PERCEPTIONS AND EXPERIENCES OF FEMALE PARTNERS OF CLIENTS OF VOLUNTARY MEDICAL MALE CIRCUMCISION IN HARARE, ZIMBABWE

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A research submitted to the faculty of health science (School of Public Health), University of the Witwatersrand, in partial fulfilment of the requirements for the Degree of Masters in Public Health in the field of Social and Behaviour Change Communication

Date: October 2017

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Declaration

I, Fine Mazambara, declare that this research report is my original work. Any work done by other people has been properly acknowledged in the text. The report is submitted in partial fulfilment of the requirements for the degree of Master of Public Health, in the field of Social and Behaviour Change Communication with the University of the Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination in this or other university.

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Abstract

Introduction

Zimbabwe is lagging behind on its target to scale up Voluntary Medical Male Circumcision (VMMC). The engagement of female partners in VMMC demand creation is important as they can play an important role in their male partners' decision to uptake VMMC. Exploring women's perceptions and experiences will help to better understand factors behind low uptake of VMMC in Zimbabwe as efforts are being made to scale up VMMC for HIV prevention. The aim of the study was to explore female partners' underlying perceptions and experiences of having their partners undergo medical male circumcision in order to inform the development of promotional messages on the basis of women's experiences with VMMC.

Methods

The study was conducted in Mbare, an urban high density suburb in the southern district of Harare utilising qualitative methodology. Individual in-depth interviews were conducted using an in-depth interview guide. Through purposive sampling a total of twenty female partners of medically circumcised men attending antenatal clinic between February and May 2016 were recruited. Interviews were audio recorded and transcripts were analysed using content analysis.

Results

The results show that women were knowledgeable about VMMC. The perception towards medical male circumcision was linked to the perceived benefits of VMMC. The main role that women played was encouraging their male partners. The perception of women towards VMMC was generally good. The perceived benefits of having a circumcised partner were

reduced risk of HIV and STIs, improved sexual experience, improved hygiene, improved sexual communication, no need to use condoms and improvement of the relationship. The risk perception towards HIV and STIs was decreased after the male partner's VMMC and fear of risk compensation was reported. Women had misconceptions about adverse events of circumcision and the age at which men can be circumcised. Mass media was the main source of VMMC information for women. VMMC was understood to offer direct protection from HIV for women and circumcised men were understood to being conferred full protection from HIV and STIs.

Conclusions

Women have knowledge on VMMC although their knowledge on adverse events associated with circumcision, age at which men can be circumcised, indirect protection for women, and partial protection for men can be improved. The perceptions of women towards VMMC were influenced by the perceived benefits of having a circumcised partner. The main perceived benefits of having a VMMC client as a male partner is reduced risk of HIV and STIs and improved sexual experience. Targeted health messages directed at women should therefore aim at increasing women's knowledge of VMMC, include improved sexual experience and take gender issues into consideration.

Acknowledgements

My gratitude goes to my supervisors Dr Tintswalo Mercy Hlungwani and Dr Anam Nyembezi for their constructive feedback.

I also want to thank the management and staff at Edith Opperman polyclinic for allowing me to conduct my research at their premises.

Finally, I would also want to thank the research participants who shared their experiences with me.

List of Abbreviations

ANC:	Antenatal Care
HIV:	Human Immunodeficiency Virus
HREC:	Human Research Ethics Committee
IDI:	In-depth Interview
MC:	Male Circumcision
MMC:	Medical Male Circumcision
MRCZ:	Medical Research Council of Zimbabwe
PSI:	Population Services International
STIs:	Sexually Transmitted Infections
UNAIDS:	The Joint United Nations Programme on HIV/AIDS
VCT:	Voluntary Counselling and Testing
VMMC:	Voluntary Medical Male Circumcision
WHO:	World Health Organisation

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CHAPTER 1

INTRODUCTION, LITERATURE REVIEW, AIMS, OBJECTIVES

1. Introduction

Brief Synopsis

This chapter gives a background of male circumcision and the literature review of the topic in the world, sub Saharan Africa and the Zimbabwean context. The chapter also highlights the problem statement, justification for the study and the aims and specific objectives of the study.

1.1 Background

Medical male circumcision (MMC) is currently being used as a strategy to prevent Human Immunodeficiency Virus (HIV) (Doyle et al., 2010) . A recommendation was made by the World Health Organisation (WHO) and The Joint United Nations Programme on HIV/AIDS (UNAIDS) that countries with widespread HIV infection and a low prevalence rate of MMC recognise MMC as a significant approach for preventing heterosexually acquired HIV infections (WHO, 2007). Adult male circumcision (MC) is highly effective in preventing HIV with a protective effect of about 60% (Doyle et al., 2010).

Impact and costing estimates suggest that increasing the proportion of MMC to 80% among 15-49 year old uncircumcised males in the priority countries by 2025 could potentially avoid about 3.36 million infections and save US $16.5 billion in Sub-Saharan Africa (Njeuhmeli et al., 2011). In 2007, UNAIDS identified a total of thirteen southern and eastern African countries as priorities for MC scale up. The countries earmarked for MC scale up are Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe (WHO, 2007). If uptake of MMC is successful, 22% of HIV deaths can potentially be avoided from 2011 to 2025 among these priority countries (Njeuhmeli et al., 2011). However, implementation of MC for prevention of HIV in sub Saharan Africa remains unacceptably slow (Wamai et al., 2011). In order to achieve the goal, there is need for a dramatic increase in Voluntary Medical Male Circumcision (VMMC) uptake among 15 to 49 year olds, especially among married men and those older than 25 (RTI International, 2014).

In 2012, Zimbabwe had an HIV prevalence rate of 14.7% and an estimated 1 400 000 people living with HIV (UNAIDS, 2014). In 2012, Zimbabwe was one of the countries reporting a VMMC coverage of less than 10% (UNAIDS, 2014). This low VMMC coverage is one of the main challenges of the country's national response to HIV (UNAIDS, 2014). VMMC was introduced in 2009 in Zimbabwe (Rupfutse et al., 2014). By the end of 2012, 7.6% of the targeted men were circumcised (Rupfutse et al., 2014). At the end of 2014 10.6% of the targeted men in Zimbabwe were circumcised and a 31% coverage was reported (WHO, 2015). A host of actors were attributed to the low uptake of VMMC in Zimbabwe, including dreading pain, anxiety about poor wound healing and discouragement by peers, relatives and female partners (Rupfutse et al., 2014).

If MMC is extensively implemented in areas with high HIV prevalence and low prevalence of circumcision, it can possibly reduce new HIV infections significantly (Doyle et al., 2010). Furthermore, if the incidence of HIV is reduced among men, then ultimately incidence among women will also be reduced (Layer et al., 2014). In addition to offering partial prevention of HIV transmission, MMC is associated with improved personal hygiene, reduced sexually transmitted infections and prevention of penile cancer (Doyle et al., 2010). MMC reduces the risk of cervical cancer in partners of circumcised men. Therefore, understanding the women's perceptions and experiences about MMC, as well as their role throughout the circumcision process of their partners is crucial as efforts are being made to scale up VMMC for HIV prevention (Layer et al., 2014).

1.2 Literature Review

1.2.1 Voluntary Medical Male Circumcision

Medical Male Circumcision is a procedure whereby a foreskin is surgically removed from the penis (WHO, 2012). VMMC is recommended as a component of the package of HIV prevention services because of credible evidence about its protective effect in female to male transmission of HIV (WHO, 2012). Globally it is estimated that 30% of males are circumcised (Weiss et al., 2008). Over 10 million VMMC have been performed in sub-Saharan Africa for HIV prevention (UNAIDS, 2015). In Zimbabwe, VMMC coverage is estimated to be at 31% (UNAIDS, 2015). Zimbabwe's national circumcision policy was launched by the then Zimbabwe's Ministry of Health and Child Welfare as part of an integral response to the HIV pandemic (Ministry of Health and Child Care, 2014). Among majority

Shona and Ndebele tribes MC is generally uncommon (Ministry of Health and Child Care, 2014). The groups that practice traditional circumcision are the Varemba, Shangaan and the Chewas who mostly reside in the southern parts of the country (Phillip et al., 2012).

Since the beginning of the VMMC policy there has been low uptake reported. Demand creation for VMMC has been noted as one of the challenges for MMC in Zimbabwe (Ashengo et al., 2014). It was estimated that if 1.9 million Zimbabwean men aged 15-49 are circumcised then 43% new HIV infections could be avoided by 2025 (Njeuhmeli et al., 2011). Women have been side-lined in the dialogue on MMC yet they may potentially play a pivotal role in encouraging their male partners to get circumcised (Mantell et al., 2013). Sexual partners, including wives of uncircumcised males, play a pivotal role in shaping the attitude of men towards VMMC (RTI International, 2014). Furthermore, considering women in the MMC process provides a better understanding of the low uptake of VMMC (Moyo et al., 2015). It should be noted however, that circumcision is not proven to directly reduce women's risk of acquiring HIV (Wawer et al., 1998). Although MMC targets sexually active men, it has important direct and indirect benefits for women too; it was estimated that in high-prevalence areas like Kenya and Zimbabwe, circumcision confers a 46% reduction in the rate of male to- female HIV transmission, with the effect of the intervention "doubling the number of infections averted among women" (Wamai et al., 2011).

1.2.2 Sources and design of VMMC information

Sources of VMMC information include mass media and community mobilisation. Radio is a mass media platform that was found to be a main source of VMMC information in Zimbabwe (Hatzold et al., 2014).Television, newspapers, billboards and posters are other mass media

platforms used to impart VMMC information (Hatzold et al., 2014). Population Services International (PSI) leads the VMMC demand creation in Zimbabwe and leverages mass media and social mobilisation in the 'SMART' campaign particularly through the purchase of radio spots television shows, road shows, celebrity campaigns, posters, banners, billboards, and social media (PSI, 2014).The media element is designed to facilitate the development of supportive social norms and trigger conversations with partners that can lead to a decision to uptake VMMC (Sgaier et al., 2015). Interpersonal communication facilitated by health workers, community workers and mobilisers is also used to impart VMMC information in Zimbabwe (Hatzold et al., 2014).

Various demand creation messages have focused on placing emphasis on preventing HIV and STIs (Sgaier et al., 2015). PSI came up with tailor made messages for women. Messages targeting women concentrate on improved hygiene, protection from cervical cancer and support for male partner to uptake VMMC (PSI, 2014). Messages have also presented VMMC as an aspirational procedure (Sgaier et al., 2015). Zimbabwe policy guidelines on VMMC communication states that VMMC messages should target specific populations including women. It also highlights that the messages should give accurate information about partial protective effect of VMMC for men, show no direct benefit for women, highlight VMMC benefits, guard against risk compensation and highlight that VMMC does not take the place of other HIV prevention measures including the use of the male and female condom (Ministry of Health and Child Care, 2014).

1.2.3 Cultural Context for Women

Zimbabwe is mainly a patriarchal society (Kambarami, 2006). Women in Zimbabwe face challenges in participating in decisions that affect them. Power relations hinder women from

participating fully in the areas of their lives including their homes (ZIMSTAT, 2013). The literacy rate for urban women in Zimbabwe is 98% and Thirty seven per cent of women are employed (ZIMSTAT and ICF International, 2012). However, women in Zimbabwe have less access to media than their male counterparts (ZIMSTAT and ICF International, 2012). Furthermore, the median age at first sexual activity for women in Zimbabwe is 18 years (Hallett et al., 2007) It is estimated that 60% of women are married and 11% of them are in polygamous unions (ZIMSTAT and ICF International, 2012). The practice of early marriage still exists in the country with 24.5% of women aged 15 to 19 years reported to be in unions or married (ZIMSTAT, 2014) and one in three women reported getting married or entering a union before turning 18 (ZIMSTAT, 2014).

1.2.4 Women's Perceptions towards MMC

Common determinants of MC acceptability among men and women are ethnicity, perceived health and sexual benefits (Jones et al., 2014, Mbonye et al., 2016, Weiss et al., 2008) . The scale up of MMC has the potential to bring about new social norms about sexuality and HIV prevention behaviour in traditionally non- circumcising communities (Riess et al., 2014) . A study in Kenya found that women were concerned about their male partners' circumcision status and it was an important factor in condom use, sexual decision making and selection of partner (Riess et al., 2014). Women in South Africa perceive MMC as an effective HIV prevention strategy (Mantell et al., 2013) Among the challenges that impede implementation of VMMC programmes are sociocultural perceptions and beliefs about MMC to which women contribute (Wamai et al., 2011) In Zimbabwe, there are mixed perceptions about MMC as a measure to prevent HIV with some women having the perception that if their male partners were medically circumcised they would start to engage in risk compensation while only 17% thought MMC would bring positive behaviour change (Phillip et al., 2012).

There is unanimity that having a better understanding of female partners could strengthen efforts to prevent HIV through VMMC (Jones et al., 2014). Studies in Zambia and Kenya found MMC acceptability among men to be influenced strongly by women (Bailey et al., 2007, Jones et al., 2014). One of the guidelines on Zimbabwe's policy on VMMC states that MMC should be delivered in a manner that compliments the rights of women, minimises the risk of harm to women and maximise the benefits for women (Ministry of Health and Child Care, 2014). In Zimbabwe, women have less knowledge on VMMC than men (Hatzold et al., 2014). Female partners influence married men's decision not to be circumcised (Hatzold et al., 2014). Also women can play a crucial role in MC implementation by changing male norms because of their high acceptability of MC as a comprehensive HIV prevention strategy (Bailey et al., 2007). An evaluation of VMMC programme for HIV prevention in Africa highlighted the need for research around MC as a platform to include women's participation so as to encourage couple sexual reproductive health (Wamai et al., 2011). Women should be an important part of VMMC demand creation and reaching them will foster helpful partner communication (RTI International, 2014).

1.2.5 Women's risk perception towards medical male circumcision

As previously mentioned VMMC offers partial protection against HIV, however, women have different subjective judgements concerning the perceived risks of having a partner circumcised. Women in Tanzania were found to have an exaggerated low risk perception of HIV and STIs when having a circumcised sexual partner (Layer et al., 2013a). In Kenya women had a low risk perception of HIV and STIs towards MMC (Lanham et al., 2012). They had an understanding that their risk is reduced in the same way as their male partners (Lanham et al., 2012). A study in South Africa found that women perceived that MMC roll out had the potential to increase the risk of women contracting HIV (Mantell et al., 2013).

Women had the perception that VMMC would lead to a decrease in condom use and an increase in the number of sexual partners (Mantell et al., 2013). Similarly, studies in Zimbabwe found that women perceived high risk towards MMC because of fear that men will engage in risk compensation due to their misconceptions about MMC's protective effect (Phillip et al., 2012, Chikutsa and Maharaj, 2015).

1.2.6 Medical Male Circumcision benefits for women

Although MMC is an intervention that is intended for men, there are direct and indirect benefits for women too (Hallett et al., 2010). The strength of MCs protective effect for women is partly dependent on the percentage of circumcised men. Women derive benefit from MMC by herd immunity whereby when the number of HIV positive men decreases the chances of women getting infected by men also decreases (Riess et al., 2014). MMC also directly benefits women through reduced STIs and lower chance of developing cervical cancer (Riess et al., 2014, Weiss et al., 2008). Mathematical modelling illustrated an estimated 46% reduction in the rate of male to female transmission of HIV due to MC. Given that MC provides some protection against sexually transmitted infections (STIs), it also serves to prevent HIV as the susceptibility to HIV is increased by the presence of STIs (White et al., 2008). Furthermore, a circumcised penis is perceived by women to have a good appearance and to be clean (Tarimo et al., 2012). Some women in a study in Tanzania reported experiencing additional sexual pleasure with a circumcised partner than with an uncircumcised partner (Tarimo et al., 2012).

1.3 Problem Statement

Zimbabwe has been scaling up VMMC since 2009 but the pace has been slow (Ashengo et al., 2014, Moyo et al., 2015). The country, as per WHO recommendations was targeting 1.3 million circumcisions by 2017 so as to achieve the desired public health impact. By 2012, progress towards the target was recorded in 2015 and a new target of achieving 90% by 2020 was set (WHO, 2015). Some of the problems that are delaying VMMC rollout are low uptake and failure to engage female partners. Engaging women in efforts to increase MMC uptake is highly recommended as an approach to encourage cultural acceptability among men and their female partners (Jones et al., 2014).Regardless of these recommendations, engagement of women in VMMC still remains poor (Jones et al., 2014). Little is known about women's experiences and perceptions of their partners' circumcision. Furthermore, little is known about power dynamics and relationships between males and females pertaining to MMC. There is lack of comprehensive literature on female sexual partners of circumcised men's perceptions and experience in urban Harare.

1.4 Justification for the Study

Zimbabwe has been grappling with challenges in demand creation for MMC among other problems (Ashengo et al., 2014). An understanding of women's experiences pertaining to their partners' experience will possibly inform efforts to create demand for MMC (Layer et al., 2014, RTI International, 2014). Appreciating the perceptions and experiences of women will help in modifying counselling messages and MMC approaches and better describe the broader impact of the MMC on women and communities (Layer et al., 2014). This study will explore the perceptions and experiences of women with their medically circumcised partners. Findings from this study will give an appreciation for how to better plan for the up scaling of

VMMC for HIV prevention. Gathering more information about the experiences and perceptions of women pertaining to MMC will help in the development of health messages on HIV Prevention methods (Riess et al., 2014). Health messages that target males and females will improve people's understanding of the benefits of male circumcision and allow them to make informed choices about MMC for themselves (WHO, 2009). Exploring perceptions of female partners will provide a unique understanding into the power dynamics and multifaceted relationships surrounding MMC) (Layer et al., 2014). Exploring women's perceptions about MMC will also help to better understand factors behind low uptake of VMMC in Zimbabwe (Moyo et al., 2015). It is crucial to capture the experiences of female partners as it has been found that women are influential in convincing their partners to be circumcised (Layer et al., 2014, Rupfutse et al., 2014).

As rapid scale up of VMMC is underway in Zimbabwe, it is imperative to capture women's perceptions and experiences. Their negative perceptions and beliefs can diminish the efforts to scale up VMMC. There is little research about perceptions of women towards MMC (Mantell et al., 2013). Most studies conducted in Zimbabwe mainly assessed the acceptability of MMC among men (Weiss et al., 2008). This research will help to contribute to the growing body of literature about female partners of clients of VMMC.

1.5 Study Aims and Objectives

The research question for the study was :

What are the female partners' underlying perceptions and experiences of having their partners undergo medical male circumcision?

The aim of the study was to explore female partners' underlying perceptions and experiences of having their partners undergo medical male circumcision.

Specific Objectives:

1. To explore and describe women's experiences on having a circumcised partner in Harare, Zimbabwe between December 2015 and December 2016

2. To explore women's risk perceptions towards male circumcision in Harare, Zimbabwe between December 2015 and December 2016.

3. To explore women's perceived benefits of having a circumcised partner in Harare, Zimbabwe between December 2015 and December 2016.

1.6 Summary of the Chapter

In this chapter, a background of the study was laid. A review of literature is presented so as to identify any gaps that exist in literature and ensure a thorough understanding of the perceptions and experiences of female partners of clients of medical male circumcision. The problem statement and the justification for this study are also presented, outlining the reasons why the study was done. The research question and aim of the study and specific objectives are also presented in this chapter showing how this study will help in understanding the perceptions and experiences of female partners of VMMC clients in order to inform the design of health messages and to contribute to the growing body of literature about female partners of VMMC clients.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 Introduction

This section gives a description of the methodological approach that was used in investigating the research question. The section describes the method and structure, how the planned actions were executed and the ethical considerations.

2.2 Research design

This was an exploratory study using qualitative methods to explore women's underlying perceptions and experiences of having a partner who is medically circumcised. Sources of data were female partners of men who are medically circumcised in Harare, Zimbabwe. Qualitative research draws rich contextual data and enables understanding life in ways that take into consideration the experiences and perspectives of people who live in it (Ulin et al., 2012). Use of qualitative research enabled the researcher to examine people's experiences in detail (Hennink et al., 2010). Thus a qualitative design enabled the researcher to explore female partners of VMMC'S experiences and perceptions in detail using an In-depth Interview (IDI) guide (appendix A).

2.3 Study site

The study was conducted at Edith Opperman clinic in Mbare in Harare's southern district. Harare is the capital and most populous city in Zimbabwe. It is largely urban and carries

16.2 per cent of the country's total population (ZIMSTAT, 2013). Mbare is one of the oldest townships in Harare (Nyenya, 2016). It is an under-resourced low income area that has housing units and old shelters which include Matapi hostels. These hostels accommodate a large number of households. The people live in squalid and detestable conditions (Chirisa et al., 2013). The flats are also labelled as a haven for unlawful and immoral activities (Chirisa et al., 2013).

Edith Opperman is a polyclinic administered by the City of Harare's City Health Department and serves residents from the high density suburb of Mbare and surrounding areas. The clinic conducts antenatal care (ANC) clinics every day and has approximately 400 deliveries a month (Mavhu et al., 2015). It also offers rapid HIV testing, management of chronic conditions, malaria screening, antiretroviral therapy, dispensing of essential drugs and tuberculosis screening (City of Harare, 2015).

2.4 Study Population

The study population were female partners of medically circumcised males aged 18 to 49. These women were attending ANC clinic at Edith Opperman Polyclinic. The women stay in Mbare and other surrounding areas. These women were chosen as the study population as they are likely to be partners of males targeted for circumcision.

2.5 Pilot Study

A total of four women attending ANC clinic at Highfield Polyclinc, were interviewed during the pilot study. Piloting the interview guide was conducted in order to assess whether the

participants understood the questions and assess if there was a need to rephrase some questions and determine whether the order of questions was logical and if the research question would be answered by the questions (Given, 2008). The interview guide was piloted in order to determine the amount of time needed to complete the interviews (Given, 2008). Piloting the interview guide also enabled the researcher to become comfortable with the interview process.

2.6 Sampling Strategy

Through purposive sampling, twenty female partners of clients of medical male circumcision were selected from Edith Opperman polyclinic. Purposive sampling allowed the selection of typical participants from the spectrum in which the researcher was interested (Joubert et al., 2007).

The selection of participants was based on meeting the inclusion criteria of being a partner to a medically circumcised male and having stayed with the male partner before his circumcision. The male partner should have been circumcised within a year prior to the interview. The exclusion criteria included women who were not staying with their partners before MMC and women whose partners were traditionally circumcised.

2.7 Data collection

In-depth interviews were used in order to answer the research question. All the interviews were audio recorded and field notes were compiled during interviews. Consent forms for

interviewing (Appendix B) and audio recording (Appendix C) were signed before data collection.

2.7.1 In-depth Interviews

Data for the study were collected using in-depth interviews. Use of IDIs enabled the reconstruction of participants' perceptions and experiences (DiCicco- Bloom and Crabtree, 2006). Open ended questions were used to elicit detailed responses from participants (DiCicco- Bloom and Crabtree, 2006). Prompts and probes were used in order to get clarification on the responses. IDIs were used to provoke honest responses in a private setting about personal matters. Conducting IDI is generally productive and provide deeper insights as there is enough time to probe (Katzenellenbogen et al., 1997). Using IDIs enabled participants to share their information without bias from other participants. Furthermore, conducting IDIs resulted in fewer distractions (Joubert et al., 2007). Face to face interaction with the participants facilitated the responses and improved the quality of the information (Joubert et al., 2007).

2.7.2 Data collection procedure

The prospective participants were approached individually by the researcher while waiting for their turn to access ANC. The prospective participants who showed interest were given the information sheet (Appendix D) and made an appointment with the researcher for the interview. Data were collected in a separate room at Edith Opperman Polyclinic to avoid distractions and maintain confidentiality. The data were collected by the researcher who at that time was working as a Social Worker at AIDS International Training and Research Program. The researcher did not have any relationship with participants prior to the

interview. Nineteen Interviews were conducted in Shona while one interview was done in English as the participant felt comfortable in expressing herself using English. An interview guide (Appendix A) was used for data collection. The duration of interviews was around 20 minutes. All interviews were audio recorded. Data were collected from 23 February to 15 April 2016 at Edith Opperman Polyclinic.

Identification of participants was done with the assistance of clinic staff who introduced the researcher to women attending ANC clinic. The researcher approached women and invited them to participate. Women who showed interest in taking part were invited for further discussion at the end of their consultation. One woman who had shown initial interest refused to participate and two participants declined to sign consent forms. A total of twenty women were interviewed. At the end of the interview women were given their bus fare reimbursements to cover travel expenses and compensate for lost time.

2.8 Data analysis

Analysis of data was done concurrently with data collection and it helped to deepen understanding of the research question. All interviews were recorded and transcribed verbatim in Microsoft Word by the researcher. Interviews were translated from Shona into English with guidance from a professional translator from the University of Zimbabwe's Department of Linguistics. All transcriptions were reviewed by the researcher to check if the transcripts truly reflected the interview. The data collected for this study constitute field notes, audio recordings and transcripts. A deductive approach was used in analysing the data whereby the researcher imposed their own structure on the data and used it to analyse the data (Pope and Zeibland, 1999, William et al., 2004). The method used for analysis was content analysis (Joubert et al., 2007). The researcher did intense reading of the transcripts. Text data were then imported into MAXQDA 10 software for organisation and analysis. The researcher

coded the data by locating text segments and assigning codes to label them (Hennink et al., 2010). Codes were then collapsed into themes (Hennink et al., 2010). Research objectives guided the formation of themes. New themes that emerged out of the data were also highlighted. Data were then analysed based on the themes in line with the study aim and objectives.

2.9 Ethical Consideration

Ethical clearance for conducting the study was granted by the University of the Witwatersrand Human Research Ethics Committee (HREC); clearance number M151172 (Appendix E). Approval to conduct the research in Zimbabwe was granted by the Medical Research Council of Zimbabwe (MRCZ), reference number MRCZ /B/960 (Appendix F). Permission was also granted from the Harare City Health Department (Appendix G).

Participants were provided with details concerning the aim of the study, probable risks and their rights (Joubert et al., 2007) through the information sheet (Appendix D). The participants gave two separate consents to participate in the study. They gave their written informed consent to participate in the interview (Appendix B) and another one to be recorded by the interviewer (Appendix C). Participants were not pressured to be part of the study (Joubert et al., 2007).

Data were recorded anonymously using pseudonyms in order to ensure confidentiality. The anonymity of the male partners of the participants was also maintained to ensure confidentiality (Joubert et al., 2007). Audio recorded interviews, field notes and hard copies of transcriptions were stored under lock and key. Data on the computer were password encrypted. Arrangements were made with the clinical social workers and counsellors at the clinic for tackling issues of psychological distress. The researcher is not aware of participants who showed signs of psychological distress during the research.

2.10 Summary of the Chapter

In this chapter a clarification was made on the processes that were followed in conducting the research off the field and in the field. A qualitative design was chosen for this study because of the research question and the sensitivity of the topic being studied. The sampling strategy chosen was appropriate for the study. In-depth interviews proved to be the most suitable approach as the study needed detailed information about the perceptions and experience of female partners of clients of VMMC. Data analysis was conducted in line with qualitative research design and ethical considerations were made throughout the study as there was use of human subjects.

CHAPTER 3

RESULTS

3.1 Introduction

This chapter outlines the results of the study. Analysis of the data started during data collection and extends into this chapter where content analysis was used to come up with deductive themes and sub themes to answer the research question guided by literature . The research objectives have been taken into account in identifying the six primary themes. The themes and sub themes for the study are summarised in table 1 below

Table 1. Themes and Sub Themes

THEMES	**SUBTHEMES**
Knowledge about VMMC	-Women's definition of VMMC -Women's misinformation about VMMC
Sources of Information about VMMC	-Mass media -Celebrities -Health care workers and campaign staff -Sexual partners -Schools -Multiple sources of VMMC information
Women's role and influence in the uptake of VMMC	- Women's role in VMMC -Women's influence in VMMC

Women's perception about VMMC	-Good opinion -Mixed opinion
Perceived Benefits of VMMC	- Reduced HIV and STIs transmission - Reduced Cervical Cancer - Improved hygiene - Improved sexual experience - Improved relationship - Improved sexual communication
Women's risk perception towards VMMC	- Change in HIV and STIs risk perception after VMMC -Overstated VMMC protection. -Fear of risk compensation -VMMC Offers direct protection for women

3.2 Socio-demographic background of the participants

All participants in this study were women attending ANC clinic at Edith Opperman Polyclinic in Mbare Suburb in Harare, Zimbabwe. A description of the participants has been summarised in Table 2, which helps in setting the context.

Table 2. Socio- demographic description of the participants

Age	21- 25 years = 6 26-30 years = 2 31-35 years =5 36 -40 years = 5 41 -45 years = 1 45-50 years = 1
Age of Male partners	21-25 years = 1 26-30 years = 6 31-35 years = 4 36 -40 years = 5 41-45 years = 3 46-50 years = 0 51-55 years = 0 56 -60 years = 1
Length of stay with partner	1-5 years = 8 6-10 years = 9 11-15 years =1 16-20 years = 1 20 years and above = 1
Number of Children	Average of 2
Employment	7 were employed 13 were not employed
Highest educational qualification	1 ended in Grade 7 South African equivalent of grade 7 1 had a Zimbabwe Junior Certificate –South

	African equivalent of grade 9 13 ended at Ordinary Level –South African equivalent of grade 11 3 had diplomas 2 ended at undergraduate level

3.3 Knowledge about VMMC

The broad theme on knowledge looks at the scope of women's knowledge and the kind of misinformation they had about VMMC.

3.3.1 Women's definition of VMMC

Almost all participants were knowledgeable about VMMC. They had an understanding that VMMC is the removal of the foreskin from the penis and that it is done on voluntary basis to protect from HIV and STIs and improve hygiene.

> *"Ah circumcision is the removal of the foreskin of the male organ in order to prevent sexually transmitted diseases plus it is smart" Lee, 37*

Some participants defined VMMC according to the benefits of improved relationship and sexual experience. The improved sexual experience was attributed to absence of fear of diseases and hygiene.

> *"It increases love between partners because you don't loathe being intimate with your partner and you are not afraid" Tariro, 43*

One participant defined VMMC to be leading to male partner fidelity.

> *".. That when a man is circumcised he will not move around looking for other women" Chido, 21*

One participant failed to define VMMC.

> *"Mm I know a little about it" Sihle, 32*

Women believed that their knowledge can be improved if they receive health education from credible sources on VMMC benefits.

> *"I also think they should keep educating people on the other advantages of male circumcision as what we mostly know is from gossip in the neighbourhood" Sithembiso, 34*

3.3.2 Women's misinformation about VMMC

Some women reported that they had misinformation about the VMMC procedure and adverse events which they believed could have affected their contribution to their partner's decision to go for VMMC.

> *"I almost stopped him and told him about the rumours that some men were getting killed." Farai, 23*

Participants reported that they had misinformation about the age at which man can be medically circumcised. They also reported that the misinformation they had were dispelled by going through their partners' VMMC.

"I used to think that it was difficult to be circumcised as an adult; I thought the wound would take longer to heal because of the adult skin texture. We used to hear that people get circumcised at a young age not knowing that it was also possible to have it done as an adult. I was scared and even when he went for the circumcision, I was not confident, I was in doubt, I only believed it when he got healed completely." Sithembiso, 34

3.4 Sources of Information about VMMC

There are different sources of VMMC information for women. Most of the sources outlined were mass media platforms. Other sources of VMMC information were also around interpersonal communication with health care workers, community mobilisers, schools and sexual partners. The sources are presented as sub themes below:

3.4.1 Multiple Sources of VMMC information

When asked about their sources of VMMC information, participants referred to more than one source of VMMC information.

"We saw an advert through media it was discussed in the radios, TVs, clinics and everywhere even in commuter omnibuses it is discussed" Lee, 37

3.4.2 Mass Media

Mass media platforms were identified as the main sources of VMMC information for the majority of participants. Participants mentioned broadcast media in the form of television as a main source of VMMC information.

"Well of late it's been advertised so much in the media ... on TV" Hailey, 32

Radio was mentioned as sources of VMMC information for some participants.

"I heard the discussion about it on radio" Nyarai, 32

Some participants got to know about VMMC through print media in the form of posters, pamphlets and newspapers.

"I really got to know about circumcision when advertisements were aired on newspapers" Rudo, 36

"There was a time when we saw posters saying come and get circumcised" Linda, 30

"So many papers with the circumcision message were distributed" Tariro, 43

3.4.3 Celebrities

Some participants reported that they got to know about VMMC through musicians.

"But I guess in the past year there has been a lot of hype; musicians have been going out trying to bring about that awareness" Hailey, 32

3.4.4 Health care workers and campaign staff

Participants reported to have become aware of VMMC through health care workers at the clinics and VMMC campaign staff.

"We heard about it at the clinics and from circumcision people walking around saying that men should go to the clinic to get circumcised" Anne, 37

One participant got to know about VMMC through the HIV Testing and counselling facility called New Start centre.

> *"I came to the clinic and it was encouraged that our partners do get circumcised and New Start Centre also kept on encouraging people to get circumcised" Tariro,43*

3.4.5 Sexual partners

Sexual partners were also identified as the main sources of information for VMMC.

> *"My husband told me there was a programme for male circumcision" Yvonne, 47*

3.4.6 Schools

Schools were reported to be another source of information about VMMC for participants.

> *"Anywhere, it is taught even in schools" Mandipa, 21*

3.5 Women's role and influence in the uptake of VMMC

The theme looks at the role played by women in their partners' VMMC and what women perceived to be their role for their partners to uptake VMMC. It also looks at the influence that women had on their partners. These are outlined in the subthemes below:

3.5.1 Women's role in VMMC

Women perceived that their main role to be that of encouraging their male partners to go for VMMC.

> *"Encouraging the man to go and get circumcised. That's a wife's duty because a woman was given a responsibility of being a helper." Tariro, 43*

In contrast, one woman perceived that women do not have a role to play in issues of medical male circumcision because they are not responsible for infecting their partners.

> *" In issues of circumcision, men are the ones who have a role to play because they bring us the disease so if they get circumcised then we are also protected, women do not play any role" Rose ,24*

In cases were women were not involved in VMMC decision making, participants expressed disappointment.

> *"It is just then difficult to have him come back home circumcised when you had not talked about it" Vimbai, 26*

Participants believed that women need to get awareness of VMMC in order to encourage their male partners to uptake VMMC.

> *"They should encourage their husbands to go and get circumcised once they have been told more about circumcision" Melody, 21*

"Some women would want their partners to be circumcised after they have been educated about its advantages" Chenai, 36

3.5.2 Women's influence in VMMC

In terms of their experience, the majority of the participants had an influence in their male partners' decision making for VMMC uptake. Most women were consulted and informed by their male partners before they went for VMMC.

"We were just discussing about it at home and he went ahead and asked me if I am ok with him getting circumcised. I told him to go and he did so" Chido, 21

Participants underscored the need for women to have an influence on their male partners who may not think about VMMC on their own.

"Men on their own may not think about going for circumcision or the woman may hear about it but many not want her husband to go for circumcision …." Linda, 30

And in some cases men are aware of VMMC but just need encouragement from their female partners.

" Besides this circumcision issue is everywhere even the cars move around with stickers about circumcision and the TV so it's something that the man are aware of but they just need encouragement" Chenai,36

Women perceived that the reason for influencing their male partners to uptake VMMC was that they also benefit from it.

> *"It is a good thing to encourage one another because you also benefit as a woman you do not contract those diseases… sixty per cent, they say that women who have circumcised men have a greater chance of not contracting diseases." Rufaro, 37*

Women perceived that they should influence their male partners to uptake VMMC because all men are promiscuous and so getting them circumcised would lessen chances of contracting diseases.

> *"..Because these men, there is none who doesn't sleep around. At least it would be better after circumcision as you won't know when he goes to sleep around if he will use protection or not so better advice that he gets circumcised so that it lessens the risk of acquiring the disease" Mandipa, 21*

3.6 Women's perception about VMMC

The broad theme looks at women's perceptions about VMMC

3.6.1 Good opinion

Overall, most women had a good opinion of VMMC and they gave their perceived benefits of VMMC as the reasons for having a good opinion.

"I think medical male circumcision is good because it has many advantages if a person is circumcised he is naturally smart and confident of himself so generally if you hear a person has volunteered to be circumcised that person will be a right person…." Rudo 36

When giving their concluding remarks, a majority of participants recommended VMMC to other women.

"What you must know is that male circumcision is good if you have your husband who is not yet circumcised, you should encourage him" Yvonne, 47

3.6.2 Mixed opinion

In contrast, two women expressed mixed opinions about VMMC due to the health benefits and concern that it makes their male partners to increase risky behaviour.

"To me it is good and bad at the same time because before circumcision I had no problems in my home I had no problems at all. I don't know if he was scared I don't know what was in his mind but soon after circumcision it seems he is now too independent knowing that I am protected, so I can see that infidelity is increasing. " Linda, 30

"I think male circumcision is good and bad at the same time because some my end being more promiscuous than before from what I heard if someone is circumcised it's not too risky for him to be infected with HIV not knowing if it is true so I think on one side its good and another is bad" Nyasha , 24

3.7 Perceived Benefits of VMMC

The broad theme looks at the perceived benefits of VMMC which include reduced risk of HIV and STIs, improved hygiene, improved sexual experience, improved relationship and improved sexual communication.

3.7.1 Reduced transmission of HIV and STIs

All participants without an exception perceived reduced risk of transmitting HIV as a benefit for women from VMMC. Reduced risk of contracting HIV and STIs risk was mentioned at several points and seemed to be crucial for women.

> *"It reduces the contracting of HIV and the percentages of getting infected. " Melody, 21*

Some participants made reference to their past experience of having STIs and the change that VMMC brought.

> *"..No more complaining of stomach pain or that his manhood is itchy even saying anything; we are not hearing of such after the circumcision." Yvonne, 47*

> *".... He used to infect me with other diseases that he would have acquired from sleeping with other girls." Farai, 23*

"So far ever since he got circumcised I have never had a sexually transmitted infection or complained of itching or have an unusual discharge, not at all." Chenai, 36

3.7.2 Reduced Cervical Cancer

Reduced chances of getting cervical cancer were also perceived as other benefits of VMMC as described below:

" .. the issue of cervical cancer meaning a woman with a circumcised man has less chances of getting cervical cancer unlike someone who is not circumcised", Rudo , 36

3.7.3 Improved hygiene

The women perceived improved hygiene to be a benefit derived from having a circumcised partner. Hygiene was perceived to be an equally important issue as HIV and STI risk reduction. Women felt that men cannot bath properly hence they need to be medically circumcised so as to maintain personal hygiene for their benefit as well. In contrast, circumcised men were perceived to clean their penises easily because of the absence of the foreskin that traps dirt.

"It is good for me as a woman in that when a man is circumcised because men can't bath properly and their private part store dirt. Some men prefer women to suck them so in that case it will be good because he will be smart and you won't be suspicious about the dirt trapped in his foreskin." Sihle, 32

The majority of participants when talking about hygiene referred to the word ‘smart’:

> *“Women should encourage their husbands to get circumcised as it is smart and the in thing.” Sithembiso, 34*

When asked what the word smart means they had this to say:

> *“Smart means cleanliness it means that you will fear for your life and to improve your personal hygiene such that when you go where other men are you will not be shy to expose your organ in the toilet” Chenai, 36*

Benefits of performing oral sex were perceived to have come about because of VMMC. Women reported that they are now comfortable performing oral sex with their circumcised partner due to improved hygiene.

> *“Now you can do it freely knowing the manhood is clean rather than when the foreskin which used to trap dirt was still there. He just needs to take a bath unlike before his circumcision where I would suck that foreskin with those you know, he just needs you to. You end up doing it out of obligation with the fear that if you don’t do it, he will end up sleeping around. Also, people say that if he’s your husband, you have to satisfy him so that he doesn’t sleep around so you will be trying to safeguard your marriage, that’s all.” Sithembiso, 34*

3.7.4 Improved sexual experience

Most participants perceived improved sexual experience as the primary benefit that women may want from having a circumcised partner.

> "*HIV and STIS are not the primary driving factors for people or for husbands to get circumcised we will be basically looking at our sexual relationship and health in terms of a clean organ and maybe that enhances the capacity or the capability of a husband to last longer thereby satisfying myself so I guess that's the primary driving factor" Hailey, 32*

A good sexual experience was highlighted by some participants as an important part of a relationship and was believed to be brought about with the absence of fear of HIV and STIs, improved hygiene and absence of bruises on their partners.

> *"After circumcision things changed, his foreskin was now hard we could have sex two or three times without any bruises. That put me in a comfort zone that my risk has lowered. Also I no longer had those infections that I used to have. He no longer had bruises because his skin became hard" Rudo, 36*

Women also reported that they are enjoying sex after their partners' VMMC.

> *"The new experience is like I said before that sex is now more enjoyable than before" Rufaro, 37*

Participants also believed that circumcision improved their male partners' sex drive.

"… mostly men who are circumcised know how to please a woman in bed "Farai, 23

Women also perceived that their sexual experience was improved because of delayed ejaculation due to VMMC.

" .. He would take about five minutes, but now he lasts longer" Chido, 21

Few participants perceived the benefits of having sex without a condom as being brought about by having a circumcised partner. Having unprotected sex was perceived to be important in strengthening the relationship between partners. Having sex without a condom was perceived to be enjoyable and was preferred in sexual relationships of HIV negative couples.

"Because when your husband is circumcised you won't be disgusted to have sex with him and you will not need to use protection…… I enjoy having unprotected sex with my husband that is what keeps marriages strong it is not possible for married people to use protection unless they are HIV positive then they are told to have unprotected sex only when they want to have children" Tariro,43

Some participants also highlighted that a penis has an improved appearance after VMMC.

"the difference that I saw was that his organ no longer has a foreskin now it looks good and when you look at it you can confess that ah its now clean (laugh) you realise that this man is clean and is different from the way he was before" Chenai, 36

Participants also noted an improved sexual experience as there is no longer delayed penetration when opening the foreskin before sexual intercourse.

> *"The sex will be good there will be no problem. I keep on referring to the issue of fore skin it delays the penetration as the partner need to open it first before he inserts which takes time. If one is circumcised there is no need to open the fore skin." Tariro, 43*

One participant believed that having a circumcised partner caused her to have a boring sexual experience. She attributed the dull sexual experience to the hardening of the penis that was caused by the removal of the foreskin.

> *"Like the manhood was created by God with that foreskin. When the foreskin is not removed, it is soft but when it has been removed, it becomes hard, so that is where I do not understand. It then makes me not interested in sex and today I actually had an altercation with him about it and I don't feel like sleeping with him as it seems like I would be wasting my time" Vimbai,26*

3.7.5 Improved Relationship

VMMC was perceived by most women to bring improvement in relationships between partners. Women believed that VMMC improved the level of trust between partners.

> *"…I think trust; you know when you just trust your partner" Lee, 37*

Women perceived that VMMC lead to the absence of fear of diseases in a relationship. They also perceived that having a male partner going for VMMC meant that the male partner is concerned about their health.

> *"Before he was circumcised I was scared of diseases but ever since he got circumcised I know that my man is someone who knows the importance of living a healthy life, he liked the programme that came to prevent diseases and for that I am no longer afraid" Ruramai,29*

Women felt that their male partners' period of recovery was important in strengthening their relationships and also afforded an opportunity for couples to explore other non-penetrative sexual activities.

> *"After he was circumcised, I think it was six weeks rather before we did engage sexually. That time I must say was actually good because well like the whole process whereby he will be healing the pain and all that, you had to nurse your guy and all that. It kind of brought us together it strengthens bonds we would talk really and you know that's when you find that you know a relationship is not about sex there is more to it" Hailey,32*

3.7.6 Improved sexual communication

In terms of sexual communication experience, most women reported an improvement in the way that they communicate with their partners after VMMC. Issues of VMMC were reported to have set the mood for discussing sexual issues in cases were sexual communication was not present.

"We used not to discuss about those issues its only when the issue of circumcision came that is when we started to discuss about it" Farai, 23

On that note some women underscored the need for good sexual communication as a basis for being able to influence their male partners to uptake VMMC.

"If as a couple you do not have good communication and a sound relationship, it is difficult for you to discuss deep issues like circumcision. Women should know how to approach their men to go and get circumcised. They should do it in the same way they ask for groceries or sex. It's not easy for a woman to convince a man to go for circumcision. It takes time and lengthy discussions for men to be convinced. "Tariro, 43

3.8 Women's risk perception towards VMMC

The broad theme on risk perception looks at women's HIV and STI risk perception before and after VMMC, overstated VMMC protective effect and fear of risk compensation.

3.8.1 Change in HIV and STI risk perception after VMMC

Before their male partners' VMMC, women perceived themselves to be at high risk for HIV and STIs infection. After their male partner's medical circumcision the risk was perceived to have decreased.

"Before his circumcision it was bad. If things remained the way they were, we would be on antiretroviral treatment now……. Now things are better ..." Chenai 36

"Before he was circumcised I was scared of diseases" Ruramai, 29

On the contrary one participant did not see any change in risk perception and attributed that to having a trustworthy male partner.

" My risk perceptions they are still low ah because the thing is well my relationship with this husband of mine has been one that is open we communicate a lot" Hailey, 32

3.8.2 Overstated MMC protection

According to their responses, participants thought that the MMC process involves the penis being applied something to protect men from diseases.

"…… so when they get circumcised there is something that they put for him to be protected on his organ …." Linda, 30

Participants also believed that MMC fully protects their male partners from all STIs.

"A circumcised man will not contract disease it is just good" Farai, 23

"Even if a man has intercourse with a woman he won't get sexually transmitted diseases like wounds and others "Nyarai, 32

"I just say it is good that my husband has been circumcised because he cannot catch any disease" Anne, 37

3.8.3 Fear of risk compensation

In some cases women reported experiencing increased risky behaviour on their male partners after VMMC and expressed fear of risk compensation on their male partners.

> "*What I mean is bad is that issue where it seems that circumcision is encouraging men to be more promiscuous since when they go for circumcision they are told that it is done to prevent HIV so in my view it causes mischief" Nyasha,24*

> *"I think initially he was scared of having many girlfriends. If ever he used to have them he didn't let it show but now I can see that there is something happening so he knows that he has some level of protection, so if I do anything there is something that protects me from the disease" Linda,30*

3.8.4 VMMC offers direct protection for women from HIV and STIs

Some participants perceived that VMMC offered direct protection from HIV and STIs for women in the same way it does to their male partners. The misconceptions about the existence of direct HIV –risk reduction for women were echoed by the participant:

> *"So if they (men) get circumcised then we are also protected" Rose, 24*

3.9 Summary of Chapter

This chapter has presented major findings for the study. Women had good knowledge on defining VMMC and misinformation about adverse events, age at which men can be circumcised and the percentage protection from HIV. Women received VMMC information from multiple sources in mass media and interpersonal communication. The perceived main

role of women was of influencing their male partners to seek VMMC services. The general perception about MMC was good among the participants. Participants perceived the benefits of having a circumcised partner as improved sexual experience, improved relationship and sexual communication, reduced chances of HIV and STIs, reduced chances of cervical cancer and improved hygiene. The risk perception of women was reported to be high before MMC and reduced after male partner's circumcision. Condom use was perceived by some not to be important after VMMC. The participants had fears and experiences of risk compensation on their male partners.

CHAPTER 4

DISCUSSION

4.1 Introduction

Exploring the experiences and perceptions of women, the study unearthed a unique insight on the factors that influence the role that women play in VMMC. Main factors emerged around the main themes which are women's knowledge about VMMC, sources of VMMC information, perceived women's role, perceived benefits of VMMC and perceived risks of having a circumcised partner. The main aim of the study was to contribute to the growing body of literature about perceptions and experiences of female partners of clients of VMMC in order to inform health messages. Findings from this study have uncovered depictions that are critical in informing the development of health messages.

4.2 Women's knowledge about of VMMC

In a recent study that looked at the barriers and motivators of VMMC uptake in Zimbabwe, (Hatzold et al., 2014) indicated that knowledge about VMMC was lower among females. The findings of this study show that women have knowledge about VMMC. This is consistent with the findings of a study that was conducted in Kenya among sexually active women aged between 18 and 34 years (Lanham et al., 2012). The improvement in women's knowledge can be attributed to vigorous demand creation activities especially during campaigns (Kanagat et al., 2013). While most women in this study could define VMMC correctly, their definition was always made in terms of their perception of VMMC benefits that is VMMC as the voluntary removal of the foreskin for the purposes of protection from HIV and STIs,

improved hygiene, improved sexual experience, improved relationship between partners and improved fidelity of male partner. Most women know that VMMC is done in order to improve hygiene, prevent STIs and HIV. The prevention of HIV has been mentioned in a number of studies (Haberland et al., 2016, Chikutsa and Maharaj, 2015). Women's knowledge is important since they can meaningfully contribute to VMMC if they have adequate information (Tarimo et al., 2012). Women must possess sufficient and correct knowledge about VMMC in order to influence their male partner with correct messages (Lanham et al., 2012). While the women in this study demonstrated good knowledge of VMMC, they tended to state the benefits in absolute terms which may be viewed as overstating the benefits of VMMC. Influencing their male partners in these terms may help to give circumcised men a false sense of security thereby increasing their chance of engaging in risky sexual practices (Barone et al., 2016) found that a minority of males who demonstrated poor knowledge of VMMC also showed risky behaviour such as reduced condom use post-circumcision.

Questions may be raised concerning the VMMC knowledge sources and the nature of the messages they communicated to the participants of this study. The fact that VMMC knowledge came from a variety of sources, chances are that the messages may also have varied leaving the participants with an incorrect impression of absolute rather than partial beneficial effect. It is also possible that the various messages given could have overstated the benefits of VMMC as understood by the women. The importance of communicating correct messages cannot be over-emphasised (L'Engle et al., 2013).

Further, the fact that some participants could not define VMMC and that those who demonstrated good knowledge still felt that their knowledge could be improved may indicate that even though there has been multiple sources of VMMC information, the information either may not have been received or it might have been misunderstood by all people. Another study reported similar findings and demonstrated the value of repeated communication of messages to enhance understanding by recipients (Lanham et al., 2012).

What came out strongly in this study is that some women were once misinformed about VMMC. The participants reported that they were misinformed about the purposes of VMMC, the targeted age and the adverse consequences. Similar findings were reported in a study in Malawi (Shacham et al., 2014). This could have contributed to their sexual partners' decision in VMMC uptake. Misinformed female partners may influence their male partners not to uptake VMMC services since sexual partners play a crucial role in shaping the attitudes of their male partners (RTI International, 2014).

4.3 Sources of VMMC information

Participants cited multiple sources of VMMC information that fall into two categories: mass media (TV, radio, newspapers) and interpersonal communication (male partners, schools, HIV counselling and testing centres) channels. This is in line with the VMMC demand creation strategy in Zimbabwe which recommended the use of multiple communicating channels for maximum impact (RTI International, 2014). Another Zimbabwean study by (Hatzold et al., 2014) confirmed that this demand creation strategy was mirrored in the VMMC information sources cited by participants . The findings of this study may provide an

insight into the impact of the VMMC health communication strategies implemented in Zimbabwe prior to the study.

An evaluation of the impact of health communication on VMMC indicated that multiple communication channels were used effectively in many Sub-Saharan countries (Health Communication Capacity Collaborative, 2015). The use of multiple channels is an effective way of VMMC demand creation (Sgaier et al., 2015). The use of multiple channels was valuable as women refer to more than one source of VMMC information. This concurs with the findings from a study conducted in Tanzania (Tarimo et al., 2012). These findings brings to the fore the need to use multiple channels in health communication as it is useful in VMMC demand creation (Sgaier et al., 2015).

With regards to interpersonal communication, sexual partners were reported as sources of VMMC information for the participants. This finding implies that males have more knowledge about VMMC than women. This is consistent with a study conducted in Zimbabwe that found that women had less knowledge on VMMC than men (Phillip et al., 2012). Thus suggesting that women's education and information needs about VMMC are still not being met (Layer et al., 2014).

According to this study, health care workers are another source of VMMC information for women. This is consistent with the findings of a study conducted in Zambia (Price et al., 2014). The findings present an opportunity for VMMC demand creation efforts to leverage on women's frequent interaction with the health care system, whereby women can act as message bearers to their male partners. A study in Tanzania showed that women interacted

with health care workers more frequently and conveyed the VMMC messages to their male partners (Glick, 2014). This study also showed that VMMC messages were integrated into VCT services thus confirming that integrating VMMC into the broader context of HIV prevention is crucial (Bertrand et al., 2011). Moreover success of health communication interventions depends on how people internalise those messages and act on them.

Women also mentioned schools as sources of VMMC information. The finding reiterates the need to use formal institutions like schools in disseminating education about VMMC benefits (Tarimo et al., 2012). Schools have been documented as mobilisation sites for VMMC in Zimbabwe (Ashengo et al., 2014), thus affirming the need to target women using the same channel.

This study adds to the existing evidence that mass media is the main source of health information. The results are consistent with the findings of studies held in Kenya, Tanzania and Zimbabwe (Hatzold et al., 2014, Layer et al., 2013a, Lanham et al., 2012). These findings need to be viewed as urban context specific since rural residents are not as exposed to all forms of mass media as the urban residents (ZIMSTAT and ICF International, 2012).

Furthermore, the present study also showed that mass media developed the social norm that a circumcised man is smart. The frequent mention of the word smart by participants also demonstrates the positive effect of mass media on women's knowledge of VMMC. The same word is currently being used in VMMC demand creation by PSI under the 'SMART' campaign leveraging on mass media and social mobilisation. PSI is the leading implementer and communication partner for VMMC in Zimbabwe. Billboards, radio, television and print

media are mass media platforms utilised by PSI in imparting information about VMMC (PSI, 2014).

Media triggers conversation with partners that could result in a decision to take on VMMC (PSI, 2014). The findings from this study confirm this assertion as mass communication provided a platform for discussion of VMMC between partners. Similar observations were made in a study conducted in Tanzania (Layer et al., 2013a). Based on the findings of this study and elsewhere, health communication for VMMC demand creation should continue leveraging on mass media to initiate conversation about VMMC as well as make women influence their male partners to uptake VMMC. However, mass media need to address women misinformation about the VMMC procedure as these can downplay efforts to increase VMMC uptake. More so, VMMC uptake possibly will be improved if VMMC messages are clearly and effectively framed (Kahari, 2013).

4.4 Perceived women's role in VMMC

This study found that women perceived that their role is to encourage male partners to go for VMMC. This perceived role is corroborated by a study that was conducted in Kenya (Lanham et al., 2012). The participants also reported that their role is to influence their partners' decision to uptake VMMC. A study conducted in Tanzania also show the same role (Osaki et al., 2015). From the participants' experience almost all male partners initiated conversation about VMMC. This contradicts a study in Tanzania, where almost all women initiated the conversation about VMMC (Osaki et al., 2015). The role that women played was restricted by the gendered power structures within which their relationships are set. However, these findings should be viewed in light of Zimbabwe being a patriarchal society

(Kambarami, 2006). This accentuates the importance of taking into consideration the evidence about cultural and structural barriers to VMMC in developing and improving strategies (SGAIER 2015) .

Gender and power relations impact on the role that women play in VMMC and what they perceive to be their main role. Unequal power dynamics were apparent in the study findings whereby most women did not initiate conversation about VMMC. These findings concur with the assertion that women in Zimbabwe are faced with barriers to full and equal participation in relationships (ZIMSTAT, 2013). Women remain limited by the gender based power differentials in their sexual relations (Langen, 2005). However, women should make use of negotiating strategies that are in line with their relative position within relationships (Layer et al., 2014). According to (Peltzer et al., 2007) gender issues fundamental to VMMC have been neglected. The findings therefore reiterate the need to consider gender issues in VMMC demand creation. VMMC demand creation should also look at the ability of women to dissuade or persuade their male partners in the uptake of VMMC services (Glick, 2014).

Issues of VMMC were perceived to be male spaces in this study. Though it was limited to a minority, the fact that participants felt that they did not have a role to play in VMMC is worrisome. The same findings came out of study held in Kenya where women saw VMMC as an issue for men only (Layer et al., 2014). These perceptions limit the role and influence of women since they are the key influencers in VMMC (Sgaier et al., 2015).

4.5 Women's perception about VMMC

Women support VMMC basing on their beliefs and experiences. VMMC in general was perceived to be good and women would encourage their partners to go for VMMC. This was also found in studies conducted in South Africa and Kenya (Ikwegbue et al., 2015, Westercamp, 2013). The results present an opportunity that can be used for VMMC demand creation whereby women can share their experiences as in the case of Kenya where women were imparted VMMC education in women's groups, ANC clinics and health care institutions (Sgaier et al., 2015). Nonetheless, understanding how women's perceptions influence VMMC is also important.

4.6 Perceived Improved relationship and sexual communication

One of the key elements that women spoke about in this study was the way VMMC processes improved their relationships; particularly with regards to enhanced trust, absence of fear of diseases and caring during the healing processes. These findings are supported by a study that looked at the improved relationship during VMMC process in Tanzania (Layer et al., 2013a). These issues are worth exploring in VMMC messaging. This study also found improved sexual communication as one of the benefits attributed to VMMC. Participants reported that the existence of sexual communication made it easier for them to influence their male partners to go for VMMC. Implementers of VMMC can leverage on already existing sexual communication between partners for the promotion of HIV protective behaviours. (Layer et al., 2013a).

4.7 Perceived Sexual Benefits

This study found that participants reported an increased aesthetic preference for circumcised penises and a resultant improvement in sexual satisfaction following VMMC of their male partners. Women in this study believed that circumcision improved the appearance of the penis and this seemed to influence their sexual experiences and satisfaction. Moreover some women found a circumcised penis more acceptable for oral sex than an uncircumcised penis on the grounds of perceived improvement in hygiene and cleanliness following circumcision. These findings are consistent with other studies in Zimbabwe and Kenya (Chikutsa and Maharaj, 2015, Layer et al., 2013a). An online survey on the impact of male circumcision on their sexual partners found that female partners of circumcised men had increased sexual satisfaction that was closely linked to their preference for circumcised penises for both vaginal and oral sex (Bossio et al., 2015).

Furthermore, participants in this study attributed their increased sexual satisfaction and enjoyment to the fact that their circumcised partners took longer to ejaculate thereby increasing their chance for achieving orgasmic sexual satisfaction. While these findings are confirmed by other studies in Zambia (Zulu et al., 2015) and Kenya (Riess et al., 2014), other studies found the contrary : circumcision was associated with orgasm problems and diminished sexual pleasure and satisfaction for women with circumcised partners(Frisch et al., 2011) with older women experiencing increased dryness during coitus (Cortés-Gonzalez et al., 2009). A systematic review evaluating the impact of circumcision on sexual function and pleasure concluded that even though circumcision did not seem to negatively affect sexual function and pleasure for circumcised men and their partners , there was a dearth of high quality studies around the subject of male circumcision (Morris and Krieger, 2013).

The improved sexual satisfaction after male partners were circumcised was also attributed to the belief that VMMC improved the sex drive of their partners. A study on women's beliefs about VMMC had similar findings (Riess et al., 2014). The absence of the foreskin due to VMMC was stated by women as leading to increased sexual pleasure due to the belief that the foreskin interferes with penetrative sex. Studies in Tanzania also came up with similar findings (Layer et al., 2013b, Tarimo et al., 2012).

However, findings of this study reveal powerful perceptions that may influence the role of women in VMMC. The perceived benefits of increased sexual pleasure may be a motivating influence, among other benefits, for women to engage their partners to participate in VMMC.

4.8 Perceived health benefits

Reduced chance of cervical cancer is one of the health benefits according to the participants. Studies conducted in Zimbabwe and Kenya had the same finding (Hatzold et al., 2014, Riess et al., 2014). VMMC messages in Zimbabwe communicate the reduced risk of cervical cancer as a benefit for women (PSI, 2014). Results reveal the effect of VMMC messages. That awareness is important for women since cervical cancer is the second most common cancer among women in Zimbabwe (Ministry of Health and Child Care, 2014).

Hygiene is another benefit of VMMC reported in this study. Studies conducted in Zambia and Kenya also found the same (Zulu et al., 2015, Chanda et al., 2012, Riess et al., 2014). Through the perception of women themselves, hygiene benefits were also linked to improved sexual experience.

The commonly discussed benefit of VMMC was reduced risk of STIs. The same findings came out of studies in Tanzania and South Africa (Riess et al., 2014, Layer et al., 2013b, Mantell et al., 2013). Participants also related their experience in reduced STIs after their male partners' circumcision as was found in a Tanzanian study (Layer et al., 2013a). However it is crucial for women to understand that VMMC does not affect the risk of all STIs (Layer et al., 2013b).In addition it is also essential for women to understand that VMMC offers their male partners 60% (partial) protection from HIV.

What also came out of this study was that women felt that VMMC confers their male partners' full protection from HIV. Similar findings came out of studies in Zambia and Tanzania (Haberland et al., 2016, Plotkin et al., 2013). The findings suggest that although the messages are reaching women, they are being interpreted in ways that makes women feel more protected than they actually are. Deducing incorrect aspects from VMMC messages may weaken the efficiency of such campaigns (Maughan-Brown et al., 2015). It therefore implies that more attention needs to be given to the explanation of VMMC health benefits for women. Furthermore it is important for women to understand partial protection of VMMC so that they decide to protect themselves after their male partners have undergone VMMC (Lanham et al., 2012). If women learn correct information they are able to shape their sexual behaviours in ways that decrease risks of STIs and HIV (Riess et al., 2014).

Women erroneously inferred that VMMC afforded them direct protection from HIV in the same way it does to their male partners. The results concur with those of other studies in Kenya and Malawi (Lanham et al., 2012, Maughan-Brown et al., 2015). A study conducted in Zambia on the contrary, found that women benefit indirectly from VMMC (Zulu et al., 2015).

Issues of lack of direct protection for women have been inadequately considered (Mantell et al., 2013). If women understand that they are not directly protected from HIV then they are able to continue negotiating for condom use with a circumcised partner (Hankins, 2007). Ignoring these issues may make women to feel more comfortable in engaging in risky sexual behaviours that possibly may offset MMC's protective effect (Cassell et al., 2006). VMMC communication will effectively address the issues of protection conferred by VMMC to women although it is complicated because the amount of protection is not yet known (Lanham et al., 2012, Weiss et al., 2008).

4.9 Perceived risks

Findings show that although women had awareness of VMMC they had a lowered risk perception of having a medically circumcised partner. Findings also revealed that women believed that condom use was not important after VMMC. The same views were expressed in studies conducted in Zimbabwe, Tanzania and Kenya (Chikutsa and Maharaj, 2015, Lanham et al., 2012, Layer et al., 2014). As a result female partners of VMMC clients who hold this belief may incorrectly lower their perceived risk of HIV and not find condom use to be important (Maughan-Brown et al., 2015). On the contrary, a study in Kenya found that male partners' circumcision status did not have an effect on condom use (Riess et al., 2014). Nonetheless, it is important to monitor and minimise the possible negative gender related influence of VMMC programmes on condom use (Hankins, 2007). Zimbabwe's VMMC policy postulates that correct and consistent use of female and male condoms is an important part in VMMC messages (Ministry of Health and Child Care, 2014). However, there is need for messages to clearly and consistently emphasise that MMC is another HIV prevention method and does not replace condom use (Hankins, 2007). Also, there is need for women to

understand that a woman's risk of HIV depends on her partner's status and both partners' sexual behaviour.

Corresponding with the study by (Ikwegbue et al., 2015), women feared that MMC may lead to risk compensation on the part of their male partners. Participants also reported that they experienced an increase in risky behaviour on their male partners' post-VMMC. Similar findings were reported in studies in South Africa, Kenya and Tanzania (Riess et al., 2014, Layer et al., 2014, Mantell et al., 2013). The fear of risk compensation on part of their male partners may make some women dissuade their male partners to go for VMMC. Nevertheless fear of risk compensation must not hamper VMMC implementation (Westercamp, 2013). A more complex consideration of risk compensation is needed (Layer et al., 2014). However, an increased HIV risk for women results from only moderate levels of risk compensation in men, particularly in the short term (Westercamp, 2013). The epidemiological modelling studies suggest that, only extreme increase in risk behaviour will counteract the protection that VMMC gives to men (Westercamp, 2013).

4.10 Summary of the Chapter

The general conclusion of this chapter is that the knowledge of women is important and determines the role that they are likely to play in their male partners' circumcision. Participants received information from multiple sources of information; mass media and interpersonal communication. Misinformation on VMMC derives from multiple sources of information and how those messages were internalised. The perceived role of women was limited by gender and power relations in their relationships. The good perception of women

was influenced by the perceived benefits of having a circumcised partner. The perceived benefits of having a circumcised partner go beyond health benefits to improved relationship and sexual experience. In order for women to play a supportive role in their male partners' circumcision, the design of VMMC messages needs to address their misconceptions.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The study explored the underlying perceptions and experiences of female partners of clients of voluntary medical male circumcision in Mbare, Harare. The study had three specific objectives which are to explore women's experiences on having a circumcised partner, to explore women's risk perceptions towards male circumcision and to explore women's perceived benefits of having a circumcised partner.

5.2 General concluding remarks

Study findings show that women were generally knowledgeable about VMMC. Participants once had misinformation about the age at which men can be circumcised and the adverse events. Mass media platforms were the main sources of VMMC information. The majority of participants had more than one source of VMMC information. Other sources of VMMC mentioned were celebrities, health care workers, male partners and schools. Women perceived encouraging their male partners to be their main role. The majority of women were involved in their male partner's decision to uptake VMMC. Women who were not involved in their male partners' decision expressed disappointment. According to the women's experience, conversation about VMMC was mainly initiated by male partners. The role that women played was limited by gender roles and power dynamics within which their

relationships are set. Women were motivated to influence their male partners' decision to uptake VMMC because they felt that men were promiscuous, they need encouragement and that women benefited from having a circumcised partner.

Women's perceptions about having a circumcised partner were mainly revolving about the perceived benefits of VMMC. A mixed opinion was brought about by fear of risk compensation on the male partner. The benefits of VMMC perceived by women were mainly to do with health, sexual and relational benefits. Reduced transmission of HIV and STIs was found to be one of the major benefits of having a circumcised partner. The participants' experiences with circumcised partners showed a reduction in STI cases. Improved sexual experience was also reported as one of the main benefits of VMMC. Having a circumcised partner was shown to bring about absence of fear of disease during sex, chances to perform oral sex, and increased sexual pleasure and satisfaction. Sexual intercourse was seen as important element of a relationship. Improved relationships and improved sexual communication were also found to be benefits of having a circumcised partner.

Risk perception of HIV and STIs was found to have decreased in majority of participants after male partners' VMMC. The risk perception of women was reported to have decreased due to the misconception that women had about the same amount of protection from HIV and STI offered by VMMC to their male partners. In addition, women perceived that VMMC offered direct protection for women from STIs and HIV. Participants feared that VMMC may lead to increased risk compensation which may lead to an increased risk of HIV and STIs.

5.3 Recommendations of the research

In light of the research findings and the research objectives the following recommendations are made in order to inform the development of VMMC health messages.

5.3.1 Increase women's knowledge of VMMC

Strategies should be put into place to improve the knowledge of women about VMMC. Health education should be tailor made to address the misconceptions women have about VMMC. There is need to find gender specific messages about partial efficacy of VMMC for male partners and how women benefit from VMMC. Consideration should be made to also include the impact of male partner's risk compensation on their female partners. Findings suggest that women experiences differ so different strategies should be put in place to engage them differently. Findings also show that women are better able to play a role in VMMC if they have enough information.

The study highlights some of the misconceptions women have about VMMC which need to be addressed in the design of health messages so that those misconceptions do not lead women to dissuade their male partners from VMMC uptake. Myths about circumcision can be dispelled by including women in pre circumcision counselling (Riess et al., 2014).

5.3.2 Consider Gender dynamics in VMMC demand creation strategies

VMMC messaging should explicitly address the needs of women and should take into consideration the power dynamics and the social norms around the role of women. The power imbalances should be taken into account in the design of messages and in coming up with strategies that woman can use to negotiate for VMMC uptake within the power relationships they are in.

5.3.3 Use non HIV benefits in the design of VMMC messages targeting women

Findings from this study show that non-health benefits of VMMC are important to women; Improved sexual experience, improved relationship and improved sexual communication. Although there is no biological basis, integrating these issues into the design of VMMC messages targeting women will be useful. There is need to utilise experiences of female partners of clients of VMMC to shape communication messages for VMMC.

5.3 4 Involvement of Women in Pre and Post VMMC counselling

Involving women in pre and post-operative counselling of their male partners is recommended given their conceptions about condom use. The findings also highlight possible topics to be incorporated in pre- or post-operative counselling for VMMC clients and their partners. Involving women will help clear misconceptions and make it easy for them to negotiate condom use after VMMC. Lengthy counselling sessions are often not realistic given the nature of how MMC is offered, however In the long run plans to increase the time for counselling can be considered.

5.4 Limitations of the Study

The findings of the study should be viewed through the following limitations. There is likelihood that some respondents may have fabricated their responses or withheld some information based on what is socially desirable particularly on sensitive topics such as sex since the study relied on self-reported data. In addition, there is a possibility of recall bias since participants were relating events that had happened up to a year after the event. Furthermore, the use of one method and technique; qualitative and in-depth interview may be considered a limitation as the findings from data using these method and techniques cannot be generalizable and makes the issue of reliability , dependability , validity and trustworthiness questionable.

Nevertheless this study makes a contribution in exploring female partners' underlying perceptions and experiences of having their partners undergo medical male circumcision in order to inform the development of health messages.

5.5 Further research required

There is need for research on the protective effect of VMMC in order to inform women about the level of protection VMMC affords to women. This will also inform VMMC for demand creation targeting women. Further research into the relationship and gender dynamics around VMMC is needed as it brings underlying issues that influence the role that women can play in

their male partners' decision to be circumcised. This study can also be replicated using mixed methods.

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Appendix A
Interview Guide

1. Biographical information

1.1 What is your age? [years and months]

1.2 What is the age of your male partner [years and months]

1.3 How long have you been living with your partner [years and months]

1.4 How many children do you have? [number of children]

1.5 Are you employed? [Yes/No]

1.6 What is your highest educational qualification?

2. Knowledge and opinions about VMMC

2.1 Can you please tell me what you know about VMMC?

Probes

- What do you know about VMMC?
- How did you come to know about VMMC?
- When did you know about VMMC?

2.2 What is your general opinion about VMMC?

Probes

- What do you think about women's role in VMMC?

- What makes you think women should have any role in VMMC?
- What makes you think women should not have any role in VMMC?

3. **Experiences of having a medically circumcised partner**

3.1 Tell me what influenced your male partner to make the decision to be medially circumcised?

Probes

- How did that influence him?
- Tell me more about that?

3.2 Tell me about your experiences with your partner before and after he got medically circumcised?

Probes

- Tell me about your sexual experiences before he got medical circumcision?
- Tell me about your sexual experiences after he got medical circumcision?
- Did you talk with your partner about your sexual experiences before and after medical circumcision? Please tell me more about your sexual communication experiences with your partner?
- In your opinion what differences did VMMC bring to your relationship with your partner?
- Tell me about your relationship dynamics before he got medically circumcised?
- Tell me about your relationship dynamics after he got medical circumcision?

4. Risk perceptions towards VMMC

4.1 What were your risk perceptions before your partner's medical circumcision?

Probes

- Tell me about your STIs perceptions before he got medical circumcision?
- Tell me about your HIV perceptions before he got medical circumcision?

4.2 What are your risk perceptions after your partner's circumcision?

Probes

- Tell me about your STIs perceptions after he got medical circumcision?
- Tell me about your HIV perceptions after he got medical circumcision?

5. Perceived benefits of having a circumcised partner

5.1 What are some of the possible reasons women want their partners to be circumcised?

Probes

- Do you think it is because of the perceived reduced risks of contracting STIs?
- Do you think it is because of the perceived reduced risks of contracting HIV?
- Do you think it is because of the perceived benefits of having sex without a condom?
- Do you think it is because of the perceived look of the circumcised penis?
- Do you think it is because of the perceived benefits of other sexual experiences such as oral sex?

Thank you for your participation

Appendix B

Consent Form (Interview)

I _____ agree/disagree to be interviewed by Fine Mazambara for this study on exploring underlying perceptions and experiences of female partners with medical male circumcision clients at a VMMC facility in Harare, Zimbabwe. She explained to me the aim of the study and the procedures to be followed in collecting the data. She also explained the risks and benefits and my rights as a participant of the study.

I have received the information for the study in Shona and I have had enough time to read it and ask questions where I needed clarification. I sense that I am comfortable to participate in the study.

I am aware that the information to be gathered in this study will be treated with confidentiality and will be used in a research project. I am aware that this information will be generated into a report that may further be published.

I am aware that it is my right to withdraw my consent from the study without any prejudice. I hereby freely and voluntarily give my consent to take part in the study

Respondent

Name _____

Signature _____

Date _____

Researcher

Name : _____

Signature: _____

Date: _____

Appendix C

Consent Form (Audio taping)

I hereby confirm that the person seeking my informed consent to participate in the study has given me satisfactory information. She has fully explained the purpose of the study, risks and benefits associated with the study and the procedures to be involved.

I am aware that my voice will be recorded and I am informed that only the research team and unless otherwise required by the Human research ethics committee and other human rights organisations will have access to the audio tapes and listen to the recorded voices. I am informed that the audio recordings will be kept under lock and key and will be disposed by shredding after three years.

I am cognisant of the fact that I have the right to withdraw my consent from this study without any prejudice. I hereby freely and voluntarily grant my consent to be audio recorded in this study.

Respondent

Name _____

Signature _____

Date _____

Researcher

Name: _____

Signature: _____

Date _____

Appendix D:

Information Sheet

Study Tittle: Perceptions and experiences of female partners of clients of voluntary medical male circumcision in Harare, Zimbabwe

Hello and welcome, I would like to thank you for giving me your time. My name is Fine Mazambara. I am a student at the University of the Witwatersrand. I am conducting research that looks at exploring underlying perceptions and experiences of female partners of medical male circumcision clients in Harare, Zimbabwe.

Invitation to participate

I would like to invite you to participate in this study which will be conducted in Harare's central district. You may agree to participate in the study when you fully understand the questions that will be asked and you are completely in agreement with the procedures that will follow. Feel free to ask me if you have any questions.

What the study involves

If you volunteer to participate in the study, I will interview you at a place that is easily accessible for you. The interview will last about an hour. With your permission the interview will be recorded. Taking part in this study is voluntary and choosing not to participate in this study will not result in any disadvantages on your part. You may choose not to answer any questions that you are not comfortable in answering. You can choose to withdraw from the study at any time.

Risks

The probable risks that are associated with participating in this study are:

- You may lose valuable time amounting to at least an hour to participate in this study
- You may feel uncomfortable in responding to some questions touching on sensitive issues; however you can choose not to answer the questions that make you feel uncomfortable.

Benefits

Participating in this study will not give you direct benefits. Information from this study will help in supporting the Government of Zimbabwe and its partners concerted to scale up VMMC as part of HIV prevention efforts.

Confidentiality

All the information collected in this study will be treated with strict confidence. The report will not contain information that identifies you. Audio recorded interview information will not be heard by any other person besides me and my supervisor. Recordings and notes will be kept under lock and key for two years before being destroyed. The completed research report will be seen by the University of the Witwatersrand. If you would like to participate in the study, complete the attached consent form. I will collect the form after two weeks.

Information and Contact person

For any queries with regards to this study, please contact:

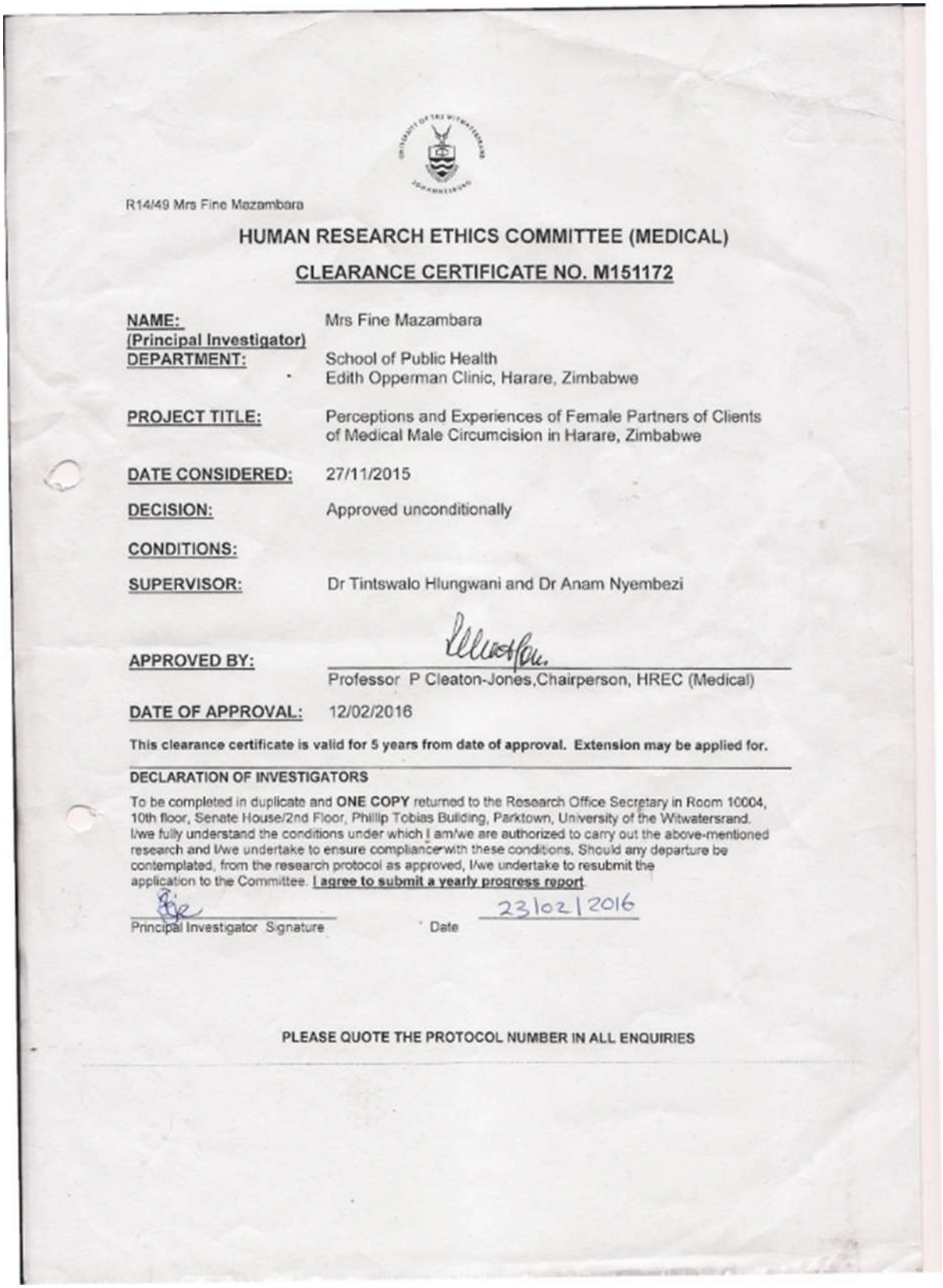
Fine Mazambara on the following numbers +263 772 975865 or email to mazambaraf@gmail.com

Contact details of researcher

If you need more information pertaining your rights as a research participant or you want to lodge a complaint about this research , please contact the Chairperson of the University of the Witwatersrand , Human Research Ethics Committee on +27 11 717 2230/1

Appendix E:

Wits Ethical Clearance



R14/49 Mrs Fine Mazambara

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M151172

NAME: (Principal Investigator)	Mrs Fine Mazambara
DEPARTMENT:	School of Public Health Edith Opperman Clinic, Harare, Zimbabwe
PROJECT TITLE:	Perceptions and Experiences of Female Partners of Clients of Medical Male Circumcision in Harare, Zimbabwe
DATE CONSIDERED:	27/11/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Tintswalo Hlungwani and Dr Anam Nyembezi
APPROVED BY:	Professor P Cleaton-Jones,Chairperson, HREC (Medical)
DATE OF APPROVAL:	12/02/2016

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004, 10th floor, Senate House/2nd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature

Date 23/02/2016

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix F:

Medical Research Council of Zimbabwe Ethical Clearance

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

Ref: MRCZ/B/960 **29 January, 2016**

Fine Mazambara
9 Malgast Crescent
St Martins
Harare

RE: - Perceptions and experiences of female partners of clients of medical male circumcision in Harare, Zimbabwe.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents (among others) that were submitted to the MRCZ for review:

a) Research Protocol
b) Informed Consent forms (English and Shona)
c) Data Collection Sheets, English and Shona

- **APPROVAL NUMBER : MRCZ/B/960**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF REVIEW : EXPEDITED**
- **EFFECTIVE APPROVAL DATE : 29 January, 2016**
- **EXPIRATION DATE : 28 January, 2017**
- After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Website should be submitted three months before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Website is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw
- **Other**
- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

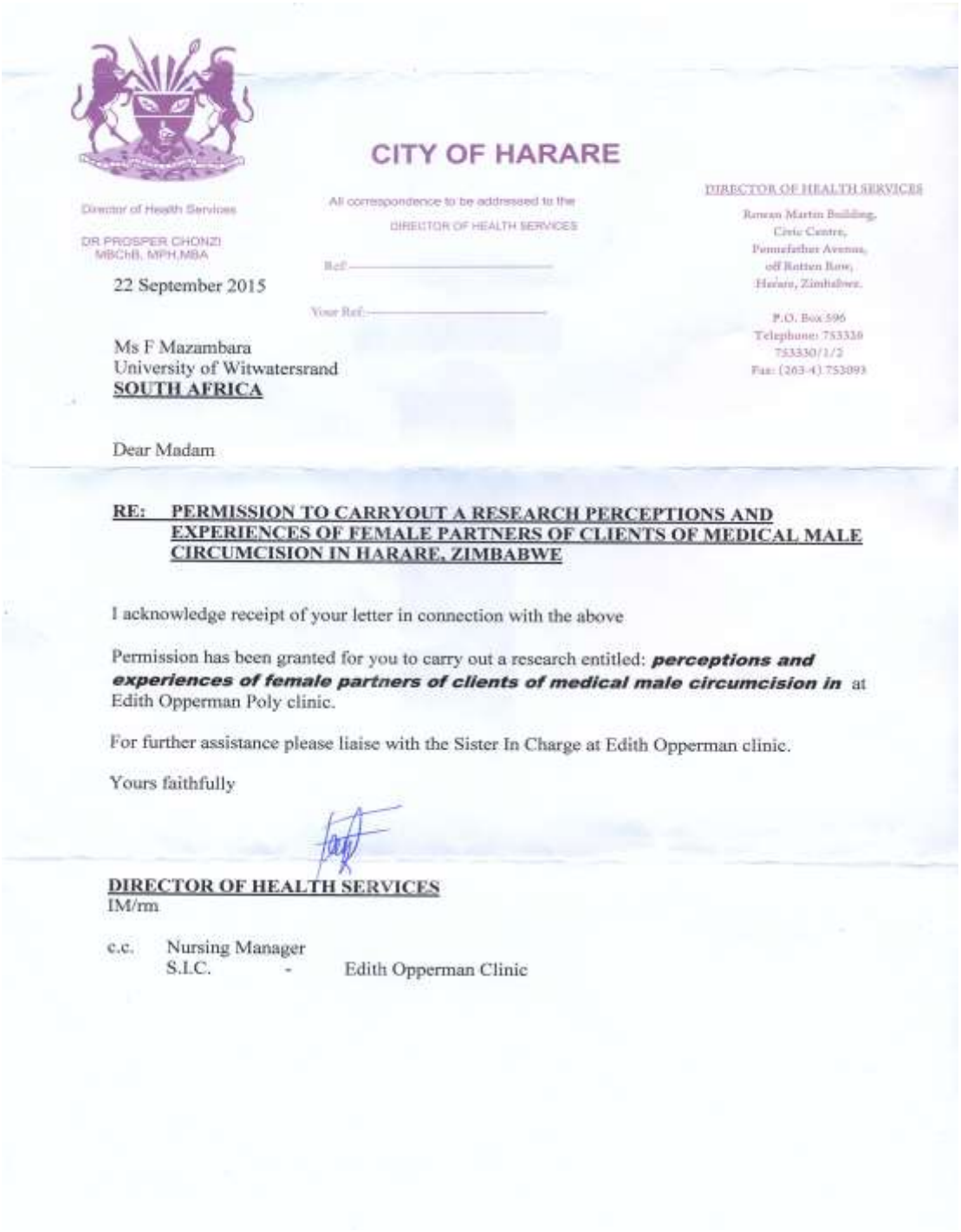
.....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2016 -01- 29
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix G:
City of Harare Permission



CITY OF HARARE

Director of Health Services

DR PROSPER CHONZI
MBChB, MPH,MBA

All correspondence to be addressed to the
DIRECTOR OF HEALTH SERVICES

Ref:

Your Ref:

DIRECTOR OF HEALTH SERVICES
Rowan Martin Building,
Civic Centre,
Pennefather Avenue,
off Rotten Row,
Harare, Zimbabwe.

P.O. Box 596
Telephone: 753330
753330/1/2
Fax: (263-4) 753093

22 September 2015

Ms F Mazambara
University of Witwatersrand
SOUTH AFRICA

Dear Madam

RE: PERMISSION TO CARRYOUT A RESEARCH PERCEPTIONS AND EXPERIENCES OF FEMALE PARTNERS OF CLIENTS OF MEDICAL MALE CIRCUMCISION IN HARARE, ZIMBABWE

I acknowledge receipt of your letter in connection with the above

Permission has been granted for you to carry out a research entitled: ***perceptions and experiences of female partners of clients of medical male circumcision in*** at Edith Opperman Poly clinic.

For further assistance please liaise with the Sister In Charge at Edith Opperman clinic.

Yours faithfully

DIRECTOR OF HEALTH SERVICES
IM/rm

c.c. Nursing Manager
S.I.C. - Edith Opperman Clinic