women believed that the man must make the decision because he is the one who knows whether or not that is practiced in his clan and as the father of the house he makes all decisions pertaining to family matters.

## Views on circumcised men

How men are viewed in society when they are circumcised instills a positive or negative effect on their decisions with regards to whether they should get circumcised or not. The respondents of the study postulated that in their culture a circumcised man is viewed as worthless and shameful. Such views therefore stand as a barrier towards circumcision. Twenty percent of the respondents stated that a circumcised man is viewed as promiscuous, such views therefore stand as a discouragement to those who want to get circumcised as they would want to maintain a good reputation. Focus group discussions in a study by Macintyre, Andrinopolous, Moses, Bornstein and Ochieng (2014) revealed that women tend to ask their partners why they now have a sudden interest in circumcision yet they have been together for a long time without being circumcised, insinuating that they are having sex with other women. Only a tenth of the respondents had a positive view that a circumcised man is viewed as honourable.

## 5.4 Psychological factors

### Fear of surgical complications

The study findings showed that fear of surgical operations; pain, bleeding and other complications are the reasons for not undergoing MMC as shown by the majority with only 20% in disagreement with it. Similar findings were reflected in study findings on the factors associated with uptake of VMMC in Mazowe district Zimbabwe by Rapfute, Tshuma, Tshimanga, Gombe, Bangwe and Wellington (2014); reflecting fear of pain and possibility of

complications such as death as what was holding them from undergoing MMC. Fear of death may have been stimulated by national media report that confirmed 5 deaths of adolescent boys due to inept and unhygienic ritual circumcision by some cultural groups in South Africa in June 2001 (Jackson, 2009). Darby and Van Howe (2011) however state that, death from MMC is exceedingly rare since they are mostly done by general anaesthesia and local anaesthesia.

### **Fear of long wound healing time**

Fear of long wound healing time has also shown to be one of the barriers to undergoing circumcision as almost three quarters stated the notion. There is a possibility that wound healing might be delayed during MC especially when there is an infection. Westercamp et al., (2007) in a study conducted in Kenya identified the perception of long healing period following circumcision procedure as barriers to circumcision. Similar findings were noted by Herman-Roloff et al., (2011) that delayed wound healing and prolonged time away from work are common barriers of MC uptake among men. It is therefore paramount that the responsible authority improves the quality of MMC services focusing on reducing long wound healing time so that this does not stand as a barrier towards MMC.

### **Ashamed and dehumanized**

Only a tenth of the population indicated that circumcision did not make them feel ashamed or dehumanized. Sixty seven of them stated that MMC would bring feelings of shame and make them feel dehumanized. Older man maybe experiencing shame of undergoing circumcision at their age and also having to brush shoulders with younger boys at circumcision sites. In focus groups done in Tanzania by Plotkins et al., (2013) respondents acknowledged that an older man would lose face if he met a younger man or boy in this setting. Furthermore, their status within the family and society would be demeaned if they get circumcised at the perceived inappropriate age of circumcision.

### **Fear of stigma and discrimination**

The study findings by Hargreave (2010) are in conjunction with the study findings that indicate a majority of the respondents feeling that MMC would lead to stigma and discrimination. A minority (11%) of the respondents in the study had no fear of stigma and discrimination. Mbusa

and Nkala (2014) asserts that depending on the cultural values and norms of a particular community, men and boys undergo circumcision for fear of being stigmatized especially if the majority is circumcised. For example, no matter how old they may be, but if they did not participate in circumcision ritual practice, they remain treated as immature individuals who are not expected to make adult decisions such as being involved in marriage issues. Fear of stigma and discrimination thus stands as a barrier against MMC.

### **Enhancing a false sense of security**

Pertaining to whether MMC enhances a false sense of security most of the respondents were in disagreement with the notion. In contrast, a study by Mateveke and Mashoko (2012) when they asked if circumcision will encourage undesired sexual intercourse, 100 % of the respondents agreed. The respondents argued that since one is circumcised, he would in turn indulge in many sexual relationships. Furthermore, respondents reported the ability to increase the number of rounds of sex after being circumcised which could potentially lead to greater exposure to HIV and STI through an increased frequency of sexual acts (Greenheart, 2008).

### **HIV testing prior to the procedure as a hindrance**

The study findings revealed that nearly half of the respondents (49%) regarded HIV testing before the procedure as the reason for not wanting to be circumcised. Gwata (2009) confirms the above assertion that fear of HIV results made some people dread going for circumcision as they know it is a prerequisite before circumcision. The researcher observed that those who want to be circumcised are compelled to be firstly tested for their HIV status before undertaking male circumcision as promulgated in the health medical policy of male circumcision. Such a scenario is likely to scare males from participating in the service delivery.

### **Women do not like circumcised men**

Regarding the notion that women do not like circumcised men, 67% of the respondents were in disagreement with it. Only 8% were in agreement with the notion that women do not like circumcised men, 25% stated that they were unsure pertaining to women's preference. However, results of the study done on the Apostolic Marange sect in Zimbabwe do not coincide with what most respondents stated as they feared to lose their wives as they may not enjoy sexual

intercourse with circumcised husbands as they used to before circumcision. This they said was especially worrying since the procedure was irreversible (Gore, Chiweshe, Mangundu & Mangundu, 2014). In other studies women stated that a circumcised penis brought uncomfotability during sex and made the men ejaculate early thus discouraged men from being circumcised.

### **Circumcision reduces penis size**

The result findings indicated that most men perceived that circumcision reduces penis size. The penis is an important attribute if not the greatest attribute in a man's body and the issue of its size is of great significance. The penis is not only a source of pride, pleasure and procreation; it is a symbol of who a man is. In the present study, men believed that circumcision reduces penis size, pertaining to this Bensley and Boyle (2012) came up with the conclusion that reduced penile skin may also have a 'burying' effect causing the erect circumcised penis to protrude less from the body than an intact penis. In the same vein, a study investigating the adequacy of condom sizes by Richters, Gerofi, and Donovan (1995) noted that circumcised men had significantly shorter erect penises by a mean length of 8mm than intact men. The difference in erect penile size was attributed to insufficient skin to accommodate the erection.

### **Fear of losing partner during waiting period**

Above half of the respondents shared sentiments of fear of losing a partner during the waiting period, whilst (42%) did not share the same sentiments. Results of the study findings of a research that was done in Swaziland by Khehla and Adams (2012) share the same view as respondents hesitated waiting for six weeks for the wound to heal before resuming sexual activity. Most of the older men had live-in partners and some were married thus sharing a bed with a woman for such a long time without having intercourse with her was regarded as punishing the woman and tempting her to go outside and get sex from someone else. Such fears therefore made them dread to go for circumcision as they fear losing their partners to other men.

### **Fear of loss of the capability of having an erection and having an erection during waiting period**

The results of the study indicated fear of loss of capability of having an erection after circumcision as well as having an erection during waiting period as a major barrier against circumcision as reflected by 95% of the respondents. Plotkins et al (2013) states that fear of penile injury from erections in the immediate post-operative period also emerged as a potential barrier. In particular, participants described a fear of erection causing stitches to rupture, resulting in pain and delayed wound healing.

On the same notion, Coursey et al (2001) state that removal of the nerves of the foreskin by circumcision produces a deficit in sensory input into the central, parasympathetic, and sympathetic nervous systems. He reports that adult circumcision degrades erectile function. Fink et al (2012) also reported worsened erectile function after adult circumcision and, in addition, a degradation of penile sensitivity. Pang and Kim (2002) carried out a survey in South Korea, where many adult males have been circumcised, and report that a man was twice as likely to have experienced diminished sexuality rather than improved sexuality. These reports make uncircumcised men reluctant to be circumcised.

### **Sexual pleasure is diminished and may lose my partner**

Diminishing of sexual pleasure and losing a partner due to it are postulated by the respondents as reasons that make them dread going for circumcision. Eighty seven percent of the respondents were in agreement that circumcision diminished sexual pleasure and this could lead them to losing their partners. Thirteen percent of the respondents did not think it would diminish their sexual pleasure or lead them to losing their partner. Wilcken et al., (2010) opposes the above assertion as he postulates that younger men felt circumcision enhanced sexual pleasure and satisfaction for women, a belief that is widely held among both young men and women and often discussed in community gatherings of men. Supporting this notion as described by some men is the mechanism that explained women's enhanced sexual pleasure since circumcision acted like a natural condom. This implies that it eliminates the need for barrier protection and the effect of circumcision made consistent condom use less important.

### **Women prefer to have sex with men who are circumcised**

The study findings showed that most women prefer to have sex with uncircumcised men (66%). Studies done by various authors indicated that women were significantly more likely to report vaginal dryness with a circumcised partner (Frisch et al., 2011). Furthermore, the study reports that male circumcision is associated with orgasm difficulties, dyspareunia and a sense of incomplete sexual needs fulfillment. Such experiences thus lead women to discourage their male partners from getting circumcised as this does not bring sexual fulfillment than the time when one was uncircumcised.

### **5.5 Socio- economic factors**

#### **Takes time away from work**

Nearly all the respondents (95%) stated circumcision as likely to take their time away from work. Local MMC guidance recommends several days rest at home following the procedure, working men, men in education and men who want to keep their circumcision choices private identified this as a potential barrier (Sengwayo, Colvin, Newell & Imrie, 2012). A qualitative study on the factors affecting adult attendance at VMMC services in Tanzania by Plotkin et al., (2013) also aired out the concern of time as a major deterrent to seeking MMC. The respondents stated that MMC would take time away from work leading to loss of income from absence on critical, income generating days.

#### **Loss of job if the pain persists for a long time**

The study findings revealed that loss of jobs if the pain persists was not a major concern for them. A significant number of the respondents indicated uncertainty with persistence of pain for a long time leading to job loss. Fear of the respondents may not be of job loss as a person can get a sick leave but the horror of the matter is failing to get money for those days they will be absent from work. Given that the respondents use their daily earnings to feed themselves and their families, taking much time off from work requires advance planning or external support. Therefore, as the head of the house and the provider, one would not want to fail providing for his family thus would rather not get circumcised.

### **Complications arising leading to use of money in treatment**

The estimated rate of complication worldwide has been reported as lying between 0.1 and 35% (Hirji et al., 2012). The power of these studies and the criteria for complication incidence varies widely depending on technique, setting and the training of the surgeon. The respondents in the study had strong fears of complications that may arise leading to use of money in treatment. Though the complication risk of circumcision is said to be low, respondents would rather not take chances as this may have an effect on their families financially.

### **Lack of transport money to a health centre**

Few of the respondents (9) indicated that lack of transport money was a barrier for circumcision. The findings of the study thus insinuate that the issue of finance is not their major drawback but other reasons which are stated above. This is, however, in conflict with their earlier response which revealed fear of spending money on treatment if complications arose.

## **5.6 Cross tabulation of demographic characteristics and particular questions**

### **Cross tabulation of educational level and the definition of circumcision**

The results of the present study do not show a relationship between educational level and the definition of circumcision. However, in Shiselweni (southern region of Swaziland) an ethnographic study pointed out that school going males were more educated on MMC than those out of school (Burtscher, 2012).

### **Cross tabulation of marital status and the fear of loss of erection capability and erection during waiting period**

Alarmingly, all the married respondents who took part in the study (106 out of 234) strongly feared loss of erection capability and an erection during waiting period. The results support findings of this study that reflect that men fear losing their partner during the waiting period. Married men have an obligation to satisfy their spouse sexually therefore loss of erection capability may stand as a hindrance to it. Khehla and Adams (2012) shared that men dreaded sharing a bed with a woman for such a long time without having intercourse with her as this will be punishing her and tempting her to go outside and get sex from someone else.

### **Employment status and lack of time to go to the centre for circumcision**

The relationship between employment status and lack of time to go to the centre for circumcision was identified. The majority of the employed respondents revealed that they did not have time to go to a centre for circumcision. Pierotti and Thornton (2012) in their study, respondents revealed that they did not have time to go to the hospital due to work commitments. Respondents felt that if they go for circumcision they will lose money for several days that they could have used supporting their families. Furthermore, their outcry was that their earnings were currently not enough thus would not risk worsening the situation.

### **Conclusion and Recommendations**

The purpose of the study is to investigate factors leading to the low uptake of MMC. The researcher managed to ask a number of questions according to each objective thus coming up with rich detailed information. Findings from this study could help to frame questions asked in future studies, as well as provide a framework for interpreting data from larger studies. Below are the deduced conclusions.

#### **Socio cultural factors**

The major findings of the study revealed that religious affiliation has an influence on one's decision to be circumcised or not. Certain beliefs associated with one's religious affiliation had impact shown by respondents who strongly followed their traditional beliefs and Christian beliefs which viewed MMC as a taboo. The men remain decision makers in families, thus having the power to allow their child to be circumcised or not. In order for young boys to be circumcised, it is important to be able to reach out to the fathers as they are the decision makers. The societal view of circumcised men as worthless, shameful and promiscuous also stands as a major barrier towards MMC.

#### **Psychological factors**

In conjunction with other studies fear of surgical operations, pain, bleeding and complications were established as main reasons for not getting circumcised. Fear of long wound healing time, diminished sexual pleasure, loss of erection, reduction of penis size are some of the major concerns of the respondents. The researcher found that the key to their worry is in relation to the urge of wanting to satisfy their partner. Furthermore, men take anything related to their penis seriously, by going for the surgery their penis is in jeopardy of getting damaged for life. There is

a fear that adverse events or mistakes could happen during the procedure. The argument here is that the penis is central to a man's identity; it carries a symbolic meaning for manhood and being 'the stronger sex'. Therefore, with the above perceptions, men shut out the thoughts of MMC mainly based on how it would make them feel as a man and whether it may lead them to lose their partner.

### **Socio economic factors**

The reports obtained from the study reflected that time taken away from work and costs that may be incurred before and after circumcision stand as a barrier against circumcision. Travelling expenses to the circumcision site, money lost by absence due to the healing period and treatment money spent if complications arise stand as a hindrance towards MMC.

### **Recommendations**

- Data analysed indicated reluctance by older men to engage in MMC as compared to younger men (18-29 years). Therefore, in order for MMC implementers and health planners to boost MMC uptake, more resources should be spent on circumcising younger men and more campaigns in schools and engaging MMC in their school curricula would be of more influence.
- Culture and religion were shown to have great impact on decision making for MMC. Dissemination of information should thus be increased in the various religious and traditional groups as they are holding back on circumcision due to certain misconceptions. Leaders of these groups should be engaged as they have great influence.
- Misconceptions and myths on MMC remain high especially in rural areas as indicated in the study. Therefore, provision of accurate information is of paramount importance in order to educate people on the benefits and risks associated with MMC. The Ministry of Health and Child welfare should come up with more campaign strategies in order to increase the adoption of MMC.
- The Ministry of health and child welfare should come up with strategies to curb the following major barriers identified in the study. Long wound healing time, pain, complications such as death, costs incurred before and after circumcision and also providing accurate information on MMC.

- Medical personnel offering antenatal services should be educated on the benefits and risks of MMC so that they can disseminate the information to expecting parents during antenatal clinics, with the hope of raising awareness among parents.
- Medical doctors and nurses in the maternity wards should be trained and empowered so that they can offer circumcision services to mothers willing to have their children circumcised soon after delivery or during infancy.

### Summary

This chapter presented an analysis of the research findings. Some conclusions drawn from the study have also been outlined and recommendations have been done on the subject under study. This was done by making reference to the research objectives set in chapter one and basing on the findings presented in chapter four.

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## ANNEXURE 1: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Irene Onicah Chiriga. I am a student at the University of Venda registered for the Masters in Public Health Management degree (MPHM). My research focuses on the factors leading to the low uptake of Medical Male Circumcision (MMC) in Mutare district, Zimbabwe. I am inviting you to participate in this study. Any information you will provide will be treated as confidential and therefore will not be divulged to anyone without your consent. Note that your participation is voluntary, meaning to say you are free to

The Headmen

Bambazonge village

Mutare rural district

RE: Permission to conduct a research on the factors leading to the low uptake of Medical Male Circumcision (MMC) in Bambazonge village, Mutare rural district

I hereby, kindly request to be granted permission to conduct a research in Bambazonge village. I am a student at the University of Venda, doing Master in Public Health as a requirement for this curriculum I am expected to conduct research that will benefit the community. The study focuses on the factors leading to the low uptake of MMC. However for the purpose of this mini dissertation the study will only focus on Bambazonge village.

Upon completion of the studies the researcher will provide the headmen with a copy of report and information acquired will be kept confidential and the names of the respondents shall not be disclosed or linked to them in any way. Measures to prevent any kind of harm (psychological, physical and emotional) have been looked out for.

Your cooperation will be highly appreciated

Kind Regards

Chiringa Irene Onicah

(Contact details: onicah.nicky@gmail.com, 0606237655)

## ANNEXURE 2: PARTICIPANT CONSENT FORM (ENGLISH)

My name is **Irene Onicah Chiringa**. I am a student at the University of Venda registered for the Masters in Public Health Management degree (MPH). My research focuses on the **factors leading to the low uptake of Medical Male Circumcision (MMC) in Mutare district, Zimbabwe**. I am inviting you to participate in this study. Please note that any information you will provide will be treated as confidential and therefore will not be divulged to anyone without your consent. Note that your participation is voluntary, meaning to say you are free to discontinue at any time should you feel uncomfortable during the course of the study.

Signature of researcher..... Date.....

I ..... Have read and understood the contents and terms of this invitation to participate in this study. I hereby declare that I am voluntarily participating in this research.

Respondent signature..... Date.....

For more information contact Chiringa IO (Researcher)-0730341783 or onicah.nicky@gmail.com

### ANNEXURE 3: RESEARCH QUESTIONNAIRE (ENGLISH)

#### INSTRUCTIONS

Questionnaire Number-----

Date-----/-----/-----

Instructions:

1. Please do not write your name or number on any part of this questionnaire.
2. Do not tear any page.
3. Please answer every question
4. Please do not hold any conversation with any one concerning this questionnaire and its content.
5. Please tick or fill the gap in the spaces provided as appropriate.

Respondent's code (For official use)

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## SECTION A: BIOGRAPHICAL DATA

Please tick:

1. Age

18-29yrs	1
30-40yrs	2
41-49yrs	3

2. Which section are you coming

1. Mudopa	1
2. Mawire	2
3. Ngeza	3
4. Nyandera	4

from/

3. Highest standard passed

5.1 Never attended school	1
5.2 Grade1-Grade7	2
5.3 Grade 8-Grade 1	3
5.4 Grade12 and above	4
Diploma/degree	5

4. Employment status

Unemployed	1
Employed	2

5. Marital Status

Single	1
Divorced	2
Widowed	3
Married	4

**SECTION B: Socio Cultural**

6. Are you a member of any faith or religious group, e.g. church or denomination?

Yes	No	Unsure
1	2	3

7. If yes, to which religion do you belong?

Christianity	
Islam	
Baha'i faith	
Traditional	
Other	

(iv) sexual pleasure

8. Which ethnic group are you?

Shangani	1
Varemba	2
Korekore	3
Zezuru	4
Karanga	5
Ndebele	6
Alien	7

9. What is circumcision?

- (i) The removal of the foreskin of the head of the penis
- (ii) the removal of the penis head
- (iii) preparation into manhood
- (iv) I have no idea

10. Are you circumcised?

Yes..... No..... Don't know.....

11. If yes, what are your reasons for undergoing circumcision?

- (i) status in society .....
- (ii) reduces sexual transmission by 60% .....
- (iii) reduces the risks of HIV infection .....

(iv) sexual pleasure .....

(v) religious purposes .....

12. If not circumcised, what are the reasons?

(i) Ancestors permission

(ii) Pain *makes decision regarding male circumcision in your family?*

(iii) being shunned from the community

(iv) fear of unsatisfactory sexual performance

(v) Fear of the unknown

13. If you were circumcised, what type of circumcision did you undergo?

(i) medical .....

(ii) traditional .....

(iii) religious .....

(iv) none of the above *is it in your culture if they are circumcised?*

14. Where do you think is the best place to be circumcised?

(i) Clinic/ hospital .....

(ii) At home .....

(iii) Traditional setting .....

(iv) Church .....

iv) circumcision is not acceptable .....

15. What is your personal view with regard to the best age for circumcision

(i) new born baby

- (ii) 2-6 years
- (iii) 7-13 years
- (iv) above 20 years
- (v) unsure
1. Strongly Disagree (SD)      2. Disagree (D)      3. Unsure (U)  
4. Agree (A)      5. Strongly Agree (SA)

16. Who makes decision regarding male circumcision in your family?

	SD	D	U	A	SA
(i) My father					
(ii) My mother					
(iii) My grandfather	1	2	3	4	5
(iv) My grandmother	1	2	3	4	5
(v) Myself	1	2	3	4	5
(vi) My uncle	1	2	3	4	5
(vii) Other, specify.....	1	2	3	4	5

17. How are the men viewed in your culture if they are circumcised?

	SD	D	U	A	SA
(i) Worthless	1	2	3	4	5
(ii) Defied by the gods	1	2	3	4	5
(iii) honourable	1	2	3	4	5
(iv) Shameful	1	2	3	4	5
(v) Promiscuous	1	2	3	4	5

**C: Psychological factors**

**D: Socio economic factors**

Read each of the following statements below and indicate your best choice by selecting the number that best describes your agreements:

1. Strongly Disagree [SD]      2. Disagree [D].      3. Unsure [U]  
4. Agree [A]      5. Strongly Agree [SA]

<b>C: Psychological factors</b>	<b>SD</b>	<b>D</b>	<b>U</b>	<b>A</b>	<b>SA</b>
18. I fear surgical operation, pain, bleeding and other complications	1	2	3	4	5
19. I fear that circumcision would lead to infection and wound will take too long to heal	1	2	3	4	5
20. I feel ashamed and dehumanised due to circumcision	1	2	3	4	5
21. I fear being stigmatised and discriminated	1	2	3	4	5
22. Circumcision gives me a false sense of security	1	2	3	4	5
23. HIV testing before the procedure prevents me from get circumcised	1	2	3	4	5
24. I heard women do not like circumcised men	1	2	3	4	5
25. Circumcision reduces penis size	1	2	3	4	5
26. I fear losing my partner or wife during the waiting period	1	2	3	4	5
27. I may lose the capability of having an erection and I am scared of having an erection during waiting period	1	2	3	4	5
28. Sexual pleasure is diminished when a person is circumcised and I might end up losing my partner	1	2	3	4	5
29. Women prefer to have sex with men who are circumcised	1	2	3	4	5
<b>D Socio – economic factors</b>					
30. I don't have time to go to a centre for circumcision	1	2	3	4	5
31. It takes time away from work	1	2	3	4	5
32. I might lose my job if the pain persists for a long time	1	2	3	4	5

33. Complications may arise and I may end up spending money on treatment	1	2	3	4	5
34. I don't have money for transport to the health centres	1	2	3	4	5

ZVAMINOTARIRWA

Questionnaire Number: \_\_\_\_\_

Ziva: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Zimambatarirwa:

1. Musokumbirwa kutarurira ziva zere
2. Musabvare rapera kutarurira
3. Musokumbirwa kupendera kutarurira
4. Musokumbirwa kuti musate bhandari rwe ziva pazvirevo ino pagwiro ino
5. Zadzwa pakafamba pazvirevo ino

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## ANNEXURE 4: RESEARCH QUESTIONNAIRE ( SHONA)

CHIKATU A:

### ZVAMUNOTARIRWA

1. Mafanana

Questionnaire Number-----

Zuva-----/-----/-----

Zvamunotarirwa:

1. Munokumbirwa kusanyora zita renyu
2. Musabvarure mapepa emugwaro iri
3. Munokumbirwa kupindura mubvunzo wese
4. Munokurudzirwa kuti musaita hurukuro naani zvake pamubvunzo iri pagwaro iri
5. Zadzisai pakafanira pamibvunzo inotevera

1. Mubvunzo	2
2. Mubvunzo	3
3. Mubvunzo	4

3. Danho repamusoro rezidzo rakabudiswa

5.1 Kusimbogadzira bichikoro	1
5.2 Giredhi 1-Giredhi 7	2
5.3 Giredhi 8-Giredhi 11	3
5.4 Giredhi 12 ndekururira	4
Dipulomani/di giki	5

**CHIKAMU A:**

**Ratidza: Rondedzero yomunhu**

**1. Makore**

Makore 18-29	1
Makore 30-40	2
Makore 41-49	3

**2. Nzvimbo yaunobva**

1. Mudopa	1
2. Mawire	2
3. Ngeza	3
4. Nyandera	4

**3. Danho repamusoro redzidzo rakabudirirwa**

5.1 Kusamboenda kuchikoro	1
5.2 Giredhi 1-Giredhi 7	2
5.3 Giredhi 8-Giredhi 11	3
5.4 Giredhi 12 nekupfuura	4
Dhipuloma/dhigirii	5

Chikwanda	
Chikwanda	
Zvakanaka	

4 Maerano nezvemabasa

Asiri pabasa	1
Ari pabasa	2

5 Uri werudzi rwupi?

Vetsonga	
Varemfa	
5. Maererano newanano	
Zvare	
Karanga	
Kujekwa	
Vakawana	

Asati awanikwa	1
Vakarambana	2
Vakafirwa	3
Vakawanikwa	4

5. Kur **CHIKAMU B: Magariro nezvitendero**

6 Uri mutezo wechimwe chezvkwata zverutendo kana chitendero se; kereke kana chitendero

- (a) Kubvira musoro wenhanga yamunhu
- (b) gudzira yehupinda munhanga
- (c) Handina
- 10. Matadzimwa hore?

Hongu	Kwete	Handina chokwadi

7 Kana mhinduro iri hongu, unotenda kachitendero chipi?

- 11. Kana mhinduro iri hongu, chikonzero chokwadi
- (a) chikwanda munhanga
- (b) Zvirovira kuti zvapukira tsvakwira zvegashunde

Chikristu	
Chichawa	

Chibhudha .....	
Chivanhu	
Zvimwewo	

8 Uri werudzi rwupi?

Vatsonga	
Varemba	
Korekore	
Zezuru	
Karanga	
Ndebele	
Vabvakure	

9. Kudzingiswa kuita sei?

- (i) Kubviswa kweganda remusoro weganda renhengo yemunhu rume
- (ii) Kubviswa musoro wenhengo yemunhu rume
- (iii) gadziriro yekupinda muhurume
- (iv) Handizivi

10. Makadzingiswa here?

Hongu..... Kwete..... Handizivi.....

11. Kana mhinduro iri hongu, chikonzero chekunodzingisa chii?

- (i) chimiro munharaunda .....
- (ii) Zvinoderedza kutapukira kwezvirwere zvepabonde ne60% .....

(iii) Zvinoderedza zviitisi zvekuwana utachiwana hweshura matongo .....

(iv) Mufaro wepabonde .....

(v) Zvikonzero zvechitendero .....

12. Kana musina kudzingisa, chikonzero chii?

(i) Kutenderwa nevadzimu

(ii) Kurwadziwa .....

(iii) Kudzingwa munharaunda

(iv) Kuzeza kusava nemufaro pabonde

(v) Kutya zvingaitika .....

13. Kana maka dzingisa, makadzingisa kupi?

(i) Kuchipatara .....

(ii) Zvechivanhu .....

(iii) Zvechitendero .....

(iv) Hapana chimwe chezvikonzero zvarehwa pamusoro .....

14. Munofunga kuti ndekupi kwaka kwakanakira kudzingisa?

(i) Kiriniki/Chipatara .....

(ii) Kumba .....

(iii) Kuchivanhu .....

(iv) Kukereke .....

(v) Kudzingisa hakutenderwi .....

15. Mafungiiro enyu maererano nemakore akafanira kudzingisa

(i) Mwana achangozvara .....

(ii) Makore 2-6

(iii) Makore 7-13

(iv) Makore anopfuura 20



**C: Zvinechekuita nemafungiro evanhu nezveupfumi**

**D:Zvinechekuita nemagariro nemafungiro**

**Verenga zvose zvinotevera, woratidza zvaunobvumirana nazvo**

1. Handibvumirani nazvo Zvakanyanya (HZ) 2. Handibvumirani nazvo (HN)

3. Handina Chokwadi (HC) 4. Ndinobvumirana Nazvo (NN)

5. Ndinobvumirana nazvo Zvakanyanya (NZ)

<b>C :Zvinechekuita nemaungiro evanhu</b>					
	<b>HZ</b>	<b>HN</b>	<b>HC</b>	<b>NN</b>	<b>NZ</b>
18. Ndinoty bkuvhayiwa, kurwadziwa, kubuda ropa nezvimwe zvimhinga mupini	1	2	3	4	5
19. Ndinoty kuti kudzinga kungaunza utachiwana, uye chironda chacho chingazononoka kupora	1	2	3	4	5
20. Ndinonyara, uye ndinozwa sendabva hunhu nekudzingwa	1	2	3	4	5
21. Ndinoty kusagashirwa nekusarurwa	1	2	3	4	5
22. Kudzingwa kunondiita kuti ndinzwe sendakadzivirika zvenhema	1	2	3	4	5
23. Kutanga kuongororwa chirwere chemukondombera kunonditadzisa kuzodzingisa	1	2	3	4	5
24. Ndakanzwa kuti vanhu kadzi havadi varume vakadzingisa	1	2	3	4	5
25. Kudzingisa kuita kuti nhengo yemunhu rume ive diki	1	2	3	4	5
26. Ndinoty kusiiwa nemumwe wangu kana mukadzi panguva yekupora	1	2	3	4	5
27. Ndingangotadza kusvika pagadziriro yebonde kwenhengo yemunhu rume uye ndinoty kuti ndingasvika pamamiriro enhengo yemurume pabonde ndiri panguva yekupora kwechironda	1	2	3	4	5
28. Mufaro pabonde ungakanganisika kana munhu akadzingisa zvinozoita kuti apedzisire atizwa nemukadzi	1	2	3	4	5
29. Vanhu kadzi vanofarira kuita zvepabonde nevanhu rume vakadzingisa	1	2	3	4	5

D : Zvinechekuita nemagariro neupfumi					
30. Handina nguva yekuenda kunoitwa nezvekudzingisa	1	2	3	4	5
31. Zvinozonditorera nguva yebasa	1	2	3	4	5
32. Ndingango pererwa nebasa	1	2	3	4	5
33. Panganoita zvimhingamupinyi zvinozoda mari pakurapwa	1	2	3	4	5
34. Handina mari yekuenda kuchipatara kwazvinoitwa	1	2	3	4	5

RESEARCH AND INNOVATION  
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:  
**Ms IO Chiringa**

Student No:  
**11595318**

**PROJECT TITLE: Factors contributing to the low uptake of medical male circumcision in Bambazonge village within Mutare Rural District, Zimbabwe.**

PROJECT NO: SHS/14/PH/16/0312

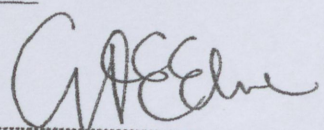
SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr DU Ramathuba	University of Venda	Supervisor
Dr NS Mashau	University of Venda	Co-Supervisor
Ms IO Chiringa	University of Venda	Investigator - Student

ISSUED BY:  
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: December 2014

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: Prof. G.E. Ekosse



University of Venda

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