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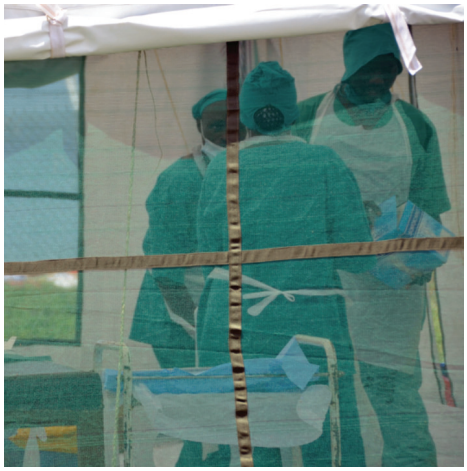
INTEGRATING GENDER IN VOLUNTARY MEDICAL MALE CIRCUMCISION PROGRAMS TO IMPROVE OUTCOMES

Background

Male circumcision is proven to reduce the risk of sexual transmission of HIV from women to men by 60% (WHO, 2012), and it is estimated that 80% coverage could reduce HIV incidence in Uganda by 30-50% (UNAIDS, 2011). Voluntary Medical Male Circumcision (VMMC) is recommended as part of a comprehensive HIV prevention package, which includes HIV testing and counseling, correct and consistent use of male and female condoms, treatment of sexually transmitted infections and promotion of safer sex behaviors. VMMC is a relatively new approach for HIV prevention, and there are limited data or reporting on VMMC programs. This offers an important opportunity to apply improvement methods, including gender integration, in the scale-up of VMMC in order to learn how to effectively implement the intervention.

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

While VMMC reduces HIV acquisition among heterosexual men by 60%, it does not directly reduce the risk of male-to-female transmission. Yet the gradual reduction of men with HIV does indirectly lead to a decrease in HIV among women and girls. One model estimates a 46% long-term reduction in male-to-female transmission (Jones, 2013). Male circumcision also reduces the risks of other sexually transmitted infections and cervical cancer in women and girls. A study conducted in South Africa found that circumcised men were about half as likely to have the human papilloma virus as uncircumcised men, when controlling for other factors (Auvert et al., 2009). This translates to a lower rate of HPV and cervical cancer among their female partners.



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

Photo by Kim Burns Case/JHUCCP, Courtesy of Photoshare

Box 1. Gender issues in VMMC services

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

Traditions surrounding circumcision vary by region, community, and generation. Many myths surround the procedure, some of which can lead to gender-based risky behaviors and negative social implications surrounding circumcision status. Men and women may also have different perspectives and knowledge about the effects of male circumcision on sexual experiences; a woman's opinion may motivate or deter her partner from undergoing circumcision. Misunderstandings about VMMC, particularly when not delivered as part of a comprehensive HIV program, may lead to distrust and violence in a relationship. Finally, leaving women out of this HIV-prevention activity misses an opportunity for couples' counseling and testing and linking women to other services.

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Gender Issues to Consider in VMMC

Myths and traditions surrounding male circumcision

For many, male circumcision is an important tradition or rite accompanying meanings of status, manliness, sexuality, and religion. VMMC programs must respect local traditions while aiming to provide a safe alternative for the reduction of HIV risk. In many cultures in Sub-Saharan Africa, circumcision marks the transition into adulthood and the time to initiate sexual activity (WHO, 2009). However, WHO safety guidelines for VMMC state that clients must abstain from sexual intercourse for 6 weeks after the surgery to ensure proper healing. Men are more at risk of acquiring HIV immediately following circumcision.

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

Some beliefs and practices which may lead to negative health consequences for men and women or lead to strains in intimate partnerships include the belief that a married man should have sex with a virgin after circumcision to promote healing. The reason given is that the tighter vaginal opening of a virgin would force the skin of the suture together and improve the healing after circumcision. Another common practice is to have sex with a woman (not necessarily a virgin) other than one's wife or intimate partner after circumcision as a protective measure. Some believe that the first woman that a man has sex with after circumcision will be cursed to become a harlot; others hold that men release curses from their body after circumcision and that they should have intercourse with another woman to avoid instilling these curses on their partner. Examples of "curses" include infertility, only bearing girl children, and HIV. Such practices not only encourage risky behaviors, but also cause some female partners to dissuade their husband from seeking services or to become suspicious and angry with their partners after circumcision, which can itself lead to violence. (Examples were collected during focus group discussions in Uganda in April 2013 through the USAID ASSIST Project.)

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

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

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

Teams identified engaging female partners to attend educational sessions and clinic visits with male clients as a change to test. From January to December 2013, the proportion of clients who attended educational sessions with partners increased from 0 to 23%. Anecdotal evidence suggests that this had contributed to an increase in retention of follow-up visits and a decrease in adverse events. Couples who attend SMC visits as partners are offered HIV counseling and testing, and female partners are encouraged to access reproductive and other health services at visits. By December 2013, two health facilities reported an increase in uptake of others health services like family planning and immunization because of engaging female partners.

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

Female partners' roles in VMMC decisions

Educational programs must challenge traditional and harmful beliefs and reach both men and women. Because VMMC reduces female-to-male transmission of HIV, care must be taken in its promotion to avoid spreading the harmful misconception that women are the chief vectors of HIV.

Discussing circumcision with a female sexual partner was the greatest predictor of readiness to undergo VMMC in one study in Zambia (Jones, 2013). A survey conducted by the Women's HIV Prevention Tracking Project found that 74% of women would like to be involved in the decision-making for VMMC. Both men and women expressed fear that their partner would be unfaithful during the six weeks of medically-advised abstinence following circumcision (WHIPT, 2010). Many men say they would change their decision of whether to undergo VMMC based on a partner's opinion. Female partners can help encourage men to get medical

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

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

Case 1

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

Case 2

Staff at an ASSIST-supported facility circumcised a man in a polygamous arrangement with two wives. Seven weeks after the procedure, the patient returned to the clinic with complaints. He passed the physical examination but was found to be distressed. He told the clinician that his wives had left him when they learned he was circumcised. The regional office contacted the two wives. The women reported that they were not informed prior to the circumcision and presumed that the circumcision would decrease his sexual performance. The facility team invited the patient and his two wives for counseling and educated them on SMC and its benefits—including informing them that there is no proof that SMC alters sexual performance. After two months of counseling, the women returned to their husband's home. The facility team concluded that this would not have happened if the wives had been involved prior to the procedure.

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

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

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

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

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

Criterion 2.4: Male and female condoms available at the facility

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

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

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

circumcision by assuring their partner of their support. In many households, women are responsible for health-related matters. By educating women on the benefits of the VMMC service, they serve as the gatekeepers for access to services.

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

After undergoing VMMC, men must abstain from sexual activity for six weeks in order to properly heal. During this period, they are susceptible to wound infection and more likely to transmit HIV infections. Both men and women express difficulty adhering to this requirement. Discussing this requirement as a couple and approaching the issue together will improve adherence and foster joint accountability. Men who receive this clinical guidance alone may not tell their female partners, or if they inform their partners, their partners may not believe them. Cases have been cited where women perceived their partners as lying in order to pursue someone else. At the same time, some men do not abstain because they fear their wives will seek to fulfill their sexual needs with someone else. Including women in the process also offers an opportunity for couples' testing and counseling which will increase their knowledge about protection and can link both men and women to treatment and services as needed.

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

Negative consequences of excluding women

Excluding female partners from VMMC services may lead to gender-based violence and conflicts. Many of these conflicts can be avoided through proper education, counseling, and joint decision-making. Women who learn of their partner's circumcision without prior discussion may accuse them of

accessing services in order to have multiple partners or of being HIV-positive.

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

Considerations for Integrating Gender into VMMC Services

1. Educate men and women in the community on VMMC

- Counter myths and harmful traditional practices by working with community leaders
- Disseminate radio and media messages on the importance of engaging women in VMMC
- Enlist community health workers as messengers

2. Encourage women to come to clinics

- Provide individual/couples counseling and testing
- Reach out to women's groups about VMMC and engage women to be involved in and educated about their partner's VMMC procedure
- When recruiting men, encourage them to bring partners
- Provide education sessions for couples, but also make sure men who come without a partner receive counseling and required information
- Always ensure both partners agree to counseling, testing, and sharing their status
- Protect the privacy and confidentiality of all clients

3. Create an inclusive environment

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

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Resources to learn more

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

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

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

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

Accessed at: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0044825

This resource presents findings from a study which explores the importance of women as an audience for VMMC communication messages so that they are aware that VMMC provides only partial protection against HIV. It also discusses women's potential influence in encouraging their male partners to get circumcised and practice other HIV protective measures after VMMC. The resource also mentions reaching out to women as a valuable intervention strategy for increasing VMMC uptake and promoting use of other HIV protective measures after VMMC.

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

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

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