# Understanding the Sexual Practices of Medically Circumcised Males in the Context of HIV and AIDS: A Study in Harare Zimbabwe

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## ABSTRACT

Zimbabwe is one of the priority countries nominated by the World Health Organisation and the Joint United Nations Programme on HIV and AIDS to adopt and implement voluntary medical male circumcision (VMMC) because of its high rate of HIV prevalence and its low level of male circumcision. VMMC, which was introduced in Zimbabwe in 2009, is a new HIV prevention method which reportedly offers partial protection of about 60 percent for circumcised males with respect to contracting HIV through sexual relations. The other key prevention method, namely the use of condoms consistently and correctly, has a protection rate of up to 95 percent. As a result, because of only partial protection, medically-circumcised men are encouraged to use condoms to decrease the chances of HIV infection. Concerns though have been raised about the possibility of risk compensation by circumcised males by way of increases in unsafe or risky sexual practices subsequent to circumcision and arising from perceptions of reduced risk through VMMC. This compensation may take the form of condom use aversion including when involved with concurrent sexual partners. If risk compensation does take place, this would lead to increases in HIV transmissions affecting not only the circumcised men but their sexual partners as well.

The supposed effectiveness of VMMC as a HIV prevention method has been subjected to significant criticism and, as yet, no significant study has been undertaken in Zimbabwe on the relationship between VMMC, condom use, concurrent sexual partners and risk compensation. Based on a study of twenty-five medically-circumcised males in Harare, the capital of Zimbabwe, this thesis seeks to understand and explain the relationship between voluntary medical male circumcision and risky sexual practices with particular reference to condom use amongst men engaged in concurrent sexual partnerships. While the thesis finds evidence of risky sexual practices subsequent to circumcision, risk compensation does not seem to be particularly prevalent.

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## ACRONYMS

| | |
|---|---|
| **ART** | Antiretroviral Therapy |
| **ARVs** | Antiretroviral Drugs |
| **CDC** | Centre for Disease Control and Prevention |
| **CHBC** | Community and Home Based Care |
| **CSPs** | Concurrent Sexual Partners |
| **CT** | Counselling and Testing |
| **ESAP** | Economic Structural Adjustment Programme |
| **ESTP** | Emergency Short Term Plan |
| **GCS** | Group Counselling Session |
| **GoZ** | Government of Zimbabwe |
| **HDI** | Human Development Index |
| **HDN** | Health and Development Networks |
| **HIV and AIDS** | Human Immunodeficiency Virus and Acquired Immuno Deficiency Syndrome |
| **HPV** | Human Papillomavirus |
| **HTC** | HIV Testing and Counselling |
| **ICPD** | International Conference on Population and Development |
| **IMF** | International Monetary Fund |
| **LSBHE** | Life Skills Based HIV and AIDS Education |
| **MC** | Male Circumcision |
| **MDGs** | Millennium Development Goals |
| **MoESC** | Ministry of Education, Arts, Sports and Culture |
| **MoHCW** | Ministry of Health and Child Welfare |
| **MTP** | Medium Term Plan |
| **NAC** | National AIDS Council of Zimbabwe |

| | |
|---|---|
| **NGO** | Non-Governmental Organisation |
| **OIs** | Opportunistic Infections |
| **PLWH** | People Living with HIV |
| **PMTCT** | Prevention from Mother to Child Transmission |
| **SADC** | Southern African Development Community |
| **SAfAIDS** | Southern Africa HIV and AIDS Dissemination Service |
| **STI** | Sexually Transmitted Infection |
| **TMC** | Traditional Male Circumcision |
| **UN** | United Nations |
| **UNAIDS** | Joint United Nations Program on HIV/AIDS |
| **UNDP** | United Nations Development Programme |
| **UNFPA** | United Nations Population Fund |
| **UNGASS** | United Nations General Assembly Special Session on HIV and AIDS |
| **VCT** | Voluntary Counselling and Testing |
| **VMMC** | Voluntary Medical Male Circumcision |
| **WB** | World Bank |
| **WHO** | World Health Organisation |
| **ZHDR** | Zimbabwe Human Development Report |

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# CHAPTER ONE
# INTRODUCTION AND METHODOLOGY

## 1.1 Introduction

Zimbabwe is one of the priority countries which were nominated by the World Health Organisation and the Joint United Nations Programme on HIV and AIDS to adopt and roll out voluntary medical male circumcision (VMMC) due to its high HIV prevalence levels coupled with low circumcision levels. VMMC is a HIV prevention method which reportedly offers partial protection of about 60 percent for males with regard to contracting HIV through sexual intercourse. The other key prevention method, correct and consistent condom use, has a protection rate of up to 95 percent. As a result, medically-circumcised men are encouraged to use condoms to increase the chances of HIV prevention in heterosexual relationships. Concerns though have been raised about risk compensation, which entails increases in unsafe sexual practices arising from perceptions of reduced risk because of the presence of some preventative measure (in this case VMMC) (MacPhail et al. 2012, Cassel et al. 2006), with such compensation taking the form of condom use aversion and concurrent sexual partners. If risk compensation in actual fact happens, as a result of such new partial HIV prevention methods as VMMC, this would lead to an increase in HIV transmission affecting not just circumcised men but their partners as well. This thesis seeks to examine the question of risk compensation and VMMC amongst medically-circumcised males in Zimbabwe with particular reference to condom use amongst circumcised men who have concurrent sexual partners.

This introductory chapter is divided into the following sections. In section two I outline and discuss the key research objectives. Section three then discusses the methods and techniques pursued in undertaking the research for the thesis, as well as the challenges encountered and the ethics followed. And the last section provides an outline for the following chapters of the thesis.

## 1.2 Thesis Objective

Two important factors underpin the motivation for undertaking this study. First of all, currently, there are no significant studies about the sexual practices of medically-circumcised males in Zimbabwe in as far as risk compensation and condom use in concurrent sexual

partnerships is concerned. Secondly, in fact, the prevailing studies globally which formed the very basis for the introduction in 2009 of VMMC in Zimbabwe (and elsewhere) was controlled studies and – as will be shown – these have been subjected to considerable criticism. As a result, basic claims about the significance of VMMC for reducing HIV infections under real-life conditions have been called into question. For these reasons, my study is of considerable significance in adding not only to the prevailing Zimbabwean literature but to the broader international literature on VMMC. In doing so, the thesis hopefully adds value in filling in empirical gaps in the existing literature but also in providing insights into the relationship between VMMC and condom use.

In this context, the primary objective of the thesis is as follows: *To understand and explain the relationship between voluntary medical male circumcision and risky sexual practices with particular reference to condom use amongst men engaged in concurrent sexual partnerships*. The empirical focus is a group of twenty-five men in the capital city of Zimbabwe, namely Harare. Secondary objectives include:

a) To determine if medically-circumcised males know of the reported linkages between VMMC and other HIV-prevention methods, such as condom use;
b) To explore the reasons and rationale for being circumcised medically;
c) To examine the sexual practices of medically-circumcised men both before and after circumcision; and
d) To understand the basis for changes in the sexual practices of medically-circumcised males insofar as such changes exist.

### 1.3 Research Design and Methods

In general, sex and sexual practices are considered to be very private and confidential affairs and are not regularly discussed amongst strangers. There are, therefore, many factors which pose challenges to researchers of sexual practices, including the frequently stigmatised character of sexual practices, the diverse and sometimes dubious motives behind sexual practices and the promiscuity sometimes linked to particular sexual practices (Schroder et al 2003:1). It becomes extremely difficult then for researchers to access empirically and to capture analytically questions pertaining to sexual practices (Di Mauro 1996). As a result, according to Fenton et al. (2001:84), studies on sexual practices can be dominated by errors as a result of "participation bias, recall and comprehension problems and respondents' willingness to report sensitive and sometimes socially censored attitudes and behaviour". Notwithstanding these challenges, and I note below some of my own fieldwork challenges,

the significance of the study in contributing to existing knowledge about medically-circumcised males and sexual practices compelled me to undertake the thesis.

This research for this thesis is chiefly qualitative in character since the thesis investigates and endeavours to explain social practices from lenses that appreciate the subjective experiences of social actors. In other words, qualitative research facilitates a comprehension of subjective understandings, conscious deliberation and choice-making highly pertinent to the key objective and subsidiary objectives of the thesis. At the same time, qualitative research is able to explore the relationship and interplay between individual agency and social conditioning, which is highly relevant to making sense of the choices around sexual practices made by medically-circumcised men in the light of perceived risks. As a general tendency, qualitative research has proven to be suitable for exploring issues around sexual practices and sexuality, including in the domain and HIV and AIDS, because it is able to enter into the realm of the "personal, intensely private, and sometimes illicit" (Power 2007:87).

In this context, the fieldwork research for this study involved primarily extended informal interviews which in some ways bordered on life-story interviews. However, I also made extensive use of primary documentation (both global and Zimbabwean sources) about HIV and responses to it. Atkinson (1998:8) notes that a life story is "the life a person chooses to tell about the life he or she has lived, told as completely and honestly as possible, what is remembered of it, and what the teller wants others to know of it, usually as a result of a guided interview by another". The interviewee provides a picture of what has transpired in the storyteller's life from the earliest memories to the present and, in doing so, major events as well as important influences, experiences, circumstances, and lessons come to the fore. In this way, life-story interviews show how individuals handled issues in a social context and who that individual has eventually become as a result of his life experiences. This implies that individuals are not the mere bearers of structures in the Althusserian sense or simple products of structures, as agency plays a mediating role in for instance the forms of sexual practices pursued.

In undertaking this line of social inquiry, I first needed to select a sample of medically-circumcised males. Although I had the option of obtaining a list of names of circumcised males from circumcision centres or circumcision-related organisations in Harare, I opted for a snowball non-random sampling technique in accessing participants for this study. Snowball sampling is also known as chain or referral sampling in the sense that the

researcher is linked to other participants by the participants whom he or she has contacted or interviewed already (Biernacki and Waldorf 1981, Browne 2005, Noy 2008).

I chose this method in part to avoid the possibility of participant response bias, whereby the participants tell the researcher what he 'wants' to hear as a result of them knowing that he was referred from the organisations that deal closely with them. An additional reason for choosing snowball sampling was the sensitive and private nature of the topic under study and the problem of access (Faugier and Sargeant 1997), such that it would be highly unlikely for circumcision centres to in fact divulge personal details about circumcised men and for circumcised men to find it acceptable that they did. Topics with low social visibility and which border at times on socially unacceptable images and practices, such as VMMC and sexual practices, are highly suitable to referral sampling as participants are difficult to identify and they often identified by others with whom they have a social network relationship of familiarity and trust (Biernack and Waldorf 1981, Browne 2005, Bell 1997). In the case of VMMC in Zimbabwe, it has been received with mixed feelings resulting in a low uptake by men of the circumcision procedure (SAfAIDS 2013, Chimuti 2013), and the prevailing social networks amongst circumcised men became critical to the identification of study participants.

As a way of identifying potential research participants, I initially approached circumcised men known to me (two men), based on discussions with my friends. None of my friends were circumcised but they had other friends who were circumcised. Approaching a potential participant after referral by a mutual friend or acquaintance has the advantage of "word of mouth assurances which are significant when the research is of a sensitive nature" especially if participants are cagey about talking about sensitive personal life issues to an unfamiliar person (Browne 2005:50). However, before I reached a total of 25 participants, there were breaks in the referrals. In this respect, every successful referral by a participant makes a wave but the wave ends when a participant makes no further referral (Shafie undated). In such cases, I visited different places and areas in Harare thronged by men so as to talk to men from different backgrounds. These areas were in the city centre of Harare, and included market malls, bus termini, beer halls, night clubs, churches, colleges, schools and workplaces. At these places I was able to identify an additional participant for the study and start another referral wave until the fieldwork was completed. Breaking a wave of referrals is of great significance particularly if a selection wave leads to the selection of participants who, because they are likely friends, may be quite similar for instance in their sexual activity and

practices. Thus, numerous waves allowed me to ensure some diversity within the sampled men.

The interviews of the 25 men were conducted in the month of primarily August 2013. In using the snowball sampling procedure, I attempted "to ensure that the sample includes an array of respondents that, in qualitative terms, if not rigorous statistical ones, reflect what is thought to be the general characteristics of the population in question" (Biernack and Waldorf (1981:155). The profile of the 25 men is provided later in the thesis (in chapter five). Though the sample technique used was not random sampling drawn from a well-defined universe or population and therefore broader generalisations of a statistical kind cannot be generated, the men interviewed are very diverse in terms of for example education, marital status, and work status. Medical circumcision occurs on teenagers down to the age of 13 in Zimbabwe, but I restricted my study to men 18 years and older and who were circumcised at least 3 months prior to the study. The minimum three-month period was seen as necessary to evaluate the post-circumcision sexual practices of medically-circumcised males. Though statistical generalisations are not possible, the evidence collected during the research identifies and captures general trends and divergent tendencies amongst medically-circumcised men in Harare in relation to sexual practices, condom use and concurrent sexual partners. The interviewee schedule used for the interviews appears as Appendix 1. All questions in the schedule were asked of all sampled males, but at times the interviewee deviated from course depending on the content of the interview.

To be in a position to classify practices as safe or risky in relation to HIV transmission, I adopted the use of scaling techniques as embodied in the close-ended questions in the interview schedule. Kothari (2004:76) notes:

> Scaling describes the procedures of assigning numbers to various degrees of opinion, attitude and other concepts. This can be done by making a judgement about some characteristic of an individual and then placing him directly on a scale that has been defined in terms of that characteristic

Scaling reduces the problem of assigning a specific measurement to complex and abstract concepts without a standardised measurement tool. In this study, I used a summated scale or Likert-type scale and dichotomous measures, involving statements expressing favourable and unfavourable responses to particular issues raised. To avoid the difficulty in categorisation, I used dichotomous measures which only give interviewees two options which in this case categorises participants as 'low-risk' individuals and 'high risk' individuals in relation to sexual practices (Schroder et al. 2003:3). In this research, individuals categorised as low-risk

individuals are sexually-inactive, those who do not have concurrent sexual partners and use condoms consistently; the high risk category uses condoms inconsistently or not at all particularly with concurrent sexual partners.

In conducting actual interviews, it is important to remember that every interview is dynamic and is a meaning-making event (Berg, 1998). Hence, it is critical to ensure that reliable and not biased evidence is collected during the interviews. It is a difficult task to convince men to talk freely and frankly about sensitive issues which relate to their sexual practices, and honesty on my part was critical from the start. I told the participants that the research is for academic purposes and that it hopefully would benefit Zimbabwean society through providing insights into the phenomenon of VMMC in the country in connection to the HIV pandemic. I also assured them that the interviews were confidential and that they would remain anonymous for purposes of the thesis. Overall, I abided by all the standard research protocols including informed consent, no deception, privacy and confidentiality, and accuracy (Olgletree and Kawulich 2012:64). All men who agreed to be participants in the study were asked to sign a consent form. During the narration of personal events and experiences, I engaged the interviewee by listening attentively and guiding gently the direction of the interview. Due to the sensitive nature of this study, I avoided showing signs of astonishment or surprise as if I were judging or even condemning the participants with reference to their views about sexuality and sexual practice patterns. In carrying out the interviews, I was aware of the importance in conducting them in a language most familiar to the participant (Willig 2001).

In terms of research challenges, authenticating a research participant's circumcision status was not an easy task since I could not examine them physically to establish if they are truly circumcised or not. In this regard, Biernach and Waldorf (1981) note that researchers should not take at face value the self-representations made by potential participants who volunteer or agree to participant in such sensitive researches. However, false self-presentations are likely to be high when people know that there is money given as a token of appreciation for participating in a given research (Biernack and Waldorf 1981). For my research, no honorarium was given. Also, the fact that I had snowball sampling referrals reduced the chances of false self-representations since the point of reference worked as a confirmation of the circumcision status for participants in this research. As a way of trying to check authenticity in terms of circumcision status I visited one circumcision centre and joined other men during a group counselling session (GCS) on the 18th July 2013, which is part of the circumcision process. From this I came up with verification questions for my interviews,

which included: Did you go through HIV counselling and testing before circumcision? If so, how many sessions of counselling did you go through before getting circumcised? How did you nurse the circumcision wound?

Another challenge I faced was that of participant hesitancy despite the fact that many referrals for participants came from a mutual friend. Some participants still needed to verify my identity before participating in the interviews because the interviews took place during national election time. Run up to elections in Zimbabwe have been associated with violence and by a very high level activity of spying by central intelligence officers, hence there is considerable reluctance and suspicion when it comes to entertaining strangers. As well, in this regard, I used a digital tape recorder in conducting the in-depth interviews. While recording went well with some participants, others did not like the idea of being recorded but they nevertheless allowed me to use the recorder.

In relation to data analysis, the interview schedule provided a strong basis for this. I first though had to transcribe all interviews from Shona into English. Though there was considerable overlap, themes and sub-themes were identified and reworked, and evidence was allocated accordingly. Because of the relative paucity of literature on VMMC and risky sexual practices, the themes and sub-themes have a pronounced grounded feel to them and therefore are rooted strongly in the subjective experiences and understandings of the 25 medically-circumcised men from Harare. These themes formed the basis for the discussions in the two chapters focused on the sampled males.

### 1.4 Thesis Outline

The thesis has five major chapters excluding the introduction and conclusion. I briefly outline the chapters.

Chapter 2 focuses on the prevalence of HIV and AIDS at a global scale and prevention responses undertaken against the pandemic at the global scale in relation to prevention, support and treatment. This chapter focuses on the two major HIV prevention methods which form the basis of this thesis, namely condoms and medical circumcision; and it also discusses the question of risk compensation in relation to VMMC. Theories of sexuality, as they relate to the thesis topic, are also outlined given the centrality of patriarchy in Zimbabwe and the significance of gender in sexual relationships and practices.

Chapters 3 and 4 focus more specifically on Zimbabwe. Combined, they outline the character of the HIV pandemic in the country and the significant state-driven strides made in relation to addressing the consequences of the pandemic. Again, the focus is on prevention,

specifically condoms and VMMC, but the full breadth of state responses is also presented. The sexual practices of medically-circumcised men cannot be read off directly from state policies and programmes and, therefore, it is important to examine other social factors which mediate the relationship between these responses of actual practices. These more structural factors include socio-cultural traditions pertaining to sexuality and patriarchy, and socio-economic conditions in the country entailing crisis which lead to situations conducive to the transmission of HIV.

Chapters 5 and 6 discuss my empirical research in Harare. Together, they offer a profile of the study participants and then go on to examine in great detail the sexual activity and practices of the 25 medically-circumcised men. These practices, in the context of HIV testing and counselling, relate to questions about resuming sex after circumcision, condom use both before and after circumcision, and concurrent sexual partners again both before and after circumcision. In providing this overview, I specifically address the issue of risk compensation and the relationship between VMMC and condom use, particularly amongst men who are engaged with concurrent sexual partners. I also detail the reasoning behind being circumcised and how the differences in reasoning lead to significant variation in the extent to which sexual practices alter subsequent to the circumcision procedure.

# CHAPTER TWO
# HIV AND AIDS GLOBALLY:
# CONDOMS, CIRCUMCISION AND RISKY SEXUAL PRACTICES

## 2.1 Introduction

The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) remains a global public health problem despite significant advances in prevention, care and treatment. This chapter discusses HIV and AIDS from a global perspective. After briefly outlining some of the key global responses to the pandemic in relation to prevention and treatment (in section two), I examine the two key methods of HIV prevention which form the basis of this study: condoms and circumcision. In section three, I focus on condoms, including their character and effectiveness, and debates around their use. In the ensuing extended section (section 4), I examine voluntary medical male circumcision as a HIV prevention method in relation to condom use and risky sexual practices. In the end, I argue that the relationship between the supposed medical efficacy of circumcision and reduced HIV transmission is mediated by social factors which impinge on sexual practices and risk compensation. I follow this up, in section five, with a discussion of sexuality.

## 2.2 Global Responses to HIV and AIDS

Critical to responding to the HIV and AIDS pandemic is both prevention and treatment. With regard to prevention, global and national campaigns have been launched which emphasise, amongst other practices, abstaining from sex, being faithful to one's sexual partner and the consistent use of condoms (known sometimes as the ABC of HIV prevention, with 'A' for 'abstaining', 'B' for 'being faithful' and 'C' for 'condoms'). In the case of treatment, antiretroviral therapy (ART) has been highly significant with ongoing advancements in the quality and effectiveness of this drug-based therapy. The global vision is encapsulated under the call for 'Zero new HIV Infections, Zero Discrimination and Zero AIDS-related Deaths'. The global response against the pandemic is clearly bearing fruit. For instance, new HIV infections are declining gradually, from 3.1 million to 2.3 million from 2002 to 2012. Also, AIDS-related deaths are decreasing, from 2 million to 1.8 million people during the same period (WHO et al. 2011, UNAIDS 2013). By the end of 2012, though, it was estimated that 35.2 million people were HIV-positive (UNAIDS 2013). This total figure is of course deeply

disturbing and, in addition, there are very serious challenges with respect to strategies of prevention and treatment, For example, significant numbers of people – for a diverse range of reasons – do not abide to the ABC of HIV prevention, and access to HIV therapy continues to be difficult in many parts of the world and particularly for vulnerable groups.

I now discuss the international response to HIV and AIDS or at least key components of it, as the Zimbabwean state initiated and developed its response in this global context. For now, it can be noted that the Zimbabwean state's response was at first tentative and ill-defined, much like in other countries around the world. But it (along with local and international stakeholders) has worked towards promoting and pursuing a favourable statutory, policy, programmatic and institutional environment over an extended period to tackle HIV and AIDS. The emphasis in Zimbabwe has been on sound policies to guide short- and long-term plans of action and strategies which are put into action to address the complexities of the pandemic on the ground. A range of sectoral responses are seen as crucial in Zimbabwe, because HIV and AIDS is a cross-cutting and omnipresent problem which needs to be mainstreamed in every dimension of social life. By 2013, the government had developed several HIV and AIDS-related policies, plans and strategies in guiding the national response, including programmes for both prevention and treatment. These were in large part guided and influenced by a number of international agreements focusing on the response to HIV and AIDS, as Zimbabwe is a signatory to many international declarations on HIV and AIDS. The following table (Table 2.1) lists some of the key agreements, declarations, policies and strategies at international level against the epidemic. I discuss a few of these below and the associated Zimbabwean initiatives, though these initiatives are described in fuller detail in the following chapter on Zimbabwe.

First of all, there were a set of eight goals formulated during the Millennium Summit in 2000, at which all nations present adopted the United Nations Millennium Declaration. The Millennium Declaration was also supported by the World Bank (WB), the International Monetary Fund (IMF) and the Organisation for Economic Co-operation and Development (OECD). The Millennium Development Goals (MDGs) were essentially drawn from various agreements and resolutions of United Nations (UN) international conferences in previous years. These included the following: eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; ensure environmental sustainability; and develop a Global Partnership for Development. One of the goals was also to combat communicable diseases with a particular emphasis on HIV and AIDS. Overall, the goals sought, by 2015, to facilitate

socio-economic development in underdeveloped countries marked by grinding levels of poverty and inequality. The developed countries and the multilateral institutions were mandated to assist financially in the implementing of these goals (World Bank 2013).

**Table 2.1: International HIV and AIDS Agreements**

| INTERNATIONAL AGREEMENTS | YEAR |
|---|---|
| International Conference on Population and Development (ICPD) | 1994 |
| Millennium Development Goal 6: To halt and reverse the spread of the epidemic by 2015 | 2000 |
| United Nations General Assembly Special Session on HIV and AIDS (UNGASS) | 2001 |
| Maseru Declaration on HIV and AIDS | 2003 |
| Southern Africa HIV and AIDS Strategic Framework and Programme of Action 2003-2007 | 2003 |
| Sexual and Reproductive Health Strategy for the SADC region 2006-2015 | 2006 |
| 2006 United Nations Political Declarations on HIV/AIDS | 2006 |
| 2011 United Nations Political Declaration on HIV/AIDS | 2011 |
| Global Plan Towards the Elimination of New HIV infections in Children and Keeping Mothers Alive | 2011 |

Zimbabwe, as a participant at the summit, adopted in particular as national priorities the following goals: eradicate extreme poverty and hunger, promote gender equality and empower women, and combat HIV and AIDS (GoZ 2009a). In the context of this summit, the government of Zimbabwe and relevant local stakeholders aimed to halt and indeed reverse the spread of HIV and AIDS by 2015. The indicators decided upon to measure progress in this regard were: HIV prevalence among people aged 15-24 years; condom use among high risk sex groups, and the proportion of people aged between 15-24 years with comprehensive knowledge of HIV and AIDS. Zimbabwe also committed itself to achieve (by 2010) universal access to treatment for HIV and AIDS (particularly for the poor), as measured by the proportion of the population with advanced HIV infection which has access to antiretroviral treatment.

Secondly, at the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS in 2001, global leaders adopted the Declaration of Commitment on HIV and AIDS, including from a human rights perspective. The conference highlighted the severe

suffering caused by HIV and AIDS to humankind and how it had hampered and even undermined development initiatives especially in Africa. The leaders agreed on the need for resources to be committed by governments, multilateral organisations, civil society organisations, the private sector and communities in order to reverse the wide-ranging negative effects of the pandemic (UNAIDS 2001), including questions of prevention, care and support, and treatment. Also highlighted was the importance of addressing specifically children who had been orphaned and made vulnerable by the effects of HIV and AIDS on affected households. Declarations 37 and 38 emphasise the importance of national interventions in the fight against the pandemic. Declaration 37 therefore stipulates the following:

> By 2003, ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms, confront stigma, silence and denial, address gender and age based dimensions of the epidemic; eliminate discrimination and marginalisation; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk particularly women and young people …; fully promote and protect all human rights and fundamental freedoms including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risky sex, …; prevention, care, treatment and support and reduction of the impact of the epidemic and strengthen health, education and legal system capacity (UNAIDS 2001:15-16).

Declaration 38 adds:

> By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation priorities into the mainstream of development, including in poverty eradication strategies, national budget allocations and sectoral developments plans (UNAIDS 2001:16).

In compliance with the above recommendations (and others not cited here), the government of Zimbabwe intensified their efforts in responding to HIV and AIDS. This is evidenced by a multi-sectoral strategy which broadened the response to HIV and AIDS (NAC 2006). An example of the intensified response in line with the declarations is the implementation of a behaviour change strategy which sought to address challenges which perpetuate HIV and AIDS. These challenges include imbalanced gender relations; concurrent sexual partners; inconsistent condom use; unfaithfulness; stigma and discrimination against people living with AIDS; and a low uptake of HIV and AIDS prevention and mitigation services (GoZ 2006a).

A third international initiative, but one with a more regional focus, is the Maseru Declaration on HIV and AIDS in 2003. The heads of states of the Southern Africa Development Community (SADC) adopted the Maseru Declaration in seeking to establish a

common ground for fighting the pandemic by member countries, particularly given the fact that the region has countries with the highest prevalence rates in the world (including Botswana, Mozambique, Lesotho and Zimbabwe). The conference was a follow-up to the UNGASS Declaration which encouraged member states to address the pandemic by implementing effective programmes in response to HIV/AIDS. According to the documentation emerging from the conference, governments "affirmed their commitment to the combating of the AIDS pandemic in all its manifestations as a matter of urgency through multi-sectoral strategic interventions" (SADC 2003:3). The heads of states identified priority areas requiring urgent attention and action as follows: prevention and social mobilisation; improving care; access to counselling and testing services, treatment and support; mitigating the impact of HIV and AIDS; intensifying sources of resource mobilisation; and strengthening institutional, monitoring and evaluation mechanisms.

Fourthly and lastly, there were two political declarations on HIV and AIDS arising out of United Nation conferences in 2006 and 2011 (UN 2006, UN 2011). These sought to invigorate renewed political will and strong, accountable leadership in working together in a meaningful partnership with all stakeholders in the fight against the pandemic. In the 2011 Declaration, nations were encouraged to intensify their efforts so as to fulfil the millennium development goal of halting and possibly beginning to reverse the spread of the pandemic (by 2015) by swiftly scaling up efforts to incorporate HIV prevention, treatment, care and support in an integrated manner (UN 2011).

These and other international conferences and declarations facilitated the formulation and implementation of the national HIV and AIDS policy (and many other policies that are directly or indirectly related to the epidemic) in Zimbabwe, as well as plans and strategies that seek to curtail HIV and AIDS in the country. These have been further streamlined into implementable interventions which resulted in intensified calls for behavioural change with reference to sexual relations and included strategies around prevention, treatment and care, and support and mitigation.

With the advent and tenacity of HIV and AIDS, there are relentless efforts to curb new HIV incidences or infections, and hence the need to have numerous HIV prevention or transmission reduction methods. According to WHO (2008), prevention is indeed the lifeblood of reducing new HIV cases and it is, therefore, central for health care authorities the world over to discover effective ways of preventing HIV transmission. Such initiatives will go a long way in helping governments, donors, multilateral institutions, communities and individuals to realise set goals in reducing HIV and AIDS in line with international goals.

The international agreements on HIV and AIDS cover the full ambit of prevention, care and treatment. However, the particular focus of this thesis is prevention rather than care and treatment, and with specific reference to condom use and medical circumcision of males as two HIV prevention methods. In the balance of this chapter I discuss in some detail these two methods, starting off with condom use and then discussing medical circumcision in greater detail.

### 2.3 Condom Use

Given that the thesis considers the sexual practices of medically-circumcised males in relation to the risk of becoming HIV positive, and in particular the relationship between condom use and medical circumcision as two prevention methods, it is important to examine condom use as a method of prevention. This is particularly important in the light of the possibility that medically-circumcised males engage in risk-taking by not consistently using condoms. This section therefore examines condoms, including controversies around their effectiveness in preventing HIV infections and reasons for not using them.

A condom is a latex or rubber tubular sheath used during sexual intercourse to form a two-way physical barrier that prevents the passage of genital fluids (semen and vaginal fluids) between sexual partners with the aim of preventing sexually-transmitted infections (STIs), including HIV, as well as unwanted pregnancy in heterosexual partners. There are two types of condoms, namely, male and female condoms. The male condom is a rubber sheath put on an erect penis whereas the female condom is inserted into the woman's vagina before sex (Family Planning Queensland 2012). According to Steiner and Cates (2008:184),

> Condoms reduce the risk of infections that are transmitted primarily to or from the penile urethra such as HIV, gonorrhoea, chlamydia, trichomoniasis, and hepatitis B. Condoms also reduce the risk of infections that are transmitted primarily through skin or mucosal surfaces when these areas are covered by the condom, such as genital herpes, syphilis, chancroid, and human papillomavirus infection.

In this context, I first look at the history of condoms and their effectiveness. One of the earliest known illustrations of condom use is a painting of a man on a cave wall in France and is estimated to be between 12,000 to 15,000 years old (Dexter-McCormick 2000). Condoms though have been used since the 16$^{th}$ century to prevent STIs (Dexter-McCormick 2000). By the 18$^{th}$ century, condoms made from dried intestines of domestic livestock were popularly recognised in Europe as a means of preventing venereal infections (Valdiserri 1989). During World War 1, the allies of the United States, for example New Zealand,

provided their troops with condoms to inhibit the transmission of STIs. However, condom use has faced opposition including from American moralists since the 19th century who misunderstood and/or denied their public health benefits (Brodie 1994). Dexter-McCormick (2000) notes that sexual moralists (people who focus on controlling human sexuality and not on the benefits of condoms) have often foiled public health endeavours in support of condom use.

With improvements in technology, latex condoms came into popular use and gained support when they proved to be almost impermeable to STI pathogens as well as ensuring pregnancy prevention (Dexter-McCormick 2000). Despite scientific facts on the effectiveness of condoms in protecting against STIs (and now HIV), those who argue against condom use continue to claim that condoms lead to an increase in AIDS-related diseases since HIV can pass through the microscopic pores in the latex, yet people think they are protected. Arguments against the use of condoms also include the following: that they cause cervical cancer in women and they promote sexual promiscuity since people have a false sense of security regarding risks associated with sexual intercourse (Dexter-McCormick 2000).

Regardless of endeavours to stall or undermine the use of condoms, they remain a fundamental and significant part of comprehensive HIV prevention and care programmes across the world such that condom use promotion is being accelerated and sustained (WHO, UNAIDS and UNFPA 2004). Condom effectiveness against HIV and other STIs has been vindicated through numerous rigorous laboratory studies (or *in vitro* studies) and epidemiological studies (McKay 2007). Laboratory studies entail researchers testing condoms and establishing that they provide a barrier against particles the size of HIV and STI pathogens (McKay 2007). Epidemiological studies involve real-life situations amongst discordant couples whereby one partner is HIV negative and the other is HIV positive (McKay 2007). Although condoms do not offer 100 percent protection from HIV, extensive research in heterosexual discordant couples shows that correct and consistent condom use remarkably reduces HIV transmission from men to women and vice versa (CDC 2000, WHO et al. 2004, Mckay 2007). When used correctly and consistently, a condom reduces the chances of contracting or transmitting HIV by up to 96 percent (Holmes et al. 2004). Condoms are thus a highly effective barrier against HIV transmission (CDC 1998).

With continuous investment in research and development, the female condom was introduced to supplement the male condom. This involved a process of female empowerment since women are now in a position to initiate sexual protection (Meekers and Ritcher 2005). It therefore facilitates a female-controlled method of contraception and protection from STIs

and HIV for women from all walks of life (Ray and Maposhere 2005). According to Macaluso et al. (2003:289),

> A female condom is a lubricated intra-vaginal barrier consisting of a soft loose-fitting polyurethane sheath with a flexible ring at each end. The inner ring is pushed into the vagina until it rests above the symphysis anchoring the condom and the external ring of the sheath remains outside the vagina.

The female condom is just as effective as the male condom when used correctly and consistently.

There are two important issues which need to be underlined constantly with reference to condom use, that is, correct and consistent condom use. These have to be observed at all times if condoms are to reach their optimum effectiveness. However, according to Stein and Cates (2008), the problem with condoms is that the typical person, particularly when aroused, does not use them consistently and correctly regardless of their knowledge of the significance of condoms.

In this regard, there are a number of condom commandments which should be observed. These are as follows: store condoms correctly and always check expiry dates; put the condom on before intercourse and leave it on until finished; do not completely unroll the condom before putting it on an upward held erect penis; squeeze the air out of the condom tip and leave some space at the tip of the condom; put the condom on the right way after checking the inside of the condom; be careful not to damage the condom and check if it is fixed correctly before sexual intercourse; withdraw correctly and remove it correctly by directing the penis downwards to avoid spilling the semen; and do not re-use condoms (Youth Portal undated).

However, there are some strongly-held generalised condom misconceptions which have resulted in some people disliking the use of condoms. These misconceptions include: condoms cause irritation and break during sex, they are sticky and oily, they reduce or obstruct sexual pleasure, and they cause erections to fail when putting them on (Youth Portal undated). Valdiserri (1989) identifies a variety of further reasons which inhibit the use of condoms. Some people might not use condoms because they are not readily available through access points; situations arise whereby partners fail to plan in advance to have sexual intercourse so that when they become aroused and are ready for sex, condoms are not immediately accessible; condoms are offensive to their sexual partners; purchasing condoms from access points is embarrassing; and condoms are deplorable since they are associated with promiscuity and prostitution.

The importance of condoms in preventing HIV infection is particularly critical in relation to casual sexual partners outside marital or steady relationships. For example, a study done by Kongnyuy et al. (2006) in Cameroon on unsafe sexual practices shows that men regularly have concurrent sexual partners and have unprotected sex (without condoms) with non-spousal partners or non-cohabiting partners. This study was conducted amongst wealthy men but inconsistent condom use is not found exclusively within particular groups in society but cuts across all social groups. The use of condoms, even with reference to a particular individual, may be highly contingent and situational. As Fishbein (2000) notes, for example, individuals might adopt condom use when engaging in sex for the first time; however, as a particular partnership becomes more regular, condom use aversion may set in thereby heightening HIV risks.

### 2.4 Male Circumcision

The balance of this chapter focuses on the key theme of this thesis, namely, voluntary medical male circumcision. In the context of continuous health scientific research, voluntary medical male circumcision has been identified as a seemingly effective method of reducing HIV infection (WHO 2008, UNAIDS 2011). The focus is on the relationship between medical male circumcision, sexual practices and risk compensation. Before considering this, I detail the traditional form of male circumcision in order to capture the distinctiveness of medical circumcision.

#### 2.4.1 Traditional Male Circumcision

For my purposes, tradition is a "model of past life-ways that people use in the construction of their [current] identity" (Linnekin 1983:241), including gender identities relating to masculinity and femininity. Though tradition is not static, cultural ideas and practices are continuously passed onto subsequent generations and this leads to the existence of cultural identities around questions of for instance sexuality (Ceertz 1966:8). In this context, male circumcision entails "the surgical removal of all or part of the foreskin of the penis" and it is "one of the oldest and most common surgical procedures worldwide undertaken for religious, cultural, social or medical reasons" (WHO et al. 2007:1). Hence, it can be defined as the removal of all or part of the foreskin for cultural, social or religious purposes (Rashid et al. 2009:19). However, VMMC entails the removal of the entire foreskin.

The inception of male circumcision (MC) is linked to ancient times with for instance the well-known account of male circumcision mentioned in the Christian Bible when God

entered into a covenant with the childless Abram (Rizvi et al. 1999) for a kingdom, with circumcision of all male children as the sign of that covenant. MC became an everlasting or permanent mark or 'cut' in male descendants of Abram (now Abraham) to remind them of the covenant (Silverman 2004:425), and thus was of religious significance in distinguishing Abraham's descendants from other nations. To date, the Jewish faith still practices circumcision for boys eight days after their birth as a way of perpetuating and honouring God's covenant. In Islam as well, male circumcision is practised for religious and social reasons, and it is "considered one of the rules of [spiritual] cleanliness in Islam and is allowed by the prophet Mohammed as a continuity of the covenant of Abraham" (Rizvi et al. 1999:15-16). There is no mention in either religion of undertaking circumcision for sexual health reasons.

In other cultures, African cultures to be specific, including the Xhosa in South Africa, the Bukusu in Kenya, and the Shangani and VaRemba in Zimbabwe, male circumcision is practiced as a rite of passage from childhood to adulthood and acceptance into the world of manhood (Mhlahlo 2009, Mbachi and Likoko 2013, Maposa 2011, Sibanda 2013). As Silverman (2004:423) notes in this regard, MC is of paramount importance because it "mirrors the psychosocial movement of boys from youthful mother-child dyad to the adult pairings of father-son, man-ancestor and husband and wife". It is a heroic scar of masculinity which prepares and hardens boys to overcome life's future hardships, and it marks male virility and fecundity as well as preparing the initiates for marriage and adult sexuality (Silverman 2004, Sarvestani et al. 2012). MC in Africa, therefore, comes with labels and beliefs about true manhood which are consensually agreed upon by circumcising groups and such labels are loaded with meaning about men's social status.

In societies in Africa that practice MC, a male of circumcision age who is not circumcised is ridiculed, looked down upon and ill-treated by both men and women for not being a 'real man' (Meintjies 1998). Often, the ill-treatment includes violence directed at the uncircumcised male including forced circumcision (Mhlahlo 2009). To strengthen the stigma towards uncircumcised males, words have been coined to distinguish them from 'real men', including in the case of Xhosa terms such as *Inja* (meaning dog) and *Inqambi* (meaning an unclean thing). The stigma is vividly demonstrated during traditional functions when men sit according to their circumcision status. Uncircumcised males are invariably made to sit with young boys to show their social inadequacy and inferior status. They are not in any way allowed to participate in conversations between the 'real men' who are circumcised (Meintjies 1998).

MC in relation to the rite of passage, therefore, is meant to instil and engrave real manhood qualities and attributes of bravery and masculinity in initiates. The attributes of masculinity are imparted to the initiates through enduring and surviving the pain and trauma of circumcision in the circumcision schools which are held mainly in the bush (Mhlahlo 2009). Unlike voluntary medical male circumcision (as discussed below), in which the 'initiates' are privileged to be under the comfort of anaesthesia during circumcision, no medicine is used to suppress pain during MC since the initiates are said to grace the pain of the knife. Consequently, males circumcised under anaesthesia in hospitals are treated socially like uncircumcised males such that they are not allowed to participate in traditional activities since they are regarded as boys. They would not have gone through the traditional circumcision school where males are taught the essence of being a man and their sacred and moral responsibilities as men in their families and communities (Mbachi and Likoko 2013).

MC is not widely practiced in Zimbabwe as the majority of Shona and Ndebele men are not circumcised (GoZ 2009). As discussed later, this resulted in the nomination of Zimbabwe as a voluntary medical male circumcision (VMMC) priority country by WHO and UNAIDS in massively rolling out VMMC to reduce HIV infections (UNAIDS 2011). MC in Zimbabwe is practised by groups dotted across the country which include the Shangani and VaRemba (Maposa 2011, Sibanda 2013), the Xhosa and Chewa (Cowen and Mavhu undated) and the Tonga, Venda and Muslims (GoZ 2009). An estimated ten percent of Zimbabwean men were circumcised for traditional and religious reasons in 2009 (GoZ 2009).

The practice of MC, regardless of its importance and the meanings attached to it, is nonetheless opposed. MC is seen by some individuals, people and organisations as a health hazard which if not abolished or modified may result in the transmission of HIV among initiates (Mhlahlo 2009). During circumcision, the risk of HIV transmission emanates from using the same knife on many if not all initiates, particularly if the HIV status of the initiates is unknown. In this regard, one traditional circumciser in Malaysia professed ignorance of passing HIV to initiates during circumcision and, in fact, denied the possibility of infecting initiates in referring to the belief in the sacredness and thus cleanliness of the practice (Rashid et al. 2009). However, even if their HIV status is known, it is not appropriate to use one knife on all initiates for hygiene reasons.

As well, there seems to be a clash of interests between MC and governments stemming from alarming cases of MC tragedies. According to Mhlahlo (2009:14), MC tragedies include amputation of initiates' sex organs, wound infection due to inadequate care and attention from traditional guardians, death resulting from dehydration due to restrictions

on water or fluids intake, and excessive blood loss due to a problematic operation and wound infections. In the case of a botched circumcision, if an initiate survives the tragedy he may have life-long sexual dysfunction including penile sensation loss with high chances of failing to reach orgasm (News24 2013). At the same time, there is considerable resistance from traditional male circumcisers on engaging trained medical physicians to circumcise initiates. This is mainly because of the religious, cultural and historical meanings ascribed to male circumcision which the traditional guardians do not want adulterated by using modern physicians. If the process of creating a 'real man' is tampered with, the circumcised man will be treated as if he was an uncircumcised man. Further, any attempt to make male circumcision safe undermines its emblem of bravery, virility and masculinity which is certified by the present danger it represents (Meintjes 1998).

One country practicing MC with high incidences of circumcision tragedies is South Africa (Mhlahlo 2009). A minimum of 35 initiates died in botched circumcisions in Mpumalanga and Limpopo Provinces in South Africa in 2013. Along with these tragedies has come intense public discussion about the future of traditional circumcision (eNCA 2013) but, alarmingly, the tragedy of numerous deaths in circumcision schools has not been adequately addressed. Sometimes the deaths are seen as reflecting the weakling character of the initiates who are believed not to be real men; amongst Xhosa groups, these men are seen as not man enough to withstand the hardships and display the bravery arising from the process of circumcision. Indeed, the death of initiates in the circumcision schools is sometimes embraced as a way of uprooting weak boys who are not strong enough to assume male roles in life (Meintjes 1998). At other times, the traditional leaders attribute the deaths to acts of witchcraft in the local area (eNCA 2013).

### 2.4.2 Voluntary Medical Male Circumcision

To distinguish the form of circumcision for HIV prevention from other forms of circumcision which are for cultural or religious purposes (as discussed above), I adopt the name popularised by WHO and UNAIDS for circumcision which is not carried out for traditional purposes, namely, voluntary medical male circumcision (VMMC) (UNAIDS 2011). By definition, VMMC entails the removal of all foreskin from the male's penis for purposes of preventing HIV infection (Auvert et al. 2005, Gray et al. 2007, Bailey et al. 2007); this is where it differs from many types of MC which remove part of the foreskin. VMMC is prefixed with the words 'voluntary medical' showing that no male or boy is forced into being circumcised but does so willingly, and the operation is carried out by medically-trained

doctors or physicians using modern medical procedures. In the case of a child, consent is sought from an informed parent or guardian (UNAIDS 2011). VMMC is clearly practiced for medical or health reasons and not for traditional purposes, whether cultural or religious.

VMMC was recommended as an HIV infection transmission reduction method (specifically female to male transmission) by WHO and UNAIDS in 2007 after being satisfied with the efficacy of VMMC results in three randomised controlled trials (RCTs) conducted in Orange Farm in South Africa in 2005, and Kisumu in Kenya and Rakai in Uganda in 2006 (Auvert et al. 2005, Gray et al. 2007, Bailey et al. 2007, WHO 2008, UNAIDS 2011). In the RCT in Rakai, Uganda, the efficacy of VMMC in reducing HIV incidence was 51 percent while in Kisumu, Kenya and Orange Farm, South Africa, the reduction rates were 53 percent and 60 percent respectively. As a result,

> All three trials testing the efficacy of male circumcision against HIV acquisition in African men were stopped by their data and safety monitoring boards before their designed completion because of significant reductions in HIV incidence in the circumcision groups, making it unethical to continue following control group participants without offering them circumcision (Bailey et al. 2007:663).

The efficacy of male circumcision for HIV prevention had also been previously confirmed in systematic reviews and meta-analysis of observational studies (Weiss et al. 2000). The VMMC recommendation was passed at an international consultation meeting held in 2007 where the results of the randomised controlled trials (mentioned above) were reviewed and it was established that VMMC reduced the chances of a male contracting HIV from a female partner by at least 60 percent (WHO 2008).

At this international consultation meeting, issues pertaining to policy and programmes on VMMC were discussed and a way forward was mapped out on how best to effectively integrate VMMC into other comprehensive HIV prevention methods (WHO 2008). Indeed, it was recommended that VMMC should be rolled out massively in countries or settings with high HIV prevalence and incidence rates coupled with low levels of male circumcision, as well as where HIV transmission through heterosexual contacts was significant (UNAIDS 2011). This resulted in thirteen countries being targeted as priorities for the massive rolling out of VMMC, namely, Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe. VMMC was expected to reduce the burden of new HIV infections in these highly-affected countries in sub-Saharan Africa because it offers "life-long, substantial (albeit partial) protection against female-male sexual transmission of HIV as well as from STI" (WHO and UNAIDS 2011:7).

2.4.2.1 VMMC efficacy against HIV transmission

There are many studies done that explain how VMMC reduces the incidence of HIV infection in heterosexual contacts and why uncircumcised men with foreskins are more susceptible to HIV infection than circumcised men. WHO and UNAIDS (2007:13) define the foreskin as

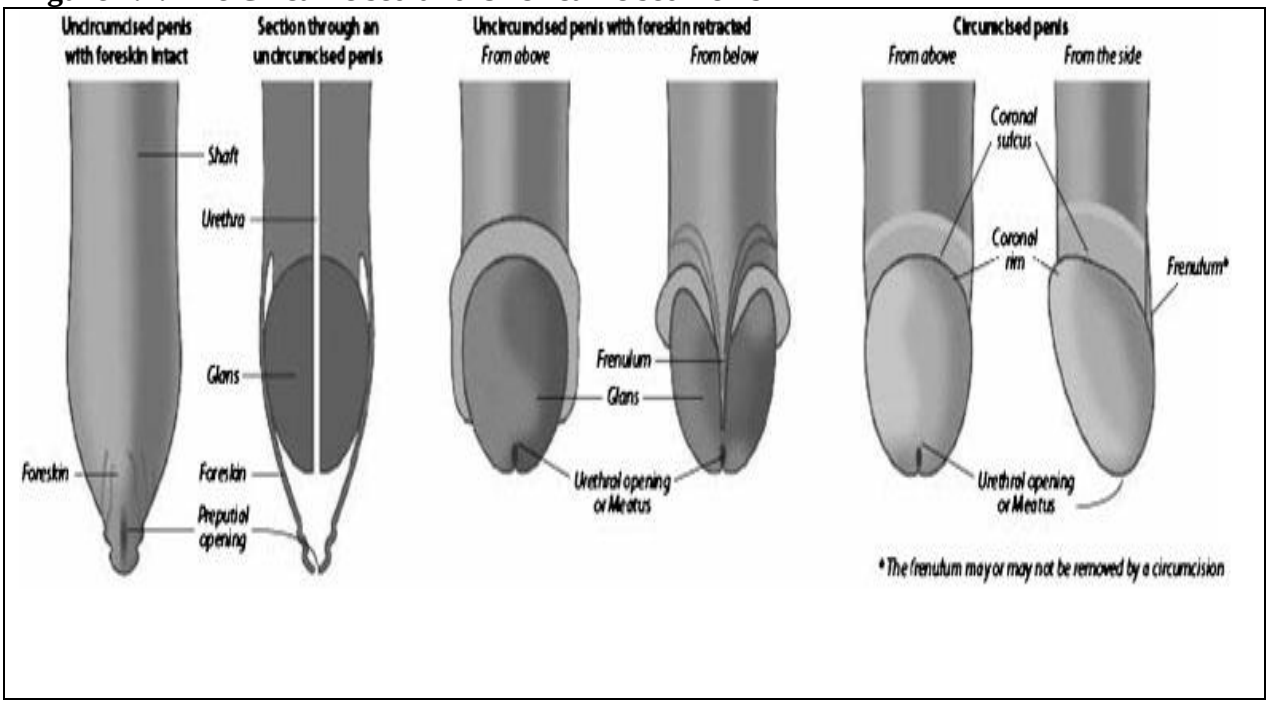
> A continuation of skin from the shaft of the penis that covers the glans penis and the urethral meatus which is attached to the glans by the frenulum, a highly vascularised tissue of the penis. The frenulum forms the interface between the outer and inner foreskin layers, and when the penis is not erect, it tightens to narrow the foreskin opening.

The foreskin covers the penile head and by so doing provides a warm mucosal environment suitable for the survival, replication and thriving of STI pathogens (including HIV) since it is thinly keratinised unlike the outer penile skin which is thickly keratinised (WHO and UNAIDS 2007). In effect, the thinly keratinised inner mucosal surface area has a high number of HIV target cells (Patterson et al. 2002). Some of the cells include CD4+T lymphocytes, Langerhans and dendritic cells. Also, during sexual intercourse, the foreskin pulls back over the shaft of the erect penis thereby exposing the penile head or the inner mucosa to possibly-infected vaginal secretions. The foreskin mucosa is also traumatised and suffers abrasions or inflammations during intercourse, thereby exposing it to easier entry by the virus (Hussain and Lehner 1995, Szabo and Short 2000, Patterson et al. 2002, Gray et al. 2007, Kigozi et al. 2009, WHO et al. 2007, Hirbod et al. 2010). Circumcision removes the foreskin thereby removing the mucosal environment suitable for the thriving of the virus; this makes the skin more keratinised and hence reduces the chances of HIV infection. In other words, the penile head will dry quickly after penetrative heterosexual intercourse, thereby reducing the viral multiplication. Additionally, the chances of traumatisation leading to inflammations as a result of abrasions are greatly reduced. This means that the main target area for the HIV attack is removed since the remaining skin is keratinised or hardened. Therefore viral survival and multiplication is lessened (WHO et al. 2007, Gray et al. 2007, Castellsague et al. 2002). Figure 2.1 illustrates the explanation given above.

VMMC, it is argued, has brought about a boost in public health not only in relation to HIV but with reference to STI preventions and health issues more broadly. For example, studies show that VMMC reduces the chances of transmission of Human Papillomavirus (HPV) from HIV negative men to HIV negative women. Also, compared to female partners of uncircumcised males, female partners of circumcised males have lower rates of genital ulcer disease, trichomonas vaginalis and bacterial vaginosis (Wawer et al. 2011, Gray et al. 2009). In another study done by Castellsague et al. (2002:1105) it was established that “male

circumcision is associated with a reduced risk of penile HPV infection and, in the case of men with a history of multiple sexual partners, a reduced risk of cervical cancer in their female partners". Finally, according to Tobian et al. (2010:7) "male circumcision decreases viral STIs, genital ulcer disease, and penile inflammatory disorders in men, and bacterial vaginosis, *T vaginalis* infection, and genital ulcer disease in their female partners".

**Figure 2.1: The Circumcised and Uncircumcised Penis**




**Source: Morris 2007:1147.**

2.4.2.2 Adopting VMMC as an HIV Prevention Method

WHO and UNAIDS at the international consultation meeting (mentioned above) made some standing recommendations which governments of targeted priority countries are supposed to adopt or observe with regards to VMMC so that VMMC fits neatly and consistently into the wide ranging continuum of HIV prevention strategies or methods in place. Due to the only partial protection provided by VMMC in reducing the chances of female to male transmission of HIV, circumcised males are encouraged to continue using condoms because it offers only partial protection against HIV. In other words, VMMC should not be seen in isolation as a stand-alone prevention method. Rather, it should complement other HIV prevention methods, becoming part of the available comprehensive package of HIV prevention methods. Some of the already-existing methods to be complemented by VMMC include reduction in the number of concurrent sexual partners (or casual sex), delaying of the onset of sexual activity,

abstinence, faithfulness, HIV counselling and testing, and correct and consistent condom use (WHO et al. 2007, UNAIDS 2011).

Furthermore, government leaders in priority countries were encouraged to take ownership of the VMMC initiative in encouraging the adoption of VMMC as an HIV prevention method in their respective countries. This would require a multi-sectoral approach in which governments are expected to collaborate with the private sector, NGOs, donors and multilateral institutions in determining country strategies and programmes with regard to implementing VMMC and perpetuating its progress. For this purpose, governments were encouraged to commit local resources as well as source funding from external organisational partners and agencies (WHO et al. 2007, UNAIDS 2011).

Regardless of the desperation the world may have in wanting to identify and pursue a range of HIV prevention methods, WHO and UNAIDS emphasised the need to observe human rights as far as VMMC is concerned. For this reason, VMMC was to be on a voluntary basis, meaning that it should be offered to willing and consenting males. It should be provided in medically-certified environments with qualified medical specialists to minimise risks associated with male circumcision procedures. In light of this recommendation of informed consent, individuals are expected, prior to circumcision, to access adequate information on VMMC which includes its advantages and disadvantages. This information should come together with comprehensive HIV testing and counselling (HTC). Country programmes and policies should be designed to accommodate adult males, adolescent boys and children but should give precedence to adolescent boys who comprehend issues of VMMC benefit and risk (UNAIDS 2011).

#### 2.4.2.3 Sexual Practices of Medically-Circumcised Males

The main objective of this thesis is to identify and understand the sexual practices of medically-circumcised males in Harare. For this reason, my attention is not focused on the scientific debates about VMMC in terms of the extent to which it provides protection against HIV and other STIs. The scientific debates are not of great significance in this sociological analysis although they show the preventive capacity of VMMC. Now that VMMC has been adopted as part of HIV and other STI comprehensive prevention methods, the focus should be on understanding circumcised males' sexual practices in relation to checks on risky sexual practices. As shown above, VMMC is a plausible biomedical achievement in so far as HIV prevention is concerned. It adds to the already-approved methods, and efforts are now

directed – in terms of VMMC policies – at ensuring that it complements these methods (including condom use, HTC, abstinence, and faithfulness to partners).

The adoption of VMMC as an HIV prevention method though was and still is coupled with cautionary ideas of fears of risky sexual practices by medically-circumcised males as a result of a false sense of safety, overlooking the fact that VMMC only provides partial protection (Bailey et al. 2007, WHO et al. 2008). The prevailing literature has identified certain sexual practices as entailing HIV risk and these include: having concurrent sexual partners, unfaithfulness, aversion to condom use, sex under the influence of alcohol or drug intoxication, sexual assertiveness, and younger age at first sexual intercourse (Cooper 2000, Parks et al. 2009). The concern about risky practices is often particularly expressed in relation to non-circumcising countries such as Zimbabwe. Such practices might offset the prevention benefits of VMMC given the fact that VMMC offers incomplete protection.

The adoption of risky practices (such as non-use of condoms after VMMC) is known as disinhibition or risk compensation. The concept of risk compensation derives from the use of car seat belts in which it is believed that the introduction of seat belts resulted in some drivers feeling safer, thereby triggering higher speeds of travel and/or irresponsible driving compared to when they were not using seat belts (Richens et al. 2000). In referring to risk compensation, Richens et al. (2000:401) note:

> When a safety device is introduced that leads to a perception of lessened risk, the rewards of risk-taking become more attractive and engender a compensatory increase in risk-taking (risk compensation), which may bring accident rates back to their original level (risk homoeostasis), or may produce a rearrangement of hazard with the new risk being transferred to others (risk displacement).

In this sense, risk compensation implies increases in unsafe practices arising from perceptions of reduced risk because of the presence of some preventative measure (MacPhail et al. 2012). Disinhibition also may happen when people discontinue efforts to avoid risk to themselves or others; at times, this may occur because people believe that harm is inevitable and, because of this, they do not try to avert harm (Hogben and Liddon 2008). In relation to sexual practices, disinhibition has traditionally occurred when someone is under the influence of alcohol which results in incautious or aggressive behaviour resulting in the loss of care in preventing sexual risks.

For the purposes of this study I will use the terms disinhibition and risk compensation interchangeably. Extrapolating from the car seat belt metaphor, fears have been raised as to whether VMMC will lead to an increase in unsafe sexual practices. In the three RCTs which

were done in South Africa, Kenya and Uganda, researchers warned of the likelihood of offsetting the protective effects of VMMC as men adopted risk compensation behaviour believing that, since they are circumcised, they are safe from HIV infection; yet, to reiterate, VMMC offers only partial protection. There are a number of risky sexual practices that medically-circumcised males may adopt through believing that they are safe from contracting HIV and other STIs, and these include concurrent sexual partners and condom use circumvention as well as having unprotected sex before the end of the stipulated (circumcision-induced) wound healing period of six weeks (Hewett 2012, Odoyo-June 2013).

2.4.2.4 Significance of VMMC Research

WHO and UNAIDS, in propagating VMMC as part of a comprehensive HIV prevention programme, made a number of recommendations with regards to VMMC. Out of the many enacted recommendations, my attention focuses only on two, which are particularly relevant to my thesis. These are as follows:

> Male circumcision should not be delivered in isolation but as part of a recommended minimum package which includes information about the risks and benefits of the procedure, counselling about the need to adopt and maintain safer sexual practices, access to HIV counselling and testing, condom promotion and provision, and the management of sexually transmitted infections … Careful monitoring and evaluation of male circumcision service delivery should include consideration of possible untoward effects such as increases in unsafe sex and increases in sexual violence, and should be undertaken to ensure that programmes promoting male circumcision for HIV prevention meet their desired objectives (WHO 2008:7).

These two closely-related recommendations, that of VMMC as part of a comprehensive HIV prevention package and the possibilities of riskier sexual practices arising from VMMC, in fact formed the inspiration to undertake this study on the sexual practices of medically-circumcised males with specific regard to condom use.

VMMC has been introduced primarily to traditionally non-circumcising countries with the chief purpose of reducing HIV transmission. The key question becomes: Do medically-circumcised males adopt risky sexual practices, such as non-use of condoms, since they have a 60 percent chance of not contracting HIV through VMMC? In other words, are circumcised males going to practice un-safer sex? Auvert et al. (2005), Bailey et al. (2007), Gray et al. (2007) and Gwandure (2011) have all raised such questions – indeed concerns – about the sexual practices of medically-circumcised males and my aim is to further investigate this important theme. Gwandure (2011) in particular notes the likelihood of

circumcised males becoming misled by the VMMC partial protection argument and therefore have unprotected sex with concurrent sexual partners (CSP). However, as he adds: "Even though the percentage of HIV infection risk is low, the chance of infection is either one or zero" (Gwandure 2011:91).

In this regard, there are important questions which need to be addressed with reference to VMMC and condom use. For instance, does VMMC and condom use offer double protection in HIV prevention? More specifically, have condoms failed to offer sufficient protection to such an extent that they need to be complemented by VMMC? Studies have shown that, in sub-Sahara Africa, double protection has not been effective in preventing transmission of HIV (Gwandure 2011); in fact it might increase it as VMMC may lead to risk compensation in sexual practices. Indeed, why would a man get circumcised and still be encouraged to continue using condoms? As it stands, most of the heterosexual HIV infections in Zimbabwe occur as a result of risky sexual practices mainly due to concurrent sexual partners and condom use aversion (Fraser et al. 2011). As a result, if men in uncircumcised states brave unprotected sex knowing that they are almost certain of contracting HIV when the HIV status of the female partner may be unknown, will they not continue to engage in unprotected sex once circumcised and subject now to partial HIV protection? Despite the laboratory-certified efficacy of condoms to protect sexual partners in contracting or transmitting HIV, some sexual partners avoid the use of condoms citing sexual pleasure interference as a reason for aversion (MacPhail et al. 2012). So, now that VMMC is taking place in Zimbabwe, what are the sexual practices of sexually-circumcised males in the country?

The truth of the matter lays in the way circumcised males and their sexual partners understand the significance of VMMC. Circumcision was adopted programmatically in Zimbabwe and elsewhere but it was never meant to replace other HIV prevention methods (WHO et al. 2007). The intention is to reduce HIV infections but this can only be achieved if circumcised males are willing and able to adopt safe sexual practices, for example, correct and consistent condom use and faithfulness to one sexual partner. Bonner (2001:152) argues, quite rightly, that the "evidence suggests that circumcision may reduce the risk of infection when exposure happens". However true this may be, the fear is that circumcised males – in banking on the partial protection effectiveness of VMMC – may decide not to use condoms and thereby end up contracting as well as later spreading HIV. In seeking to understand the sexual practices of circumcised males and the possibility of contracting HIV, risk must be

taken into consideration as conditioning their sexual practices or possibly as being triggered by the fact that the male is circumcised and assumes heightened protection from risk.

A significant number of warnings have come to the fore regarding the need for fostering and instilling safe sexual practices in people whenever there is the introduction of a new partial HIV prevention measure. As indicated already, this is because of the possibility of risk disinhibition or risk compensation (Guest et al. 2008:1002). The warnings hinge on the belief that risk compensation may off-set the intended benefits of the mostly partial biomedical prevention strategies (Eaton and Kalichman 2007). When implementing partial HIV prevention methods (such as VMMC), "those interested in changing public health behaviour should at least be aware of the possibility of risk compensation" (Hogben and Liddon 2008:1009). Also, when implementing programmes presumed to culminate in risk compensation behaviour (in this case VMMC), it becomes advisable if not necessary to put in place strong monitoring and evaluation mechanisms to check if the protection benefits of the programmes are not offset (Hogben and Liddon 2008). Eaton and Kalichman (2007:167) second the preceding point when they avow that "an important step reducing HIV transmission involves understanding how individuals contemplate their own risk particularly in the context of increasingly available biomedical technologies".

Hogben and Liddon (2008) further note that disinhibition tends to happen chiefly in preventive interventions as individuals, once feeling protected from a health risk, become complacent vis-à-vis protective or safe practices resulting in exposing themselves and others to risk. Likewise, Cassell et al. (2006:205) make the claim that "the benefits of new methods of prevention of HIV could be jeopardised if they are not accompanied by efforts to change risk behaviour". They were referring not only to VMMC but to other promising methods for HIV prevention including vaginal microbicides, pre-exposure antiretroviral prophylaxis and vaccines (Cassell et al. 2006:605, Guest et al. 2008:1002). These cautionary calls are not meant to discourage the recommendation and pursuance of such prevention methods, since these methods do make a potentially-significant contribution in inhibiting the universal spread of the pandemic. Rather, such calls are primarily focusing on minimising peoples' risk behaviour to enhance the intended effects of the methods in reducing the transmission of HIV.

#### 2.4.2.5 Prevention Studies on Sexual Risk Compensation

There are a number of studies, including on microbicides, which show cases of risk compensation by participants which resulted from the overly-optimistic sense of safety by

participants or users of partially-effective HIV prevention methods. Such studies have resulted in the need to influence sexual prevention benefactors to adopt safe sexual practices to avoid off-setting the protective effective of the method in use. Microbicides are intra-vaginal products which include vaginal gels, vaginal rings and vaginal tablets used discretely by women during sex to prevent HIV infection and STIs (Ndesendo et al. 2008, Buckheit et al. 2008, Ramjee and Whitaker 2011). According to Dhawan and Mayer (2006:36), "mechanisms of action" in relation to microbicides include "disruption of the viral membrane by surfactants, maintenance of an acidic vaginal pH, binding to the viral envelope to block receptor binding, and blocking of receptors".

An important and revealing study by Mantell et al. (2006) on vaginal microbicides used by HIV-negative high risk women in South Africa shows that the beliefs and attitudes of some women caused them to adopt risky sexual practices which might have exposed them to HIV infection, and this was despite the fact that they were told that the microbicide was not necessarily effective as a prevention measure. Some of the women did not see the need to insist on the use of male condoms when having sex, because they were optimistic that the microbicide had a prophylaxis protection against HIV. And some women even professed to have concerns about condom effectiveness and preferred using the microbicides instead. This was complicated even further by unscientifically-proven beliefs which increased the risk. Thus, condom aversion was augmented by common sense beliefs amongst women and men about the cleansing effects of microbicides; for example, that the microbicide has the ability to cleanse penises and heal genital sores. Women also claimed that the use of microbicides heightened sexual pleasure compared to sex with condoms. This sexual risk compensation took place regardless of the fact that participants had received comprehensive HIV counselling as a group and individually from trained HIV counsellors. As noted below, similar risk compensation can occur in relation to the question of a vaccine for HIV.

A safe and effective HIV vaccine is probably the ultimate breakthrough that the world is waiting for due to the overwhelming effect of HIV and AIDS in the public health domain (Gamble and Mathews 2011). According to Eaton and Kalichman (2007:166) "a safe and effective vaccine is arguably the single most sought after HIV prevention technology". However, there is only limited success registered in the endeavour to come up with a vaccine regardless of the ongoing and relentless scientific efforts (Gamble and Matthews 2011). Many vaccine initiatives have only managed to reach but not go beyond phase three of clinical trials because they proved ineffective and thus were never tested on humans for fear of endangering people's lives (Eaton and Kalichman 2007). At the same time, there are

encouraging developments within scientific and clinical circles in identifying a vaccine (Reynell and Trkola 2012).

In the viewpoint of Eaton and Kalichman (2007), mathematic models show that risk compensation can occur due to the possible introduction of a future, at least partial, vaccine. Also, more qualitative studies on community perceptions on HIV vaccines, such as the one done by Nyamathi et al (2006) in India, show that people's anticipated sexual practices in the event that a partial vaccine is introduced confirm the likelihood of risk compensation. In that study, participants "almost unanimously" concurred that risk disinhibition would ensue where a vaccine was introduced; this is based on a safety optimism, which has been exhibited as well in other studies (Nyamathi et al. 2004:626). In a hypothetical vaccine study done by Crosby and Holtgrave (2006) in the United States, about 25 percent of the participants indicated that they would increase risky sexual practices if they were vaccinated. In another study in South Africa, of a hypothetical HIV vaccine of low efficacy, participants showed anticipated risky sexual practices in the form of a decrease in condom use frequency and increased sexual frequency with casual partners if they were vaccinated against HIV (Andersson et al. 2012). Such anticipations were made by informed participants who were aware of the fact that the vaccine offers only partial protection. There are only limited studies on risk compensation behaviour during vaccine trials. Nonetheless, in these studies, risk compensation was reported (Eaton and Kalichman 2007).

#### 2.4.2.6 VMMC and Risk Compensation

With respect specifically to sexual risk compensation, I know of no studies which explore this in the case of Zimbabwe, and hence the significance of this study in the context of the rolling-out programme of VMMC as a HIV prevention method in the country.

In terms of studies elsewhere, risky sexual practices were examined and reported on in the randomised clinical trial (RCT) in Orange Farm in South Africa (Auvert et al. 2005). In this study, circumcised men indicated an increase in the number of sexual partners but there was no significant condom aversion by circumcised males. Overall, the South African RCT showed "consistent patterns of risk compensation following circumcision" (Eaton and Kalichman 2009:4). Such a clinical trial though cannot be readily generalised to real-life conditions (Eaton and Kalichman 2009) such that the prospects for greater risk exists in natural settings. For example, during RTCs, programme implementers supplied participants with condoms on a regular basis whereas, in real-life, condoms are not always readily available when needed. In the RCT studies in Uganda and Kenya, there was also some risk

compensation despite regular monitoring (Eaton and Kalichman 2009) which, again, does not exist in natural settings. Hence, there are strong grounds for the necessity and significance of carrying out a study, such as mine, on sexual practices of medically-circumcised males in a real world setting. Dowsett and Couch (2007) are of the same opinion. They argue that RCTs are well-funded programmes augmented by best clinical standards and backed by well trained personnel. Such conditions are believed to have enhanced the efficacy of VMMC during the trials which might not be replicated in real life situations. Hence there is a need to "investigate the effects of those other social and contextual factors that will be in play in real world settings – because the effectiveness of male circumcision will not be generated by the efficacy of the surgery alone" (Dowsett and Couch 2007:37). This is a critical point which will be discussed during my Zimbabwean case study in chapters five and six.

One method noted to have reduced risky sexual practices among circumcised males during the RCTs is comprehensive risk-reduction counselling (Auvert et al. 2005, Bailey et al. 2007, Gray et al. 2007). However, the provision of risk-reduction HTC may not completely eradicate risk given the thin line between full protection and partial protection (Eaton and Kalichman 2009). There is the likelihood of a difficulty in developing and propagating an effective and convincing risk-reduction message for medically-circumcised males who might not want to use condoms consistently (Eaton and Kalichman 2009). The fact that some – albeit a minor – level of condom aversion took place during the trials despite regular comprehensive HTC and condom provision reiterates the need for studies on sexual practices of medically-circumcised males in a real world setting. According to Eaton and Kalichman (2009:5) "articulating a prevention message that encourages both male circumcision and safer sexual behaviour such as condom use is not straightforward".

There is another concern which is closely related to HTC in adopting VMMC as an HIV prevention method, based on the results of the RCTs. In this regard, Dowsett and Couch (2007) argue that, besides HTC as a possible compliance enhancer during the trials, participants in the trials were monitored on an ongoing basis – this might have had an influence on the practices of the participants by resulting in lower incidences of risk compensation during the trials. Regular monitoring is difficult to achieve under real world conditions and, insofar as monitoring reduces risky practices, there is the possibility of higher rates of sexual risk compensation (Dowsett and Couch 2007).

Despite broad agreement and recommendations in favour of adopting VMMC as an HIV prevention method by various researchers, scholars and multilateral organisations (like WHO and UNAIDS), some scholars and researchers (like the ones above) continue to argue

that the results of the RCTs should not form the basis of adopting VMMC as an HIV prevention strategy since the whole research process was fundamentally flawed. Boyle and Gill (2011) claim for instance that the trials were characterised by methodological problems which include researcher bias, selection bias, sampling bias, experiment bias, participant expectation bias and early termination of the research among other flaws. For instance, researcher bias relates to the fact that the principal investigators are "documented circumcision advocates" (Boyle and Gill 2011:319, Gray et al. 2007) that co-authored many papers on VMMC and had relentlessly endeavoured to promote the adoption of VMMC as an HIV prevention method.

In fact, regardless of the evidence from the RCTs and other observational studies which show that VMMC reduces the chances of HIV transmission from women to men, there are other observational studies that contradict such evidence. Observational studies for instance by Green et al. (2008) show no correlation between VMMC and HIV prevention, as does an evaluation of epidemiological studies conducted by Moses et al. (1994). Another study, done by Garenne (2008), in fact shows that HIV prevalence is high among circumcised men in Cameroon, Malawi, Lesotho, Uganda, Ghana, Rwanda, Swaziland and Kenya. In this context, Boyle and Gill (2011:327) pose a difficult question to answer, namely, "if male circumcision reduces HIV transmission as the RCT authors would have us believe, then why is HIV prevalence much higher in the United States (where most men are circumcised) than in developed countries where most men are intact (e.g. Europe, Scandinavia and United Kingdom)".

In the end, the study of VMMC, sexual practices and risk compensation must be understood sociologically, particularly the socially-conditioned sexual practices of medically-circumcised men. These practices, as socially-contingent, seem to be sidelined and silenced by those who focus on the narrow perspective of 'science' (Dowsett and Couch 2007). In this respect, science's rigidity in focusing on HIV prevention methods from a purely medical perspective (including VMMC) is a cause of concern to HIV activists and practitioners who fear that science's narrow and short-sightedness may reverse efforts of "their hard-won shifts in sexual culture in many places towards safe sex practices" (Dowsett and Couch 2007:34). In other words, if the scientific evidence on the efficacy of VMMC is the only reason used by males to accept VMMC as an HIV prevention method, this ignores the critical significance of social conditioning, cultural values and moral issues (Dowsett and Couch 2007:35) in seeking to undercut the transmission of HIV. These two aspects, the scientific and the social (cultural and moral), are invariably interlinked, with the success of the former (the scientific efficacy

of VMMC) arguably shaped dramatically by the latter (more specifically, by the sexual practices of medically-circumcised men which arise and are reproduced in social settings) in terms of the transmission of HIV.

This does not to imply an overtly over-structuralist argument in which sexual practices are determined fully by social conditions, as it is important to be sensitive to human agency. As Fishbein (2000:273) puts it: "AIDS is first and foremost a consequence of behaviour. It is not who one is [as identified through social structure], but what one does [practices], that determines whether he or she will expose themselves or others to HIV". Sexual practices, in the end, are a complex and shifting combination of 'structure' and 'agency' such that sexual practices cannot be tidily read-off and understood from the social structures in which individuals are located. Reflection, deliberation and choice are also critical. In this context, I briefly discuss theories of sexuality.

**2.5 Theories of Sexuality**

It would be naive and short-sighted to believe that calls to adopt safe sexual practices would result in people necessarily engaging in safe sexual practices, such as using condoms on a consistent basis in the event of them failing to abstain from sex or being unfaithful to their partners. This though was the initial thinking around reducing the prevalence of HIV. In fact, the major assumption was that individuals "simply needed the knowledge, the attitudes and the skills to make the correct decisions and these can be provided to them through [counselling] initiatives, social marketing and life skills programmes" (Aggleton 2004:6). This entailed an emphasis on agency alone, as if individuals were free-floating people detached from social structures (including gendered structures} and from the effects of structures.

Aggleton (2004:4) goes on to note that, in the early stages of the pandemic, "scant attention was paid to sexual meanings, motivations and desires". Fortunately, there is increasing recognition of the relationship between socially-conditioned sexuality, sexual practices and HIV and AIDS. In a very real sense, sexual practices are socially conditioned and are embedded in the very complex domain of sexuality. It is therefore critical to identify and understand the linkages between human sexuality (and gender dynamics more broadly) and sexual practices. The World Health Organisation (WHO 2006:5), in speaking to the HIV pandemic, defines sexuality as

> A central human aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is

> experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

The WHO (2006) hastens to add that sexuality has a range of dimensions, including biological, psychological, social, economic, political, cultural ethical, legal, religious and spiritual. All these factors directly or indirectly affect sexuality, which in turn has a direct bearing on sexual practice such as condom use. Safe sexual practices can be enhanced or thwarted depending on the ways in which these factors play themselves out under specific conditions.

A number of theories have been formulated to help elucidate and understand sexuality, though I make no attempt to outline the full range of theories. One important sexuality theory is based on social constructionism. According to DeLamater and Hyde (1998:14), social constructionists assert that sexuality is "created by culture, by the defining of some behaviour and some relationships as 'sexual' and the learning of these definitions or scripts by members of the society". Though human biology provides a sexualised body (Maunze 2009), ultimately sexual realities, experiences and practices are culturally-bound (Rushing 1995). For social constructionists, sexuality and sexual practices are shaped in and through socialisation, which conditions where, when and with what object a person engages in sexual practices and pleasures. Sexuality becomes directed in directions as socially-shaped (Delamater and Hyde 1998). In this way, social constructionism concurs with the mainstream feminist argument that sexual viewpoints and practices are grounded in gender roles constructed and shared in certain cultures over time. In other words, sexuality has to do with socially-gendered differences between men and women, and differences which are normally marked by patriarchy.

At the same time, sexuality does entail a form of exchange, and understanding sexuality is bolstered by social exchange theory which focuses on the exchange of resources (both material and immaterial) between people. Using economic terminology, it speaks about rewards, costs and reciprocity (Sprecher 1998). Three basic assumptions underpin the theory: social practices are a series of exchanges; during exchanges, individuals attempt to maximise their rewards and minimise their costs; and when individuals receive rewards from others they are obligated to reciprocate in some way. In applying this is to sexual practices, the emphasis is on sex and sexuality as a transaction with potential benefits and costs. The benefits, at least potentially, include love, pleasure, status and attention while the costs include disease, heartbreak and disgrace (Maunze 2009). Social exchange theory explores sexual processes and practices as they occur at different stages of a relationship, such as the

early stage involving partner selection and the onset of sexual negotiations. Critical to the theory though is what happens subsequent to sexual engagement, such as evaluation of sexual satisfaction, refusals to partake of sex at certain times and engaging in extra-dyadic sex.

Both theories stress the complexities of sexuality and its contingent character because it is dependent on social and historical contexts. In other words, as emphasised by Kippax (2010), sexuality and sexual practices are socially fabricated and negotiated and, in this way, have implications for the transmission of HIV. It is possible therefore to speak about pre-existing sexual (and gendered) scripts which shape (or condition) – but do not fully determine – sexual views and practices. Sexual scripts are learnt sexual norms and roles aligned to culturally-acceptable practices relative to social context (Rosen 1984). These scripts, which arise from socialisation, guide individuals in the choice and acceptance of sexual partners and practices, and in the rationale and motivations behind sex (such as pleasure, love, relaxation, exploitation, lust or duty) (Rosen 1984). To stress, these sexual scripts clearly have a very strong gendered dimension to them, particularly under conditions of pronounced patriarchy (Rosen 1984). Some men, for example, given the patriarchal socio-cultural context in which they exist, do not see and understand extra-dyadic sexual relationships as problematic, at least for men.

Even once sexual encounters begin, considerable negotiation between partners takes place. As Sprecher (1998:37) underlines, "once a romantic pair becomes sexually involved the partners are not always in the mood for sex at the same time and may not agree about where to have sex (bedroom versus a more exciting location) and in which specific behaviours or acts to engage". Partners usually identify sexual acts that they would like their partners to do, and more or less often. In a sense, consent to or rejection of certain acts based on sexual tastes, such as oral sex, in a sexual relationship entails negotiations, reciprocity, rewards and costs. Unsuccessful negotiations may be used as a scapegoat for moving beyond monogamy and for engaging in extra-dyadic sexual behaviour or multiple partners. This may in particular be the case with males, based in large part on dissatisfaction in their primary relationship due to claims about the partner's physical appearance, the ways in which the partner expresses love, and how the partner performs in bed. Opportunities for extra-dyadic relationships may become available as a temptation difficult to resist, including for those in very committed monogamous relationships (Feldma and MacCulloch 1980, Low 2000). Again, it is important to reiterate that the reasoning behind extra-dyadic sexual relationships is situational hence it should not be universalised (Rosen 1984). Such relationships though continue to take place even in the era of HIV and AIDS, including unprotected sex.

## 2.6 Conclusion

This chapter has examined the theme of HIV and AIDS globally with a particular focus on HIV prevention. This thesis studies voluntary medical male circumcision (VCCM) as a specific type of HIV prevention method and does so in relation to another method, namely, condoms. In discussing circumcision, the emphasis was on the possibility that circumcision increases the prospects of risky sexual practices (such as inconsistent condom use) and leads to risk compensation. The prevailing literature on this is limited and inconclusive and no significant study has been done on the relationship between VCCM and risk compensation; hence a key significance of this thesis. The relationship between VCCM, risky sexual practices and risk compensation cannot be understood outside of questions around human sexuality and gendered sexuality, which I highlighted in the preceding section. In the following two chapters (three and four), and in this global context, I pursue an examination of Zimbabwe in relation to HIV and AIDS, state responses to the pandemic, VCCM and sexual practices (before the more empirical work in chapters five and six).

# CHAPTER THREE
# HIV AND AIDS IN ZIMBABWE: POLICIES AND PROGRAMMES

## 3.1 Introduction

This chapter is one of two chapters (along with chapter four) on HIV and AIDS in Zimbabwe and which provide the national context for the two chapters (chapters five and six) based on my Harare study of circumcised males. In this chapter, I first provide an overview of the extent of the HIV pandemic in Zimbabwe as well as evidence indicating that the pandemic shows signs of being contained. I then (in section three) detail key policies and plans introduced by the Zimbabwean government to address, along with other stakeholders, the many dimensions of the HIV crisis. In section four, I focus on more programmatic interventions in relation to the themes of treatment and care, and support and mitigation; in chapter four, I focus on the key theme of this study, namely prevention (and more specifically VMMC). Of course, neither policies nor programmatic interventions in themselves determine in any strong sense what is taking place on the ground, but they do condition in some way what is taking place. Ultimately, it is necessary to consider the everyday social realities of HIV and sexual practices, which I undertake in my Harare-based study.

## 3.2 Overview of HIV and AIDS

HIV and AIDS in Zimbabwe, which has a population of approximately 12.7 million people, is a generalised epidemic with similar prevalence rates across the country. The first HIV case in Zimbabwe was reported in 1985 (GoZ 2012) and the HIV prevalence rate increased quickly in the early to mid-1990s. It reached an estimated peak of 26.5 percent in 1997 (GoZ 2012) of the adult population between 15 and 49 and started to decline thereafter. By 2001 it had fallen to 24.3 percent (UNAIDS 2013), before declining further to 18.4 percent in 2005 (GoZ 2012) and to 16.0 percent in 2007 (Halperin et al. 2011). By the end of 2012 the HIV prevalence rate was 14.7 percent of the adult population of 15 to 49 years (UNAIDS 2012). This means that, in 2012, about 1,2 million adults within this age category were living with HIV (UNAIDS 2013). The number of new HIV infections amongst adults in 2012 was estimated to be 59,000, down from about 97,000 in 2001. Additionally, in relation to annual AIDS-related deaths, there was a decrease from an estimated 160,000 deaths in 2001 to 39,000 in 2012. However, there are worrying trends and statistics. For instance, the total

number of AIDS orphans stood at about one million children in 2012 (GoZ 2012). As well, the current HIV prevalence rate in the 15-24 years age group remains significant, at 5.5 percent (with the rate for females in this age group at 7.3 percent). And although condom distribution is very significant in Zimbabwe, the challenge of consistent and correct use of condoms in practice remains. One particularly disturbing fact is that, although more women than men have comprehensive and correct information about the intricacies of HIV and AIDS (GoZ 2012), lifelong gender imbalances invariably disadvantage women when it comes to negotiating for safer sex.

The decline in the rate of HIV prevalence, in the number of new HIV infections and in AIDS-related deaths, notably since 2000, is significant given that these had all steadily increased during the 1990s. Generally, the declines appear to emanate in large part from comprehensive state policies and programmes – discussed later – around HIV and AIDS prevention, care and treatment. For example, the high mortality rate in the 1990s arose due to major shortfalls in the availability of ARV drugs in the country. However, Zimbabwe has made significant strides in the provision of ARVs. By the end of 2012, about 80 percent of infected (HIV-positive) people in need of ARVs were accessing them (UNAIDS 2013). The decline in AIDS-related deaths also needs to be understood though with reference to reduced, though certainly not low, numbers of new HIV infections. And this relates, at least it seems, to successful HIV prevention programmes which discourage risky sexual practices such as inconsistent condom use and concurrent sexual partners (Halperin et al. 2011).

However, according to Fraser et al. (2011), great caution should be exercised when interpreting trends showing decreases and declines since, for example, a lowering of the prevalence rate and the stabilisation of this rate does not necessarily mean that the epidemic is in any way contained. It may simply mean that the number of new HIV infections is over-compensated by a greater fall in the AIDS-death rate. The number of new HIV infections each year indeed has fallen markedly in Zimbabwe especially after the year 2000; in 2000, the incidence figure was five infections per 100 persons, and this dropped to less than two infections per 100 persons in 2010 (Alcorn 2011). But the AIDS-death rate is decreasing more rapidly because of the national roll-out of the ARV regime and therefore any national fall in the HIV prevalence may have more to do with treatment than with prevention.

### 3.3 National Policy Response to HIV and AIDS

Like elsewhere, in Zimbabwe the government took time before responding effectively in a bid to curtail the pandemic after the first HIV case was reported in 1985. Immediately

thereafter and in subsequent years into the early 1990s, the government did not intervene in any significant manner. Certainly the absence of a response gave the pandemic a chance to spread quickly among the populace, who were highly ignorant about HIV during that time. In explaining this, the Zimbabwe Human Development Report (ZHDR) (ZHDR 2003) points out that Zimbabwe, like many other African countries in the midst of a scarcely understood health problem, went through three stages in responding to HIV and AIDS: namely, denial, panic and acceptance.

The denial stage was the initial stage which resulted from the fact that the government did not have the knowhow or the capacity to deal with the problem at hand. At this stage no significant coordination or action took place to curtail the problem; in fact, the problem was minimised and was not believed to be a major threat. At the onset of the pandemic and in the following years, the Zimbabwean government was by and large in a state of denial as officials turned a blind eye or developed a wait-and-see attitude. There was an absolute dearth of knowledge on the epidemic and its potential damage to the country in both the short- and long-term. This paucity of information among politicians and state officials was evidenced by the limited or negligible public pronouncements about the disease in Zimbabwe (Makamani 2009), including on the best way to respond to the pandemic. It was at this stage that HIV spread at an alarming rate and thereby rooted itself as a generalised pandemic in the country. This was of course facilitated by the secretive or silent character of the pandemic because HIV infects a person and takes years before it becomes manifested bodily as AIDS.

The denial stage gave birth to the panic stage which entailed a collective awakening by the authorities (and the populace) not simply about the arrival of the pandemic but about the need to come together in a bid to formulate a coordinated response to inhibit and stall the pandemic. Knowledge about the pandemic and its wide-ranging ramifications emerged as people became aware of – and indeed directly experienced – the devastation it is capable of causing at both micro- and macro- levels if no serious interventions are quickly developed and implemented. For any intervention to be a success, the ZHDR (2003:122) notes that it "demands an understanding of people's lived realities in order to develop programmes of action that address socially differentiated vulnerabilities found in peoples' environments". As a result of the panic, the HIV and AIDS epidemic was first declared a national state of emergency in 2002 and then again in 2003 (NAC 2006). The government's HIV state of emergency declaration in 2003, according to the National AIDS Council (NAC 2006:8), resulted in the "importation of generic drugs into the country". Zimbabwe in fact has declared

several states of emergencies with the original state of emergency being repeatedly extended because of the overwhelming HIV and AIDS burden.

After the panic stage, the acceptance stage emerged. This involved the recognition that the pandemic had become generalised in the sense that it was no longer seen as a problem mainly confined to risky groups (traditionally seen for instance as prevalent amongst sex workers and gay men) but infecting and affecting all citizens. In this context, the government (and all stakeholders) came together to map a way forward, as the contributions of all relevant groups was seen as crucial to a coordinated and systematic effort in response to the pandemic. Zimbabwe is at the acceptance stage (ZHDR 2003) and has been for a decade.

But this comprehensive and inclusive effort did not come automatically. The initial tentative response in Zimbabwe, like elsewhere, was biomedical in character, which is far below the level and form needed to come to terms with the forms of transmission and consequences of HIV and AIDS. The biomedical approach envisioned HIV and AIDS as exclusively a viral problem (or HIV), that is to say, a viral infection problem which enters the body weakening it and paving the way for opportunistic infections (ZHDR 2003). From a strictly medical perspective, this framing of the problem is quite acceptable because the AIDS pandemic exists as a result of HIV. However, a biomedical approach is merely therapeutic in form and is blind to a range of macro-factors, notably the cultural, political and economic dimensions which for instance condition and facilitate the participation in risky sexual practices (even regardless of accurate knowledge about the disease). The biomedical approach, coupled with government denial, provided HIV and AIDS with a social environment conducive to securely and firmly establishing itself in Zimbabwe. Efforts to curtail the pandemic, as the Zimbabwean government came eventually to realise, should encompass all dimensions of the pandemic (including medical and social) (Coates et al. 2008).

In relation to HIV and AIDS in Zimbabwe, it seems clear that overall the "national response has to be understood within the context of the co-existence of complacency, panic and acceptance among top officials, government departments, private sector and civil society" (ZHDR 2003:123). The Zimbabwean government was slow to get off the ground. Thus, writing in the late 1990s in the prologue to the *National HIV/AIDS Strategic Framework for a National Response 2000-2004*, the President of Zimbabwe, Robert Mugabe, acknowledged that the response to HIV and AIDS was slow, weak and selective (GoZ 1999c). It took many years, into the acceptance stage, before the adoption of a fully-fledged

multi-sectoral approach to the epidemic which took into consideration all the complexities of HIV and AIDS, particularly the social dimension.

The government of Zimbabwe started with the Emergency Short Term Plan (ESTP) in 1987 (two years after the pandemic was first reported). The plan was meant to create public awareness about HIV as well as train health personnel with regard to HIV and AIDS interventions. The ESTP led to the implementation of the First Mid Term Plan (MTP1) in 1993 with the aim of increasing and expanding intervention including targeting, prevention (including changes in sexual practices), care and support. However, it was filled with many irregularities and inconsistencies which were a manifestation of the then-existing deficiencies in knowledge about HIV transmission and effective means of curbing transmission; additionally, the political will to carry though the plan seemed limited. Thereafter, the Second Medium Term Plan (MTP2) was put in place in 1994 and this mainly targeted the participation and mobilization of other players outside of the state's health sector, including other government ministries and departments and private employers, all of whom until then had not been concerned about the pandemic or did not recognise its wide-ranging impacts on all spheres of Zimbabwean society (NAC 2006).

In this context, in the discussion below, I look at major policy and strategic interventions, including the following: the National HIV/AIDS Policy 1999, the National Gender Policy 1999, the Zimbabwe National Behaviour Change Strategy 2006-2010, and the Zimbabwe National HIV/AIDS Strategic Plan of 2006-2010. These are some of the key state documents pertaining to HIV and AIDS, but a fuller list of policies and strategies are detailed in Table 3.1. Combined, these documents address questions around prevention, care and support, and treatment. Clearly, though, the everyday lived realities of HIV and AIDS cannot be read-off from state policies and programmes and chapters five and six (based on my Harare-based study) speak directly to these realities and experiences. Nevertheless, an understanding of HIV policies and strategies is critical given the emphasis of the thesis on state initiatives around voluntary medical circumcision for men.

### 3.3.1 Zimbabwe National HIV/AIDS Policy (1999)

This national policy, which arose in the transition from the panic to the acceptance stage, was implemented in 1999 to promote and guide responses to the pandemic in Zimbabwe. To effectively fight against the pandemic, the national policy advocates for a multi-sectoral approach (in other words, not just the health sector) coordinated by the National AIDS Council through mainstreaming the pandemic across-the-board. The National AIDS Council

(NAC) of Zimbabwe is mandated to co-ordinate and facilitate a national multi-sectoral response to HIV and AIDS and it was enacted by an act of parliament in 1999 (NAC 2011). It does so, at least formally, by ensuring active and effective participation by government ministries, departments, politicians, the private sector, civil society, nongovernmental organisations, communities, churches, electronic and print media, and multilateral institutions (WHO 2005). In order to enhance efficiency and success, the policy calls for massive resource mobilisation and commitment. To maximise the availability of finance and on a consistent basis, as well as to avoid exclusive dependence on – often erratic – external donors, including multilateral and nongovernmental organisational funding, the government formed the National AIDS Trust Fund in 1999 which is popularly known as the AIDS levy (GoZ 1999a, WHO 2005). The levy is collected by way of a three percent tax of all taxable income from individual employees and corporations and it goes towards financing HIV and AIDS programmes and activities (GoZ 1999a, WHO 2005, Duri et al. 2013).

The response against HIV and AIDS in Zimbabwe is, as elsewhere, hampered by stigma and discrimination against people infected (HIV-positive) and affected (relatives of the infected) by the pandemic. However, these two drawbacks are not as rife as they were in the past (particularly in the 1990s) when there was inaccurate and insufficient information about the epidemic and only minimal levels of treatment (Campbell et al. 2011). To fight against stigma and discrimination, HIV and AIDS was mainstreamed into the human rights arena in Zimbabwe. Thus, the national policy underlines the fact that the human rights and dignity of people living with HIV and AIDS should be promoted and protected. In order to sustain a supportive environment against stigma and discrimination, the policy advocates for the implementation of education and information interventions designed to counter the stereotypical labelling of and against people living with HIV (PLWH).

**Table 3.1: Zimbabwean Government HIV and AIDS Policies, Plans and Strategies**

| **NATIONAL POLICIES** | |
|---|---|
| Zimbabwe National HIV/AIDS Policy | 1999 |
| National Youth Policy | 2000 |
| National Gender Policy | 2004 |
| Zimbabwe National Reproductive Health Policy | 2006 |
| Zimbabwe Guidelines on Safe and Voluntary Circumcision | 2009 |
| **HIV PROGRAMME STRATEGIES** | |
| Emergency Short Term Plan (ESTP) | 1987 |
| Mid Term Plan (MTP1)<br><br>Mid Term Plan (MTP2) | 1988-1993<br><br>1994-1999 |
| National HIV and AIDS Strategic Framework – 2000-2004 | 1999 |
| Zimbabwe National Behavioural Change Strategy | 2006 |
| The Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 | 2006 |
| Prevention from Mother To Child Transmission and Paediatric HIV Prevention and Care National Plan | 2006 |
| National Female Condom Strategy 2006-2010 | 2006 |
| Zimbabwe Health Sector HIV Prevention Strategic Framework 2007-2010 | 2007 |
| National Guidelines on HIV Testing and Counselling Strategic Plan 2008-2010 | 2008 |
| Plan for the Nationwide Provision of Antiretroviral Therapy 2008 – 2012 | 2008 |
| National Adolescent Sexual and Reproductive Health Strategy 2010-2015 | 2010 |
| Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 | 2011 |
| National Male Circumcision Strategy | 2011 |
| **SECTORAL POLICIES** | |
| Public Service Commission HIV and AIDS Policy | 2003 |
| HIV and AIDS Policy for the Transport Sector of Zimbabwe | 2003 |
| HIV and AIDS Policy for the Mining Sector | 2006 |
| Agricultural Sector Strategy on HIV and AIDS | 2006 |
| HIV and AIDS Policy for the Micro, Small and Medium Enterprise (MSMEs) in Zimbabwe | 2008 |
| HIV and AIDS Policy for the Textile Industry of Zimbabwe | 2009 |
| HIV and AIDS Policy for the Energy Sector of Zimbabwe | 2009 |
| HIV and AIDS Policy for the Motor Industry of Zimbabwe | 2009 |

The policy, therefore, outlines the need to pursue and administer legislation which safeguards citizens against human rights violation and discrimination in respect of their personal HIV status. In this vein, the policy underlines the need to uphold confidentiality of an individual's medical information pertaining to HIV. Confidentiality is defined in the policy as "not disclosing private or personal information with regards to one's HIV status without consent" (GoZ 1999a:5). However, the policy clearly cautions against over-emphasising confidentiality since it may perpetuate stigma and discrimination. As a result, shared confidentiality is advocated for; this is where medical information about personal HIV status is shared with the spouse, partner and care givers of the person living with HIV to enable proper care giving. This is done in line with appropriate education, information and communication to encourage 'going public' about one's HIV status to reduce stigma (GoZ 1999a).

On condom use, the national policy underlines the need to encourage and promote correct and consistent use of male (and female) condoms by providing comprehensive information and user instructions on the package (including the proper disposal of condoms after use). Condoms, in terms of the policy, should be readily available, accessible and affordable to everyone. To make sure that there are no defective condoms in circulation, and hence in trying to build loyalty and trust within the populace about condom distribution and use, the government came up with condom quality control measures. Every batch of condoms is – at least officially – tested to ascertain that the optimum quality of condoms exists to avoid breakages which might endanger condom users.

When HIV first emerged in Zimbabwe, no one seemed to know how to best deal with the pandemic. In essence, there was a dearth of accurate information and education about the disease and how to inhibit its spread. In this respect, the national policy encourages the development of clear and accurate information and education communicated and delivered through a well-understood medium (especially the mass media) to deepen understandings about HIV and AIDS. To avoid monotony around the HIV and AIDS communication in the public sphere and possible resistance to the 'media blast', the policy supports the diverse use of dramas, films and television soaps (which led for instance to the popular television show, *Studio 263*). Such presentations are designed to discourage promiscuity and highlight the advantages of fidelity to partners, as well as acceptable social and moral values needed to protect oneself from HIV and ultimately AIDS (GoZ 1999a: 22-25).

Critical to the policy in relation to HIV prevention, treatment, support and care is the promotion of counselling and testing. Counselling and testing are integral methods for

preventing the spread of HIV and specifically in communities with pronounced rates of infection. This entails encouraging and motivating people (who are either HIV positive or negative) to adopt safe sexual practices (Denison et al. 2007). In this regard, according to the United Nations Population Fund (UNFPA 2002:1):

> Knowing one's HIV negative status can serve as a motivating factor to remain negative, particularly for those who may assume it is too late to adopt safer sexual practices. For people who test positive, while VCT [voluntary counselling and testing] services can link them to options for treatment if and where they exist and to care and support, just as important it allows for adoption preventive measures. For some self-protection is a stronger motivator for safer sex than the need to protect others; for others, the responsibility to avoid spreading the virus is itself the crucial motivator.

Counselling, hence, offers psychological and social support to HIV-positive individuals to deal with a wide range of social, cultural, economic and medical problems.

One other vital area the policy focuses on is research. It stressed the need for multidisciplinary and collaborative research on key priority areas in the country so as to provide sound and reliable evidence to address the diverse challenges posed by the pandemic. To achieve this there is a vital need to develop and implement a comprehensive national HIV and AIDS research agenda and plan of action. Since the late 1990s, as will become clearer during the thesis, there has been considerable research done on HIV and AIDS in Zimbabwe and this thesis is positioned to add to the existing knowledge base.

### 3.3.2 National Gender Policy (1999)

Zimbabwe has showed its commitment to promoting gender equality and equity by ratifying several regional and international conventions and declarations in this domain (GoZ 1999b). These include the Convention on Elimination of all Forms of Discrimination Against Women of 1979, the Southern Africa Development Community Declaration on Gender and Development of 1997 and the Fourth World Conference on Women: Action for Equality, Development and Peace (also known as the Beijing Declaration and Platform of Action) in 1995. Such international agreements influenced the formation by the Zimbabwean government and stakeholders of the National Gender Policy in 1999. The policy aims to enhance gender equality by pursuing a multi-sectoral approach which addresses and challenges long-standing cultural, religious, social, economic and political practices which oppress and disadvantage women as a social category in Zimbabwe. This is critical, because

the prevalence of HIV and AIDS has a gendered dimension to it and the causes of HIV amongst women are often linked to gender oppression.

Zimbabwe is a deeply patriarchal society and patriarchy is reproduced through a range of systems, discourses and practices including in relation to sexuality and marriage (Kambarami 2006). This means that policy alone is insufficient unless HIV and AIDS reach deep into the realm of everyday relations and experiences. At the same time, despite some progressive initiatives, the Zimbabwean state since the early 1990s has not vigorously and consistently followed gender-based restructuring through its plans, programmes and strategies. But, to reiterate, gender roles and relationships predispose women to HIV because of unequal power relations.

Quite often, pervasive socio-cultural norms of masculinity take precedence over femininity and this promotes and perpetuates a breeding environment for the epidemic as manifested for instance in gender-based physical violence or at least sustained emotional trauma for women. In the words of the United Nations (1993: no page number), gender-based violence is "violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life". The Zimbabwean government's gender policy seeks to challenge this, along with other forms of coercive sexual practices that propagate vulnerability for women (for example, widow inheritance and child pledging). All forms of gender inequalities inevitability make women more vulnerable as they are stripped of their power to negotiate safe sexual practices and initiate prevention measures against HIV (Chirawu 2009).

To reduce gender oppression, the policy highlights the need to empower women by making decent education fully accessible to all women. This in part is designed to enhance their chances of attaining independent means of livelihoods to avoid dependency on men and thereby reduce vulnerability. Women can also be empowered through instituting in practice the full constitutional rights of women in every sphere of life. One of the ways to reduce gender-based violence in particular, the policy states, is to strengthen existing and upcoming women community-based organisations as a way of enabling them to expand and improve services in providing support to women who are victims of violence. With specific reference to women and HIV, men in Zimbabwe would need to gain acceptance of gender equality and, through a range of programmes, become sexually responsible in relation to the costs of multiple and concurrent partners and other high risk sexual practices which are detrimental to women (GoZ 1999b).

### 3.3.3 Zimbabwe National HIV and AIDS Strategic Plan (2006-2010)

The Zimbabwe National HIV and AIDS Strategic Plan **(**ZNASP) of 2006 does not bring any radically-new ideas into play with respect to tackling the HIV and AIDS pandemic. Its main aim is "to reduce the spread of HIV, improve the quality of life of those affected and infected and mitigate the socio-economic impact of the epidemic in Zimbabwe" (GoZ 2006b:16). Its significance is that it emerged as a result of wide-ranging reviews of then-existing policies and strategies, including the 1999 Zimbabwe National HIV and AIDS Policy and the earlier National HIV/AIDS Strategic Framework for 2000 to 2004. It also emerged from the 'Three One Principles' adopted at the International Conference on AIDS and STIs in Africa (ICASA) held in Kenya in 2003. The 'Three One' principles are as follows: "One agreed HIV/AIDS Action Framework that provides the basis for co-ordinating the work of all partners; One National AIDS Co-ordinating Authority with a broad based multi-sector mandate and One agreed country level Monitoring and Evaluation System" (UNAIDS 2004:1). The 2006-2010 strategic plan, thus, builds on already-existing policies and plans by calling for scaling-up endeavours to contain and possibly reverse the pandemic.

The strategic plan acknowledges that, despite the fact that the prevalence of HIV was on the decline in the 2000s, HIV and AIDS was still a national emergency which required all stakeholders to participate in a multi-sectoral way. The plan underlines the importance for the government and stakeholders of intensifying and honouring their commitments to the various (previously-discussed) international conventions. In doing so, it emphasises the need to address the pandemic by allocating ample resources and ensuring gender equality and equity. On the question of gender, the plan provides a framework for mainstreaming gender into HIV and AIDS programmes by foregrounding that all prevention and advocacy strategies are to be gender inclusive to reduce women's vulnerability and risk with regard to the pandemic. To ensure full representation of women's views in this endeavour, the plan adopted the contributions made by the United Nation Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa (in 2000) which advocates for equality between men and women in relation to property and inheritance rights, access to HIV treatment, and the burden of care for the HIV-infected. Like other policies, plans and strategies, the plan discourages gender-based violence which is rife in Zimbabwe (GoZ 2006b, Chirawu undated).

The Zimbabwe National AIDS Strategic Plan also calls for the intensification of programmes and practices which discourage stigma and discrimination against PLWH**.** To achieve this, it adopted an initiative called the 'meaningful involvement of people living with HIV/AIDS' (or MIPA). With stigma and discrimination ongoing, the plan pushes for full

representation in HIV and AIDS programme and strategic structures of people who are publicly open about their HIV-positive status. This is to be done by strengthening networks for PLWH through their participation in prevention programmes.

### 3.3.4 Zimbabwe National Behaviour Change Strategy (2006-2010)

The Zimbabwe National Behaviour Change Strategy (ZNBCS) is a consolidated and comprehensive multi-sectoral framework the primary goal of which is to promote responsible and safe sexual behaviour (or practices) in order to reduce HIV transmission in heterosexual relationships in the country (such relationships account for 80 to 90 percent of transmissions of the virus). In addition, it seeks to encourage the use of available HIV and AIDS services in relation to testing, prevention and treatment. To achieve its goals and objectives, the strategy sought to repackage, sustain and expand the existing intervention programmes that address the key challenges perpetuating heightened HIV levels in the country. These challenges include imbalanced gender relations; concurrent sexual partners or casual partners; age mixing (mainly older men and younger women); condom use; unfaithfulness; stigma and discrimination against PLWH; and low uptake of HIV and AIDS prevention and mitigation services. In formulating the strategy, the government and stakeholders acknowledged that behaviour change campaigns had been operational for many years but they saw it pertinent to formulate a multi-sectoral strategy which guides and encourages responsible sexual practices.

In the following discussion, I summarise the ways in which this strategy seeks to address some of the key challenges (GoZ 2006a).

a) Imbalanced gender relations

The strategy is concerned with pursuing actions which focus on persistent imbalanced (power-ridden) gender relations which perpetuate HIV transmission, and to do this through massive private and public media campaigns as well as interpersonal campaigns. The strategy speaks about taking an anti gender-based violence campaign programme to rural communities, targeting all kinds of community leadership (which are often men) and men in general. In this context, several District AIDS Action Committees (DAACs) and Ward AIDS Action Committees (WAACs) have been set up throughout the country to actively participate in these campaigns. Taking gender violence campaigns to the grassroots helps communities to fully understand and embrace the importance of desisting from such violence, and eventually enabling local and public monitoring of the violence. Through the strategy, faith-based organisations were targeted as an important entry point into rural communities. In light

of gender violence, especially rape, the strategy encourages increased use of post-exposure prophylaxis (PEP) and the administration of ARV drugs within seventy-two hours by the victims to prevent HIV transmission (GoZ 2006a).

b) Stigma and discrimination

Although stigma and discrimination against PLWH is not as rife as it was in the past, it remains common throughout Zimbabwe. The strategy seeks to increase the number of people who openly speak out or 'go public' about their HIV status. In this way, the populace will come to know that being HIV positive is not a death sentence but a chronic disease that one can live with and function daily like any normal person. There have been numerous advertisements and video clips in the media of people who have gone public about their HIV-positive status and who have highlighted the advantages of knowing their HIV status as well as the importance of coming to terms with their HIV-positive status. To further this, the strategy encourages participation by leaders in every aspect of life in anti-stigma and discrimination programmes (GoZ 2006a).

c) Faithfulness

The existence of concurrent sexual partners (CSPs) or unfaithfulness is common in Zimbabwe and is one the key dimensions of HIV and AIDS in the country. It is one of the strategy's priorities to reduce unfaithfulness by unpacking the undesirability and dangers that come along with it through mass media campaigns (and in the same vein, encouraging faithfulness to one's life partner). A closer look at the issue of CSPs shows that, in many instances, it is caused by the geographical separation of spouses due to work commitments (for example men working in urban centres while wives live in rural areas). To avert this, the strategy advocates for altering work regulations and practices (such as on mines) facilitating the living together of spouses.

d) Condom Use

With faithfulness (and abstinence from sex) being difficult for some people, the behavioural change strategy seeks to encourage correct and consistent condom use through social marketing and public sector distribution of condoms. In doing so, it notes that condom use is not a stand-alone prevention method and that it can be more effective when it is mainstreamed into other programmes, notably voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART). The

strategy also zeros in on high risk groups, such as the uniformed forces (that is, the police and army) and commercial sex workers by enhancing their knowledge on the importance of using condoms whenever they indulge in sexual activities. Condoms have been at the forefront in Zimbabwe as an HIV prevention measure and most Zimbabweans know about their importance. But they (and particularly women) lack condom negotiating skills with their partners and this has exposed many people to the virus. To avoid this, the strategy develops and propagates condom negotiating tools for men and women as well as training people on how to use condoms correctly (GoZ 2006a).

e) Vulnerability of young people

The strategy focuses on reducing vulnerability of young people, as HIV prevalence amongst this group is significant. It argues that the vulnerability of young people with regard to HIV infection and the ensuing consequences can be reduced by encouraging them to delay the onset of sexual activity, faithfulness, correct and consistent condom use, and supporting emotionally those who are infected and affected by the virus. In this domain, age mixing is notably one of the causes of young peoples' vulnerability. Age mixing is whereby a sexually inexperienced or inactive young person becomes involved in a casual sexual relationship with a (five or more years) older partner who has been involved for some time in sexual activities, most of which is unsafe. This exposes the inexperienced partner, especially women, to HIV. In the same vein, however, the strategy hastens to acknowledge that it is not always the case that men who are five or more years older than female partners should not be involved with these partners. But it encourages men to be fully responsible in their sexual contacts and not to endanger the lives of young women. In this regard, the government consented to the introduction of life skills in the school curricula as a way of empowering young people with respect to reducing vulnerability to HIV and AIDS. Over and above these activities, the government and stakeholders are encouraged to reduce poverty-induced vulnerability by offering financial or material support to AIDS-orphaned children particularly those from poor families. Overall, then, the aim is for young people to abstain from sex or at least to delay sexual debut, negotiate for safe sex and to be faithful in their relationships (GoZ 2006a).

f) Risky Socio-cultural practices

Zimbabwe has a number of entrenched socio-cultural practices which increase vulnerability to HIV. These include widow (and widower inheritance), vaginal douching, dry sex, girl-child pledging to appease spirits, polygamy and *chiramu*. According to Kanchense (2007:

373), "*Chiramu* consists of a collection of privileges typically given to uncles and brothers-in-law. These allow them to fondle and even engage in sexual activity with younger girls in the family". *Chiramu* in some instances has resulted in pregnancies and a key problem is that it is not regarded as rape or incest (Kanchense 2005). Any woman who is involved in this practice is accused of (and regarded as) being sexually loose and of inviting the man to participate (Kanchense 2005). This would mean that, even if one is infected with HIV through *chiramu*, the young victim has nowhere to report this (normally, there is limited if no protection at all for the victims). This is common particularly in rural areas and, to reduce its pervasiveness, the strategy targets traditional leaders in communal areas of Zimbabwe as well as all kinds of local leadership in the country including DAACs and WAACs (GoZ 2006a).

g) Increased utilisation and expansion of HIV services

One effective way of fighting HIV and AIDS is to put to maximum use the available HIV services as well as to expand them and make them more accessible to potential users. These include voluntary counselling and testing (VCT) centres, post-test support services, PMTCT and ART. VCT is an integral part of HIV prevention in Zimbabwe of which the populace needs to make greater use. The strategy encourages people to use this service in order to know their status and – through counselling – to know what type of lives they should lead in relation to their status. Pre- and in-marriage testing and counselling is highly advised to the extent that people are advised not to consent to sex if they are not aware of their partner's HIV status. VCT is in effect a passage of initiation to other prevention services, such as ARVs, PMTCT and condom use between discordant couples. The strategy stresses the necessity of establishing support groups consisting of people living with AIDS across the country to accommodate and encourage positive living of people who are stigmatised and discriminated against.

### 3.4 HIV Programmes

In the preceding section, I identified and discussed a number of HIV and AIDS policy and strategic initiatives of the Zimbabwean government. In doing so, a number of themes arose, such as the significance of gender relations, condom use, and HIV testing and counselling. Most of the specific HIV programmes implemented in Zimbabwe emanate from these various HIV policies, strategies and plans. In other words, HIV programmes are the various policies, strategies and plans in action. The programmes in operation by necessity address many of the themes already identified, and they can be categorized as prevention, support and mitigation

and treatment and care. Prevention is discussed thoroughly in chapter four, as it is the more specific focus of the thesis. In this chapter, in relation to treatment and care, and support and mitigation, I discuss one or two programmes currently being implemented in Zimbabwe, all of which are intended to curtail HIV and AIDS in Zimbabwe.

### 3.4.1 Treatment and Care

In this section I detail the range of treatment-and-care preventative programmes currently in operation in Zimbabwe. Though the evidence – given the statistics provided earlier – suggests that these programmes are having some impact in slowing down the rate of new infections of HIV, the infection rate in Zimbabwe – particularly from a global perspective – remains high. In this context, treatment and care of HIV-positive (or infected) individuals becomes critical.

Treatment and care relate primarily to ARVs. When the HIV and AIDS pandemic started in the 1980s, it was a death sentence chiefly due to lack of treatment (Noguera et al. 2003), as people who were HIV-positive would invariably face death. Nonetheless, through continued research and development of effective and human-friendly ARVs, PLWH can live longer than before if not indefinitely. By definition, antiretroviral (ARVs) therapy is a combination of drugs or medicines used to fight HIV in the body (UN 2000). Although ARVs cannot cure the HIV infection, they can contain or prevent the development of AIDS by suppressing the replication of HIV in the body which – if not guarded against – impairs the human immune system. Continued infection of the immune cells, popularly known as CD4 cells, leads to the deterioration of the immune system resulting in immune deficiency which leaves the body exposed to opportunistic infections (OIs) (UNAIDS undated). In other words, ART suppresses the reproduction or multiplication of HIV in one's body, therefore enabling the CD4 cells to stand on guard against OIs, and this means that the person can live a better quality and longer life than without ART (Patel et al. 2008).

ARVs in Zimbabwe are administered in both public and private health institutions across the country (Fraser et al. 2011). As a way of ensuring safety of clients and drug efficiency, the government of Zimbabwe with the help of stakeholders adopted – and is compliant with – the WHO guidelines on ART (Fraser et al. 2011). To ensure continuity and sustainability of the programme, capacity development was enhanced by working on logistics management and relevant clinical matters. Health care workers in Zimbabwe were therefore trained in the care of OIs and about standard treatment regimens in Zimbabwe for adults and children as well as ensuring proper dispensing and correct use of ART by patients (Noguera et al. 2003, Gwinji 2011).

Progress has been made in Zimbabwe in the provision and administering of ART in a way compliant with the WHO recommendations in 2013 of initiating a patient on ART with a CD4 cell count of equal to or less than 500 cell/mm3 (up from an earlier recommendation of 350 cell/mm3 in 2010), as well as in administering a safer single preferred first-line regimen (also in 2013). As a result of the new recommendations by WHO (and the changed CD4 count), there is a likelihood of an increase in the number of people in need of ART and therefore those who will start using HIV therapy. There was an earlier recommendation in 2009 by WHO to start initiating ART to PLWH with a CD4 count of 350 cell/mm3 (which the Zimbabwean government implemented). As a result, statistics show that the number of people on ART increased from 85,000 to 215,000 between 2008 and 2009. Remarkable progress was made as, by 2012, 518,801 people were receiving ART (UNAIDS 2012), which constitutes about 80 percent of PLWH who needed ART based on the 2009 recommendation (the number of HIV-positive people in need of ART was 640,000). Stakeholders in support and provision of ART are, however, expected to brace up for a boom in demand of ART as a result of the WHO 2013 recommendation. According to UNAIDS (2012) the new WHO recommendations on ART would result in an estimated 1,200,000 (this consists of all HIV-positive people with a CD4 cell count of equal to less than 500 cell/mm3) in need of ART by 2015 (an increase from 640, 000 in 2012).

The introduction of ARVs in Zimbabwe was a relief of course to infected and affected people but also to government and other stakeholders, since more lives could be saved than before. Before ARVs, high death tolls were recorded and AIDS was in fact the deadliest killer disease with, for example, an estimated 3,800 people dying every week in Zimbabwe in 2003 (Nougero et al. 2003). At least 70 percent of beds in most public health institutions were occupied by AIDS patients. This led, at the height of the pandemic, to a life expectancy rate of only 43 years in the country (Noguera et al. 2003). Once a person developed signs and symptoms of HIV and AIDS, he or she and the people around them (the affected) would know that it was just a matter of waiting to die (Campbell et al. 2011).

As a result, HIV and AIDS was named a killer disease and, because of its relationship to sexual activity, this led to high levels of stigma and discrimination attached to the HIV-infected (as noted previously). Shona derogative words were coined and name-calling pointed to the lethality of the pandemic. These included: *Shuramatongo* (which means abandoned or deserted homestead), *Mukondombera* (which means a plague) and *Akakwira bhazi* (which means that s/he boarded a bus or s/he is moving to the grave or is a moving grave) (Mawadza 2004). However, though stigma and discrimination still exist, the severity of it has lessened

since the introduction of ARVs. ARVs have led to undermining the notion of the HIV-infected as 'moving graves' and have helped to break the despondency, denial, shame and silence around HIV and particularly AIDS. Increasingly, Zimbabweans speak openly about HIV and AIDS, the possible treatment available and living with HIV positively (Noguera et al. 2003). The stigma which continues is no longer associated with the status of HIV and AIDS as a slow agonising tortuous disease; rather, it lies in Zimbabwe as a conservative sexual-moralising society linking HIV infection to promiscuous practices (Campbell et al. 2011**).**

It is essential to note that, for ART to be effective, adherence to treatment and retention in care need to be austerely observed. Adherence to treatment is "the ability to start, manage and maintain a given medication regimen at the times, frequencies and under specified conditions as prescribed by a health care provider" (Patel et al. 2008:2). Studies conducted in the United States and Europe on adherence to treatment show that the optimal level of ART adherence to enhance full and effective ART benefit for viral suppression can be achieved when adherence is maintained as high as 95 percent (Patel et al. 2008). PLWH who are on ART are, therefore, encouraged to observe the highest possible level of adherence for best ART results.

Failure to adhere to treatment results in inconsistent drug levels in the body which promotes viral multiplication and, as a result, increases the chances of the formation of a drug-resistant virus which no longer responds to the drug regimen (Hermankova et al. 2001, Kozal et al. 2007). Low or disrupted adherence to ARVs has many disadvantages focusing on an increase in the rate of progression to AIDS (which ultimately means a higher death rate), high levels of hospitalisation, and time, energy and money lost for affected households because of the prolonged un-productivity of the infected individual (Hogg et al. 2002). Although rigorous adherence to treatment is known to be crucial in boosting the immune system of PLWH there are inconsistencies cited hampering adherence to treatment.

The introduction of ART in Zimbabwe on a significant scale no doubt has resulted in revived hope for PLWH. Generally, people in Zimbabwe now believe that AIDS is not a death sentence, with many instances in fact of HIV-negative people dying for reasons other than AIDS and thereby leaving behind PLWH in their households. But, as noted, vigilant adherence to the drug regime is critical, but this is often difficult to sustain. In the case of Zimbabwe, studies done by Skovdal et al. (2011), Campbell et al. (2011a) and Campbell et al. (2011b) show for instance that costs related to treatment are a major hindrance to adherence, with some people even unable to afford the transport costs to replenish the medication.

### 3.4.2 Support and Mitigation

As elsewhere, support and mitigation are of importance in Zimbabwe, and it primarily takes the form of community and home based care (CHBC). CHBC was first offered in Zimbabwe before independence in 1980 to physically and mentally challenged people as well as terminally-ill patients. It did not arise though due to any incapacity on the part of the health system to cope with the demand for health services, because it was seen as an appropriate methodology for support and mitigation. However, with the emergence of HIV and AIDS, the increasingly constrained official health system in Zimbabwe (notably from the early 1990s) was unable to accommodate the pressure to hospitalise HIV patients. To mitigate this HIV crisis, CHBC was further developed and seriously advocated for as an extension to the formal health system (SAfAIDS and HND 2007). CHBC is any form of care given to sick people in their homes by families and communities which includes physical, psychosocial, palliative and spiritual activities. The health ministry in Zimbabwe (MoHCW 2004) indicates that it involves alternative nursing care measures, continual and uninterrupted care from hospital to the home and vice versa, and counselling and bereavement support. CHBC programmes also include taking care of orphaned and vulnerable children affected by HIV in their households (SAfAIDS and HND 2007). CHBC has gone through various phases in Zimbabwe with reference to the AIDS pandemic.

When it was intensified in the early HIV era, with no ARVS in place, it was seen as a way of effectively giving up on seriously ill HIV-infected people who could not do anything by and for themselves. They were released from hospital into the family or community with the expectation that they would die shortly after their discharge. The introduction of ARVs in Zimbabwe on an increasing scale changed the way CHBC has been viewed, since people can 'come back to life' and have a strong semblance of health when they are the ART regime. Locating HIV-infected people on ARVs in their places of residence is now seen as a haven of hope for many HIV-positive patients. Initially, community and home based care was mainly carried out by volunteers and not necessarily by family members. But because of the increase in the sheer number of HIV patients, family members have been trained on how to take care of their HIV-positive relatives. However, because of patriarchal discourses and practices, CHBC in Zimbabwe is highly gendered with male participation being low; this is problematic given that HIV and the care of HIV patients are not inherently female problems.

But, as a care programme, CHBC has immeasurably rescued the limping health system, and it complements HIV treatment by providing assistance to HIV patients through support groups and easing pressure for hospital beds and demand for medical attention. The

number of HIV-positive people receiving CHBC increased dramatically from 489,000 in 2008 to 697,000 in 2009, a forty percent increase in just one year (GoZ 2012). The success of CHBC hinges on a number of services provided by the government, NGOs, communities and individuals. These services include community home based care kits, nutritional support, training of care-givers, access to treatment and ART, access to education for orphaned and abandoned children, and general material support. Most PLWH join support groups which are hailed as motivators for adherence to HIV treatment. In such groups, members influence each other to accept their HIV-positive status and to strengthen each other in fighting discrimination and stigma. According to Matshalaga (2006), ART has a strong link to CHBC in the sense that, through viral suppression emanating from adherence to ART, PLWH are able to give each other material, nutritional and spiritual support but also collective assistance through for example ploughing fields and repairing houses.

One of the critical burdens arising from HIV and AIDS is the number of orphans and vulnerable children. For Zimbabwe, it is estimated that there are one million children with either one or both parents deceased due to HIV and AIDS or related diseases (GoZ 2012). Two-thirds of these children are living under the poverty datum line which impedes their access to basic services (for example education and health). These children are living with a single parent, guardians or foster parents (including older brothers and sisters, or in-laws) or by themselves (as child-headed households). The government through the Ministry of Labour and Social Welfare has developed a National Plan for Orphans and Vulnerable Children (NAP-OVCs) to alleviate the poverty burden for these children. By the end of 2010, the government had reached 440,000 children with financial, material and services support (including food, medication, psychological, education and health). This programme falls within the community and home based HIV and AIDS programme (GoZ 2012).

### 3.5 Conclusion

This chapter has discussed the extent and character of the HIV pandemic in Zimbabwe and the stages through which the Zimbabwean government has gone in addressing and tackling the pandemic. As noted, there is a range of national policies and programmes which seem quite comprehensive and coherent. These policies and programmes have made a difference in easing the prevalence and consequences of the pandemic but the social realities of HIV and sexual practices cannot be read-off from institutional arrangements such as policies and programmes. The following chapter examines further policies and programmes with specific regard to prevention and particularly VMMC. But it also identifies and discusses key

challenges which keep the pandemic alive in Zimbabwe by impacting directly or indirectly on sexual practices. Thereby, along with chapter three, chapter four provides the Zimbabwean context to the Harare study covered in chapters five and six.

# CHAPTER FOUR
# HIV AND AIDS IN ZIMBABWE: HIV PREVENTION, VMMC, SOCIO-CULTURAL PRACTICES AND SOCIO-ECONOMIC CRISIS

## 4.1 Introduction

This chapter further discusses HIV and AIDS in Zimbabwe. It starts off by looking specifically at HIV prevention programmes in the country. Of particular importance is voluntary medical male circumcision (VMMC) as a particular HIV prevention method and its relationship to condom use as another prevention method, so specific emphasis is placed on these two methods. After examining HIV prevention programmes, the chapter then goes on to examine socio-cultural practices and socio-economic conditions in contemporary Zimbabwe. The previous chapter discussed state policies and programmes around HIV with reference to prevention, support and treatment. All state policies and programmes about HIV do not in-themselves determine the sexual practices of Zimbabweans, including the practices of medically-circumcised males. They simply condition these practices. Likewise, socio-cultural practices and socio-economic conditions must be taken into consideration when understanding the kinds of sexual practices existing in Zimbabwe and the prevalence of these practices amongst particular social groupings. Again, it is important to emphasise that the socio-cultural and socio-economic dimensions simply condition sexual practices. Furthermore, these many conditioning factors, even when combined and considered as an integrated system of conditions, still leave room for human agency with respect to sexual practices. After discussing VMMC, I therefore first examine socio-cultural practices (with a focus on patriarchy and sexuality in Zimbabwe) and then examine socio-economic conditions, notably the ongoing economic crises emanating from structural adjustment during the 1990s and fast track land reform from the year 2000.

## 4.2 Prevention Programmes

In this section on HIV prevention, I discuss five interrelated programmes, namely, condom use, prevention of mother-to-child transmission, testing and counselling and life skills education. I discuss VMMC in the following section.

a) Condom Use

Condom use (male and female condoms) is an integral part of HIV prevention in Zimbabwe. Zimbabwe today is known for a relatively successful condom programme in Africa (NAC 2006). Condom promotion and distribution is done by government agencies and NGOs, so that both public sector-rebranded condoms and NGO socially-marketed condoms are available in Zimbabwe. In this regard, there has been a commendable change recorded in condom distribution and use patterns in Zimbabwe. Fraser et al. (2011) show that there were high levels of minimal, incorrect and inconsistent use of condoms in the early 1990s, which exposed many lives to the danger of contracting HIV. As promotional information increased with reference to the importance of correct and consistent condom use, peoples' practices towards condom use changed positively.

Statistics show that there has been an increase in male condom distribution from 48,810,415 in 2000 to a high of 95,463,490 in 2008. Although numbers are still low on female condom distribution, there is a clear upward trend – distribution hence rose dramatically from 362,724 in 2000 to 5,276,705 in 2008 (Fraser et al. 2011). According to ZIMSTAT (2012), 81 and 82 percent of women and men respectively reported that correct and consistent condom use is an effective way of preventing HIV and AIDS through heterosexual contacts. This is an improvement from 2006 in which 65 and 71 percent of women and men respectively professed the importance of correct and consistent condom use. However whether supporters of condom use make use of condoms consistently in practice remains unclear.

b) Prevention of Mother To Child Transmission (PMTCT)

Prevention of mother to child transmission (PMTCT) is another central component of the HIV prevention programme in Zimbabwe. The essence of PMTCT is to prevent the passing of the HIV virus from the mother to the child before, during and after birth. In this respect, the government and stakeholders emphasise the importance of achieving zero infections to babies. PMTCT can be ensured by preventing HIV infection in women in the first place, preventing unwanted or unplanned pregnancies in HIV-positive women, and by providing proper care and support to HIV-positive mothers and babies (Fraser et al. 2011:82, NAC 2006:19).

After pilot studies to ascertain PMTCT feasibility in Zimbabwe proved to be successful, the programme was designed to meet the recommendations of the World Health Organisation (WHO). Since 2002, when the first global guidelines on use of ART in relation

to PMTCT were introduced, there have been several guidelines released in line with ART and in relation to PMTCT as a way of improving the programme. According to WHO (2013), there have been remarkable changes in technologies which influence the need to introduce new guidelines to suppress viral load and save more lives. As a result, Zimbabwe has always complied with the WHO guidelines on PMTCT and has constantly adopted new guidelines which are recommended by WHO. Zimbabwe recently adopted the new 2013 guidelines (NAC 2013). These include:

> Earlier initiation on antiretroviral therapy (ART) for people with a CD4 count of plus or less than 500 and immediate ART for all pregnant and breastfeeding women PMTCT options: ART for all pregnant and breastfeeding women with the option to discontinue treatment after the MTCT risk period has ceased for women who do not meet the eligibility criteria (Option B) or lifelong ART in all pregnant and breastfeeding women (Option B+) (WHO 2103:7,10).

Support services such as voluntary counselling and testing, provider-initiated counselling and testing (PICT) – see below – and ART were set up at selected hospitals and clinics around the country to help the benefactors of PMTCT. PMTCT, however, has noticeable gaps which have made it difficult for the programme to run smoothly and successfully in Zimbabwe. For example, there is an acute shortage of capacity to perform CD4 counts to establish who should start on ART. This results in many people delaying the start of the ART regime (especially those from rural areas) which in the end endangers both the mother and the child (Fraser et al. 2011).

Additionally, Bolu et al. (2007) bemoan the low involvement of males in PMTCT and there is thus the need to raise the consciousness of males about the importance of participation in PMTCT. In many African countries, most women in fact seek the assent of their partners to be tested for HIV. Research shows that the participation of both partners accelerates the provision of PMTCT services and interventions (for example, condom use, ARV therapy, and the avoidance of breast feeding). PMTCT is also known as 'Prevention of Parent to Child Transmission' (PPTCT), as a way of emphasising the need for male involvement in the programme, since it takes both parents to raise a child in a sound and safe manner. Further, couple-based counselling reduces the chances of social ills, for example, wives being abandoned or abused when tested HIV positive (Bolu et al. 2007).

c) HIV Testing and Counselling (HTC)

Counselling and testing are important components of HIV prevention, but also of care and support. There are two types of counselling and testing, namely, voluntary counselling and

testing (VCT) and provider-initiated counselling and testing (PICT). With VCT, the initiative comes from the individual in seeking to benefit from the service, whereas with PICT it is the initiative of the health practitioner to test a client. The essence of counselling and testing is based on the supposition that if a person knows his or her HIV status and this is coupled with comprehensive pre- and post-counselling, chances are high that he or she will adopt or maintain safe sexual practices. This reduces the chances of becoming infected or infecting others or being re-infected (ZHDS 2003).

People visit counselling and testing centres for various reasons. Research done by Morin et al. (2006) established that some people wanted to know their HIV status because they had fallen sick with a sexually-transmitted disease or tuberculosis or had experienced unprecedented weight loss. For some, it was from panic after they had eye-witnessed the illness or death of a close family member or friend with a known or suspected AIDS-related disease. For others, it was because they wanted to get married or were planning to have a child. The various reasons are in some way linked to known or suspected risky practices at some point, with most men citing such behaviour especially when they were drunk. Most women were driven by suspicion or established knowledge of their partners being promiscuous.

Van Praag et al. (1997) describe counselling as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions, in this case related to HIV and AIDS. They emphasise that confidentiality should be observed during and after the counselling process since HIV and AIDS is a highly stigmatised disease which in most cases leads to discrimination, abandonment and abuse. Counselling facilitates openness by the client with regard to fears and complexities which come as a result of being HIV-positive and with the aim of giving the client hope.

There are two stages of counselling, that is, pre- and post-test counselling. Pre-test counselling occurs between the care giver and the client(s) prior to the actual test to discuss the implications that come along with one's HIV status. The discussion between the counsellor and the client prior to testing leads to informed consent by the latter as to whether to proceed with the test or not. After the actual HIV test comes post-test counselling, and this is meant to address post-test sexual practices to reduce risk. Through counselling and testing, an individual (if tested HIV positive) benefits because of appropriate advice on treatment and nutrition as well as the available options on reproduction and infant feeding (UNAIDS 2000). When dealing with an HIV positive client, post-test counselling ascertains the client's

understanding and acceptance of their status. In a nutshell, counselling ensures the assimilation of prevention, treatment and appropriate care to the client as a result of the test.

The Ministry of Health and Child Welfare (MoHCW) espouses four delivery models to boost availability of counselling and testing in Zimbabwe. These are as follows: a) the integrated model which is operational in government-run health institutions; b) the stand-alone model run by NGOs; c) the mobile outreach model run by NGOs; and d) the private sector workplace model. In so doing, the government of Zimbabwe and stakeholders have focused on enhancing the accessibility, availability and consumption or uptake of VCT and subsequent services. To enhance this counselling and testing, appropriate services were put in place firstly in large urban centres before being decentralised to peripheral towns and rural areas. Human resources development capacity was enhanced by equipping nurses with counselling skills as well as training counsellors. Standardized guidelines as well as best practices on counselling and testing were implemented with the latter including maintaining anonymity and assuring confidentiality when dealing with the client as well as linking counselling and testing to other prevention and care services (Commonwealth Regional Health Community Secretariat 2002).

To date, there have been significant improvements in the provision of point-of-care HIV rapid testing in VCT centres across the country (Mtapuri-Zinyowera et al. 2010). By 2009, there were 27 VCTs managed by NGOs across the country, 502 HIV testing and counselling points integrated within state health services, and approximately 1,000 counselling and referral-only delivery points. The government and stakeholders also decentralised HIV counselling and testing services to enhance PMTCT in health facilities across the country to reach people in far-flung rural areas. Available statistics show an increase in the number of people accessing VCT services from 579,767 in 2007 to 1,071,740 in 2009 (Fraser et al. 2011).

Although this increase is important, the uptake of counselling and testing (CT) services could still be improved. One major hindrance to increased uptake of CT is the fear of being HIV positive. It is a colossal task for some individuals to go for counselling and testing. In the study by Morin et al. (2006), most of the non-testers cited the fear of being HIV positive as their major reason for not using CT services. They prefer dying without knowing what ails them, rather than acknowledging that they are dying from the ‘deadly stigmatised incurable disease’. Unreasonable as it may sound, the fear of testing HIV positive is deterring large numbers of people from attending CT centres, especially those who know of or suspect risky sexual practices. Castro and Farmer (2005) attribute the fear of knowing one’s HIV

status not solely to stigma and discrimination, but also to problems with availability of ARVs in the country as well as limited psycho-support for HIV sufferers.

Mtapuri-Zinyowera et al. (2010) also cite an acute shortage of, and limited access to, CT facilities and services chiefly in rural areas. Rural people travel long distances to access those limited facilities which exist, and this makes it difficult for them to undergo thorough post-counselling if they are tested as HIV positive. Client follow up therefore is problematic. Moreover, the testing period is quite long. In some places, people make an average of two to three visits, over long distances, to complete the testing process. Although people have full knowledge of the importance of follow-up counselling sessions (if tested HIV-positive), visits are made rarely or occasionally in these areas. This complicates the counselling process, given the fact that it is difficult and takes time for many people to absorb the pressure and accept that they are living with an incurable stigmatised disease. Knowing that one is HIV-positive comes with tense painful emotional feelings of guilt, fear, anger, depression and self-blame. Once-off-counselling does not go far in dealing with an 'emotional roller coaster'. Resultantly, a person may deteriorate quickly since he or she does not know what it means to be HIV-positive and how to cope with the emotional trauma (ZHDS 2003).

d) Life Skills Education

With HIV and AIDS affecting all sectors of society, including young people, HIV and AIDS education programmes have been implemented throughout the country. The Ministry of Education, Arts, Sports and Culture introduced the Life Skills Based HIV and AIDS Education (LSBHE) in 1993 which target students from grade four to seven (MoEASC 1993). The LSBHE syllabus gives information on HIV and AIDS including its modes of transmission and prevention, myths and misconceptions about HIV and AIDS, how to live positively with HIV and to care for PLWH. This is designed to make children aware of the existence of the pandemic and the best practices to be adopted to prevent it.

For students in tertiary education, the Ministry of Higher and Tertiary Education has a programme called 'Access to Reproductive Health Services in Tertiary Institutions' (GoZ 2011). In 2003, tertiary education students formed a student organisation on reproductive health called Students and Youths Working on Reproductive Health Action Team (SAYWHAT). This organisation was established out of the realisation that, when students enter into tertiary education, they tend to become sexually active. Information on sexual and reproductive health was seen as critical given the high prevalence of unplanned pregnancies

amongst youth which in some cases resulted in unsafe abortions. In addition, a high incidence of HIV and sexually-transmitted diseases prevails in tertiary education institutions.

In this context, the University of Zimbabwe in Harare implemented a Life-Skills Model programme starting in 2011. Amongst other things, the model gives comprehensive information on HIV and AIDS along the lines of the LSBHE, including about transmission, prevention, treatment, care, support and mitigation. The implementation was necessitated by the fact that students from different backgrounds at the university were engaging in unsafe sexual practices such as multiple concurrent sexual partners, transactional sex and unprotected sex. This model, as a change intervention, therefore seeks to influence students' practices to enable the development of HIV and AIDS prevention skills (UZ 2011).

Zimbabwe, however, is criticised for having a weak educational drive on HIV and AIDS. The government of Zimbabwe, in 2002, formed the HIV and AIDS in Education Assessment Team (HEAT) to assess the impact of HIV and AIDS in the educational sector. According to a report compiled by HEAT (2004), teaching HIV and AIDS in school is not taken seriously chiefly because it is not an examinable subject. In addition, some teachers have refrained from teaching the subject because they have failed to lead by example (for example, by dating their students). UNESCO (GoZ 2011) has recently affirmed that serious weaknesses exist in Zimbabwe in terms of the HIV and AIDS educational sector response.

Some teachers also have cited the sensitive nature of HIV and AIDS as an excuse for not teaching it in class. This type of approach has been supported by senior government leaders and officials. For instance, Senator David Coltart objected to the teaching of condom use as well as the distribution of condoms in schools. He said:

> There is no way we can allow distribution of condoms in schools. Parents want their children to abstain from sex at school age. School children should focus on their studies; we can't have condoms in school toilets, classrooms and libraries. Those who would want condoms should go outside the school premises maybe at nightclubs and street corners not at schools (Radio VOP 2011: no page number).

Zimbabwe Teachers Association Chief Executive Officer, Sifiso Ndlovu, in 2012 vented the same sentiments when he said:

> You can't introduce condoms in schools; there is no way we can allow 10 to 12 year-olds to have sex. This will confuse the mental and physical development of our children. These kids don't know much about their bodies yet and you want to confuse them further by allowing them to engage in sex. As educationists there is no way we can allow the distribution of condoms in schools (Bulawayo24 2012: no page number).

There in fact have been heated debates in Parliament by legislators and among parents as to whether condom use should be taught in schools.

The majority of legislators, parents and religious leaders are against the promotion of condom use in schools. The main reason for downplaying the teaching of condom use in schools is to avoid propping up sexual activities among children of school going age. Plausible as this argument might be, statistics however show that children of school-going age are sexually active. In Zimbabwe the legal age of consent for sex is sixteen years, and sexually-active students under the age of sixteen are likely unaware of the correct procedure for using condoms. Because these sexually-active teenagers are still regarded as children, they are expected to seek approval from their parents or guardians in order to access HIV services (for example, VCT and VMMC); but the evidence suggests that parents – if and when asked – do not normally consent to facilitating this access (Fraser et al. 2011).

### 4.3 VMMC in Zimbabwe

As part of its overall HIV prevention strategies and programmes, Zimbabwe came to recognise voluntary medical male circumcision (VMMC) as a legitimate and useful method for reducing the chances (for men) of contracting HIV. Hence, a five-year VMMC policy and strategy (2010-2105) was developed and launched in 2009 with the aim of circumcising 80 percent of males aged between 15 to 29 years by 2015. This, the strategy document (GoZ 2009) argues, will contribute to a reduction in new HIV infections by between 25 to 35 percent during the five-year period (2010-2015). At first, a pilot study was carried out in five sites in the country to ascertain feasibility before rolling out the programme nationally (GoZ 2011), with just over 2,000 men being circumcised during the study (GoZ 2012). The number of circumcised males reached 11,176 in 2010 and increased to 36,740 in 2011 (a 300 per cent increase in one year) (GoZ 2012:21).

The key government document on VMMC is the National Male Circumcision Policy for HIV Prevention whose goal is to "reduce the incidence of HIV infection and other STIs, penile and cervical cancer through provision of safe and voluntary male circumcision services" (GoZ 2009:1). The policy argues that VMMC is to be provided in terms of a human rights-based approach which emphasises safe delivery of the programme coupled with informed consent, voluntarism and confidentiality. The policy underlines the importance of incorporating VMMC into the then-existing HIV prevention package and HIV policy more broadly in Zimbabwe and the National AIDS Council is mandated to do this. VMMC is to be pursued in conjunction with HIV testing and counselling and with safe sexual practices

including the reduction in sexual partners and the promotion of correct and consistent condom use. As well, the delaying of sexual activities after circumcision for a period of six weeks is stressed to reduce chances of HIV infection during the healing period. Embodied in the policy is the need to fully respect women's rights by enhancing the full realisation of VMMC benefits to women, for example, reducing the chances of developing cervical cancer. Also important is the need to minimise any potential harm of VMMC to women as men may go around demanding unprotected sex with women on the basis of the 60 percent protection against HIV for men (GoZ 2009).

In Zimbabwe, VMMC is delivered in a multi-sectoral way. Partnerships have been formed within the public and private sectors (including donors, NGOs and traditional male circumcision practitioners) in the provision of VMMC, and each of these partners has their own mandate to undertake. The Ministry of Health and Child Welfare (MoHCW) has the overall responsibility of providing VMMC services and in the process ensuring professional, technical and administrative excellence. Currently, medical male circumcision is offered in five certified centres in Zimbabwe and, by the end of 2011, 540 health workers had received specialised training on VMMC (GoZ 2011). The MoHCW together with other stakeholders – such as NAC and Population Services International (PSI) Zimbabwe, which is a technical NGO partner in the VMMC programme – has devised appropriate communication packages about VMMC and operational standards including quality control. They also mobilise resources for VMMC and act as a link with traditional VMMC guardians and practitioners in exploring opportunities for the provision of safe male circumcision with these practitioners (GoZ 2009, Hatzold and Madidi 2013).

In fact, the government managed to convince traditional circumcision guardians to let trained medical male circumcision physicians and nurses from the VMMC programme to circumcise males during male circumcision among the Shangani, Venda and Varemba groupings. As a way of preserving the cultural significance of traditional circumcision, it was agreed that only male physicians and nurses would be allowed to carry out circumcision and only near a traditional site and not a healthcare facility (Hatzold and Madidi 2013). The 'marriage' between traditional and medical circumcision is a sign of mutual tolerance and respect. And the use of properly-trained health personnel has helped in reducing the number of tragedies during traditional circumcision (Hatzold and Madidi 2013). In addition, the traditionally-circumcised men are now provided with comprehensive information on HIV prevention including HTC, screening for STIs and condom promotion (before the initiates are circumcised).

In providing VMMC in Zimbabwe, as noted, human rights are supposed to be observed. In this context, no one is discriminated from accessing VMMC for non-medical reasons such as "race, religion, ethnic origin, sexual orientation or one's affiliation to labelled groups such as prisoners, men having sex with men or male sex workers" (GoZ 2009:2). With regard to discrimination on medical grounds, VMMC is not performed on HIV-positive men as a precautionary measure to avoid the risk of infecting female partners of these men. Counselling to HIV positive men is given to explain why they are not to be circumcised. In seeking to abide to the human rights dimension of the programme, VMMC is carried out only with voluntary informed consent. With respect to young children and infants, informed consent is obtained from parents or the toddler's legal guardian(s). Counselling is given to adolescent boys from 13 years and above so that they recognise and appreciate the benefits and costs of VMMC before making a decision to be circumcised or not. For both adults and children, counselling is done in a language they are comfortable with to make sure that they fully understand the concept and practice of VMMC (GoZ 2009). One human rights aspect highly observed, unlike in the case of traditional circumcision, is that of confidentiality such that one's privacy is respected. Medical practitioners are, therefore, expected to uphold this privacy and to not disclose any information on circumcision status without the consent of the circumcised male (GoZ 2009).

Communication messages have been developed to provide correct information on male circumcision and make it clear that VMMC is an additional prevention method for HIV-negative men (Hartzold et al. 2010, GoZ 2012). The VMMC initiative is linked closely with HTC to ascertain the HIV status of circumcised males before circumcision can take place; in a sense, HTC services is a key male circumcision entry point. As a way of reducing risk compensation by circumcised men (that is, to ensure that they do not see VMMC as a stand-alone measure), men who are interested in being circumcised go through an extensive counselling process through which they learn about the advantages and disadvantages of VMMC (Hatzold et al. 2010). They are all encouraged to avoid the kind of risky sexual practices outlined earlier, including the use of condoms since VMMC is not an invisible condom. Married men are specifically encouraged to be accompanied by their wives when they go for circumcision, so that wives also learn about the advantages and disadvantages.

An information pack is readily available in Zimbabwe on frequently asked questions on VMMC, and it details many of the points discussed above. The information provided though also seeks to clarify a number of key issues people often raise with regard to VMMC. For example, it indicates that the pain associated with the circumcision procedure is

manageable by the use of pain killers and that one can normally go back to work or school the day after circumcision. The wound arising from the procedure closes externally within about a week's time, but circumcised males are asked to observe and practice high levels of hygiene to avoid internal infections. Circumcised men are also encouraged to avoid erections and abstain from sex for six weeks to allow the wound to heal completely. The six-week abstinence period is insisted upon by medical practitioners since unprotected sexual intercourse any time earlier than six weeks exposes one to infection since the wound would not have healed completely internally. In relation to sexual activity after circumcision, many circumcised men testify that circumcision prolongs sexual pleasure.

VMMC in Zimbabwe has been affected by a number of challenges. Notably, the rolling out of VMMC has not been spared by the economic and financial problems deeply affecting the country (discussed later in the chapter). According to the government (GoZ 2012), the shortage of funds has stalled the implementation of VMMC services to district and community levels resulting in low uptake of the service in these places. This of course affects the national target of circumcising 80 percent of boys and men aged between 15-29 years by 2015, a target which is very unlikely to be met.

### 4.3.1 VMMC and Condoms

Because of the centrality of the use of condoms to this study, I provide a brief discussion of condoms in Zimbabwe in the context of VMMC. Without any vaccine available or in sight, ultimately HIV prevention is the mainstay of the response to the AIDS scourge in the country, including – but not exclusively involving – condoms and VMMC. Condoms are particularly important for individuals who fail to be faithful to their primary partners and have concurrent and casual sexual partners. Zimbabwe is recognised internationally as a country with high rates of condom distribution (Evans et al. 2012).

Condoms gained popularity in Zimbabwe in the HIV era although they were also used for the control of STIs prior to the rise of HIV (Mwajuma 2012). Despite the widespread distribution of condoms, and all the comprehensive laboratory tests and known scientific facts about condom effectiveness, condoms are still treated with some suspicion in Zimbabwe. There have been claims for example (admittedly more so in the past) that condoms facilitate the transmission of HIV through the lubricant mixing with the virus, and that condoms are not a source of protection since they regularly break during sex (ZHDR 2003). More importantly, though, it should be stressed that high condom distribution does not necessarily translate into high condom use or correct and consistent condom use, a point

pursued in my Harare study. Traditionally, there are two popular condom brands in Zimbabwe: the Protector Plus (P+), and the government-branded blue condoms (Evans et al. 2011). The P+ condoms are sold at a subsidised price of $0.10 (U.S.) each while the government's condoms are distributed free to users. The public though prefers the P+ to the government-branded condoms. Through social marketing, the P+ brand has managed to gain brand loyalty and this is supported by the fact that many people see it as "easy to use, strong, reliable, and effective" (Evans et al. 2011:2). Whether or not medically-circumcised males feel inclined to use condoms is important, in that their failure to do so (particularly if engaged in casual sex) makes them and their partners subject to the risk of HIV infection.

In Zimbabwe, the female condom was introduced by Population Services International Zimbabwe in 1997. The ensuing female condom programme involved the National AIDS Coordination Programme and the Zimbabwe National Family Planning Council, and it was part of a larger social marketing programme designed initially for male condoms and funded by the United States Agency for International Development and the British Department for International Development (Meekers and Ritcher 2005). This occurred after market research in Zimbabwe showed high levels of acceptability for female condoms (Meekers and Ritcher 2005:31). The female condom was introduced under the brand name 'CARE' as a 'contraceptive sheath' (rather than as a condom) and this was seen as necessary to reduce the stigma associated with sexually-transmitted infections and condom use. The product was supported by catchphrases such as 'the care contraceptive sheath is for caring partners' and 'for women and men who care' through mass media campaigns (Meekers and Ritcher 2005). Female condoms are sold, at a subsidised price, in pharmacies, supermarkets, hair-salons and other non-traditional outlets. These condoms are seen as important in empowering women because of pronounced patriarchal practices in the country which weaken women in negotiating their sexual relations. If medically-circumcised men engage in casual sex, and without using a male condom, then the female condom may offer their partners a degree of protection from HIV infection.

Studies on medically-circumcised males in Zimbabwe and condom use have yet to be undertaken, and hence the significance of my Harare-based study. But the available studies on condom use in the country demonstrate condom use as a site of contestation and negotiation between sexual partners. A study for instance conducted by Ray and Maposhere (2005) in Harare on female and male condom use by sex workers noted that about 30 percent of sex workers reported that they did not use condoms even with non-regular clients while 60 percent reported that they rarely or never used condoms with their boyfriends. As ludicrous

as it might sound, the sex workers argued that there was reciprocity between them and their boyfriends on the unwillingness to use condoms as a way of showing trust. Non-condom use also applied to their regular clients as a way of rewarding them for being good clients. In terms of HIV infection, such decisions result in all parties (sex workers, clients, boyfriends, and beyond) becoming potentially infected with HIV. At times, HIV infection may become malicious. Clients of sex workers in Harare have been accused of "wanting to leave a mark" on sex workers by making holes in the condoms so that the sex workers will either become infected or fall pregnant (Ray and Maposhere 2005:101).

Also of significance is negotiating skills around condom use. In the same study, it was established that most sex workers who were part of a peer education programme (which included condom use promotion and condom negotiation skills) were able to convince their clients to use condoms. They managed to do this by expressing and demonstrating the mutual interest (of both the sex worker and client) in consistently using condoms so as not to infect or re-infect each other. This did not detrimentally impact on the activities of sex workers in terms of business levels. Such education programmes, if pursued more extensively, presumably would be relevant beyond sex work activities and apply to the general public as a whole. But for this thesis the key point is that, because VMMC provides only partial protection, the question of condoms and condom use invariably enters into the sexual relations and activities of VMMC males.

### 4.4 Socio-Cultural Practices and Socio-Economic Crises

In order to contextualise my Harare-based study further, it is necessary to examine the social conditions and realities of life in contemporary Zimbabwe and how this impacts on sexual practices. With all the policies, strategies, campaigns and programmes implemented so far in Zimbabwe in a bid to curtail HIV and AIDS, it would seem clear that the majority of Zimbabweans know the importance of safe sexual practices, especially the importance of using condoms in heterosexual relationships as a way of preventing HIV with casual sexual partners. The ABC method of prevention, namely, abstaining from sex, being faithful to your partner and condom use (correct and consistent), is widely recognised and known. But a linear relationship between knowledge and practices does not exist, as knowledge is mediated by on-the-ground social realities. For instance, as Caceres and Race (2010:177) note, pursuing particular sexual practices is not simply a question of making rational choices based on sound knowledge:

> By focusing on modifying individual high risk behaviour, … early intervention presumed empowered individuals [empowered through knowledge] will make decisions based on rational choices but disregarded the extent to which individuals either did not decide what they did sexually or did not have the chance to so decide given the power imbalances and the partners broader conditions of vulnerability.

In this context, I examine socio-cultural practices linked to sexuality and patriarchy, and the socio-economic conditions characterised by ongoing crises of livelihoods in Zimbabwe. These more, macro-level, structural dimensions must be taken into consideration when seeking to understand sexual practices, as individuals and individual choices about sexual practices are conditioned by them.

### 4.4.1 Patriarchy, Sexuality and Morality

I first endeavour to examine issues around sexuality and patriarchy in Zimbabwe which may lead to vulnerability with regard to HIV and AIDS by for example compromising prevention for certain individuals or social groupings in and through risky sexual practices (Amon and Kasambala 2009, Blankenship et al. 2006). In other words, socio-cultural factors in Zimbabwe entail power relations particularly between men and women and thereby influence sexuality and the spread of HIV because of questions of protection, risk and vulnerability.

Zimbabwe is a pronounced patriarchal society. Patriarchal structures, practices and discourses tighten the grip on women in terms of power differentials and female subordination. The hold of patriarchy is distinctively felt and exercised in marriages. According to Mate (2002:557) "marriage not only compels women to marry but also romanticises female subordination to men". She further notes that gendered messages, including religious-based messages, encourage women to be submissive to their husbands and, in the era of HIV, this is particularly dangerous as it exposes women to HIV infection. By and large, women in Zimbabwe are not supposed to question their husbands and they may find it difficult to introduce the use of protection (such as condoms) into marital sexual relations even when they suspect promiscuity on the part of their husbands.

Although clearly discouraged in HIV prevention programmes in Zimbabwe because of their role in transmitting HIV, both polygamy and concurrent sexual partners (CSPs) among men are common and everyday practices in the country (Government of Zimbabwe 2006, Chingandu 2007, Leclerc-Madlala 2004). In fact, polygamy is as acceptable in Zimbabwe as is the practice of CSPs. These practices continue to be embedded in cultural beliefs as is denoted by the local proverb that says that 'a man is like a bull which is not

restricted to one kraal' (Schapera 1940). They also depict the notion that a man's manhood or masculinity in society is exhibited and reinforced by the number of sexual partners he has (Gumbo 2011). According to Maunze (2009), men in Zimbabwe are not blamed for their infidelity and promiscuity as the plurality of sexual partners is taken for granted and discreetly anticipated for any normal male (Rushing 1995). In addition, women (particularly female spouses) are regularly blamed for men's extra-marital affairs, and people rush to conclude that there is something women "are not doing right" (Mate 2002:558) when a married man engages in extra-marital sex. Male promiscuity in Zimbabwe, therefore, is almost seen as naturally inherent in the embodied male.

In Zimbabwe, besides polygamy, there is a new rampant phenomenon of concurrent sexual partners called 'small houses', which has taken the centre stage in the country in so far as sexuality is concerned. This phenomenon is so grave that the President of Zimbabwe, Robert Mugabe, makes mention of it and cites the seeming difficulty of men in refraining from it much to the detriment of women (Gumbo 2011). As Chingandu (2007:1) puts it, a small house is "an informal, long term, secret sexual relationship with another woman who is not a man's legal wife, carried on in a house that is a smaller version of the man's own home in another residential area". In this type of relationship, a man will have a regular sexual relationship with a woman secretively, while maintaining conjugal duties with his primary partner who is either his legal wife or permanent partner with whom he lives.

Chingandu (2007) undertook a study to identify the reason for the widespread existence of small houses. In this regard, most men are aware of the dangers of contracting HIV from prostitutes and – as a way of quenching their desire for extra-dyadic sexual relationships – they have shifted their attention to a 'safer' way of sexual enjoyment through small houses. Most of the men interviewed in the study indicated that the practices of abstinence, faithfulness and condom use as well as monogamy are unsuitable since they know that, culturally, a man is entitled to several sexual partners. The men also indicated that they considered their permanent partners as nagging and too demanding in terms of purchases of household requirements and, because of this, there was no peace in the home. As well, permanent partners become relaxed and complacent, and refrain from properly undertaking their domestic duties including pampering their husbands. The conflict which arose often led to women adopting sex deprivation as a way of punishing their husbands. Men resort to small houses as a way of re-acquiring respect and love, with 'small house' women supposedly going the extra mile sexually including consenting to oral and anal sex (which is grossly objected to by their wives or primary partners). In this regard, *Xtra Large* (a Zimbabwean

music group) sings of the ways in which men seek to justify the existence of small houses. In their song *Amai* Linda (Mother of Linda, which refers to the name of a small house), they mention filthiness of permanent partners as one of the major reasons why men establish small houses, as manifested in the failure of wives to brush their teeth and shave their pubic hair. *Amai* Linda is depicted as the very opposite of this.

In Zimbabwe, small houses, polygamy and concurrent sexual partners more broadly regularly entail risky sexual practices, as most men involved in these relationships do not use condoms. For instance, in their view, women living in small houses are different from casual sexual partners and are therefore treated as safe (or clean) in terms of the transmission of HIV. They see them as faithful and trustworthy and thus, like their permanent partners, they feel no obligation to introduce the use of condoms into the relationship. And women in small houses, because of their subordinate role and the material gains coming their way, are disinclined to insist on condom use. The work by Gregson et al. (2007) in fact shows very minimal evidence of condom use in small houses, such that perceptions and claims about non-risk in contracting HIV through small houses has facilitated the spread of HIV.

### 4.4.2 Socio-Economic Conditions and Crisis

Socio-economic conditions and crisis also play a major role in understanding and explaining the spread of HIV and AIDS in Zimbabwe. The Zimbabwean political economy after independence in 1980 can be broken down into three phases, namely: the early post-colonial period from 1980 to 1990, the neoliberal period from 1991 to 1999, and the 'crisis' period from the year 2000. Events in the economic and political domains of these periods, particularly the latter two periods, culminated in fragile conditions which enhanced HIV risk and vulnerability; and I therefore focus on these two periods.

In the initial years after independence, Zimbabwe was one of the wealthiest countries in sub-Saharan Africa (UNDP 1990). Economic growth was relatively steady and significant during the 1980s, with an average growth rate of between three to four percent per annum and registering a peak of seven percent in 1990 (GoZ 2010). There was significant public expenditure of a redistributive kind (in health and education in particular), a growing diversification of exports driven by agriculture, mining and manufacturing, and broad-based food security (Kingston et al. 2011, Amon and Kasambala 2009). All this changed in the 1990s.

#### 4.4.2.1 Crises – Structural Adjustment and Fast Track

The government of Zimbabwe succumbed to global pressure from the World Bank and the International Monetary Fund (IMF) to adopt a structural adjustment programme known as Economic Structural Adjustment Programme (ESAP) in 1991 because of – from a neoliberal perspective – problematic macro-economic indicators (Pappas 2012) including national trade imbalances and financial deficits; though there were also local social forces supportive of ESAP. Like structural adjustment programmes internationally, ESAP came with a range of conditionalities to which the Zimbabwean government had to adhere to allow for ongoing loans from global multilateral organisations like the IMF. In general, the conditionalities included: privatisation of state-owned or -run institutions; minimum government intervention in the provision of basic goods and services including health and education; devaluation of the local currency; trade liberalisation; market liberalisation; and reduction of the budget deficit by reducing the civil service labour force (Pappas 2012, Kingston et al. 2011, Gibbon 1995, GoZ 2010, Barnett and Blackwell undated).

Most scholars concur that the implementation of ESAP brought more harm than good to Zimbabwe (Kawewe and Dibie 2000, Malaba 2006). This is chiefly because ESAP resulted in the downsizing of the formal economy throughout the country (Pappas 2012) which was not compensated for by significant developments in the informal economy (Gibbon 1995). ESAP unleashed a string of massive retrenchments and salary cuts (in real terms) in both the public and private sectors, and thereby increased rates of poverty or near poverty (Malaba 2006). Those who were fortunate enough to remain at work had their real incomes reduced. The overall result of ESAP in Zimbabwe, therefore, was increased poverty as a result of for example decreases in real wages, a rise in unemployment, incessant inflation and a plummeting in export competitiveness. This was manifested in a fall in the value of the Zimbabwean dollar. In 1990, before adopting ESAP, the United States/Zimbabwe exchange rate was 1USD:2.53ZWD but by 1994 the rate was 1USD:8ZWD (Gibbon 1995). As well, the inflation rate rose to 22.9 percent by 1995 from 12.4 percent in 1990 (Malaba 2006). The real GDP growth averaged only 1.5 percent per annum from 1991 to 1995 compared to 7 percent in 1990.

After ESAP, various government macro-economic programmes were developed and implemented to rectify the problems emanating from ESAP. This was done through the implementation of so-called ‘home-grown’ packages, namely: the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST 1996-2000); the Millennium Economic Recovery Programme (MERP) in 2001 and the National Economic Revival Programme

(NERP) in 2003. These programmes though did not lead to significant economic recovery, particularly in the light of the pursuance of the fast track land reform programme from the year 2000, which led to a deeper economic crisis. Fast track reform arose in the context of significant urban-based struggles against ESAP.

Thus in the late 1990s, in response to ESAP, there was heightening mobilisation by the trade union movement, and growing militancy from discontented workers including the previously-loyal public service employees. Strikes and stay-aways took place, organised by the main union federation – Zimbabwe Congress of Trade Union (ZCTU) – as workers demanded higher wages in the light of high rates of inflation. The actions by ZCTU also had a pronounced political dimension and, in alliance with the burgeoning urban civic movement, the protests resulted in the formation of a new political party, the Movement for Democratic Change (MDC) in late 1999 (Raftopolous and Phimister 2003). In early 2000, after the defeat of the ruling ZANU-PF party in a constitutional referendum (February 2000), land occupations of white commercial farms started to occur throughout the Zimbabwean countryside. The government, in response, introduced the fast track land reform programme which legitimised the occupations and the economy went into a downward spiral in this context.

The post-2000 period has been dominated by a range of economic crisis indicators. Inflationary pressures for instance exploded in this period. Inflation had already risen from 19 percent in 1997 to 56 percent in 2000 but, in 2008, it shot up to an astronomical 231 million percent such that Zimbabwean money was valued in sextillions (Chagonda 2010). In the year 2008, near the height of the crisis, more than 70 percent of the Zimbabwean population was in need of food aid (IMF 2009). There were basic food shortages, including mealie meal (the staple food), cooking oil and even salt. In fact, supermarkets and grocery shops were literally empty since there was nothing to shelve. Fuel and cash were also in short supply and winding queues became an everyday sight as people waited indefinitely to withdraw money from banks for purchasing whatever foodstuffs were available. Due to shortage of basic commodities, there was a major resurgence of an informal market economy which in effect was an illegal black market. The market forces of demand and supply ostensibly came into play with demand extraordinarily surpassing supply since the local manufacturing industry was no longer viable. Many companies in fact closed down. The growth in GDP in 2006 was a negative -5.7 percent, employment growth recorded a negative rate -7.5 percent and it was estimated that only 7 percent of economically-active individuals were formally employed (IMF 2009, Coltart 2008).

4.4.2.2 Crisis and HIV

Like the socio-cultural dimension, the socio-economic conditions prevailing in Zimbabwe have had both direct and indirect implications for HIV and the transmission of HIV. Indeed, the socio-economic crisis in particular disadvantaged women and hence the crisis relates to the socio-cultural dimension.

The introduction of ESAP exacerbated the prevalence of the feminisation of poverty (or poverty amongst women) as witnessed by the increased number of female-headed households as well as increasing intra-household inequalities with a bias against women (Moghadam 2005). This is indicated in statistics on poverty. According to Malaba (2006), poverty became generalised in Zimbabwe because of ESAP. For example, the Human Development Index (HDI) for Zimbabwe fell from 0.468 percent in 1995 to 0.410 percent in 2003. However, the average percentage of female-headed households in dire poverty between 1995 and 2003 is more than that of male-headed households, with the respective figures being 68 percent and 60 percent. More generally, by the end of the 1990s, the HDI for females in Zimbabwe stood at 0.373 percent as compared to that of males which stood at 0.429 percent (Malaba 2006).

With regard to HIV, Pappas (2011:29) claims that "the rise in the level of poverty and unemployment as a result of economic problems caused largely by programmes instituted through ESAPs greatly affected the spread of HIV and AIDS throughout the population". Kawewe and Dibie (2000) concur and, in the prevailing HIV and AIDS discourse globally, poverty is privileged as one of the distinct causes of the HIV pandemic such that it is sometimes called a disease of poverty (Gillies et al. 1996). It is clear that deepening poverty leads to further socio-economic marginalisation and to increased levels of vulnerability vis-à-vis HIV. For some women in urban Zimbabwe, survival was enhanced by engaging in transactional sex as a way of earning a living. Particularly in the light of patriarchy, such transactions leave women without considerable say with respect to safe sex.

Socio-economic challenges in Zimbabwe have disrupting the lives of working people in other ways, thereby increasing their vulnerability to HIV. In this regard, such challenges regularly led to heightened mobility and migration, both internally and across the Zimbabwean border. This has been particularly prevalent since the year 2000, including significant movements to South Africa and Botswana in search of employment and improved livelihoods. Migration plays a very important role in facilitating the spread of HIV due to the inter-connectedness between disease and mobility. In this regard, the International Organisation for Mobility (IOM 2005:21-22) identifies four key ways through which

mobility or migration enhances the transmission of HIV. These are: through encouraging direct vulnerability to high risk sexual practices; putting people out of reach of preventative education, condom provision and HIV testing; the existence of multi-local social networks amongst migrants which create opportunities for sexual networking; and higher rates of HIV infection in 'communities of the mobile', which often include socially, economically and politically marginalized people.

In the years prior to independence in Zimbabwe, rural to urban migration was dominated by men who went to look for employment in the urban areas or mines in Zimbabwe. Since these men retained families in the rural areas they would often travel back to the rural areas to be with their families. Many of these men became infected by STIs in urban centres as they sought out extra-marital sexual relationships to satisfy their sexual desires in the absence of their partners; on return to rural areas, they would often infect their partners there. The attainment of Zimbabwean independence saw women travelling more freely to urban areas to seek employment in a process which can be labelled as the feminisation of migration. The relationship between mobility and infection (STIs and HIV) though is bidirectional, whereby the migrant as well as the partner who remains behind may both become ensnared in engaging in unsafe sexual encounters in the absence of the partner. Thus, as central to broader processes of mobility, migrant labour has "almost certainly been one of the key factors driving the HIV epidemic in Southern Africa [including Zimbabwe] with migration in which men are separated from their wives, and vice versa, being one of the most important determinants of the spread of HIV infection" (IOM 2005:27).

ESAP and subsequent periods of socio-economic crisis in Zimbabwe, as noted earlier, saw substantial growth of the informal economy. Although informal activities are a demonstration of the ingenuity and perseverance of working people under dire circumstances, these activities are rooted in a set of production relations which "reverse the process of proletarianisation, weakens the right of workers and unions and disenfranchises large sections of the working class – who are then condemned to undeclared, non-contractual, badly paid and hazardous work" (Gibbon 1995:22). As part of this process, and sometimes as a reaction against it, Zimbabweans have ventured into cross border trading in which they purchase products outside the country (notably in South Africa) and sell these products back home in order to survive. Women have in particular been involved in cross border trading and, for them it has proven to be "an effective response to poverty and economic hardships" (Muzvidziwa 2012:218, United Nations Entity and Empowerment for Women undated). The

phrase *'vakadzi vekuSouth'* has been coined to highlight the prevalence of women traders going to South Africa and other neighbouring countries.

However, due to increased mobility across borders and the absence of permanent partners while away, cross border trading exposes traders and their sexual partners back home to HIV (GoZ 2008). In particular, "entrepreneurs and workers highly mobile [and] away from spouses for long periods … with limited access to HIV prevention information and services" are subject to high risk sexual activities (GoZ 2008:2). Besides consensual sexual relationships of an unsafe kind, Chiliya et al. (2011) point out that women are regularly forced to engage in transactional sex along the trading corridors to secure accommodation and transport or even to facilitate movement across borders. Some are also sexually abused through rape which in most cases goes unreported or, if they do make a report, it may be too late for prophylaxis to be applied to prevent HIV infection.

A study done by Nyangairi (2010) focuses on migrant women from Zimbabwe who ended up joining the sex work industry as a livelihood strategy in Johannesburg, South Africa. Women perceived this as a temporary and expedient strategy in their time of crisis, as they failed to secure the much anticipated employment opportunities in South Africa. In other words, sex work was a second option or an afterthought after they had failed to secure other forms of employment and given that they had the responsibility to send remittances back home to Zimbabwe. Also, societal (gender-based) expectations on what makes a good mother, daughter, sister or aunt therefore impacted on these female immigrants, as they remitted goods or cash to their nuclear or extended families. Youngleson (2006:11) refers to this as the "good mother discourse which stresses the duty of the mother as a care giver to her children and one who is 'ever bountiful, ever giving and self-sacrificing mother'". Their sex work activities clearly exposed them to the danger of HIV, particularly when the client compensates for the risk to the women by paying the sex worker extra for sex without a condom (Nyangairi 2010). In this way, paying for sex by men results in men having the power to determine condom use (Ray and Maposhere undated).

The government of Zimbabwe, in its supposed quest to restore sanity in major cities and towns in terms of housing and informal economic activities, implemented the locally and internationally bemoaned Operation *Murambatsvina* (translated it means Operation Restore Order) in June 2005. This led to significant internal displacement. According to Tibaijuka (2005:2) Operation *Murambabtsvina* was officially described as a programme to enforce by-laws to stop all forms of alleged "illegal activities in areas such as vending, illegal structures, [and] illegal cultivation". With the Zimbabwean economy increasingly dependent upon the

informal sector from the early 1990s, the operation plunged urban working people into calamitous poverty since their means of existence and livelihoods were literally destroyed with the mass destruction of backyard shelters and informal businesses. In her detailed report, Tibaijuka (2005:39) concluded that:

> The Operation has led to an increase of vulnerability and, probably, risky sexual practices and gender-based violence. It has also led to a disruption in HIV and AIDS services, particularly ARV treatment, home-based care and prevention. Immediate consequences likely include shortened life expectancy and death owing to lack of treatment and care in a situation where life expectancy has already dropped to only 33 years, malnutrition and exposure to the elements. Medium to long-term consequences include increased transmission of HIV, leading to higher infection rates and a more rapid progression of the disease that may only be detected over the next few years.

In light of this, it is not only the spread of HIV which is enhanced by people's movements, as the provision of HIV and AIDS related services was also gravely disturbed in Zimbabwe, including the availability of condoms, home-based care, and counselling and testing services. In some cases, more problematic cases of AIDS arose because of the development of drug resistant regimens as patients defaulted on their treatment because of internal displacement from Operation *Murambabtsvina*.

### 4.5 Conclusion

This chapter, along with the previous chapter, provides the Zimbabwean context to my Harare-based study discussed in chapters five and six. In this chapter, I spoke specifically about HIV prevention methods, with a particular focus on voluntary medical male circumcision in Zimbabwe and its relationship to condom use. I also discussed the socio-cultural practices and socio-economic conditions in Zimbabwe which impact in some way on all dimensions of the HIV pandemic, including prevention, support and treatment. Medically-circumcised men in Zimbabwe, like everyone else, do not live as free-floating agents outside of conditioning forces. Besides the conditioning of state policies and programmes around HIV discussed in chapter three, in which they are involved directly and intimately because of their circumcised status, they are also in their own way conditioned by the socio-cultural practices and socio-economic crises. In the end, these conditioning forces shape their day-to-day sexual practices subsequent to circumcision. This should not imply though that all medically-circumcised males engage in the same sexual practices, as each circumcised male has his own personal history and social biography and has a degree of agency to pursue

particular sexual practices to the exclusion of others. In the following two chapters, I discuss the sexual practices of twenty-five medically-circumcised males from Harare but with some sensitivity to diversity within this group.

# CHAPTER FIVE
# CASE STUDIES FROM HARARE: CIRCUMCISION, SEXUAL PRACTICES AND CONDOM USE

## 5.1 Introduction

This chapter and the following chapter discuss my study of medically-circumcised males in the capital city of Harare in Zimbabwe, with particular emphasis on their sexual experiences and practices in the light of circumcision. Frank and detailed interviews were conducted with twenty-five medically-circumcised males to elicit their ideas, views, and actions with respect to such sexual matters as condom use, concurrent sexual partners (CSP) and/or casual sex, and risk compensation. A particular concern is to determine if sexual practices differ after circumcision and if circumcision and condom use are treated by circumcised males as complementing each other or as substituting for each other. Based on the study, it appears that there is no clear linear relationship between medical male circumcision and reduced risky sexual practices; in fact, the relationship is highly complex and varies considerably between circumcised males such that it is difficult to come to any general and definite conclusions. Though there is some evidence of reduced risky practices, the relationship between circumcision and sexual practices is regularly mediated by intervening variables which are specific to particular males.

The main focus of this chapter is on both pre-circumcision and post-circumcision sexual practices and condom use. Before discussing these two main themes, I provide a short contextual background to the study and a profile of the twenty-five circumcised male participants (sections 5.2 and 5.3). The next section (section 5.4) on sexual practices discusses such sub-themes as sexual activity and concurrent sexual partners, while the ensuing section (section 5.5) on condoms looks at condom access, condom brands, correct usage of condoms and condom use aversion.

## 5.2 Background to the Study

The study site of the thesis is Harare, the capital city of Zimbabwe which has a total population of 2,098,199 million people (Zimstat 2012). VMMC is a new practice in Zimbabwe and it began in the capital city but is now also being performed in other parts of the country. Although studies show significant VMMC acceptability amongst adult men in

Zimbabwe, generally speaking there are mixed feelings amongst males as manifested in the low levels of uptake by uncircumcised males (Chimuti 2013, SAfAIDS 2013). Indeed, ever since the introduction of VMMC in 2009, the practice has failed to gather the expected momentum in terms of the sheer number of males undergoing VMMC (Chimuti 2013).

Currently, the government and other stakeholders (including NGOs, donors and multilateral institutions) advocating for VMMC are bemoaning this seeming resistance, particularly since statistical projections show that official circumcision targets will not be reached by a long shot (SAfAIDS 2013). Zimbabwe aims to circumcise, between 2010 and 2105, at least 80 percent of HIV negative adolescent and adult males aged between 15-29 years which amounts to 1.2 million males (Fraser et al. 2012). To this day, since 2009, about 8 percent of the targeted number of males has been circumcised (SAfAIDS 2013). There are clearly serious problems confronting the Zimbabwean state in this regard, and it may need to go back to the drawing board and re-strategise the ways in which men can be convinced to undergo VMMC.

Starting in 2009, VMMC was adopted in Zimbabwe mainly as an HIV prevention method to partner with the already-existing methods, specifically correct and consistent condom use, being faithful to one's partner, and prevention of mother-to-child transmission (Fraser et al. 2011). Male candidates for VMMC must meet strict criteria, as a form of screening, before being considered for the operation, notably with reference to HIV status and age. The state at no time has sought to minimise or loosen the criteria in order to facilitate broader uptake of VMMC.

VMMC is offered on the basis of age starting from 13 years of age (Government of Zimbabwe undated). At the age of 13, the adolescent is envisaged as able to understand his actions although not totally responsible for such actions. For this reason, boys from 13 to 17 years have to seek parental or guardian consent for the operation. Males under the age of 13 years of age are not entitled to VMMC. Men older than 29 are also encouraged to be circumcised though they do not form part of the priority age grouping. HIV status is also a critical screening factor for VMMC. With VMMC mainly done for the purposes of HIV prevention from HIV positive women to men, only HIV negative men qualify for this programme as an HIV incidence reduction measure (Fraser et al. 2011). Men who are interested in being circumcised undergo HIV testing as well as risk reduction counselling prior to getting circumcised (Fraser et al. 2011).

Risk reduction counselling is offered in two sessions, namely, group and individual counselling. I attended one of the group counselling sessions (on July 18, 2013). At such

sessions, discussions about circumcision as an HIV prevention measure are conducted by a trained professional counsellor with the candidates volunteering to be circumcised. The following in particular is brought to the fore: explanations of how circumcision reduces the HIV transmission probability from infected women to men; the need to continue using protection in the form of condoms with a person of unknown HIV status despite the fact that one is circumcised (since VMMC offers partial protection only); demonstrations by the counsellor of how to correctly put on a condom before sex and how to remove and dispose of it after sex; how to look after the wound arising from the VMMC operation to avoid infection; the need to avoid erotic thoughts soon after the operation which might trigger an erection and break the post-operation stitching prematurely; and the need to observe the waiting period before one resumes sex after circumcision. At the session I attended, the counsellor also responded to questions and any other matters arising from the discussion.

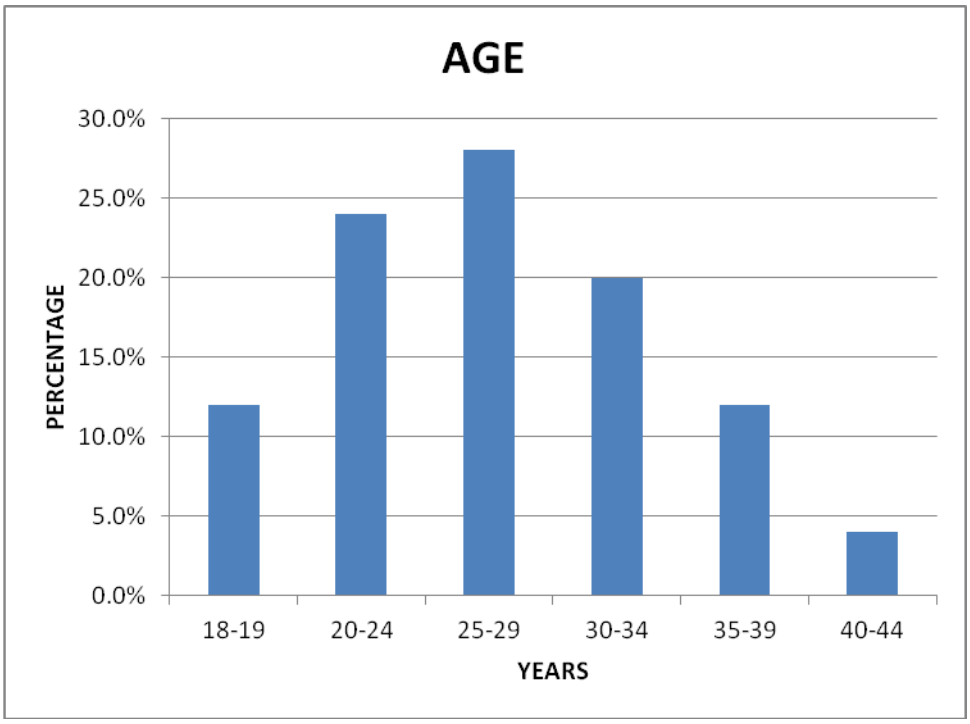
The study population for this thesis focuses exclusively on men who were circumcised for HIV prevention at the recently-established circumcision centres in Harare and who – prior to the operation – received HIV testing and risk reduction counselling. As indicated, HIV testing and counselling is used during the screening process. A man interested in undergoing VMMC first undertakes HIV testing and counselling and qualifies for circumcision when found HIV negative. Counselling is, therefore, given according to one's HIV status (positive or negative). Thus, individuals who participated in this study went through the screening process successfully and qualified for circumcision.

### 5.3 Profile of Study Population

In this section, I profile the medically-circumcised males who form the basis of the study, before going on to examine their sexual practices. The profile variables pertinent to the study participants, as discussed below, include the following: age, marital status, education and employment.

The majority (52%) of the participants in this study are in their twenties. More specifically, 24 percent of medically-circumcised males in this study fall within the 20-24 years age range and 28 percent within the 25-29 years age grouping. Additionally, 12 percent is aged either 18 or 19 years, 20 percent is within the 30-34 year age range, 12 percent is in the 35-39 age grouping and the smallest grouping (4 per cent) is between 40 to 44 years (See Figure 5.1).

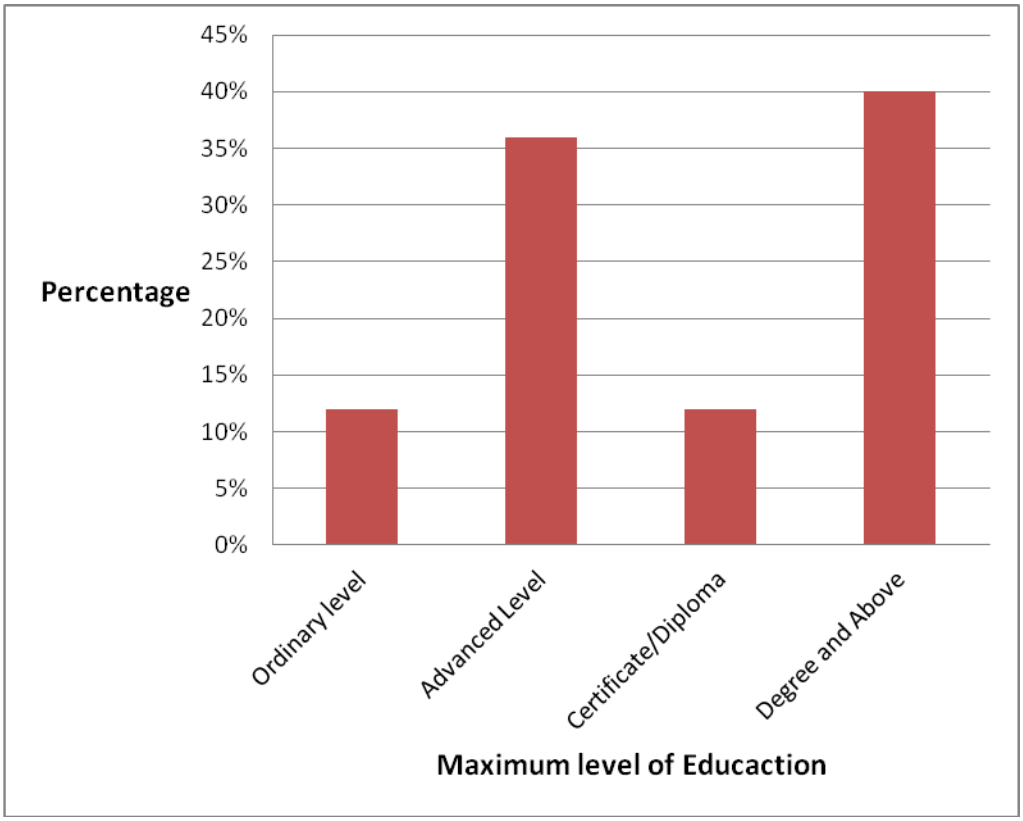
**Figure 5.1: Ages of Study Participants**




In this study, 32 percent of the population is made up of married men whilst the majority (68 percent) consists of single men. Single men predominate amongst the under-30 age groups. For instance, the 18 and 19 year olds are still in school, and only 2 of the thirteen males in their twenties are married. None of the participants in this study reported being widowed or divorced.

In this study, 12 percent of the men had achieved an ordinary secondary level education as their highest qualification of education while 36 percent had advanced secondary school education and 12 percent a post-secondary school certificate or diploma. Nearly half (40 per cent) of the men had at least a degree as their highest educational level (See Figure 5.2). There is a correlation between the level of education and knowledge of medical male circumcision and its potential benefits. Thus, participants with a diploma/certificate or degree knew more about the preventative effects of medical circumcision over and above simply basic knowledge of sexually-transmitted diseases (including HIV), as compared to participants with a secondary school education. Besides mentioning the commonly-known preventative advantages of male circumcision (in relation to HIV, cervical and penile cancer) those with post-secondary education also made mention for example of the preventive efficacy of circumcision against Human papillomavirus (Castellsague et al. 2002, Gray et al. 2010).

**Figure 5.2: Educational Levels of Study Participants**




With regard to employment or occupation status, 52 per cent of the circumcised males are formally employed while 20 and 8 per cent of the participants are self employed and unemployed respectively. Students make up 20 per cent of the study participants. A full list of all twenty five participants in the study is found in Table 5.1 (with a breakdown in terms of age, education, employment, marital status and – discussed below – sexual activeness).

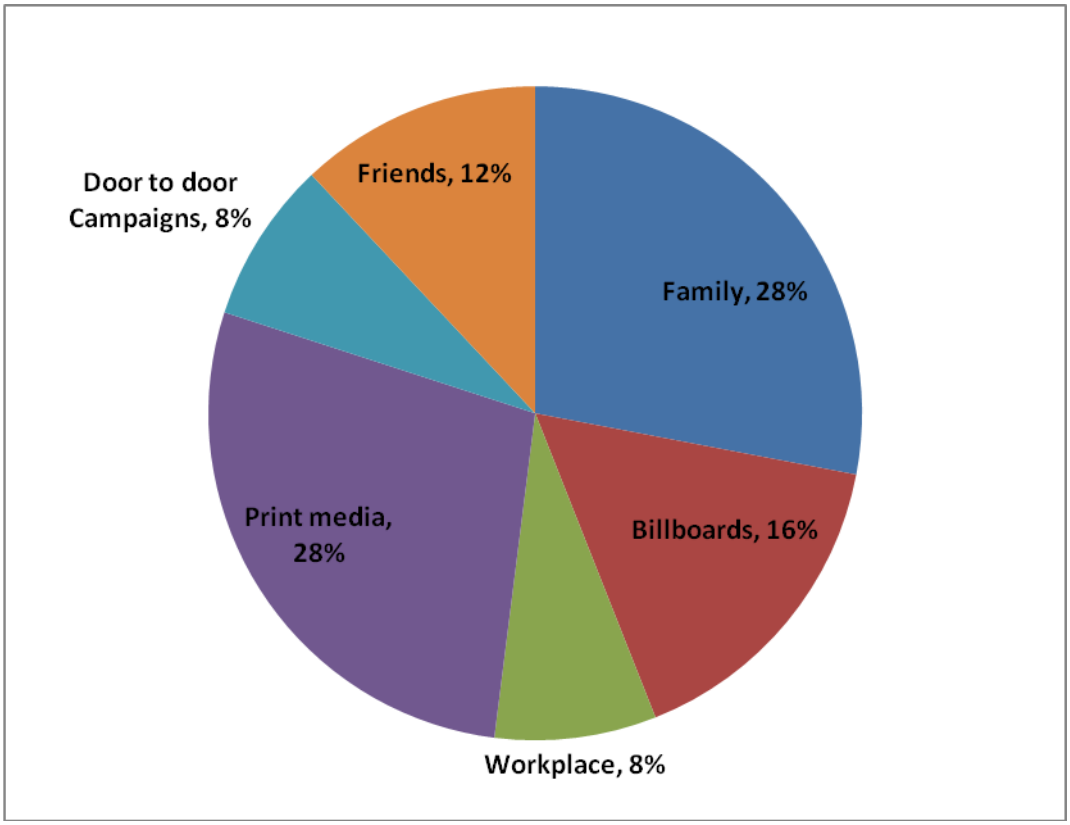
All the participants in this study reported that they heard about male circumcision from advertisements mainly on radio and television. Over and above these two media medium, there are other ways mentioned by participants that facilitated their interest in male circumcision and being circumcised. After the significance of radio and television, the following were reported as other important sources of VMMC information: 24 percent reported seeing billboards which displayed prominent international and national footballers in Zimbabwe encouraging males to become circumcised; 8 percent also heard about circumcision at work through HIV workplace prevention programmes run by their work organisations; 28 percent learnt about VMMC through the print media; 20 percent through campaigns done either in their schools or area of residence; 4 percent spoke about it with

friends; and 16 percent received encouragement from a family member or family members (see Figure 5.3 for sources other than the radio and television).

**Table 5.1: Profile of Study Participants**

| Participant Name | Age | Highest level of Education achieved | Employment Status | Marital Status | Sexual Activeness |
|---|---|---|---|---|---|
| 1 | 18 | Secondary level | Self employed | Single | Not Active |
| 2 | 19 | Advanced level | Student | Single | Not Active |
| 3 | 19 | Advanced level | Student | Single | Not Active |
| 4 | 20 | Secondary level | Student | Single | Active |
| 5 | 22 | Advanced level | Student | Single | Not Active |
| 6 | 23 | Advanced level | Self employed | Single | Active |
| 7 | 23 | Advanced level | Student | Single | Not Active |
| 8 | 24 | Advanced level | Unemployed | Single | Active |
| 9 | 24 | Degree | Unemployed | Single | Not Active |
| 10 | 25 | Degree | Employed | Single | Active |
| 11 | 25 | Diploma | Employed | Single | Active |
| 12 | 26 | Advanced level | Employed | Single | Active |
| 13 | 27 | Diploma | Employed | Single | Active |
| 14 | 28 | Degree | Employed | Married | Active |
| 15 | 29 | Degree | Employed | Single | Active |
| 16 | 29 | Degree | Employed | Single | Not Active |
| 17 | 30 | Degree | Employed | Single | Active |
| 18 | 31 | Degree | Self employed | Single | Active |
| 19 | 33 | Degree | Employed | Married | Active |
| 20 | 33 | Advanced level | Self employed | Married | Active |
| 21 | 34 | Advanced level | Self employed | Married | Active |
| 22 | 35 | Secondary level | Employed | Married | Active |
| 23 | 37 | Degree | Employed | Married | Active |
| 24 | 39 | Certificate | Employed | Married | Active |
| 25 | 40 | Degree | Employed | Married | Active |

**Figure 5.3: Sources of VMMC Information**




## 5.4 Sexual Practices

In this section, I begin to detail the sexual practices of the study participants; further discussions of these practices occur later. In particular, I focus on sexual activeness, the existence of CSPs before and after male circumcision, knowledge about their HIV status and that of their sexual partners post-circumcision, and adherence to the stipulated waiting period after the operation before resuming sexual intercourse. It should also be noted that the average number of years after circumcision of the participants is 1.5 years. The question of condoms and condom use, which is central to the thesis, is discussed in a later section. Some of the evidence suggests an acute awareness of refraining from risky sexual practices post-circumcision, but other evidence seems to indicate otherwise.

### 5.4.1 Sexual Activeness

Closely related to the subject of marital status in a study which focuses on sexual practices is the question of sexual involvement by the study participants, that is, whether participants are sexually active or not. In this respect, the total percentage of sexually-active participants

(including those who are single) is 72 per cent. All married men are sexually active while, of the single men, just below 60 per cent are active.

None of the participants in 18-19 years age group, all of whom are single, recorded sexual activeness. On being asked why they are not yet sexually active, one of these young participants said:

> *I am preoccupied with school. Besides, my dad always counsels me showing me the advantages and disadvantages of engaging in early sexual activities. I have a girlfriend and most of my friends have had sex with their girlfriends but for me I feel it's not time yet. One of them told me he had unprotected sex, a risk which my dad mentions and warns me against. I just want to finish school first. I believe there is time for everything and such time is coming.* (Interview, 7 August 2013)

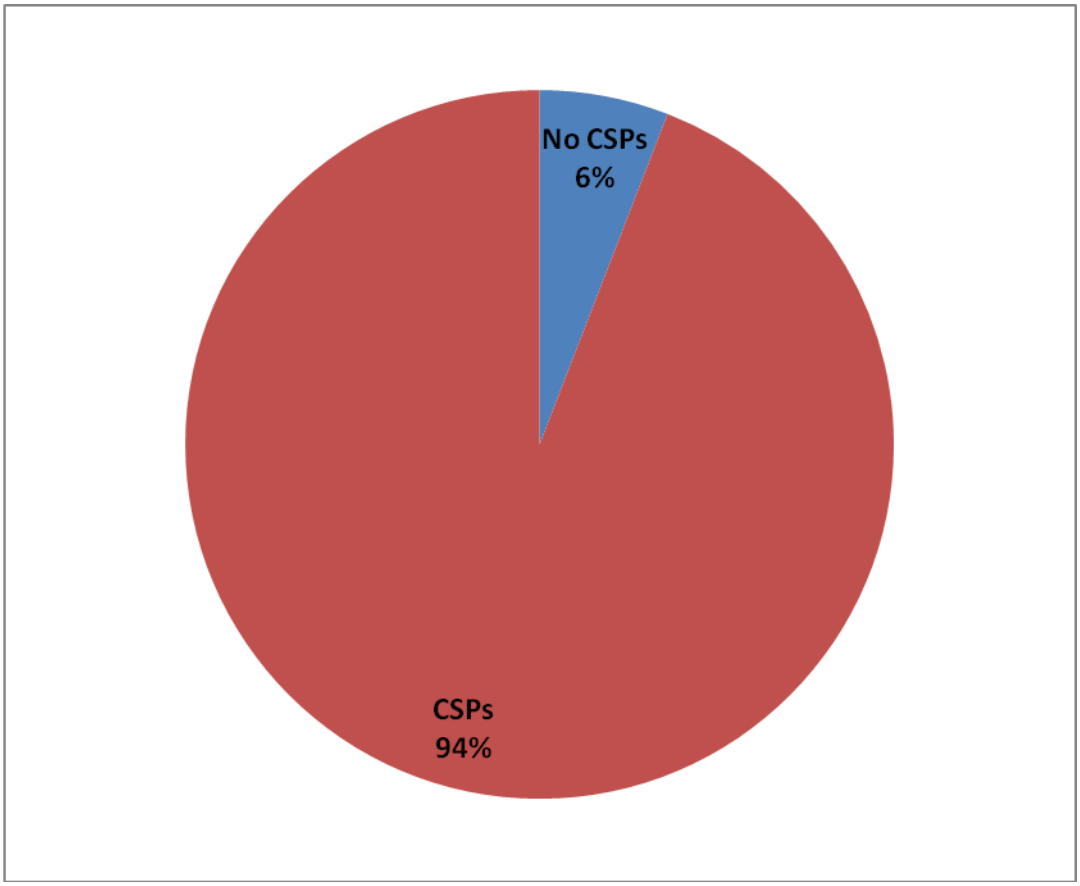
Abstinence or sexual inactivity was not only recorded among the 18-19 age grouping. It was also recorded among participants in their twenties (but not amongst any participant in their thirties or above). One of the participants (in their twenties) indicated:

> *I do not feel bad having not been involved in sexual intercourse until the age of 29. I made a personal decision not to. For me it is not good to sleep around. I have had girl friends before but having a girlfriend gives me no room to sleep with her outside marriage. I know it sounds stupid to other people but that's a personal decision I made and I will stick to it. For me, no marriage, no sex. I need to be a one-woman man and that's my definition of a real man…I have heard some people saying that circumcised men go about sleeping with women but for me my circumcision status does not in any way drive me to sleep around.* (Interview, 22 August 2013)

### 5.4.2 Concurrent sexual partners before and after circumcision

One critical issue for this study is that of concurrent sexual partners (including extra-dyadic affairs), as this provides insights into the men's sexual practices before and after medical circumcision. It relates to the question about whether medical male circumcision triggers or encourages circumcised men to undertake risky sexual practices, in this case multiple sexual partners. For the total number of participants in this study, 68 percent (17) reported having had concurrent sexual partners in their lives before being circumcised whereas 32 per cent (8) had not. This effectively means that all sexually-active participants (whether married or single) – or 17 out of the 18 sexually-active participants – engaged in these types of sexual arrangements (and 1 out of 18 did not), given that only 72% of the participants were sexually-active. In fact, 94% of the sexually-active had CSPs (see Figure 5.4).

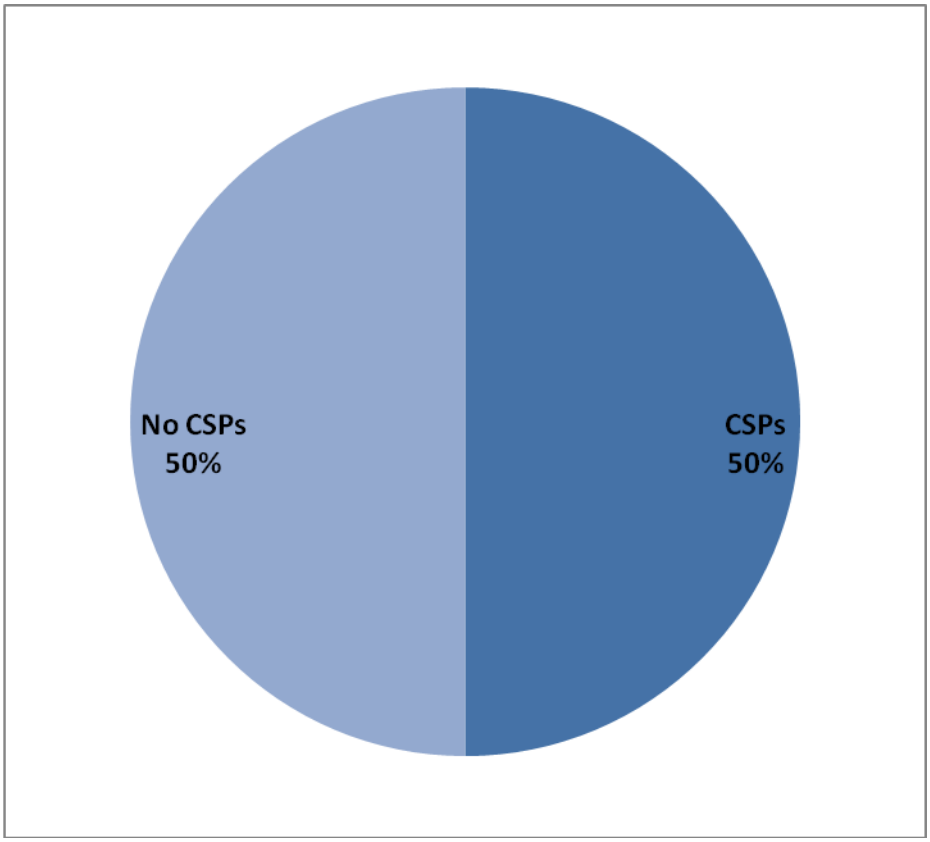
**Figure 5.4: CSPs before Circumcision (amongst the Sexually-Active)**




With regards to concurrent sexual partners after circumcision, only 36 percent (9 males) were engaged in such partnerships while the majority (64 per cent, or 16 participants) were not. This means that there had been almost a 50 per cent drop in the number of males (from 17 to 9 participants) engaging in these sexual liaisons. In fact 53 per cent of the men who had concurrent sexual partners prior to circumcision refrained from this practice after male circumcision. In consequence, only half of the sexually-active participants (9 out of 18) have concurrent sexual partners subsequent to circumcision (see Figure 5.5). Hence, there is a correlation between voluntary medical male circumcision and a change (a decline in fact) in risky sexual practices, at least in relation to the practice of concurrent sexual partners. In this regard at least, some circumcised males try to 'turn over a new leaf' or start afresh post-circumcision. If this is a general trend amongst circumcised males, and if it is maintained throughout the lives of circumcised males, the increased adoption of safe sexual practices post-circumcision would see VMMC achieve its intended goal of reducing HIV infections in

Zimbabwe. And this may imply that the campaigns and counselling around VMMC, as promoted by the state and NGOs, is having positive results.

**Figure 5.5: CSPs after Circumcision (amongst the Sexually-Active)**




At the same time, all men who did not have a history of concurrent sexual partners (whether sexually active or not) before male circumcision maintained this status after getting circumcised. This finding, along with the finding that the number of those with a history of concurrent sexual partners declined post-circumcision, goes contrary to expectations and concerns about an increase in risky sexual practices after medical circumcision. The standard fear is that risky sexual practices will increase post-circumcision since circumcised males feel protected from HIV and other infections because of their circumcised status.

### 5.4.3 Knowledge of own HIV status and sexual partners' status

Knowledge of one's own HIV status and the HIV status of one's sexual partner (or partners) is generally recognised as critical to avoiding infection and re-infection. HIV testing and counselling is offered for free in the public health sector in Zimbabwe and at a minimal cost

at New Start Centres in Zimbabwe (Fraser et al. 2011). This is mainly done to encourage people to go and get tested. It is assumed that by knowing his or her HIV status, an individual will have a positive disposition and be motivated to prevent HIV infection or re-infection through safe sexual practices (Government of Zimbabwe 2005).

Knowledge of one's HIV status is private and confidential but there are instances of shared confidentiality when one consents to allow someone close to them to know that they are HIV positive (Government of Zimbabwe 2005). In order to uphold confidentiality, I did not ask participants to reveal their HIV status, whether positive or negative. I did probe though into whether the study participants went for HIV testing post-circumcision and hence I asked if they had been tested for HIV over the last three months. Of course, all of them had been tested prior to circumcision (as testing forms part of the screening process). Overall, 64 percent of them (16 participants) reported having been tested for HIV in the last three months while 36 percent did not. Importantly, of these 16 participants, five of them were not sexually-active. In other words, 11 were sexually-active, which means that 7 out of the 18 sexually-active males (or 39% of them) had not ensured that they were being tested regularly for HIV. Equally important under this theme is whether the circumcised males prioritise or even bother to find about the HIV status of their sexual partner(s). In this respect, 72 percent of the sexually-active participants (14 out of the 18) did not know the HIV status of their sexual partner (and especially in the case of concurrent sexual partners) in the three months prior to the interviews, while only 28 percent knew their status. These figures tend to indicate the possibility of risky sexual practices post-circumcision, with post-circumcision HIV testing for some participants occurring with the prospect of being tested HIV positive (particularly if condoms are not being used).

Hence, though a critical factor in undermining the possibility of not acquiring HIV is regular HIV testing (of both the circumcised men and their partners), men are more vigilant about their status and less so about the status of their partners. For some circumcised men who reported having concurrent sexual partners and casual partners, although they absolutely agree that knowing the HIV status of their sexual partners is important, they argue that actually learning their status is difficult. One of the barriers they mentioned is that of arranging time to go and get tested together with the partners, and this problem is due to the very character of their relationships. Most of the relationships (particularly with CSPs) are anything but serious in terms of long-term commitment like marriage since they tend to be sexually impulsive in nature.

According to one participant, these relationships are treated like ‘games’. ‘Games’ in this context is used to denote and accept the wilful act of cheating by either one or both partners seeing each other on a casual basis. These are ‘friends with benefits’ kind of relationships in which one or both partners realise that the relationship is not expected to last long. One of the interviewees thus claimed:

> *There is no way I can go and get ‘nemasister’ tested. Why should I raise their hopes? After all I will spend most of my time at New Start Centre. ...I sometimes have one night stands with some of these women and there is no need to know their HIV status.* (Interview, 14 August 2013).

Ma*sister* is a mixture of Shona and English and means ‘sisters’. The word in this context is used in a derogatory way and indicates that there is nothing that one wants in a woman besides having sex with her. In this way, men in this study sometimes endanger their lives and that of their sexual partners by intentionally having unprotected sex with a non-spouse or live-in partner. These relationships therefore become a haven for HIV transmission (Gregson et al. 2007, Gumbo 2011). Like any aversion to condoms, then, aversion to HIV testing (and hence the prospects of HIV transmission) often emanates from patterns of practices which are individual-specific.

### 5.4.4 Waiting Period before Resuming Sex After Circumcision

One important factor emphasised that should be observed by medically circumcised males is the waiting period after circumcision before resuming or engaging in sex. It is a medical requisite that, after being circumcised medically, there should be a waiting period of at least six weeks before having sex so as not to aggravate the circumcision-inflicted wound and thereby avoid the risk of infection. If the wound is not healed, it may be torn open during sex thereby providing a portal of viral entry (Auvert et al. 2005, WHO and UNAIDS 2009, Hewett et al. 2012). Rogers et al. (2013:1) elucidate the problem in the following way:

> During the inflammatory and early proliferative stages of healing, the wound is open to the environment and the integrity of the dermis is compromised. If sexual activity is initiated during these early phases, HIV-negative men may be more susceptible to acquiring HIV as the wound provides an easy portal of entry in an area with a potentially high-concentration of HIV-target cells.

The waiting period and its significance is underlined and emphasised during counselling sessions in Zimbabwe prior to circumcision.

However, for some men, the wound heals earlier than the stipulated six weeks (Odoyo-June et al. 2013) and wounds often do not heal completely until after four months

(WHO and UNAIDS 2009). According to Odoyo-June et al. (2013:2) "no studies to date have assessed the post-circumcision wound and the onset of sexual activity at intervals frequent enough to establish the temporality between complete wound healing and resumption of sex." Nevertheless, when resuming sex, medically-circumcised men are encouraged to use condoms to reduce chances of infection – especially with casual sexual partners (WHO and UNAIDS 2009).

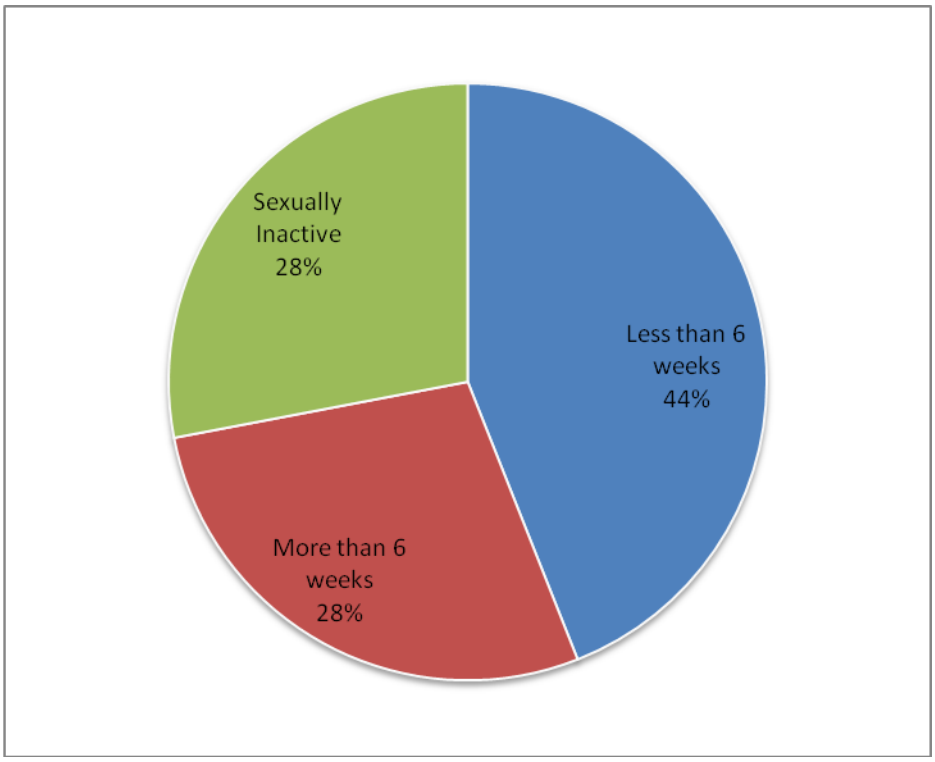
In this study, of the sexually-active males, 61 per cent (or 11 out of 18) – or 44 per cent of the entire study grouping – resumed sex in a period of less than 6 weeks after being circumcised; 4 of these males were single men (having protected sex with condoms) with CSPs. Of the married men (8), seven failed to wait for the stipulated time of six weeks. The shortest period of abstaining amongst the study participants was a mere three weeks. Only a minority of the sexually active (39 per cent) – or 28 per cent of all participants – waited to engage in sex after the stipulated six week period. The other 28 percent were not sexually active either before or after circumcision (See Figure 5.6). The problem of failing to abstain from sex for at least six weeks was also recorded in studies in other African countries, such as Zambia (Hewett 2012) and Kenya (Odoyo-June et al. 2013). Like in the Kenyan study by Odoyo-June et al. (2013), married men in particular failed to wait until the stipulated time in my Harare-based study. Some of the circumcised men in the study carried out in Zambia also resumed sex only three weeks after circumcision (Hewett 2012).

The problem of abstaining from sex within the six-week period was common among married men compared to single men who were sexually active. Of the married men, only one man reported not staying with his wife because of work-related reasons. The couple lives in different towns. One of the married men who did not manage to wait until 6 weeks said:

> *I really understand the medical concern of the doctors when they say one should wait for at least 6 weeks before resuming sex. However, for me it was not possible. If there is anything I failed to observe with regards to following the circumcision 'statutes' it is waiting for 6 weeks without having sex. I took care of the wound as per instruction and I did not have extra marital affairs since I got circumcised. In fact I repented from infidelity and chose to start a new life of fidelity which I am always reminded of by the circumcision mark. But I failed to wait until 6 weeks. I could not abstain. During the first two weeks or so, I had some pain but as it faded away the erections I had were no longer painful. I could not wait any longer. I feared that I would go back to my old girl friends yet I had vowed that I was leaving my wicked ways. Moreover, I wanted my wife to be the first person to open the parcel I brought her. I was also curious to know how it feels like having sex after getting circumcised. For me there was*

*nothing to fear and starve myself for since I was having sex with my wife.* (Interview, 22 August 2013)

**Figure 5.6: Waiting Period before Sex after Circumcision**




Another married man noted:

*After three weeks I was completely healed. In fact the wound* [after three weeks] *was as it is now…. I nursed the wound properly by dipping my penis in salt solution for about 15 to 20 minutes at least three times a day. I had no infection hence the wound healed faster. Moreover, I have very effective white blood cells which made me heal faster than the stipulated time…….My brother, it's not easy to give your back to your wife everyday for 6 weeks especially when you are used to having sex anytime. One other thing that pushed me was the issue of instantaneous erections whenever I saw my wife even in the kitchen when she was cooking partly because of circumcision and also that I had spent two weeks without having sex. So if it was that tempting even in the kitchen..*[and].. *more in bed…it was just too much for me.* (Interview, 17 August 2013)

According to most married men, abstinence until the stipulated healing time was mainly hampered by the failure to live without penetrative vaginal sex once the wound showed signs of significant healing. Some of these men also checked the wound healing progress by mutual

masturbation with their wives leading to penetrative vaginal sex once the husband was comfortable.

Although resuming sex after the stipulated time was a widespread challenge among the married men in particular, a few sexually-active unmarried circumcised males also failed to wait until the stipulated time. For both groupings of men, and as a way of reducing the chances of getting infected by HIV, some participants used condoms. Again, in the studies done in Zambia (Hewett 2012) and Kenya (Odoyo-June 2013) some circumcised men had protected sex (using condoms) to prevent infection before the stipulated healing period ended. One single man cited anxiety as the main reason behind his failure to wait, and condom use arose because of the insistence on the part of the woman. He indicated:

> *Getting circumcised is, among many things, one of the boldest personal decisions I have ever made in my life. Seeing my penile head 'naked' without the foreskin was a very scary sight. Although I knew it was for a good cause I feared for the worst with regards to sex. I feared that I was not going to perform well despite the common opinion that when one gets circumcised he lasts a little longer during sex than before circumcision. That fear made me anxious and I had sex with my girlfriend although she was against the idea because she knew the stipulated time was not up yet. She gave in after my persistence but we used a condom. I took safety precaution.* (Interview, 23 August 2013)

It should be emphasised that not everyone in the study failed to abstain for the stipulated period post-circumcision. Some of the men who managed to abstain for the stipulated time (and even beyond) cited discipline augmented by fear of negative consequences as major reasons for waiting. Other sexually-active participants, especially those who were used to having sex frequently, pointed out that it was very difficult for them to abstain but they did not see any point of going against medical advice and thereby for example risking their lives (with the possibility of HIV infection) before the stipulated time. One of them (a single man) said:

> *I chose to follow medical advice so as not to hurt or infect myself. Sometimes following proven knowledge is the best. I don't have a spare penis so I could not take chances. I feared for the worst, for example, hurting myself resulting in my penis becoming totally dysfunctional.* (Interview, 12 August 2013)

### 5.5 Condom use

This thesis is particularly concerned with condom use in the context of voluntary medical male circumcision. As noted, condoms are an integral part of HIV prevention (UNAIDS et al. 2009). Since condoms offer better protection against STIs (including HIV) than medical male

circumcision, it is emphasised that medically-circumcised males should use condoms (UNAIDS et al. 2009) even beyond the stipulated waiting period with CSPs.

All participants in this study strongly agreed with the claim that condoms offer protection from STIs, including HIV, as well as from pregnancy. In relation to this, they also recognised and understood that condoms offer better protection against HIV than VMMC (which offers about 60 percent protection). They therefore realised the need to use condoms regardless of the fact that they are circumcised, since infection is still possible for circumcised males. In addition, they denied the necessity of wearing two condoms during sex to decrease the chances of HIV prevention. However, there is variation in condom use by participants, with 5 out of the 18 sexually-active males (or 28 per cent) reporting inconsistent condom use post-circumcision. Although these circumcised men knew that they were not safe from HIV infection, they braved unprotected sex assuming that their partner was HIV-negative or that their circumcised status would protect them. Inconsistent condom use though has decreased considerably post-circumcision, as – before circumcision – 15 out of the 18 sexually-active males (83%) adopted inconsistent use (See Table 5.2). Overall, amongst the study participants, there is a clear understanding of the relationship between condom use, circumcision and HIV prevention; though at times practice deviates from this understanding.

**Table 5.2: Condom Use by Sexually Active Males**

| **Condom Use Category** | **Before Circumcision (%)** | **After Circumcision (%)** |
|---|---|---|
| Inconsistent | 83 | 28 |
| Consistent | 17 | 72 |
| **Total** | **100** | **100** |

Of critical significance is condom use by circumcised men involved specifically with concurrent sexual partners, as a way of reinforcing prevention. As noted earlier, there had been a significant drop in CSPs subsequent to circumcision, from 17 to 9 men. I narrowed down the comparison to males who are sexually active and remain involved in CSPs post-circumcision. In this regard, it is important to note that all five sexually active males still not adopting consistent condom use are involved with CSPs. In other words, 5 out of these nine males (or over 50 per cent) reported post-circumcision inconsistent condom while 4 indicated consistent condom use. The proportion of men with CSPs decreased post-circumcision but, amongst those continuing with CSPs, a significant risky practice (namely, inconsistent

condom use) remains. This in fact relates back to the reasons for these five men becoming circumcised in the first place. They did so knowing that they would remain prone to inconsistent condom use and casual sex subsequent to circumcision, and hence circumcision was seen as a basis for at least providing some sort of protection for them during casual sex. Clearly, though, this rationale totally excluded any thought of protecting their casual partners from the prospect of HIV infection.

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Correct and consistent condom use, as mentioned above, is brought to the fore during counselling sessions both before and after being circumcised, and all 25 circumcised males reported having gone through this group and individual counselling. The men were also taught by way of demonstration (using a dummy erect circumcised penis, or dildo) by the counsellor on how to put on a condom and to dispose of it. In the group session I attended, the counsellor in addition stressed the need to check the expiry date of the condom (to avoid using expired condoms), how to open a condom after making sure that it is not already open or pierced (by checking its air tightness), the importance of keeping out air by pressing the tit-shaped end of the condom before carefully rolling it down on a fully erect penis (until covering the penile shaft all the way to the base), and – when taking the condom off – using a tissue to hold it so that he (or his partner) does not used naked hands to avoid infection in case there is a wound in the hand.

The counsellor explained this in a joking manner in the vernacular (Shona) by saying:

> *Paya paunenge uchikwira munhu wakapfeka condom uchiita Mbare-City, City-Mbare, unenge muchairi wekombi unofanira kukoshesa upenyu hwako nehwevamwe vanhu veunawo nekuona kuti kombi yako iriknyatsofamba zvakanaka. Unofanira kuona kuti condom rako rakagara zvakanaka uye harina kuputika kudzivirira kutapukira kwehutachiona*. (Counselling session, 27 August 2013)

Let me explain what the above quotation means. He referred to Mbare-City (City-Mbare) which is a busy route plied by commuter omnibuses carrying commuters between Harare Central Business District (HCBD) and Mbare (a famous high-density suburb close to the HCBD). The repeated movements by the commuter omnibus between Mbare and the HCBD entailed a metaphor describing the repeated movements during sex (strokes) of the penis moving in and out of the vagina. The man having sex and putting on a condom properly before sex resembles the omnibus driver who is always reminded of the need to be cautious to preserve his own life and that of the commuters he is carrying (which, in this metaphor, is the sexual partner). In this case, the man is also reminded of the need to check the condom constantly during sex so that it stays on throughout and also to be alert in case it bursts.

There was a need to assess circumcised men's condom use in practice, including skills and knowledge. This need was accentuated by other studies done on condom use errors by researchers such as Crosby et al. (2002) and Sanders et al. (2012). At the same time, there are no significant studies on condom use errors (or incorrect usage) in the case of Zimbabwe, and hence exploring this theme would be particularly valuable. I explored this amongst all study participants, including those men not sexually-active, by asking them to describe how a condom should be used and fitted. Despite the counselling sessions, there were common condom use errors found in the study (detailed later), which may lead to heightened risk of HIV infection.

In the following sub-sections I examine the following themes pertaining to condoms: sources of condoms, condom brands, condom purchase tactics, female condoms, condom use errors and aversion to condoms.

### 5.5.1 Sources of condoms

The sources of condoms for medically-circumcised males are also important. All participants, including those not sexually-active, were asked where they would obtain condoms in the eventuality of needing them. Overall, 44 percent of the participants mentioned that they obtain (or would obtain) condoms from tuck-shops, supermarkets or pharmacies, 20 percent mentioned pubs or nightclubs, another 20 percent mentioned public toilets, 12 percent referred to clinics, and 4 percent mentioned friends.

In examining the sources of condoms, it seems that the condom source is influenced by what the person thinks other people around him would say or think of his action (in this case, purchasing condoms). Condom use, because of its association with sexuality, conjures up certain images in the minds of those witnessing the purchase of condoms by others; and

the purchaser is aware of this. All the men who mentioned public toilets as their condom source avoided buying condoms especially from places thronged by many people, for example, supermarkets. They mentioned embarrassment and shame as the major reason deterring them from buying condoms so publicly, as observers of the purchase obviously know that the purchaser is about to have sex. They also added that condoms are associated with promiscuity and sex with prostitutes (Mungwini 2009). Bell (2009) has noted that such embarrassment can lead to risky sexual behaviour (namely, condom use aversion) and it leads a medically-circumcised male to revert to protection in and through circumcision only. One of the participants said:

> *I can't stand the way other people look at me. The embarrassment is just too much for me to bear. What if I meet someone I know holding a condom pack, what would they think of me? I resort to public toilets and I am lucky that at work they put condoms in the bathroom so I secretly and quietly serve myself. If I trust the partner I am intending to have sex with I would do it without a condom. Although I am sure I am not 100 percent protected by circumcision I will always hope it will somehow save me.* (Interview, 14 August 2013)

Getting (free) and purchasing condoms at clinics or nightclubs/pubs respectively are also ways of avoiding any public gaze around sex and condoms.

### 5.5.2 Condom brands

During the interviews, it became clear that most participants have a certain condom brand they prefer to other brands. However, for some participants, condom brands do not necessarily matter and there is no loyalty to a particular brand. The preferred brands include Protector Plus (PPs), Carex, and free government condoms popularly known as *MaDembare and Mapuma/Tiger.* The reasons for the popular names given to the government condoms are of interest, at least as elaborated upon by the study participants. *MaDembare* is a name that was coined and extrapolated from *Dembare*, with *Dembare* being a popular nickname for one of the biggest football teams in the Zimbabwean premier league. *Dembare* wears a predominantly blue uniform and the condoms (which in fact are formally nameless) have a blue colour pack. A similar story goes for the *Mapuma/Tiger*. They also have no official name but on the condom pack is a picture of a Puma or Tiger-like animal, hence the colloquial name.

There are a number of factors that influence the emergence of trust in a particular condom brand at the expense of others. These include but are not limited to condom strength, packaging, availability and accessibility, and pricing. In exploring this, I included the study

participants who are not sexually active, based on their understanding of the condom market. Of the condom brands mentioned, 40 percent of the participants reported loyalty towards the PP condom brand, 32 percent mentioned the Carex brand and 12 percent referred to the two government-issued brands. The other 16 percent included a number of sexually-inactive males who vowed not to engage in sex prior to marriage or married men who indicated that they are monogamous and do not engage – at least any more – in extra dyadic relationships (and, for them, condom brands are hence not relevant).

Most of the participants who showed loyalty towards PP condoms spoke highly of the strength of the brand citing that when, used correctly, PP condoms rarely break. Also, PP condoms were reported to smell better than *MaDembare and Mapuma/MaTiger*. In addition, they are readily available (in most grocery outlets including supermarkets and tuck shops, as well as beer halls, pubs and night clubs) and their price is said to be affordable by most participants (this reiterates a point made in a study by Evans et al. 2011). As well, trust by study participants in PP condoms arose because of publicity and social marketing by the well-respected Population Services International Zimbabwe (PSI-Zimbabwe) (Evans et al. 2011). There are a number of PP advertisements in the various electronic and print media in Zimbabwe with some shown on television done during prime-time such as news. In advertising widely, the PP brand is also trying to reduce condom stigmatisation (which leads, as noted above, to the dangers of condom use aversion by affected males) by "making it [condom use] something 'everybody is doing' and 'everybody is talking about'" (Evans et al 2011:2).

Carex condoms had the second highest loyalty by participants in this study, despite being relatively new compared to the other brands. This condom is officially distributed by Elecare Pharmaceutical and, beginning in 2013, the company launched a campaign to increase proper condom use in the country. Carex condoms have a uniqueness which other brands do not have and users of this brand speak with significant passion about this uniqueness; which lured me into buying a pack of these condoms. The uniqueness, as indicated by the participants, relates to the scented flavour and texture of the condoms. These condoms come in different flavours, such as strawberry, vanilla, banana and mint. This counteracts one of the apparent problems of standard condoms, namely, their unpleasant or bad smell (Parker et al. 2004). In light of this, the Carex loyalists complained that other condoms smell like rubber which resulted in some men even refraining from using condoms at all (Parker et al. 2004, Jackson et al. undated). The superior texture of Carex condoms refers to the feel of the condoms. Unlike most condoms, which are smooth, some of the

condoms under this brand are dot textured, rib textured or a combination of both. The major reason for this texture is to increase sexual pleasure which most people complain is minimised or absent through using plain textured condoms. Brand loyalists also pointed out that Carex condoms are strong with fewer incidences of breaking during sex than other brands they have used before.

One of the participants heaped praise on Carex condoms in the following way:

> *The new kid on the block has brought a new lease of life in as far as HIV and pregnancy prevention is concerned. For me condom use was always a nightmare in the sense of the bad condom smell. I used to dodge condom use because of the unpleasant smell. Other condom brands really smell bad. If you get into a room where people were having sex using these smelling condom brands you can tell that some business was taking place in there. I have no excuse now for not using condoms because sex has been scent flavoured and textured as well… Of all the condoms brands I have used I can say Carex condoms are the strongest. They rarely break. I am yet to see a man who says he had a Carex condom breaking problem….The other thing, with my circumcision status putting on a condom is easy. Before circumcision I did not feel comfortable due to my foreskin kind of clashing with condoms.* (Interview, August 2013)

Carex condoms seem to facilitate greater use of condoms in general, including amongst circumcised men who otherwise would not be prepared (because of embarrassment) to buy condoms in places thronged by many people like supermarkets. In fact, most of the participants – mentioned above – who spoke about buying condoms in more public places (like pharmacies) were referring to the purchase of Carex condoms. It seemingly enhances the prospect that circumcised males (and other males) will not engage in unprotected sex (without condoms).

*MaDembare and maPuma/maTiger* recorded the least number of loyalists but this does not mean that these condoms are ineffective. Most of the participants who are loyal to this brand praised them for being strong as well as available for free in places where and when very few people would be present. However, they cited unpleasant smells as one main disadvantage in using this brand. Nevertheless, they vowed to keep using them since they augmented their circumcision status.

### 5.5.3 Condom purchasing tactics

Condoms-selling outlets, for example, supermarkets along with condom promoters have tried to reduce the problem of embarrassment by putting condoms close to the cash tills. In this regard, during my fieldwork, I visited a number of supermarkets and realised that they keep

condoms very close to the till amongst other small items like sweets and chocolates. Some of the participants also cited this arrangement as one factor which helped them overcome the embarrassment mentioned earlier. According to one participant this is mainly because, when someone sees him at the till, that person would not readily know what he is exactly picking out for purchasing. Intriguingly, during the current 'United States dollar era' in Zimbabwe (over the past few years), when small change is a problem, some men have resorted to obtaining condoms instead of sweets as change. At the moment there is no Zimbabwean currency in circulation and foreign currency is used as a medium of exchange with the United States dollar being dominant followed by the South African rand. This has resulted in a shortage of coins to issue as change in most shops. As a way of rectifying this shortage, most outlets including supermarkets end up giving customers small items like sweets and bubblegum; but some men who do not like sweets request condoms instead.

Mungwini (2009) noted another purchasing tactic in his study which involved an attempt to avoid stigmatisation and embarrassment when purchasing condoms. He noted that some men coined statements and names for condoms as a way of disguising the purchase of condoms from the perspective of onlookers. The following emerged as the most widely-used expressions in requesting condoms: *Ko itaka mapepa* (Can I have 'papers'), *ndipewo one munyati* (Can I have the thing please), *Itaka marubber* (Can I have the rubbers), *two packs dzemunyati shaas ita chopas* (Can I have two packs of the 'things' make it fast), *Ita machocolate* (Can I have 'chocolate' where chocolate is disguised for condoms) (Mungwini 2009:121). Such antics help reduce stigmatisation or even undermine to some extent condom use aversion. Regrettably, I did not explore the existence of this tactic in my Harare-based study.

However, as indicated above, I did check a number of retail outlets with regard to their displays of condoms and in so doing I purchased condoms in order to observe the reaction of onlookers. I did this at different times of the day during off-peak and peak business hours, at 5 supermarkets and 3 pharmacies. No comments were passed by any of the nearby customers though there were some bemused expressions. In one supermarket, I asked a male sales assistant where I could locate the condoms, and with a strange gaze on his face he indicated that he was not aware of their location. On walking away he referred me to a lady sales assistant who was busy sorting various wares in a shelf and he said in a loud voice, *'hoyo mumwe mudyi wadzo'* (which means, 'behold another serious cunt slayer'). On asking the lady assistant why he behaved the way he did, she replied that he (the male assistant) knows where condoms are displayed but he constantly makes fun out of men who ask for

condoms. Overall, the supermarket environment was more uncomfortable as compared to the pharmacy environment, as the latter allowed for greater privacy. But the incident in the supermarket brings to the fore the reason why men seek in various ways to minimise the attention coming their way when purchasing condoms.

The circumcised men in my study who were determined to use condoms found ways and means of doing so with limited embarrassment. One of the common ways of doing this was to buy condoms in supermarkets or shops not located in their area of residence where they are not known to many people. Another popular method was to buy condoms in a pharmacy, on the assumption that people who see them buying condoms from pharmacies instead of supermarkets assume it is part of a prescription given by the doctor on medical grounds (thus giving the purchase an aura of respectability). For those who purchased condoms in beer halls, pubs and nightclubs, embarrassment does not appear to be of any significance as everyone, it is claimed, minds their own business in drinking establishments. For the participants who buy condoms from these places, no adverse labelling takes place because the social environment itself is already associated with a sense of irresponsibility (through drunkenness) and these places are traditionally thought to be a haven of HIV (since they are known to be thronged with prostitutes who, before the epidemic became generalised, were among the first HIV and AIDS high-risk population) (GoZ 2012). In fact, when first introduced, condoms were mainly distributed in places like beer halls and nightclubs (Mungwini 2009).

While embarrassment as a result of societal discourses about condoms, sex and immorality is a real deterrent to condom purchase for many men (and thus may even affect the consistent use of condoms), for others it is not an issue at all. This does not mean they are not aware of the stigma but, for the sake of their health and that of their loved ones, they tend to ignore it as they prioritise their health. One of these men said:

> *When people see you buying condoms most of them give you a weird look. I used to be affected back then but I told myself that no one should stop me from doing what is right. Of what benefit is it to me that I listen to what people think or say of me when I am doing the right thing? Sex is a basic need man, but people behave as if it's a taboo. Who doesn't do sex? It's better that people look at me with 'talking eyes' when I am buying condoms than to do so when I am sick with AIDS.* (Interview, 20 August 2013).

### 5.5.4 Female Condoms

So far I have discussed male condoms without any reference to female condoms. This is not to deny their potential significance, as the existing literature indicates that when female condoms are used consistently and correctly their efficacy with regards to HIV prevention is equal to that of male condoms (Cecil et al. 1998), as well as offering prevention against pregnancy (Trussel et al. 2004). All participants in the study confirmed knowledge about the equal efficacy of female condoms against male condoms. Some married men acknowledged using female condoms with their wives and they reported mixed feelings about them. One of the key advantages, according to these men, was increased sexual pleasure (Meekers and Ritchter 2005, Cecil et al. 2005), as well as the absence of interruption in sexual intercourse. When using the male condom, the man has to slightly disengage to put a condom on, whereas the female condom can be inserted into the vagina hours before sex commences (Meekers and Ritchter 2005). In this respect, about 39 percent of the sexually active participants in this study indicated that they had at one time lost an erection when putting a male condom on. The users of female condoms also found it liberating in that the sexual act (without the male condom) was interpreted as more natural and uninhibited sex.

However, existing literature indicates that the female condom is used far more with married couples than in the case of casual sexual partners where it is less convenient. No one in the Harare study reported ever using a female condom in casual sex, as such sexual encounters are mainly driven by sexual impulses with minimal or no love involved, and this makes negotiation around female condom use difficult if not impossible. In this regard, female condom use is regularly hailed as an alternative to male condoms particularly in granting females greater control over HIV prevention since they can negotiate for safe sex with their partners (Hoffman et al. 2004). However, in my study, female condom use, and condom use more broadly, is detached from the empowerment of women and greater control over their bodies. For instance, 72 percent of the sexually-active males in my study reported not communicating with their partners about protection, which tends to imply a relatively high level of male dominance in these relationships. This could be partly because of the economic power imbalances between males and females (Cecil et al. 1998) particularly outside the marriage arrangement.

### 5.5.5 Condom Use Errors

While condom use may be common practice, correct use is a totally different matter which is also directly relevant to HIV prevention. The latter issue (correct use) is rarely studied, in part

because studies often incorrectly assume that consistent condom use entails correct condom use (Crosby et al. 2002). Incorrect condom use also negatively affects consistent condom use as it can lead to condom use frustrations including breakages, leakages and spillage. Some of the study participants confirmed incidences fitting what can be labelled as condom use errors. In fact, 44% indicated that a condom has broken during sex on at least on occasion. In classifying the condom use errors, I follow the approach by Crosby et al. (2002) in which they distinguish between technical, availability, storage and communication errors. The errors reported by sexually active participants in this research are listed in Table 5.3.

**Table 5.3: Errors in Condom Use**

| **Communication Errors** | **Percentage** |
|---|---|
| No condom discussion with partner | 72 |
| **Availability error** | |
| Did not have a condom available when wanted sex | 39 |
| Did not have another condom for backup | 11 |
| **Technical Errors** | |
| Did not check for expiry date | 22 |
| Did not check pack and condom damages | 44 |
| Used sharp objects to open pack for example teeth or nails | 28 |
| Did not hold the tip, leave space and squeeze out air | 11 |
| Wore condom on the wrong side | 28 |
| Tried to put on same condom after unrolling it | 44 |
| Took off condom during sex | 6 |
| Did not replace a broken condom during sex | 28 |
| Began sex prior to putting on a condom | 50 |
| Condom spillage or leakage | 28 |
| **Storage Error** | |
| Kept condom in a tight wallet or back pocket | 72 |
| Did not keep condoms in a cool dry place | 6 |

Though I do not have comparative figures from other studies, these percentages are quite high given the serious counselling undergone by the study participants. Again, this indicates an often significant disjuncture between condom knowledge and condom practice,

with the latter entailing risky sexual acts with the prospects of HIV infection. In this respect, although some of the men in the study were confident that they know how to correctly use a condom, their responses indicated otherwise, based in part on an unjustified expertise in condom use. As one of the participants said:

> *Putting on a condom for me is just like eating; once you know how to do it you can even do it even when you are half asleep. I haven't heard of a person who misses his or her mouth when eating. Even if I am drunk I know how to put on a condom correctly.* (Interview, 11 August 2013)

### 5.5.6 Condom use aversion

There are quite a number of reasons given by men in this study for not putting on condoms during sex with a casual sexual partner. The reasons highlighted include drunkenness, having no condom at hand, lack of trust in the effectiveness of condoms, cultural and social upbringing, use of 'minimum' force on otherwise unforthcoming partners, and embarrassment in the purchase of condoms (discussed previously). I examine these reasons below.

#### 5.5.6.1 Drunkenness

Startlingly, the very same participant quoted immediately above about using condoms correctly even in a drunken stupor went on to admit to making school-boy mistakes because of impaired thinking as a result of inebriation. He later indicated:

> *One day I was too drunk and I had a one night stand with this other girl in my class I used to flirt with. In fact we were both drunk beyond measure. I have a condom instinct but that night my first time attempt was very bad for I tried putting it on from the wrong side. Apparently, I ended up unrolling it before putting it on as I looked for the right side. I felt bad and did not want further embarrassment from the lady I longed to sleep with for a long time who was lying naked waiting for me in my bed. I just threw it away as I realised that I was losing my erection slowly and I didn't want to be sexually incompetent since I take long to erect when I am drunk. I did not want the chick to go around telling her friends on campus how useless I am. I quickly jumped on to her and started pounding her without a condom. I knew I was not safe at all but I just prayed that circumcision would save me. Fortunately it was the only round we had without a condom; the other times I made sure I wore a condom since I was concerned that I might have gotten infected. Better be sorry than never!* (Interview, 26 August 2013)

5.5.6.2 Unavailability of condoms

One of the common reasons for not using condoms, as mentioned by circumcised males, is that they did not have condoms with them at hand when they engaged in sexual activity. One of the men had this to say:

> *Eish my brother, I personally have a big problem of trying to be prepared for all these prevention measures. The thing is, issues of sex are problematic in terms of always trying to be ready, because it's not a set timetable for me. Having sexual intercourse is different from going to the toilet whereas you know, in the evening before you sleep you have to go to the loo, or maybe every morning when you wake up before a shower you use the toilet. Personally if I see someone that I am so attracted to and they seem to be sharing the same sentiments, within no time we are already in bed and we are doing the 'deed' without condoms*. (Interview, 17 August 2013).

5.5.6.3 Distrust of condoms

Other studies done on condom use (and the reasons for not using them consistently) refer quite often to the high cost of condoms (Kirby et al. 2010) but for my study participants this was not an issue. In fact, the low cost of condoms was questioned. One participant wonders why condoms are so cheap if they are life savers. This participant is a university student who seems to have a rare perspective when it comes to trusting condoms. In as much as he recognises that STIs including HIV and AIDS exist, his trust in condoms is very minimal. During the interview he said:

> *Fine, STIs including HIV and AIDS exist but whoever brought the idea of using condoms just did not want to us to enjoy sex. Why is it that they are thought of being life savers yet they are so cheap to an extent of being given for free? What else do you get for free in this world? Tell me one other man-made life saver given for free. People are capitalists these days they sell you even things given for free on humanitarian grounds. Shedding more light to this argument, I used to donate blood for free but I have since stopped. My father fell critically ill and was hospitalised. The doctor recommended that he should have blood transfusions since his blood level was low. To my surprise they made him pay for it, something they take from us for free they sell it to the people in need. So why is there generosity with condoms if they are important? After all they burst during sex and they shift all the blame on the user. For me male circumcision is way better although it is not 100 percent effective. Of the two* [condoms and circumcision], *which one is effective? Anyway they all leave you with a chance of infection. I got circumcised so that I could do away with condom use sometimes depending on the sexual partner in question.* (Interview, 15 August 2013)

Such an argument, particularly from a circumcised male who underwent extensive counselling about consistent condom use, is of course worrying and dangerous especially when one is having extra-dyadic sex with CSPs. In my interview with him, he made passing reference to the need for HIV testing (for both him and his partners) but this is cold comfort if, because of non-usage of condoms, HIV transmission has already taken place (notably in the context of casual sex, which he practices). Even the question of the acquiring of trust between partners, as a rationale for not using condoms (as also expressed by this interviewee and by other participants in my study) is clearly no substitute for practices emphasising the consistent and correct use of condoms. His points might be relevant when one sticks to one faithful HIV-negative sexual partner, but this is not the case with him.

Clearly, condoms have a record of substantial success in HIV and AIDS prevention in many countries such as Thailand (UNAIDS 2005) and Uganda (Stoneburner and Low-Beer 2004). In Thailand, they were used among commercial sex workers and they successfully reduced HIV and STI transmission between them and their clients (UNAIDS 2005). In Uganda, like in Zimbabwe, condoms formed part of the 'ABC' (abstinence, be faithful and condom use) campaigns (Dworkin and Ehrhardt 2007). Risk reduction behavioural change (including correct and consistent condom use with casual and multiple partners) is also noted as contributing to a decline in the HIV prevalence rate in Zimbabwe (Halperin et al. 2011). Circumcision without condoms is in the end self-defeating (WHO and UNAIDS 2007).

#### 5.5.6.4 Cultural barriers to condom use

Societal and cultural beliefs can perpetuate HIV transmission (Mungwini 2009). It has already been mentioned that social stigmatisation and embarrassment inhibited the purchase of condoms, but the problem runs deeper than this. Despite campaigns in Zimbabwe encouraging public discussion and openness about sex and HIV, and particularly about safe sex and condom use, sexuality as a topic in the public domain of Zimbabwe remains muted. Sexuality in fact is still a taboo topic (Chikovore et al. 2013, Mudavanhu 2010, Campbell et al. 2010). Mungwini (2009) argues that various religions in the country reinforce the stigmatisation associated with sex and condom use. If there is an aversion to publicly speaking about sex and condoms, then the difficulty in buying condoms in places thronged by many people becomes understandable.

Such a transaction in a way also goes against African morality popularly known as *Ubuntu*, (or *Unhu* in Shona) which is translated sometimes as good and respectable character (Mungwini 2009). Further, as noted, condom use in Zimbabwe is regularly associated with

extra-marital sex with casual sexual partners and specifically commercial sex workers (with the latter initially targeted for condom distribution as a high risk grouping). Condoms are thus linked with disrespectable and immoral people, although they are critical to inhibiting HIV infections. The public ridicule is so severe that medically-circumcised men may go so far as to have unprotected sex (without condoms), knowing full well that any sexual encounter with an infected person can result in a circumcised man being infected with HIV.

5.5.6.5 Masculinity and unwilling partners

In one of the interviews with circumcised men, the existence of male domination and masculinity with regard to sex came to the fore. In heterosexual relationships men regularly have the upper hand so to speak and dictate the pace and timing of events, including around sex, while women assume a subordinate role. Even when women are not ready, willing or able to engage in sex, men may impose sex upon their partner (whether in marriage, or a casual partner). In the case of the one interviewee, the participant outlined and explained his actions in encounters with his several girlfriends in a very blasé manner. He alludes to the fact that he uses minimum force at times to ensure that his girlfriends sleep with him, and this show of force requires that condoms are not used. He said:

> *It is almost in every lady's nature to say no even when she means yes. Some of my girlfriends especially the young ones do not say yes to me when I need to have sex with them. No matter how 'high' I take them during foreplay they would not say yes to sex regardless of the fact that she is wet down there, a sign of readiness to sex. This is when I use a bit of minimum force to have sex with her by way of getting between the legs; once I am in there is no going back. In most cases they are shy; as a result they would pretend not to like sex but I know they will be consenting. This does not happen to me only, my friends also testify that the same happens to them as well especially with girls who go to church most of whom believe that it's a sin to have sex out of marriage. They show 'inviting resistance'.* (Interview, 7 August 2013)

The description of events in this interview effectively qualifies as rape, with this action contingent on not interrupting the process by putting on a condom. However, the interviewee would dispute this and, indeed, he gave a further description of how he views the whole erotic scene and how it unfolds:

> *It is not rape. Rape is when you force someone entirely from the onset. You drag the person to have sex with you. You even tear someone's clothes including a pant (if one has it of course) and force your way into her. But not when you kiss, caress, fondle, roll in each other's arms and take off all your clothes. There is no way you can be said you have raped someone in this situation. She will be wet and that's a sign of arousal and an invitation to me to enter her. The*

*truth of the matter is she will be very willing but not that inviting for the fear of being called a loose person.* (Interview, 7 August 2013)

Clearly there is a diverse range of reasons for why circumcised males, at least those who participated in this study, do not use condoms. In the main, though, there is no truly justifiable reason for not using condoms and this means that there is a tendency amongst some males to engage in risky sexual practices.

## 5.6 Conclusion

This chapter provided an overall profile of the study participants and then went on to discuss the sexual practices of the circumcised men, both before and after circumcision. It seems clear that there is awareness on the part of the circumcised men that VMMC is not a stand-alone HIV prevention method and that, for this reason, other methods (such as condom use) must be pursued simultaneously. Amongst the sexually-active male participants, it is equally clear that – prior to circumcision – they were engaged in a number of risky sexy practices, notably inconsistent condom use and concurrent sexual partners and, further, that – subsequent to circumcision – there has been a reduction in these risky practices. But the extent of risky practices remains very significant and indeed disturbing, such that awareness of the need to reduce the level of these practices is often simply only that – awareness. It certainly does not always translate into practice. The following chapter pursues this more fully, as the discussion revolves around the question more explicitly of risk compensation.

# CHAPTER SIX
# CIRCUMCISION AND RISK COMPENSATION

## 6.1 Introduction

This chapter develops many of the key themes contained in chapter five. In particular, it seeks to determine if the post-circumcision sexual practices of the circumcised males in any ways entails a form of risk compensation. Risk compensation involves engaging more fully in risky sexual practices subsequent to circumcision, on the assumption that medical circumcision provides a form and level of protection against the possibilities of HIV infection. I first briefly outline and reiterate the question of risk compensation and circumcision. The following sections then outline various sub-themes relevant to the question of risky sexual practices and risk compensation, including HIV counselling, social conditions and concurrent and casual sexual partnerships. It then discusses more broadly the relationship between circumcision and other HIV prevention methods, specifically condom use, in the context of the overall objective of the thesis.

## 6.2 Risk Compensation

As noted earlier, prior to the recommendation for VMMC adoption as an HIV prevention method, randomised controlled trials (RCTs) were carried out in South Africa, Uganda and Kenya. During the RCTs, the participants were provided with condoms, underwent HIV testing and risk-reduction counselling, and were monitored regularly (Dowsett and Couch 2007). Some risky sexual practices did exist but risk compensation was not overly prevalent. The conclusions of these studies have triggered serious debate among scholars and practitioners, with some arguing that the studies were artificially-controlled experiments which could not be duplicated in (or generalised to) real-life situations. For instance, while participants in the RCTs were granted easy and ongoing access to condoms, circumcised males under real-life conditions – and for the many reasons outlined in the previous chapter, including stigma – do not always have condoms available. Further, in real-life situations, there would be the possibility of greater chances of risk compensation. If this is the case, then the RCT studies did not provide a sufficient basis for the introduction of voluntary medical male circumcision as a legitimate HIV prevention method (Eaton and Kalichman 2009, Boyle and Hill 2011, Green et al. 2008). For example, any increase in protection from HIV by

VMMC would simply be compensated for by an increase in risky sex practices such as inconsistent condom use.

The evidence from my study, as presented so far, indicates mixed results. There certainly is evidence of risk compensation by sometimes relying on circumcision as a replacement for condom use (and, more specifically, consistent and correct condom use) but, at the same time, many of the research participants seem to have adopted safe or at least safer sexual practices (compared to pre-circumcision) including the reduction in the number of concurrent sexual partners. Other safe practices, such as abstinence, cannot be attributed to VMMC as the currently sexually-inactive males in my sample abstained from sex prior to even contemplating undergoing the circumcision procedure.

Concerns continue to be expressed in Zimbabwe about the relationship between male circumcision and HIV infections. For example, the *Zimbabwe Demographic Health Survey of 2010-2011* presented evidence which created panic in the country, namely, that there is no positive relationship between male circumcision and HIV prevalence. In fact, the survey showed that circumcised men have a higher chance of becoming infected by HIV than uncircumcised men, with 14 percent of the circumcised men in this survey indicating that they were HIV positive (ZIMSTAT 2012). This implies that risk compensation by circumcised males exists to such an extent that this compensation is undermining the potential impact of circumcision in reducing HIV transmissions. However, if one looks carefully at the report, it seems that the survey was not based on medically-circumcised males, as men in the survey were not circumcised in hospital settings. The health survey though reached similar findings to a study done by Garenne (2008) which showed high rates of HIV infections among circumcised men in Cameroon, Malawi, Lesotho, Uganda, Rwanda, Swaziland and Kenya. Again, the claim is that circumcision as such leads to a greater possibility of risky sexual practices compared to uncircumcised males.

The character of my study differs from these. The conclusions arising from my study are not based on a comparative analysis of sexual practices and infection rates between circumcised males and a control group consisting of uncircumcised males. Rather the conclusions are based on a more direct comparative analysis of pre-circumcision and post-circumcision sexual practices amongst the same cohort of circumcised males. This raises, amongst other things, questions about the actual effectiveness of HIV testing and counselling in influencing day-to-day sexual practices.

In the following two sections, I argue that knowledge and encouragement through counselling does not lead to safe sexual practices unless combined with social conditions in the life-worlds of circumcised men which facilitate the adoption of these practices.

### 6.3 HIV Testing and Counselling

Concerns about the difficulty in formulating counselling procedures which discourage risk compensation should not be ignored since risk compensation can reverse the efforts in pursuing VMMC as a basis for preventing HIV infections (Hogben and Liddon 2008). In this regard, Eaton and Kalichman (2007) suggest that it is therefore crucial to understand the way in which individuals think of risk in as far as biomedical technologies are concerned. To fully understand the way circumcised men in my research conceptualise risk, I explored their sexual practices in the light of HIV testing and counselling (HTC). As indicated, I attended one group counselling session as a means of understanding its character. This topic was pursued further in the one-on-one interviews with the 25 circumcised males. The following are some of the interview extracts from my study:

> Researcher: *Did you go through HIV testing and counselling prior to getting circumcised?*
>
> Participant: *Yes, I did?*
>
> Researcher: *Did you find it useful?*
>
> Participant: *Yes, it was very useful especially for me given the fact that I was inconsistent in condom use in extra dyadic relationships prior to getting circumcised. I do not have a history of getting tested for HIV; I used to have a lot of fear given that I had risky sexual encounters before. When I went for circumcision and attended the counselling sessions and tested HIV negative I realised the need for me to be consistent with condom use. This is so because circumcision offers partial HIV prevention which means I can get infected if I don't use condoms. 60 percent is not 100 percent; I can get infected if I don't use protection in extra dyadic relationships.* (Interview, 22 August 2013)

Another participant said:

> *The counselling given before and after getting circumcised is very crucial. Emphasis is placed on the need to use condoms as protection when one has an extra dyadic affair among other things. Circumcision only offers 60 percent protection against HIV with the remaining 40 percent chance of infection being enough for one to get infected. As far as I know this is less than what condoms can offer in terms of prevention hence the need to use condoms. I have also read in the newspaper that circumcised males contracted HIV after they averted condom use. Counselling is very important because it provides one with the necessary information on the need to reduce risky behaviour. If circumcised men contract HIV, I don't think they can blame*

*someone but themselves because programme implementers provide what I call 'adequate information' pertaining to MC.* (Interview, 27 August 2013)

There seems little doubt from these interview extracts that circumcised men fully understood the risk of getting infected regardless of the fact that they are circumcised, and that the counselling was as effective as it could possibly be. This finding replicates the findings of research conducted by L'Engle et al. (2013) in Nyanza Province in Kenya, as circumcised men in this study showed an understanding of the need and importance of using protection in the form of condoms during sex. This understanding is based on the recognition that circumcision provides partial protection only. Through risk-reduction counselling, circumcised men become cognisant of the dangers of infection if they do not use condoms, particularly in extra-dyadic affairs.

Counselling alone though, no matter how sophisticated and thorough, is certainly not a panacea. In order to understand the prospects of reducing risky practices post-circumcision or of inhibiting risk compensation, social conditions in the worlds of circumcised men – in the past and in the present – need to be taken into consideration. Thus counselling by itself cannot be expected to prevent risk compensation or risky sexual practices, as there is not a direct causal link between counselling and sexual practices. These practices are mediated by a range of social conditions, some of which (such as stigma) I have noted already in relation to the consistent and correct use of condoms.

### 6.4 Social conditions

In ascertaining the relationship between circumcision and risky practices, it is necessary to consider and examine the life history and present social circumstances of individual circumcised men in relation to risk. To do this, I inquired into the past lives, or social background, of the circumcised males as well as current social influences. In the discussion below, in illustrating the significance of social conditions, I provide two contrasting stories.

To highlight the significance of the first story, it is worth repeating that nearly all sexually-active circumcised men (17 out of 18) had CSPs before being circumcised. The range in the number of sexual partners per male varied from only two to at least fifty partners. The circumcised man with over fifty partners in the past had in fact lost count of the number of sexual partners he has had, as he says he stopped counting once the figure reached fifty; and his is the first story.

In an interview about his life story, it was astonishing to learn that this man grew up in a devout Christian family which in fact – according to him – contributed immensely, at

least indirectly, to his risky sexual practices. The conversation, which I quote at length because of its revealing nature, went as follows:

Researcher: *Can you tell me about your childhood and how you were raised up?*

Participant: *I was raised in a 'very' conservative Christian family. My parents especially my father was too strict on us and kept an eye on us always. They were so ingrained in their religion to the extent that they did not allow us to watch television. We only watched television during news times, the bulk of the time it was switched off because they believed that it corrupts us since most of the stuff broadcasted on it is 'of this world'. This applies even to the radio; we were not allowed to listen to it. We had curfew. Six o'clock everyday in summer and five o'clock every day in winter we were expected to be at home. If one was running late it was upon my parent's approval and this was allowed only on exceptional cases…The way we dressed was heavily sanctioned. Before going to bed we would gather for a church service as a family. We would sing, preach the word of God and pray rotationally.*

Researcher: *How did you like that kind of upbringing?*

Participant: *To be frank with you when I was young I did not have any problems with their strictness. In fact, I saw love in whatever they did to us. I am very eloquent when it comes to singing, praying and preaching and I owe it to them. However, when I started secondary education the way I viewed life changed all of a sudden. This was mainly influenced by the experiences I shared with my friends at school since I was at a boarding school. Also, the feeling of being away from home was a major relief for me. I felt oppressed when I heard other students talk about the various programmes they always see on the television. I felt out of place and I started emulating them. I started hating my parent's approach towards our upbringing. However, there was nothing I could do about it since I was still under their roof and in need of support. Life changed for me when I went to university! There I got exposed to many things, unlike home there were no strict rules and for me it was my first ever freedom….I joined a group of friends who grew up in more or less similar conditions. One day we went out. Man oh man! I didn't know that the world is so sweet and beautiful. For the first time in my life, I had a beer in my hand and you know what, I got drunk! Although I felt bad about it at first I quickly ignored the feeling because I enjoyed the moments…It was not long before I started doing women. I had several one night stands with girls from the university as well as prostitutes who thronged the various drinking places. I don't forget the day I first kissed this other chick! It was bad because I did not know how to do it. I was embarrassed and I had the urge to keep learning and I was convinced I was able to be good at it.*

Researcher: *Did you know about HIV and AIDS?*

Participant: *Yes I did. We were taught about it at school.*

Researcher: *Did you protect yourself against STIs including HIV?*

Participant: *Truly speaking protection was an afterthought. Whenever I tried it I would ejaculate while trying to put on a condom. When I pulled my foreskin whilst putting on a condom I would climax and ejaculate. During my first days I never used condoms because of the embarrassment I faced whenever I tried to. Sleeping around since then became a normal thing for me. I cannot do without sex. I enjoy it! I am not consistent with condom use and sometimes I feel bad about it. It is dangerous, very dangerous! By getting circumcised I was trying to reduce chances of getting infected since I know that I am very inconsistent when it comes to condom use* (Interview, 19 August 2013)

From this personal account, it seems that his foray into sex (and lots of it) may have been a reaction to his strict Christian upbringing. But what is particularly intriguing about his background is the reasoning behind being circumcised. Circumcision was not part of a broader mind-set of ensuring maximum protection against becoming HIV-positive. Rather, circumcision itself is a risk compensation tactic on his part because of his inability or unwillingness to use condoms consistently (both before and after circumcision). In this context, and if this were a broader mind-set amongst medically-circumcised men, it would not be surprising to find these men with higher rates of HIV infection than uncircumcised men particularly if the latter made regular use of condoms. An uncircumcised male using condoms is indeed less likely to become HIV-positive and infect partners than a circumcised male not using condoms, because of the greater effectiveness of condoms compared to circumcision in preventing HIV transmission.

A second life story is also of significance, as it brings to the fore the linkages between sexual practices and socialisation traced from childhood and changes in life-courses. This does not imply though that sexual practices are fully determined by past socialisation, as individuals have agency and can make deliberate choices in the present. Behaviour does change and individuals can choose to pursue different sexual lives, for better or worse. The conversation went as follows:

Researcher: *How can you describe your childhood?*

Participant: *I was raised up in a very poor family. Having food to eat was a struggle. I reached Ordinary level* [secondary school completion] *but it was a struggle and I never really made it because of the way I grew up. We shared one room as a family and it was sub-divided into smaller rooms by curtains and we used the divisions as bedrooms at night as well as the kitchen and living room during the day. Due to this set up I was exposed to sexual activities at a tender age (16 years) since we shared the same room with my father and mother with the only difference that it was subdivided. My two sisters were impregnated at the ages of 16 and 17*

*years respectively and are not married. The area I grew up in encouraged me to be sexually active at the age of 16 years.*

Researcher: *Can you tell me more about the environment you grew up in with a focus on your friends?*

Participant: *Well, all my friends grew up in more or similar conditions. We are from a poor suburb as you can see. They grew up in the same set up of dividing rooms with curtains into bedrooms and were exposed to sexual activities. We had to go sell sweets, freezits* [flavoured ice] *and such like goodies to raise money for school fees and food. With girls in our area having been exposed to early sexual activities as us, talking them into sex was not that difficult given the fact that our society is a bit closed.*

Researcher: *How about using condoms for protection?*

Participant: *Condoms were never in the picture! Remember, the living set up I spoke about. We had rushed sex since we feared to be caught and there was no room* [time] *for condom use. Time was too little for that. Also, I feared condoms would put me in hot soup with my parents if they discover them. I don't think any parent would be happy to learn that their child is sexually active at an early age. I grew up into the early 20s behaving like I mentioned above sexually and I used to drink heavily.*

Researcher: *What can you say of your behaviour now?*

Participant: *Well, I got to a point I convinced myself to quit drinking and womanising. Drinking and sleeping around is not healthy. I met a certain guy one day in town who wanted to buy a phone I was selling since I am an entrepreneur. That guy had a lot of charisma. He asked me if I am married and upon learning that I am he from nowhere started to speak about his personal life, who he was in the past and who he is now. Although we are totally different people our behaviour sexually was more or less the same.*

Researcher: *What did he tell you?*

Participant: *He told me how happy he is with his family now unlike in the past. Just to be home, happy with his family regardless of the difficult economic conditions we are facing. How good and healthy it is not to have other sexual partners. He asked me, 'If you are to contract HIV will you be able to come out here and stand for many hours fending for your family?' He spoke to me as if he knew that I have extra dyadic affairs. The way he said it touched me. Towards the end of the conversation he said, 'I don't know why I spoke to you about my personal life, maybe there is a reason. If there is anything that relates to what I said happening in your life, please take heed of my words because one day you will remember me.*

Researcher: *Were you circumcised then?*

Participant: *What this guy said touched me. I went home and thought about it for a couple of nights and days. After realising that there is no need for me to have extra dyadic affairs I made up my mind not to sleep with anyone who is not my wife. I went for circumcision as a way of*

*reducing my chances of getting infected with HIV and other STIs since I was not a consistent condom user. But, I am a changed man. I am a family man now and we are happy as a family.*

Researcher: *How do you describe your relationship with your wife before and after meeting the man you spoke about?*

Participant: *We are in good books; she never did anything to push me out to other women. I cannot blame her for anything wrong I did.* (Interview, 21 August 2013)

This research participant had a very different social upbringing than the participant in the previous conversation, and an upbringing which was marked by a considerable array of sexual partners including after marriage. But through a chance meeting with someone, he reflected deeply on his sexual practices and extra-dyadic relationships and made a very conscious choice to turn his life around, including being circumcised. It is highly likely that his old friends, with whom he socialised as a teenager, are still on their old path of CSPs. It is clear then that sexual practices cannot be reduced in any strict causal sense to structural conditions (for example, of abject poverty, as this male still lived in poverty) and, as indicated above, these practices cannot be read off from the intensive HIV counselling received by circumcised males. More specifically, social conditions and agency play a mediating role in shaping sexual practices. In this particular case, the circumcised male seemed 'ripe' to experience the full benefits of circumcision. The previous male and his mind-set or subjectivity is very different. Therefore, the implications of VMMC in reducing HIV transmission depends quite fundamentally on the individuals circumcised, such that there is no inevitability in terms of the exact outcomes that VMMC will have regarding rates of HIV infection.

### 6.5 Concurrent Sexual Partners amongst the Sexually Active Men

In this regard, it is useful to focus specifically on the question of concurrent sexual partners because of the prevalence of this amongst the sample, particularly before circumcision. In doing so, and in order also to understand why there has been a reduction in the prevalence of this particular risky sexual practice, I consider why some men turned away from CSPs subsequent to circumcision and why by extension some continue with it. Again, the importance of social conditioning and agency come to the fore.

In terms of CSPs prior to circumcision, I show this in summary form in Table 6.1. This shows the following, in relation to the sexually-active participants with CSPs: 6 percent reported over 50 partners, 17 percent reported having 10 sexual partners prior to circumcision, 6 percent said 9 partners, 12 percent had 8 partners, 23 percent reported 5

sexual partners, 6 percent spoke of 4 sexual partners, 17 percent indicated 3 partners, and 12 percent reported 2 partners. For the sexually-active males, before circumcision, they had an average of over 8 sexual partners.

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**Table 6.1: Concurrent Sexual Partners before Circumcision**

| **No. of CSPs** | **Percentage** |
|---|---|
| 50 | 6 |
| 10 | 17 |
| 09 | 6 |
| 08 | 12 |
| 05 | 23 |
| 04 | 6 |
| 03 | 17 |
| 02 | 12 |
| | **100** |

The sexually-active males were also requested to indicate the extent of casual sex subsequent to resuming sex after circumcision. As note previously, the results indicate that, of the 17 sexually-active males with CSPs before circumcision, nine (more than 50 percent) continued to have casual sex post-circumcision. The breakdown in terms of the number of partners for these nine is as follows: four of them (45 percent) reported having 2 sexual partners, three (33 percent) indicated 3 partners and two (22 percent) spoke of 5 partners. For all the sexually-active males (18), after circumcision they had an average of 1.5 sexual partners (a significant reduction from the pre-circumcision period). Table 6.2 shows the breakdown of the nine participants and the number of sexual partners after circumcision.

**Table 6.2: Concurrent Sexual Partners after Circumcision**

| **No. of CSPs** | **Percentage** |
|---|---|
| 05 | 22 |
| 03 | 33 |
| 02 | 45 |
| | **100** |

Given that circumcision on average occurred 1.5 years prior to the study, it is understandable that the sheer number of CSPs would decrease post-circumcision (at the time of my study) given the lengthier period of sexual activity prior to circumcision. In fact, if there was a sheer drop in the average number of partners for sexually-active males after circumcision, with the number spread across all these males, then this would indicate that the prevalence of concurrent sexual partners has not dropped at all. But this is not the case, as a significant percentage of these males no longer engage in casual sex at all. This does therefore indicate a decrease (in fact, a discontinuation) in this particular risky sexual practice amongst certain men. In other words, not all males who had CSPs before circumcision reported CSPs after circumcision. Whether those males still engaged in CSPs are showing a reduction in the number of sexual partners is difficult to assess because of the short time period after circumcision.

### 6.5.1 Factors contributing to reduction in CSP

There are a number of factors which seemingly contribute to the reduction in the number of males engaged in casual sex with numerous partners, and these factors often relate back to why the male became circumcised in the first place. I now discuss two of these as illustrations, specifically religion and family. These social institutions became important conditioning factors in shaping the decisions made by a number of the circumcised men in my study, and formed a strong basis for discontinuing from CSP.

#### 6.5.1.1 Religion

In this study, not all men were primarily driven to become circumcised for purposes of HIV-prevention. Some did it for religious reasons. There seems to be an important link between religion and male circumcision with contributes to an explanation of reduced CSPs. One participant spoke about this in the following terms:

> *Life is way more important than sex. I used to enjoy sleeping around but I just made up my mind to stop the bad and risky behaviour when I recently gave my life to Christ. I was not born in a Christian family. My father and his brothers were all polygamists. As I grew up I was of the conviction that I should have many women around me. When I became sexually active, (at the age of 21) I did not use a condom and it went on like that for a while. Condom use was never my favourite thing to do. I should say I was an inconsistent condom user and I did not really enjoy it because I knew I would contract HIV. One thing that influenced me was alcohol and the type of friends I had then. When I was drunk, I would overlook protection and brave*

*unprotected sex. I thought of changing when I had an STI and I thought I had contracted HIV as well. I got depressed and thought of changing my way of life. I love my wife and children and thinking that I would die of AIDS was more than embarrassing for me than anything else. When I got tested and tested HIV negative I thought of becoming a Christian. When I learnt about VMMC I equated it with biblical male circumcision that signifies God's covenant with Abraham the father of faith and all his descendants. Even Jesus Christ himself was circumcised. Although nowadays in the Christian circles physical male circumcision is not of significant value especially to us non-Jews, I just made a personal decision to get circumcised as a way of turning over a new leaf in my life since I am a new creature in Christ. I told myself that the removal of my foreskin signifies the removal of my bad and risky sexual behaviour. Every time I see the circumcision marks on my penis I will remember my promise to myself, God and my wife although I did not tell her that this was the major reason for getting circumcised. In other words I made a covenant with myself and God that I will not have an extra marital affair after getting circumcised. No other woman is going to touch my 'manhood' in a sexual act except my one and only wife. It's two years now and the covenant still stands.* (Interview, 27 August 2013)

From the above interview, one can see that there is some kind of moral value being placed on VMMC as linked to religion, in this case Christianity. Again, it emphasises the significance of agency and choice and the effects of conscious deliberation on the effectiveness of VMMC in undermining HIV infections. The desire to lead a life of faithfulness to self, God and wife is in this sense symbolised by circumcision as a rite of passage to a new HIV-free life.

In my conversation with this particular participant, I learnt about the possible usefulness of church programmes that are conducted in some churches today that vehemently discourage infidelity between couples. Some of the church meetings are attended by couples (hence the name 'couples meeting') while some are gender-specific whereby men arrange *braais* and women have other types of functions at which discussions around strengthening marriages are undertaken. During these meetings, a guest who is an expert therapist in marriage counselling is often invited to facilitate discussions on various topical marriage issues. Church in this instance has been instrumental in helping couples handle problems that are marriage and family-related and which may assist in ensuring couples keep to their marriage vows. Otherwise the possibility exists of tension between couples leading to the husband engaging in extra-marital affairs that, in the case of Zimbabwe, are less frowned upon than a wife having such an affair (Chingandu 2007). In this context, I probed further about the importance of the church meetings in this participant's life:

Researcher: *What can you say about the couples as well as men's fellowship meetings?*

Respondent: *The meetings are very important, as I indicated earlier. We now know how to talk to each other as husband and wife. We sometimes joke about our past problems as a way of admitting and embracing the change that brought happiness in our family. In fact, after these couples' meetings at church and men's fellowships I realised that I was the cause of the problems including infidelity in my marriage. I was not man enough in terms creating a happy family environment and this traces back to what I grew up in. My father had several wives and he could not keep a happy family at all. When I got married I thought I was not prepared to take responsibility of the matters of the home as a father. Every time my wife suggested something meaningful I felt challenged and ended up rubbishing everything she would say just like my father. This made our communication very bad as a couple and impeded happiness in the home. Whenever she asked for money for use in the home I felt as if she was nagging me. Blatantly I used the sour relationship as a scapegoat for having extra-marital affairs all in the name of avoiding problems at home. My wife and son missed me but I kept dodging them for the lady whom I think was treating me like a king ... After attending the church meetings I realised that I am the one to blame for the tension in the home and I just made my mind to get circumcised to remind myself of the covenant I made.* (Interview, 27 August 2013)

The discourse of the nagging wife as disrupting the marital relationship and as the basis for infidelity by the husband has been identified in other studies, such as that by Chingandu (2007). The main point though is the linkage between Christian faith and circumcision, with the marks of circumcision seen by this particular participant as marking the covenant between him, God and his wife.

#### 6.5.1.2 Family

Besides the church, the family often plays a key role in encouraging males to become circumcised as well as to refrain from CSPs. In my study, 28 percent of the participants received words of encouragement to undergo circumcision from family members (or legal guardians). In an interview with an 18-year old man, the following conversation took place:

Researcher: *Who encouraged you to get circumcised?*

Respondent: *I got encouragement from my sisters to go and get circumcised. I am very close to them to the extent that my father feared I will be feminine in my conducts. We are more of friends than siblings. We discuss about anything freely. We discussed about the advantages and the need for me not to have CSPs as well as having sex without condoms. As if this was not enough my dad overheard us discussing this issue, he called me and he was privy to me about his circumcision status. Upon knowing that he was circumcised and learning of the advantages thereof I felt more encouraged to go get circumcised….Among other things he reiterated my sisters' advice on avoiding CSPs and braving unprotected sex because I am circumcised. One*

*of my sisters accompanied me to the circumcision centre as a way of giving me support. They all reminded me to make sure that I nurse the wound properly* (Interview 25 August 2013).

Another participant also spoke about family influences:

*I was at home bored and this was during a time when there was hyper-talk about voluntary male circumcision in the media. The same was happening at home; it was more of a melody from my mother. She kept on encouraging my brother and I to go get circumcised. On this particular day we woke up with nothing to do at home and mum drove us to the circumcision centre and we got circumcised.* (Interview, 27 August 2013)

Another circumcised male said that he was encouraged by his cousin's wife (who is a professional HIV counsellor) to be circumcised. In doing so, she also told him to guard against the common misconceptions held by circumcised males which lead to engaging in casual sex.

Another reason for refraining from risky sexual practices such as CSPs, which is related to the family, is the question of health. Besides the health advantage of reducing the chances of HIV and STIs, VMMC also reduces the chances of cervical cancer in partners of the circumcised males, and penile cancer. Over 50 percent of the participants in this study mentioned that they were circumcised in part because they wanted to reduce the chances of promoting the development of cervical cancer in their partners. In some cases, this was more important to the circumcised male than reducing the prospect of HIV infection, and the decision to be circumcised was a decision emanating from the couple and not just the male partner. The wife's involvement in the circumcision process from the start inhibits the circumcised male from even considering CSPs. Below is an extract of an interview with one of the participants:

*When we first heard about the advantages of male circumcision we did research as a couple to find out if there are other studies that confirm that male circumcision reduces the chances of penile and cervical cancer. Although personally I haven't heard of any person who had penile cancer I have seen and heard of a number of people who suffered and died of cervical cancer. As you know cancer is a deadly disease so as a couple we are trying to avoid it at any cost. When we had gathered enough facts I thought of bringing my wife a surprise present. I called my friend who drove me to the circumcision centre and home after getting circumcised. Upon getting home it was a surprise present indeed for my wife since she never thought that I would go there given the fact that I am afraid of seeing wounds on others worse still on myself. I overcame the fear because of the love I have for my wife and family. This has strengthened our love the more. My wife is my best friend, we can talk about anything. We are like one person, we match so perfectly.* (Interview, 25 August 2013).

This health-based rationale for circumcision has wider implications in that it arose in the context of a strong commitment between couples. When circumcised males integrate either their wife or permanent partner into the circumcision process on a systematic basis, there is a stronger likelihood of a reduction of risky sexual practices post-circumcision – though not necessarily a guarantee.

### 6.5.2 Factors not contributing to reduction in CSPs

Just as it is possible to identify strong reasons for why many sexually-active males no longer have CSPs, there are other reasons why this has not taken place in the case of other males (which again often relates back to the reasoning behind circumcision in the first place). For these other males, circumcision was never necessarily understood as a road to risk-free sexual practices but even as a justification for further indulging in risky practices; though these males never articulated it in this way during my research. In this respect, I discuss two supposed advantages of VMMC which were mentioned in my study as reasons for being circumcised, but which by themselves do not go a long way in ensuring a reduction in CSPs. Insofar as these reasons were prioritised by specific males, the chances of a decline in CSPs (or proper condom use) becomes almost negligible.

#### 6.5.2.1 Hygiene

There seems to be concordance on the hygiene benefits of male circumcision. All participants reported that male circumcision has brought about a new lease of life as far as hygiene is concerned. This is popularly known in Harare as 'smartness' based on the catchy Shona phrase *Pinda Musmart* often used in medical circumcision campaigns. When translated into English, this phrase means 'Get Smart by Getting Circumcised'. During the interviews, although participants were not asked to prioritise all the reasons for getting circumcision, 24 percent of them stressed hygiene as their primary reason for circumcision. This is not to say that these participants ignore the other advantages of circumcision, but the hygiene factor alone does not have any effect on reducing CSPs. For these participants, the removal of the foreskin has been the key advantage in the sense that there is no room for the development of smegma. In the local Shona language it is called *masadza* or *manyemba*, and it refers to the unpleasant-smelling white secretion collecting under the foreskin.

The foreskin is said to provide a suitable environment for the development of smegma which turns out to be smelly when not cleaned. For most of the participants in this study, circumcision provides a permanent solution to the smegma problem (over and above the

temporary solution of cleaning themselves regularly with soap and water). Circumcision is not a substitute for bathing; however, there are some circumstances that make it impossible for one to bathe no matter how badly they want to do so. To elaborate on this point, I refer to one interview:

> Researcher: *Can you elaborate on the advantage of being smart in as far as MC is concerned?*
> Respondent: *Circumcsion has helped me stay clean. Cleanliness is the major reason why I got circumcised. I am a 'cross border' by profession. I travel to Tanzania thrice a month by bus to buy clothes to sell here in Harare. Personally, I was not comfortable with the smell that used to come from within my foreskin before I got circumcised. This, however, got worse when I commenced my business whose wares come from Tanzania. On a good trip it takes at least two and half days of travelling to reach Tanzania. Trust me, there are very slim chances of one to get a bath* [during travelling]. *If you manage to, you have to pay for it. I had one very 'rough' trip in which the bus we were travelling with had a fault in the middle of nowhere. We spent four good days before reaching Tanzania. I didn't like the smell at all. It was awful. The area covered with the foreskin became very itchy because of the smegma that had accumulated. I was very uncomfortable, I felt as if I smelt on the outside…. After that trip I got circumcised and, you know what man, I really like my new status now! I no longer worry like I used to do in the past.* (Interview, 20 August 2013).

Though this is a common reason for being circumcised, as a major determinant of circumcision (if not combined with other reasons) it may still imply engaging in casual sex outside the marriage or with multiple concurrent partners; particularly when other life-factors are considered, such as a high level of spatial mobility as in the case of this interviewee.

#### 6.5.2.2 Sexual Performance

There is one common experience that was reported by some circumcised males, particularly the married ones who had sex before circumcision and after circumcision. And they spoke about this passionately. According to them, male circumcision has enhanced them sexually in the sense that, ever since they got circumcised, they are now lasting longer during sexual intercourse than before they got circumcised. Sexual performance is a cause of great concern for most men (both circumcised and uncircumcised) as it seen by men as a measure of a man's virility and masculinity. Lasting longer, or prolonging climaxing during sex, is a virility measure and an important aspect of male sexuality. Before these circumcised men were circumcised, they climaxed early and they felt inadequate as men.

Sexual performance becomes measured by the amount of time the male stays 'inside' a sexual partner after foreplay and before climaxing. From the perspective of these men,

circumcision enhances virility because the removal of the foreskin results in the hardening of the penile head which in turn reduces sensitivity and thereby leads to delayed ejaculation. As one man indicated:

> *Circumcision has made me a real man in the sense that it has helped me last longer during sex. Before getting circumcised I would ejaculate very fast; after a few strokes just like a rabbit. It was too short, just like a rooster. It had a serious blow on my manhood and ego. I knew I wasn't satisfying even my wife since women take long to sexually climax. I felt useless one day when my wife asked if I had already ejaculated and one day she even pleaded with me that I should try my level best to at least last a bit longer. I felt inadequate whenever we engaged in discussions on our sexual experiences with my friends especially when they pointed that a man should last longer sexually. But I am happy now because I am taking it to the wire.* (Interview, 27 August 2013)

There was another participant who shared an experience he had, the type of which was confirmed by another participant. The former had gone out for fun one night and he thought of relieving himself sexually by engaging with a commercial sex worker. To his surprise, before going for the short time session with the sex worker, the latter demanded to know if he was circumcised or not. He said that he was hesitant to reveal his circumcision status suspecting that the sex worker wanted him not to use a condom during sex. However, he was astonished when she demanded that he pay her double the normal short time rate. On asking her why she was charging him at a premium, he said that she told him that circumcised males take longer than uncircumcised males before they conclude sex.

Though male circumcision seemed to enhance sexual performance amongst the sexually-active males in the research, there is also an indication that it caused some discomfort for their wives. A few participants pointed out that their change in sexual performance, though largely welcomed by their steady partners, led to accusations of extra-marital affairs by their partners. One participant elaborated on this, saying that – in his wife's view – the reason for his delayed ejaculation was because he was sleeping with other women and would come home with an 'empty tank' and hence could not ejaculate during sex with his wife. By empty tank, he meant that after supposedly ejaculating with another woman, his sexual hormonal charge dissipated and he could no longer generate semen during sex at home. This particular couple discussed this issue and settled it amicably. Another participant reported that his wife was worried that she was no longer attractive and sexually appealing to him because of the delay in ejaculation. She lost confidence in herself because of this. She

also interpreted the 'long plays' to mean that her husband had lost sexual interest in her. In the past, the 'short plays' meant that she was too 'hot' for her husband to last longer.

Not all of the participants in my research shared the sentiments about circumcision enhancing sexual performance. Some noted no changes whatsoever with regards to sexual performance induced by circumcision. These men seconded each other in attributing sexual performance in general to one's mood during the time of having sex and not necessarily to one's circumcision status:

> *For me sex is all in the mind. It's a psychological thing not necessarily a circumcision thing. There is no marked difference in terms of performance before and after circumcision. I last longer when I am in a good mood as compared to when I am in a bad mood. Also, I last longer when I have sex regularly. For me, also, it depends on the partner I am having sex with; if I am having sex with someone to whom I am attracted, for example, my wife I always make it a point that I impress by lasting longer.* (Interview, 27 August 2013)

Though there are divergent views about the relationship between circumcision and sexual performance amongst my sample, an exclusive focus on sexual performance on the part of the circumcised man does not in-itself lead to a reduction in CSPs; it may in fact lead to the contrary, as it is linked to masculinity and virility and to the very identification of what it means to be a real man.

### 6.5.3 Circumcised men with CSPs without condoms

Of particular concern are the five men who continue to have concurrent sexual partners without using condoms. All these men recognise that VMMC provides only partial protection yet they continue with their risky sexual practices. In large part, this is because their main rationale for circumcision was to ensure ongoing risky sexual practices with at least partial protection arising from VMMC. Even such deficient justifications for VMMC as hygiene and enhanced sexual performance, as a basis for ensuring protection from HIV infections, are not part of their discourse around circumcision. In the end, for them, sexual relations – and specifically CSPs and inconsistent condom use – relates to upholding and reinforcing their socially-legitimised masculinity. In this regard, I quote from an interview from one of these men:

> Researcher: *Why do you have CSPs?*
>
> Participant: *Its natural, isn't it? We are Africans; we are entitled to many wives. I think it's better for me to have a girlfriend than to marry many wives. This is better than polygamy isn't it? This isn't the time to gather women together especially with the economic hardships we are*

*facing. Children are too expensive to look after, so having someone who doesn't bear you children (girlfriend) is the way to go*

Researcher: *What can you say about your condom use consistency?*

Participant: *There are some moments, depending upon who I am having sex, when I choose not to use a condom. Well, sex is an issue of trust; you can't keep using condoms with someone you have had sex with for so many times. There are times when I choose not to use condoms just for fun and as a reward to my girls especially those who perform well and treat me well. It's a give and take, isn't it? After all I am circumcised and that reduces my chances of contracting HIV by 60 percent. I gamble with the 60 percent. Let me give you an example so that you understand me; I love gym and there are times I feel like I should just go out wearing a vest just to show off my muscles. What's the ulterior motive of going to the gym besides the one to stay fit if it's not to show off my muscles? For me the same applies to sex. Getting circumcised knowing that I am an inconsistent condom user was a conscious move to increase my chances of safety from zero to 60 percent. However, I am aware that the 40 percent chance is still dangerous although at a lesser scale. Let me put it this way also: consistent condom use is a very complex act which I believe even the most disciplined people are found wanting. I always equate sex to soccer in which as a man I am the striker…A striker calculates his moves well. He knows that he is not allowed to be offside but no striker can tell you he never in his life has been on the offside position especially the fast one; the ones with pace. I am like that as well, sometimes I am caught offside. It's either I don't have a condom with me or I don't have time to put it on. I don't always use a condom* (Interview, 22 August 2013)

Though this man, and other four men with CSPs and inconsistent condom use, may not have increased the scale of their risky sexual practices because of VMMC, it seems clear that – in their cases – VMMC is seen as a compensation measure which allows them to engage continuously in risky sexual practices. In this sense, some form of risk compensation is taking place.

### 6.6 Condoms and Circumcision: Complements or Substitutes?

In the end, there is a diverse range of reasons why the men in my sample decided to undergo circumcision and, in certain cases (particularly amongst those still engaged with CSPs), the reasons do not seem to strongly entail a desire to reduce risky sexual practices. For most others though it did, and the extent to which these men reduce their risky practices depends quite fundamentally on the mix of reasons which formed the basis of being circumcised in the first place. For instance, family and church are stronger grounds than sexual performance and

hygiene in ensuring that circumcised males live up to the very crux of the matter, namely, the role of VMMC as a prevention method in reducing the prevalence rate of HIV in Zimbabwe.

This question about risky sexual practices brings me to an important point, namely the relationship between condoms and circumcision from the perspective of circumcised males. Do they recognise – not merely conceptually but as demonstrated in their practices – that these two methods of HIV prevention are complementary methods or alternative methods? In doing this, I first identified their specific understandings of circumcision in limiting HIV transmission. All participants attested to the fact that medical male circumcision was adopted in Zimbabwe mainly as a new HIV prevention technique. It does though have other purported advantages, including reducing the chances of cervical cancer in the partners of circumcised males and the chances of penile cancer development in circumcised males; though some of my study participants were not fully aware of these advantages.

The circumcised men then clearly recognised the significance of circumcision to HIV prevention. But I also sought to establish if circumcised men understood the biological and scientific explanations behind HIV prevention, and specifically the scientific explanation of the efficacy of male circumcision for HIV prevention (WHO and UNAIDS 2007, Patterson et al. 2002, Gray et al. 2007). The majority of the participants did know and understood the scientific explanations sufficiently though they were in large part unable to articulate it in scientific terminology. Some men though gave quite a detailed account of the role of circumcision, such as the following:

> *The foreskin contains cells that are easily targeted by HIV. So its removal means that the targeted cells are removed thus reducing the chances of HIV transmission. I am also told that during sex the foreskin develops some bruises as one strokes resulting in easy entry of the virus into one's body. The removal of the foreskin also results in the hardening of the penile head through keratinisation giving a bit of resistance to the virus. On top of that there won't be the foreskin harbouring the fluids obtained during sex providing ample time for the virus to enter into one's system. The circumcised penis dries as soon as one concludes sex. All this reduces the chances of transmitting HIV from a woman to a man.* (Interview, 07 August 2013)

It was necessary to establish if circumcision triggered risky sexual practices focusing on condom use aversion. The evidence presented suggests that this risky practice continues to exist – although unevenly – across the research sample. In understanding this further, it was necessary to know if the participants are in fact aware of the VMMC level of efficacy. All of them fully recognised that VMMC offers only partial protection as it provides a 60 percent chance of protection against HIV when condoms are not used. For the majority of the

participants in this study, the remaining 40 percent chance of infection should not be downplayed since it implies that, without condoms, infection can occur. Effectively, then, the figure could be reformulated as this: there is a 40 percent chance of infection for a circumcised male who does not use condoms consistently; and hence condoms should be seen as complementary.

Condoms clearly provide better protection from HIV infection especially with multiple concurrent sexual partners. One circumcised male said in this regard:

> *I do not undermine this 40 percent figure, to me infection is either one or zero so I won't have comfort in the 60 percent.* (Interview, 06 August 2013)

Another participant spoke emotionally and passionately on this subject. He spoke as if he was advising me not to ever consider the two prevention methods as substitutes but as complements for each other:

> Researcher: *How do you take condom use and circumcision? Can you take them as complements or substitutes for each other?*
>
> Participant: *My brother I don't know how I can knock sense into my fellow countrymen with regards to the confusion and debate on whether circumcision and condom use substitute or complement for each other. The problem with people is they do not want to research so as to find out what science says. Is it not stated that circumcision offers 60 percent protection? Is it not scientifically proven that condoms provide more than 95 percent protection if used correctly and consistently? Everyone who got circumcised should be very aware of this. Information on the efficacy of circumcision is clear on this and it's a chorus on the visual and audio media. It is clear man, isn't it? Haven't you heard the adverts explicitly stating that circumcision offers 60 percent protection? Before you get circumcised my brother you go through comprehensive group and individual counselling in which you are clearly told that you should continue using condoms when circumcised. People should not give lame excuses as a way of justifying their negligent informed behaviour. I for one would always use condoms for I know that I am not safe. The two for me are life team mates, they complement each other. They will never substitute each other.* (Interview, 15 August 2013)

One participant responded on the need to always use condoms after I asked:

> Researcher*: How do you understand male circumcision and condom use and what drives your understanding?*
>
> Participant: *Male circumcision should never be misunderstood by men. It's not a passport for risky sexually behaviour. Well, let me put it this way my brother, it is a noble idea meant to save humanity which was never meant to propel men into a sexual spree. I have told myself that I will always use a condom with a partner who is not my wife. I have a son who got circumcised recently and I told him never to substitute the two HIV prevention methods for each other*

*because it is dangerous. From the information I gathered from the counselling I went through before circumcision, male circumcision helps, say when a condom breaks during sex that's when it is mainly thought to reduce transmission not for one to brave unprotected sex under the pretext of being circumcised. Even when the condom breaks and you are aware of it, stop and put on another one. People should not over-rate sex. It's not like a demon that takes over and controls your actions. I am a very careful person, the other day the condom broke when we were in the middle of the act and we had to change it. Would you keep driving your car when you have a flat tyre? A good driver travels with a spare wheel, the same for me when I am having sex! I always make sure that I have an extra condom in case of a breakage I would use it.* (Interview, 15 August 2013)

The above interviews are quite encouraging in that they show that circumcised males are aware of the fact that circumcision offers partial protection. However, there is need for circumcised men to walk and live the talk because even the second interviewee – who is married – indicated that he 'will always use a condom with a partner who is not my wife'. This implies, in practice, a deviation away from his marital vows and the ongoing involvement with multiple concurrent partners. But, overall, subsequent to circumcision there has been – as chapter five shows – an increase in the number of sampled males now using condoms on a consistent basis.

At the same time, as indicated in chapter five, there is considerable condom use aversion and for a range of reasons, including drunkenness, having no condom at hand, lack of trust in the effectiveness of condoms, cultural and social upbringing, use of 'minimum' force on otherwise unforthcoming partners, and embarrassment in the purchase of condoms. And condom use aversion is particularly prevalent about circumcised men still involved with concurrent sexual partners. Though the number of research participants involved in CSP arrangements decreased after circumcision, most of the males (5 out of 9) still involved in these arrangements do not use condoms on a consistent basis. For these men, engaging with CSP without condoms is almost the manly thing to do, and thus the reasoning behind this relates to sexuality, masculinity and the male ego. To highlight this, I quote from two of these five male. One male argued:

*You know what, wearing a condom for absolutely every sexual partner is just impossible. With some partners, when you begin having sexual intercourse, you wear a condom. However, as time goes by, you become used to one another and wearing a condom literally no longer becomes an issue. When having sexual intercourse, with different partners, I have noticed that it is about who you are with and what the level of understanding between the two of you is. If a particular partner particularly pleases me in bed, the reverse is true, I would also want to*

*please them and ensure they get satisfied in full. If a woman takes hold of my penis, I become literally powerless due to the exhilaration of the feeling of sexual satisfaction. In this day and age in town, there is a lot of pornography and dvds being sold even on the street; blow jobs have become a common occurrence. In my case, my penis has become a favourite amongst the ladies because it no longer produces white smegma. It's now like a lollipop. Actually it's now an asset! Girls enjoy conducting a blow job on me. So, wearing a condom really man, is just something you do at the beginning. Once you are used to one another, especially with those who enjoy doing blow jobs, how can I wear a condom in that instance? It would just be mean to that particular partner. More often than not, you actually realise at the end that the condom did not do the job. It's scary because most of the times you don't know the HIV status of the person you are sleeping with. It's not practical to get tested with every lady you sleep with given the fact that you know it's only a sexual relationship and nothing more. My prayer is that circumcision should work. When I am about to ejaculate, I withdraw and as such, this does not give the virus an opportunity to enter into my system through the hole. I heard that when you ejaculate and my semen and a woman's secretion meet, that is when the virus spreads from one partner to the other.* (Interview, 15 August 2013)

A second man involved in this risky sexual practice said:

*Once I am on my knees, I don't have time to put on a condom because whenever I take a slight break putting on a condom the girls change their minds. Man! I tell you, every time this has happened I could not have sex because I could not convince them to sleep with me. According to the girls, seeing me putting on a condom acts as a sign of my determination to have sex and it scares them away. Putting on a condom needs me to use my both hands as a result the girls flee since they are shy. In such circumstances I don't have the chance to put on a condom although I know that I am not fully protected but in all this I will be hoping and praying that I do not contract an STI especially HIV. I just slide in.* (Interview, 7 August 2013)

Knowledge that male circumcision offers a degree of protection is in large part irrelevant or of no consequence when circumcised men, particularly those with multiple partners, have unprotected sex. There is no evidence of men who used condoms prior to circumcision no longer using them after circumcision, such that risk compensation (in the form of condoms acting as substitutes for VMMC) does not seem to be significantly prevalent.

Men with a history of risky sexual practices before circumcision, and who continue with the same subsequent to circumcision, at least have a 60 percent chance of protection against HIV. It would be a more worrisome situation to have men with no history of risky sexual practices compensating (by engaging in risky practices) as a result of being circumcised (Eaton and Kalichman 2009). This is not to say that programme implementers

should give up on encouraging safe sex among circumcised men with a history of risky sexual practices (and who carry on with the same after getting circumcised), for this may heighten the spread of HIV once they get infected. And it is particularly damaging to women who bear the brunt of such practices, as they will invariably be subject to the risk of HIV infection.

### 6.7 Conclusion

Based on the discussion in this chapter (in conjunction with chapter five), it appears that no significant risk compensation has taken place amongst the 25 sampled circumcised men in Harare. In this respect, the sample can be divided into four groups. First of all, the males who were not sexually active prior to circumcision have remained sexually inactive. Secondly, there is a grouping which has shown a significant reduction in risky sexual practices, namely those who no longer are involved with concurrent sexual partners and who are consistent in condom use. Thirdly, there is a group which has also shifted somewhat towards safe sexual practices by still engaging with CSPs but now using condoms consistently. And, finally, there is the group which continues to engage in ongoing risky sexual practices through their involvement with CSPs and using condoms inconsistently. It may be that this last group does have a tendency to engage in risk compensation but there is no clear evidence that the form and extent of risky sexual practices have increased after circumcision. Overall, then, the medically-circumcised males do not show a pronounced inclination to compensate for VMMC by throwing all caution to the wind and endangering both themselves and their partners with the possibility of HIV infection. In the concluding chapter to the thesis, I offer a synthesis of my study in the light of the thesis chapters.

# CHAPTER SEVEN
# CONCLUSION

## 7.1 Conclusion

In recent years, voluntary medical male circumcision has been introduced in Zimbabwe and elsewhere as a new HIV prevention method along with other existing methods, including faithfulness to a single partner and consistent condom use. It was introduced as a complementary method rather than as a substitute for existing methods because it only offers partial protection and, even then, only for circumcised males and not for their partners. The critical question which arises in this regard is whether males, once circumcised, do in fact recognize VMMC as a complementary method as evidenced by their actual sexual practices. Insofar as they do not and therefore use it more as a substitute method, then they are showing signs of engaging in risk compensation. As a result, the effectiveness of VMMC as a basis for reducing rates of HIV infection would ultimately be placed in doubt. To date, insignificant research has been undertaken on this, and this thesis has sought to fill this lacuna in the existing literature. Thus, by studying a sample of twenty-five circumcised males in Harare, the thesis sought to pursue the following objective: to understand and explain the relationship between voluntary medical male circumcision and risky sexual practices with particular reference to condom use amongst men engaged in concurrent sexual partnerships. This concluding chapter offers a synthesis of the findings of the Harare-based study. I first discuss post-circumcision safe and risky sexual practices

## 7. 2 Post-circumcision safe and risky sexual practices

It is clear that the post-circumcision sexual practices of circumcised men cannot be understood purely in terms of the act of circumcision itself or even the intense risk reduction counseling that circumcised men undergo both prior to and after the act of circumcision. Additionally, although circumcised men, through this counseling, become cognizant of the fact that VMMC allows for only partial protection and therefore should be treated as a complementary method, this does not necessarily have any bearing on their post-circumcision sexual practices. A range of social influences mediate the relationship between VMMC and sexual practices and, because these influences vary between specific circumcised men, there

is no generalized conclusion which can be drawn about the character of sexual practices subsequent to circumcision.

In my study, both pre-circumcision and post-circumcision sexual practices were explored, examined and compared to identify and understand any changes, either towards safer sexual practices or riskier sexual practices. A minority of the sampled men in Harare were not sexually-active prior to circumcision and they remained sexually inactive subsequent to circumcision. For them, VMMC had no affect on their sexual activity let alone the types of sexual practices pursued. They continued to abstain from sex, for the same reasons they abstained prior to VMMC. Thus, circumcision does not appear to induce risky sexual practices amongst men who did not have a history of such practices before getting circumcised.

The majority of the sample consisted of sexually-active men and, as a general tendency, they were involved – prior to circumcision – with concurrent sexual partnerships and often without condoms. For this group as a whole, there was a marked drop in the prevalence of concurrent sexual partners and more consistent condom use. But this general statement hides important variations within the group. Some men stopped engaging in casual sex and started using condoms, while others continued with casual sex but started using condoms. The former shifted to safe sexual practices while the latter men shifted to safer (but not safe) sexual practices. In either case, these men turned to safer sexual practices. But other men amongst the sexually active continued with concurrent sexual partners without condoms subsequent to circumcision, thereby maintaining their same risky sexual practices. Because of their divergences, VMMC in itself is neither a complementary method nor a substitute method; indeed, it can be either, depending on very specific and individualized cases. It could become a method marked more by complementary tendencies, but this is a mere potential which can only be facilitated by factors other than the circumcision process alone. This becomes clear when examining the reasoning behind being circumcised in the first place, which differs markedly within the Harare sample.

This is not to totally deny the significance of counseling during the VMMC process. During HIV testing and counseling (HTC), men are provided with detailed knowledge about VMMC and its relationship to other HIV prevention methods, including the partial protection argument. On this basis, they receive strong encouragement during the counseling sessions to refrain from engaging in concurrent sexual partnerships and to use condoms consistently and correctly (particularly with concurrent partners if they continue with this practice). All the sampled circumcised men concurred that HTC was important with regard to underlining the

existence of post-circumcision risk notably with concurrent sexual partners without condoms. And a significant number of the men, in the interviews, spoke passionately about the fundamental significance of the counseling in turning their back on pre-circumcision sexual practices. But, for others, the counseling appeared to literally go in one ear and out the other and had no lasting effect on them. Thus, HTC on its own does not result in safe sexual practices since post-circumcision decisions about sexual practices entail a degree of deliberation and choice on the part of circumcised men. And the nature of these choices seemingly relate back to the reasons for choosing to be initially circumcised.

Key reasons discussed which led to a reduction in risky sexual practices and, in some cases, to outright safe sexual practices, are religion and family. Fidelity to church and family (if only a new-found fidelity) seemed critical for many circumcised men when it came to overcoming past sexual indiscretions and making decisions to refrain from risky sexual practices after circumcision. For example, church programmes in the form of men's fellowships and couples' meetings helped spouses to handle marriage and family-related problems which in the past induced men to have CSPs as a scapegoat for seeking happiness elsewhere. The close involvement of marriage partners in the actual decision to be circumcised and constant communication about the process provided an added boost for some of the men. This shift in sexual course though was not a one-step or short-term process but involved internal struggles for the circumcised men as they sought to pursue a new or reinvigorated path of fidelity. As well, fidelity can be undermined and thus, particularly given the short period after circumcision amongst the sampled men, some men may break that fidelity.

Those men who spoke about church and family in large part engaged in less risky sexual practices after circumcision and treated VMMC in practice as a complementary method. Other men, without such clear and solid motivations for changing their ways, continued with concurrent sexual partners (either with or without consistent condom use). These men (at least the five who continued with casual sex without condoms) seemingly never intended to do away with risky sexual practices subsequent to VMMC. They were either unwilling or unable to do so, and circumcision quite consciously became a means of pursuing risky practices with at least some degree of protection (from VMMC). It is not that they were engaged in safe sex prior to circumcision and then began with risky practices after VMMC because of the partial protection it provides: if this is what is meant by risk compensation, then such compensation does not readily come to the fore amongst even these more wayward men. At the same time, VMMC was seen by them as substituting for other

HIV methods, namely, faithfulness to one partner and condom use. Insofar as men enter into the circumcision process on this basis, then VMMC will never be an effective HIV prevention method.

### 7.3 VMMC, Condoms, CSPs and Sexuality

Whether circumcised men use condoms consistently cannot be reduced though to an outright refusal to use this HIV prevention method. Condom use does not occur for a variety of reasons, and at times even amongst circumcised men committed to safer sexual practices. Significant barriers exist to accessing and using condoms, despite campaigns in Zimbabwe to normalise condom use. To use one example, this study shows that some circumcised men could not withstand the stigmatisation and public ridicule associated with the purchasing of condoms. Such stigma arises because condom use in the main continues to be associated with sex work and extra-dyadic affairs with CSPs, both of which are linked to unrespectable and immoral people. However, other men went out of their way to maximize the full benefits of VMMC – and thereby protected themselves and their partners – by using a number of tactics and visiting a number of places to access condoms. The fact that some men who continued with concurrent sexual partners after circumcision but now used condoms consistently is testimony to the possibility of acquiring condoms and using them regularly if the will and determination is present.

In the end, in seeking an understanding of the continuation of risky sexual practices after VMMC, particularly for those men engaged with CSPs without condoms but also to a lesser extent with regard to men with ongoing CSPs with consistent condom use, it is necessary to return to the theme of sexuality in the context of patriarchy and masculinity. As discussed in the thesis, and as noted specifically in the fieldwork chapters, patriarchy remains pronounced in the Zimbabwe and this filters into and becomes embedded in sexuality and male-female sexual relations. This was highlighted, on a more theoretical level, with reference to theories of sexuality – notably constructionist and exchange theory.

For Zimbabwean men, masculinity as currently defined and as socially constructed and reproduced, deters the prospects for safe sexual practices. Polygamy, ‘small houses’ and extra-marital affairs more broadly are rampant, such that most circumcised men in the study who have CSPs indicate that it is normal for men to have CSPs; it is indeed the manly thing to do. Additionally, as exchange theory indicates, this enters into the intimacy of the sexual act itself, with men often being in a position to impose their wishes and desires on partners, including the non-use of condoms. Voluntary medical male circumcision as it exists does not

make any inroads into undermining discourses and practices centering on masculinity and patriarchy either broadly or specifically in relation to sexuality and sexual relations. Until such time as it does, and unless masculinity and patriarchy are fundamentally addressed in Zimbabwe as a whole, it is unlikely that VMMC will have its intended effect of significantly reducing the rate of HIV infections.

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# APPENDIX

## HIV and AIDS AND Sexual Practices of medically circumcised males in Harare, Zimbabwe

*Please answer all the questions.*

*Follow the instructions given on some of the questions.*

| Number | Question | Response | Code |
|---|---|---|---|
| **Part A: Background** | | | |
| 1. | Age | 18-19<br>20-24<br>25-29<br>30-34<br>35-39<br>40+ | 1<br>2<br>3<br>4<br>5<br>6 |
| 2. | Marital Status. | Single<br>Married<br>Separated<br>Divorced<br>Widowed | 1<br>2<br>3<br>4<br>5 |
| 3. | Highest level of education | Primary<br>Secondary<br>Certificate/diploma<br>Degree<br>Postgraduate | 1<br>2<br>3<br>4<br>5 |
| 4. | One's Upbringing and Socialisation | What can you tell me about your upbringing? | |
| **Part B: Sexual Practices** | | | |
| 5. | Are you sexually active? | Yes<br>No (if no, please go to question 10) | 1<br>2 |
| 6. | Have you had more than one sexual partner at the same time? | Yes<br>No | 1<br>2 |
| 7. | How many sexual partners have you had in the past before getting circumcised? | | |

| | | | |
|---|---|---|---|
| 8. | If you are married have you ever had an extra marital affair? | Yes<br>No | 1<br>2 |
| 9. | If you are single, separated, divorced or widowed are you in a stable sexual relationship? | Yes<br>No | 1<br>2 |
| | **Part C: HIV** | | |
| 1 | Did you know your HIV status before circumcision? | Yes<br>No | 1<br>2 |
| 1 | Do you know your HIV status after circumcision | Yes<br>No | 1<br>2 |
| 1 | Do you know the HIV status of your sexual partner(s)? | Yes<br>No<br>Sometimes | 1<br>2<br>3 |
| | **Part D: Circumcision** | | |
| 1 | When were you circumcised? | Less than 3months ago<br>3 – 6 months ago<br>Over 6 months to a year<br>Over a year ago | 1<br>2<br>3<br>4 |
| 1 | Does your sexual partner(s) know that you are medically sexual circumcised? | Yes<br>No | 1<br>2 |
| 1 | How many sexual partners did you have before you got circumcised? | | |
| 1 | Why did you get circumcised? | | |
| 1 | How long after you got circumcised did you wait before you had sex | Three weeks<br>Four weeks (1 month)<br>6 weeks<br>8 weeks (2 months)<br>More than 2 months | 1<br>2<br>3<br>4<br>5 |

| Part D: condom use | | | |
|---|---|---|---|
| | *Please tick one for each question* | Disagree | Agree |
| 18. | Condom use protects me from STI's and HIV and unwanted pregnancies | | |
| 19. | Using two condoms at the same time increases protection from HIV, STI's and unwanted pregnancies | | |
| 20. | As a circumcised man there is no need for me to use a condom | | |
| 21. | Free government condoms are not safe when compared to Protector plus condoms. | | |
| 22. | I use a condom correctly every time I have sex with a sexual partner who is not my primary partner | | |
| 23. | Give reasons for your response on question 19 | | |
| 24. | Where do you get condoms? | | |
| 25. | Have you ever had sex using a female condom | Yes<br>No | 1<br>2 |
| 26. | If the answer is yes, did you enjoy it?<br>Give reasons | | |
| 27. | Do you prefer having sex using male or female condom<br>Give reason (s) | | |
| 28. | I use a condom | Always<br>Sometimes | 1<br>2 |

**Thank you for your time**