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Lived experiences of circumcised males aged 20 to 50 years a case of Nyanga urban district – Zimbabwe- may 2018

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Abstract
Voluntary Medical Male Circumcision is the surgical and non- surgical removal of the foreskin. In 2007, Voluntary Medical Male Circumcision (VMMC) was recommended as an additional HIV Prevention package in countries with high HIV Prevalence and low VMMC uptake WHO &UNAIDS (2007). Convincing scientific evidence had shown that circumcision reduces the risk of female-to-male sexual transmission of HIV by 60%, (WHO, 2007). There is low uptake of VMMC in Zimbabwe, which ultimately becomes a reproductive health concern. The purpose of the study was to explore lived experiences of circumcised men in Nyanga Urban using structured interview guide tool. Descriptive phenomenological design was used where 10 participants were recruited using purposive sampling method. Reference to the Health Belief Model (Champion & Skinner, 2008) [6] was made resulting in concepts of the same evolving from the study. A descriptive phenomenological analysis was used to analyze data. Two major themes emerged which were lived experiences and perceived benefits and barriers to Male Circumcision. The results of the study revealed that participants were knowledgeable about the link between Circumcision and reduction in HIV transmission. Experiences of men after circumcision were explored. The experiences vary from pain management which was cited as manageable by most participants with the use of analgesia, circumcision was associated with enhancement of sexual performance by most participants. Mandatory abstinence was described as challenging after circumcision. The study findings further demonstrated motivating factors to circumcision which varied from partial prevention of HIV transmission, prevention of other STIs, improved penile hygiene and prevention of cervical and penile cancer.

Keywords: Lived experiences, voluntary medical male circumcision

1. Introduction
Voluntary Medical Male Circumcision is the complete removal of the foreskin surgically and non- surgically. In 2007, Voluntary Medical Male Circumcision (VMMC) was recommended as an additional HIV prevention measure in countries with high HIV Prevalence and low Voluntary Medical Male Circumcision WHO, UNAIDS (2007). Convincing scientific evidence had shown that circumcision reduces chances of female-to-male sexual transmission of HIV by up to 60%, (WHO, 2007). According to (WHO, 2015), an estimated 37% men are circumcised globally and of the 37% over 70% were circumcised on religious reasons. According to Zimbabwe Demographic Health Survey (ZDHS) 2015 male circumcision prevalence stood at 14% which is still far below the projected target of 80% by 2017 to realize its value.

HIV remains a chief reproductive public health challenge in Zimbabwe. The Ministry of Health and Child Care (MOHCC) has adopted and prioritized VMMC as a national strategy to add to the suite of interventions considered to end HIV and AIDS by 2030 as ingredient of the global commitment towards the HIV and AIDS response (Zimbabwe Accelerated Strategic and Costed Operational Plan, (ASCOP, 2014 – 2018). VMMC is defined as the surgical and non-surgical removal of the foreskin by a trained health worker. It is a strategy to prevent the spread of HIV that was recommended by the World Health Organization (WHO) in 2007. Male Circumcision was purposively recommended in countries with high HIV prevalence and low prevalence of male circumcision such as Zimbabwe. This followed findings of the Randomized Control Trials (RCTs) done in South Africa, Uganda and Kenya from 2005 to 2007 which established that VMMC reduces HIV transmission by up to 60% (WHO, 2007). It has also been projected that circumcising 80% of men could prevent 45% of new HIV infections between the years 2015 and 2025 thus, inevitably protecting the woman and the unborn child. However, it is worth noting that VMMC

offers partial protection to HIV. This calls for use of other HIV prevention methods in combination with the strategy.

Human Immune Virus continues to be a major public health problem globally, having claimed not less than 35 million lives so far. In the year 2015, 1.1 to 1.3 million people succumbed from HIV associated causes globally. There were close to 36.7 million people living with HIV at the end of 2015 with 2.1 million to 2.4 million becoming newly infected with HIV in 2015 globally, UNAIDS, HIV Report, (2017). Sub Saharan Africa is the largely affected region with 25.6 million people living with HIV in 2015, accounting for two – thirds new HIV infections globally. Zimbabwe continues to experience one of the top levels of HIV prevalence in Sub – Saharan Africa. As of 2014, an estimated 1.5 million adults and children were living with HIV (MOHCC, 2015). Globally, 60% of people with HIV know their status. The remaining 40% people need to access HIV testing services. By mid-2016, 16.1 to 19 million people living with HIV were accessing antiretroviral therapy globally, which has significantly reduced Mother to Child Transmission of HIV (WHO, 2016).

In Zimbabwe, the prevalence of HIV stood at 13.8% according to the Zimbabwe Demographic Health Survey (ZDHS) of 2015. Apart from the partial prevention of HIV transmission, VMMC has been found to have other medical advantages. These include improved penile hygiene, reduction of sexually transmitted infections such as genital herpes, syphilis and Chlamydia, reduction in chances of penile cancer, prevention of ballanitis, prevention of paraphymosis, reduction in risk of urinary tract infections and reduction of cervical cancer risk in partners of circumcised men (WHO, 2012).

Despite the general VMMC awareness, Zimbabwe remained far from its set target of circumcising 1.3M men between the ages of 13 and 29 years by the end of 2018. In 2014, a decision was taken by the MOHCC to develop the Accelerated Strategic and Costed-Operational Plan for VMMC (2014-2018) [20, 21], with the aim of focusing on enhanced coordination, and use of innovative strategies to scale-up VMMC. This Plan largely covers all aspects of the VMMC program, from the key strategies required to attain effective demand generation, to efficient management and safe delivery of VMMC services.

1.1 Implications

The findings of the study identified gaps with regards to Nursing practice, Nursing research, Nursing administration and Information for policy makers. The study findings pointed to the need to strengthen monitoring and evaluation tools, adjustment in VMMC guidelines and policies as well as generation of new hypotheses for further testing.

2. Methodology

A descriptive qualitative phenomenological design was employed. Purposive sampling was used to recruit 10 participants. It involved intentional selection by the researcher of certain participants to be included in the study. Researcher sought participants with characteristics that increased theoretical understanding of some facets of the phenomenon being studied (Burns & Grove, 2013) [2]. The researcher used structured, guided in-depth interviews to obtain data from the selected participants. The researcher captured data through the use of Audio tapes and note writing.

2.1. Data Collection Procedures.

The researcher collected data through in-depth interviews. Prior to data collection the researcher did preliminary visits to the study site to familiarize with health authorities and other stakeholders. The researcher also met the potential participants for familiarization to avoid suspiciousness during data collection. Audio - recorded interviews were done face to face. The audio tapes were used to record participant's responses as a backup apart from taking field notes. Pseudonyms were used to enhance privacy and confidentiality. The researcher ceased collecting data when no more new data was realized from the respondents. This in qualitative research is known as theoretical saturation. Theoretical saturation in qualitative data analysis is when data collection is not adding value or new ideas coming to the collected information (Polit & Beck, 2014) [14].

2.2. Data Management and Analysis

Collected data was stored in a password secure computer by the researcher. All data was transcribed and analyzed manually. Data was analyzed using the thematic framework. Thematic analysis was done in six phases in order to create established significant patterns within the background information on lived experiences of circumcised males. Familiarization of data was achieved by reading and re-reading of transcribed data. The researcher went through all words and phrases in the transcripts from the data. After getting clearly what men said with regards to their lived experiences on male circumcision, the researcher then grouped similar ideas into units. Similar codes were grouped to create themes within the context. Themes developed were completed after all transcripts were analyzed and described to identify the critical meaning. The researcher randomly selected a number of interviews that had been transcribed and re-winded the translations so as to control and monitor the quality of translations, (Yin, 2016).

To reduce researcher bias on data analysis, the researcher identified an independent assistant to do data coding separately. Finally by using this thematic analysis the researcher was able to generate major themes which were able to describe the phenomenon under study. Audio tapes and transcripts were stored under lock and key after data collection and analysis for a period of 5 to 10 years to allow for data audit trail.

3. Results

3.1. Experiences of males who had undergone voluntary medical male circumcision.

In this study, 10 participants cited in depth views with regards to their circumcision status as described. All the 10 respondents interviewed had knowledge with regards to male circumcision. Two participants pointed the following views with regards to male circumcision; "I can say that VMMC is the removal of the foreskin from the penis and it has more benefits which include penile hygiene, prevention of HIV by 60%, prevention of other STI's and also prevention of cervical cancer. (P1)". P2 defined Male circumcision as P1, and added, "It is where the foreskin is removed by cutting that is surgically or non- surgical (PrePex)". The views of the respondents with regards to their experiences to pain associated with male circumcision were almost similar with the exception of one participant. Nine participants cited that pain after circumcision is manageable with pain management tablets (Paracetamol).

Non-surgical method was associated with less pain as compared to surgical method however both methods did not interfere with their activities of daily living as it was the fears of most men before circumcision.

The findings of the study showed that the experiences of all respondents with regards to erection and sexual pleasure were favourable. All respondents highlighted that there is no difference with regards to sexual pleasure and sensitivity before and after MC. This is supported by the following illustrations; P5, "Before circumcision I used to take less time during sex and my wife used to complain about that as you know women need more time in bed because they take time to respond. After circumcision to tell you the truth I started to enjoy sex, the time we take now is prolonged than before and my partner is appreciating. With regards to sensitivity and erections for me there is no difference." In this study one of the lived experiences which came out was fear of embarrassment, most interviewed men cited shame and embarrassment especially when the services are being offered by female service providers. P6 said, "Frankly speaking I was not going to be circumcised if there was a female service provider, I feel embarrassed to undress in their presence. I think this programme should have male service providers only." The experiences of men following circumcision with regards to abstinence proved to be one of the major factors of concern inherent in most men before circumcision as cited by most of the interviewed males in this study. The following responses came out from the selected respondents; P1, "To be honest, for me it was a very big challenge especially at this age of mine (30 years). Erections were harassing me especially in the early hours of the day."

3.2. Factors

In this study, the other research question was to identify the possible barriers to uptake and perceived benefits of VMMC which are outlined below. The study explored possible reasons which hinder males to embrace male circumcision as evidenced by low uptake of males in the country as the country failed to reach its set target of 80% MC prevalence by end of 2017. Some of the possible reasons cited in this study included fear of pain, religion, privacy, abstinence and sexual dysfunction. P9, "I will start with a point which sound very queer, people are saying if God created us as we are why do we want to change our anatomy? Fear of pain is one of the major reasons, other men do not want to expose their manhood (privacy), it will affect sexual performance, and Fear of the unknown and some men are just ignorant". Motivating factors cited in this study include, good penile hygiene, partial HIV prevention and prevention of cervical cancer. P1: "What I can say is that VMMC is the removal of the foreskin from the penis and it has more benefits which include penile hygiene, prevention of HIV by 60%, prevention of other STI's and also prevention of cervical cancer." P2 defined Male circumcision as P1, and added, "It is where the foreskin is removed by cutting, that is surgically or non-surgical (PrePex), on its benefits he said, it has 60% cover against HIV, penile hygiene and prevention of cervical cancer". The same information was coming out from P3 to P10.

4. Discussion

4.1. Theoretical Framework

The Health Belief Model (Champion & Skinner, 2008) [6], which provided some guidance in developing questions and analysis of data, assisted in the evolution of one such model from the study findings, which focused on the six constructs which are; perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy. The researcher developed the modified health belief model to explain the connection of identified factors in relation to VMMC uptake. This model was applicable for the study topic, methodology, data collection and findings of the study since it allows a person to be viewed as a critical agent with own perceptions with regards to diseases.

4.2. Interpretation of Findings

The findings of this study postulated that all participants had information before circumcision and they chose to do it voluntarily without coercion. Men have mixed concerns before circumcision which varied from fear of pain, fear of mandatory abstinence, fear of sexual dysfunctional, concern on foreskin disposal, fear of wound healing, fear of invasion to privacy (embarrassment) and fear of HIV testing before circumcision. Detailed findings are described below elaborated mainly on the major themes emerged which were; lived experiences and perceived benefits and barriers to circumcision. Recruitment of participants was based on circumcision status with specific age range of 20 to 50 years, healthy and at the same time sexually active. All the participants possessed the required attributes.

4.3. Lived experiences of circumcised males

The findings of this study revealed that all the interviewed males had concerns before circumcision which varied from fear of pain as the major concern, fear to sexual dysfunctional, fear to HIV testing, invasion to privacy, fear of wound healing, concern on foreskin disposal and concern on mandatory abstinence period after circumcision. In both methods, pain was manageable with the use of Paracetamol and participants were able to do their daily activities without disturbances except for one participant who advocated for a stronger analgesic. All the studies reviewed, cited pain as the major concern before and after circumcision. In these studies men were reluctant to be circumcised based on the knowledge of being injected before circumcision. In another study done by (Umar, 2013), the findings of the study revealed that competencies of service providers were very important in the management of pain and safety of the procedure as it is done in hospitals. In a study done by (Weis & Peltzer, 2012), pain was cited as a deterrent for mothers to agree to circumcise their sons.

Fear of sexual dysfunctional was one of the concerns which men hold before circumcision. The findings of this study revealed the experiences of men with regards to sexual performance after circumcision. Out of 10 participants interviewed, eight participants reported prolonged erections and enhanced sexual performance after circumcision. Other two participants reported no change with regards to sexual performance and all participants revealed no change with regards to sexual sensitivity. Enhancement of sexual performance was received as an advantage by both participants and their partners. Partners were said to be very appreciative of the prolonged time in sexual activity, in this view; the results concurred with other study findings that showed no association between circumcision and decreased sexual performance, (Weis & Peltzer, 2012). The study findings also concur with the study done by Cory

Silverberg, 2009; which confirms that circumcised men were less likely to experience sexual dysfunction than uncircumcised males. In addition, in a study reported by Berkeley Wellness, 2016; the findings confirmed that, researchers have objectively measured tactile, pain and warmth thresholds at specific points on the penis and found no differences with respect to circumcision status. Sensitivity did not differ between the circumcised and uncircumcised men. The strength of this study was that it included lived experiences that were likely more relevant to sexual pleasure than fine touch pressure thresholds alone. In this study there were similar responses with regards to experiences of men to abstinence after circumcision. Participants confirmed that abstinence after circumcision was a challenging period. Participants revealed that it was not easy to desist from sex for such a long time during wound healing. Erections were harassing them but had to comply with the instructions given as a result mandatory abstinence was regarded as one of the restraint factors to low uptake of the program. The study findings concur with the study done by (Pepfar, 2014) [14], which cited mandatory abstinence from sex as one of the barrier to VMMC uptake alongside pain from the cutting of the foreskin.

In this study, wound healing was described as gradual until complete healing took place. All participants adhered to the information given by service providers which was a good remedy to proper wound healing. Participants cited competencies of service providers as important in the care of wound healing. This coincides with the study done by Odingo *et al*, (2014) which claimed quality of service delivery among clients circumcised by trained nurses and doctors as compared to traditional circumcision which was associated with complications. However, involvement of female service providers in this study caused embarrassment to males. Circumcised males felt embarrassed and shamed to undress in the presents of an opposite gender. This confirms the findings of the study done by (Mahule, 2016 and Chinyama, 2011) [11], where culture only accepts circumcision done by males. In contrary, in this study, some men cited that they were not concerned with female service providers what matters was the issue of their competencies which coincides with the study done by (Umar, 2013) where men described female service providers as competent and caring.

In this study, participants were aware that VMMC offers partial HIV protection hence the use of condoms is important after circumcision. This is in contrary to the study done by Joanne *et al*, (2012) where the results of the study showed that women had a 'thorough understanding' of the partial efficacy of VMMC and that it afforded no direct benefit to women, in fact most thought that medical circumcision would put more women at risk of being infected by HIV. The women carried the perception that VMMC increased the risk of contracting HIV because men would stop practicing safer sex believing that they were now protected by circumcision.

4.4. Perceived Benefits and Barriers.

In this study, participants revealed that circumcision was beneficial to them. The described benefits of VMMC varied from improved penile hygiene, partial HIV prevention, prevention of other STIs, prevention of cervical cancer, prevention of penile cancer and improved sexual performance. These findings coincide with the study done by (Nyaga *et al*, 2012) [12] which postulated that knowledge that MC protects males against HIV by 60% and motivates males to get circumcised alongside penile hygiene. The findings of the study also concur with the study done by Hartzold *et al*, (2014) [10] which showed enhanced sexual performance, improved penile hygiene, prevention of STIs and cervical cancer prevention for the partners as motivators to embrace VMMC. In another study by (Marya *et al* 2013), confirmed that men are motivated to go for circumcision due to the awareness of the HIV prevention and the perception on improved penile hygiene and enhanced attractiveness to women. In contrary in a study done in Luo Nyanza by (Joseph, 2012) the results depicted that people had no knowledge on the benefits of MC, they argued that MC has no benefit at all and cited that it's a way of getting money from donors at the expense of the community. The findings of the same study revealed possible barriers to circumcision as experienced by the enrolled respondents which varied from fear of pain, decreased sexual performance, fear of HIV testing before the procedure, fear that the wound would not heal, and concern on mandatory abstinence. The findings of the study confirmed the study findings done by Hartzold, *et al*, (2014) [14], which revealed that males might hang back in fear of being asked to be screened for HIV before circumcision as males and boys are compelled to be firstly tested for their HIV status before undertaking male circumcision as reinforced in the health medical policy of male circumcision, fear of pain associated with the operation and local anesthesia as well as perceived threats to erections and abstinence after circumcision. The foregoing could likely scare males to participate in the service delivery among other factors such as stigmatization (WHO & UNAIDS, 2012). Evens, *et al*, (2014) agree with the above where the results showed that circumcision is widely understood as a surgical procedure with intrinsic risks. In another study done by George *et al*, (2014) findings revealed that men have cognitive barriers related to pain associated with the procedure and adverse events; abstinence from sex for a period of six weeks was another prohibiting factor. The results of the study done by Skolnik *et al*, (2013) suggested that fear of pain, involvement of female service providers and compulsory HIV testing were some of the barriers to circumcision.

4.5. Implications of the study findings the conclusions of the findings of the study are limited to nursing practice, nursing administration, nursing research, nursing education and Policy on VMMC as described below.

4.5.1. Nursing Practice: The ultimate goal of nursing practice is to improve the quality of services provided to the community through addressing the physical, psychological, social and spiritual needs of every client as they require it. The finding of the study postulated that, all participants were knowledgeable about VMMC as an additional HIV prevention package hence there is need to continue imparting comprehensive correct information about VMMC by health care providers and adhering to standards during the procedure to enhance safety so as to increase uptake. In addition to the usual knowledge package for VMMC, the study findings on enhanced sexual satisfaction enables the nurse educator to include the psycho – sexual satisfaction post circumcision as an added advantage. There should be continuous monitoring and evaluation of the program as

well as trainings of health care providers so as to reduce possible adverse events associated with the program.

4.5.2. Nursing administration: Administration dynamics is of paramount importance to the success of every program in the Ministry of Health and Child Care. Management at every level should be acquainted with the benefits associated with VMMC so that they appreciate its impact on the entire community as a result, this development will facilitate the channeling of adequate resources to the program to increase its uptake. Management should be involved in supportive and supervisory activities of the program to make sure quality is maintained all the time. Management should identify appropriate cadres to place at VMMC department especially males to deal with issues pertaining to males which are culturally acceptable to avoid embarrassment and shame from female service providers as much as is possible. In addition nurse administrators should network with other partners to garner more resources towards the implementation of the program so as to realize its impact as an additional suite to the existing HIV prevention strategies.

4.5.3. Nursing Education: Theory neatens practice; as a result, Voluntary Medical Male Circumcision should be wholly included in the nursing curriculum so that students are taught and comprehend its benefits and associated adverse events so that they improve their psychomotor, cognitive and affective domains in the clinical setting with regards to VMMC. There was a rare concern expressed by one participant of the study regarding the disposal of the fore-skin, therefore there is need for cultural competence as nurses are taught regarding incineration as a disposal method to allay fears of inappropriate disposal of a body part. This will improve the fight against HIV as Zimbabwe is within the low resource but associated with a high prevalent rate category of countries. There is need to facilitate adequate information dissemination without bias in providing care.

4.5.4. Nursing Research: The findings of this study generated in depth knowledge with regards to Lived experiences of circumcised males. The methodology used help to generate themes that helped understanding of how what was perceived as barriers before circumcision turned out to be false post circumcision, creating a need to study other districts and Provinces and build on the findings of this study. There is need for more researchers to study on the same phenomenon to support or critique the findings of this study. Triangulation of methods is required for future researchers on the same topic to increase the power of results. More studies which include female participants are required on VMMC especially with regards to sexual issues postulated by male participants in this study to avoid bias. Longitudinal studies also to be carried out by future researchers to assess the long-term effects in view of perceived benefits and complications after circumcision.

4.5.5. Policy Makers: The findings of this study revealed some important information which needs to be aligned to the VMMC policy guidelines. There is need for strengthening and aligning behavior change and communication in the VMMC policy guidelines. Involvement of influential community leaders in VMMC decision making is key so that they own the program before its implementation. There is need for explicit addressing of possible adverse events as done to perceived benefits so that clients have unbiased informed choices before circumcision.

4.5. Summary of the study

In 2007, Voluntary Medical Male Circumcision (VMMC) was recommended as an additional HIV prevention package in countries with high HIV Prevalence and low VMMC uptake. Convincing scientific evidence had shown that circumcision reduces the risk of female-to-male sexual transmission of HIV by up to 60%, WHO & UNAIDS (2007).

According to (WHO, 2015), an estimated of 37% men are circumcised globally and of the 37% over 70% were circumcised on religious reasons. According to Zimbabwe Demographic Health Survey (ZDHS) 2015 male circumcision prevalence stood at 14% which is still far below the projected target of 80% by 2017 to appreciate its impact.

Descriptive phenomenological design was used where 10 participants were recruited using purposive sampling method. The purpose of the study was to explore lived experiences of circumcised men in Nyanga Urban using structured interview guide tool with components addressing lived experiences as well as lived perceived barriers and motivators to Circumcision. Data was analyzed manually and two major themes emerged which were lived experiences and perceived benefits and barriers to Male Circumcision. Concerns of men before Circumcision were explored which varied from fear of pain, fear of HIV testing, mandatory abstinence period, fear of sexual performance dysfunction among others. The results of the study revealed that participants were knowledgeable about the association between Circumcision and reduction in HIV transmission. Experiences of men after circumcision were explored. The experiences vary from pain management which was cited as manageable by most participants with the use of analgesia, circumcision was associated with enhancement of sexual performance by most participants. There were no complications experienced during wound healing and mandatory abstinence was described as challenging by most participants after circumcision. The study findings further demonstrated motivating factors to circumcision which varied from partial prevention of HIV transmission, prevention of other STIs, improved penile hygiene and prevention of cervical and penile cancer.

4.6. Conclusion

The study sought to explore lived experiences of circumcised men of an age range 20 to 50 years old. Ten participants were recruited purposively. The study established perceived barriers and motivators to Circumcision. It also explored lived experiences of men after circumcision which varied from improved sexual performance, pain management, abstinence and wound healing. All participants demonstrated adequate knowledge with regards to VMMC. Most participants preferred non surgical method to surgical method as they associated it with less pain. The major themes of the study were lived experiences of males after circumcision and barriers to male circumcision.

4.8. Recommendations

In view of the findings of this study, the following recommendations were made;

1. Voluntary Medical Male Circumcision can be offered by any competent health care provider; however, contextual preferences should be taken into considerations for only male service providers to carry out the procedure which is culturally acceptable to increase uptake.
2. The study established a strong base for further research on the same phenomenon which can yield more evidence through the use of Quantitative or mixed methods since there was limited information published on this phenomenon as evidenced by little literature review for Zimbabwe.
3. The study came out with concerns which policy makers may take into considerations to adjust VMMC Policy with regards to demand creation and service delivery.
4. Pain management approach should be based on individual perceptions (subjective). The researcher recommends for stronger analgesic options not only restricted to paracetamol for pain management especially following surgical method which was associated with more pain as compared to non-surgical method in this study.
5. The recruitment of circumcised males as champions in demand creation activities since they reflect true realities of the program hence less bias on promoting the program.

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