LOW ACCEPTANCE OF VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) AMONG ADULT MEN IN SPECIFIC REGIONS (IRINGA KAGERA, MARA, MWANZA, RUKWA, SHINYANGA AND TABORA) OF TANZANIA – A SOCIAL NORM PERSPECTIVE

Case Study for Learning Program on Changing Social Conventions and Social Norms
University of Pennsylvania

By Godfrey YIKII
Communication for Development Specialist
UNICEF Tanzania Country Office

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EXECUTIVE SUMMARY

Adult men’s decisions about seeking voluntary medical male circumcision (VMMC) services are complex, influenced by core beliefs, culture and history, traditional beliefs, education, sexuality, gender relations, economic and marital status, exposure to urban or modern culture, age, past experiences with community health care service providers and many more factors that are external such as economic, enabling environment, policy dimension and others.

The understanding of attitudes and core beliefs of adult men and women that may enhance acceptance and or hinder decision of male circumcision (MC) is vital, as is a detailed exploration of their views on service delivery. It may also be important to understand the role of men’s social expectations with respect to this practice –both empirical (do they believe that other men are also practising Voluntary medical male circumcision?). Whether or not to circumcise is clearly wrapped up in ideas of masculinity (what does it mean to be a real man?) and Identity (e.g., practice varies strongly based on religious affiliation).

Although the VMMC program is still relatively new in Tanzania, only 20% of recent MC clients were aged 20 and below. VMMC for HIV prevention will have the greatest immediate impact if adult males are accessing MC services within the rural areas. The need to promote MC in men over 20 years of age is supported by the fact that HIV prevalence is highest in men aged 15–24 in Tanzania [THMIS 2011].

Since male circumcision is now shown to be effective in reducing the risk of HIV acquisition, care must be taken to ensure that men and women understand that the procedure does not provide complete protection against HIV infection. In this regard, mixed strategies should be applied both from formal and informal institutional to effectively address collective behavioral change. This will engage men and women not only around traditional HIV prevention strategies, but also build and strengthen innovative combination prevention initiatives that seek to transform social norms related to sex and gender.
I. DESCRIPTION OF THE CHALLENGE

Background

Male circumcision is one of the oldest and most common surgical procedures known, traditionally undertaken as a mark of cultural identity or religious importance. It involves partial or total removal of the external male foreskin or other deliberate injury to the male genital organs whether for cultural or non-therapeutic reasons.

It has been variously proposed that it began as a religious sacrifice, as a rite of passage marking a boy’s entrance into adulthood (which most communities in Africa today strongly believe), or, as a form of sympathetic magic to ensure fertility. With advances in surgery in the 19th century, and increased mobility in the 20th century, the procedure was introduced into some previously non-circumcising cultures for both health-related (medical) and social reasons. Recent study findings argue that male circumcision significantly reduces a man’s risk of acquiring HIV infection by about 60% - 80%, the practice is receiving renewed interest, as the world looks to understand what this will mean for HIV prevention (UNAIDS 2010).

Looking at the determinants of voluntary medical male circumcision and the acceptability of the practice in non-circumcising communities will give a better picture of how to put the latest research findings into practice.

In Tanzania the practice of male circumcision (MC) is often for religious and cultural reasons rather than HIV prevention. The national prevalence of MC is estimated to be 70%, with considerable variation between regions. Nearly three-quarters (72%) of Tanzanian men age 15-49 report having been circumcised but circumcision is more common in urban areas than in rural areas (94% versus 64%, respectively). More than half of the regions on Mainland Tanzania show levels of male circumcision of 50% or more however, the prevalence of male circumcision is lowest in Rukwa (28%), Simiyu (30%), and Shinyanga (32%) regions. In this case, HIV Prevalence and MC of circumcised men are less likely to be at risk of HIV infection than uncircumcised men (3.3% versus 5.2%). Among circumcised men, HIV prevalence is highest in the southwest highlands zone (7.0%) and lowest in the southern zone (1.4%). HIV prevalence for uncircumcised men increases with age until it peaks at age 35-39 (11.3%) beyond the national average 5.1% (THMIS 2011).

In contrast, male circumcision in Zanzibar, Dar es Salaam, Mtwara, Tanga, Lindi, and Pwani regions is almost universal (THMIS 2011). Unlike in other parts of the country, such as the pastoralist communities and coastal areas—where rates of male circumcision are high and HIV prevalence is low and MC is not the norm in these regions. Therefore, male circumcision is currently used as a combination with other HIV prevention measures, including condoms, partner reduction and abstinence, promoted as an important addition to men’s HIV-prevention options.

A survey in Tanzania where circumcision occurs shortly after birth, found that parents, especially fathers, of new-born boys cited social reasons as the main determinant for choosing circumcision (e.g. not wanting the son to ‘look different’ from the father).

In this context, VMMC is seen as something that may be done based on perceived health benefits, aesthetics, social status and self-confidence. Barriers to VMMC care-seeking could include: physical, emotional, cultural or psychological elements that would hinder a man’s
decision to have circumcision and to seek available VMMC services. In regions and districts where the VMMC programme has been introduced, the services are not yet decentralized to lower levels of health care facility that is in the village and ward level. In most districts, there is a static VMMC site at the district hospital or headquarters but not in rural/satellite health facilities.

There are deficiencies in the enabling environment - for example within Tanzania some villages may be as far as 100-200 kilometres away from the district headquarters or nearest health care facility making it very difficult for those communities to access the services. The outreach campaigns used for mobilizing communities tried to reach distant communities but do so only inadequately. The issue of commodities (supplies) is still inadequate. At all levels it is seen that the Private Sector is not yet fully involved in the VMMC programme in Tanzania.

The policy in Tanzania is that VMMC is free for users as a ‘public health good’; this could be established as an innovative mechanism of involving the private sector as a means of discharging their corporate social responsibility. For example the VMMC project in Mwanza targets the fishing villages in Ukerewe and other smaller islands in Lake Victoria. This is the best use of scarce resources available to target the higher risk populations. However, this is only driven by development partners, not the government.

![HIV Prevalence by Male Circumcision by Age](image_url)

Table 1: Male HIV prevalence and Male circumcision prevalence among 15-49 in eight regions of Tanzania

<table>
<thead>
<tr>
<th>No.</th>
<th>Region</th>
<th>HIV prevalence</th>
<th>MC prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Iringa</td>
<td>12.1%</td>
<td>37.7%</td>
</tr>
<tr>
<td>2</td>
<td>Mbeya</td>
<td>9.2%</td>
<td>34.4%</td>
</tr>
<tr>
<td>3</td>
<td>Shinyanga</td>
<td>6.3%</td>
<td>26.5%</td>
</tr>
<tr>
<td>4</td>
<td>Tabora</td>
<td>5.6%</td>
<td>42.8%</td>
</tr>
<tr>
<td>5</td>
<td>Mara</td>
<td>6.6%</td>
<td>89.0%</td>
</tr>
<tr>
<td>6</td>
<td>Mwanza</td>
<td>3.7%</td>
<td>54.1%</td>
</tr>
<tr>
<td>7</td>
<td>Rukwa</td>
<td>4.1%</td>
<td>31.4%</td>
</tr>
<tr>
<td>8</td>
<td>Kagera</td>
<td>3.3%</td>
<td>26.4%</td>
</tr>
</tbody>
</table>

*Source: Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08.*
I.1 DESCRIPTION OF THE CHALLENGES USING THE THEORETICAL TOOLS LEARNED

Male circumcision as a social norm

Empirical studies have shown that the parental/adult male decision to circumcise is based primarily on social reasons, not medical, considerations (Michael Benatar and David Benatar 2003). Even if one withholds normative judgment about circumcision—labelling it neither good nor bad but simply something that is appropriately left to parental discretion—more time should be spent examining the actual reasons parents/adult men choose to circumcise, especially the cognitive underpinnings as norms are socially shared schema/scripts (C. Bicchieri, 2013).

Too often the discussion is about only the medical advantages and disadvantages, even though the strength of the cultural norm (preferences are followed) frequently prevents parents or male adults from assessing the medical considerations. For example the social reasons behind male circumcision are becoming ever more common. The desire to conform or identify is an important motivation for circumcision in places where the majority of boys/adult men are circumcised.

Legal theorists have observed that norms often regulate behavior at least as effectively as the law (self-enforcement) as is the case when we believe most people obey a norm, and we prefer to obey it since we expect most to obey it as our collective behavior reinforces our beliefs (C. Bicchieri, 2013). For example Indeed, some norms control behavior so effectively that the distinction between what is law and what is convention almost ceases to exist: people comply with whatever the rule might be, without giving much thought to its source(s). To illustrate this point, when male circumcision rates in the United Republic of Tanzania particularly in Zanzibar were more than 90 percent, nearly 20 percent of parents thought the procedure were required by law yet it was a religious legitimate obligation. If this is a progressive law that protects children, inheritance and right to health then its legitimacy to observe will be strong and acceptability will be high but when the law is observed to be far from the norms it’s difficult to domesticate its enforcement (C. Bicchieri, 2013).

In part, norms are effective because of the costs that are associated with noncompliance. Individuals who deviate from the norm might suffer from self-imposed guilt (Cooter 1996) or experience shame for the case of MC and a loss of esteem among their peers (McAdams 1997), or simply fail to signal that they are of a good type (Posner 2000). These phenomena are apparent with male circumcision.

Empirical expectations: VMMC derived from what is thought others will do as they belief it as tradition, and as a rite of passage from marking a boy's entrance into adulthood is conditioned by the behaviour of the community members practices. For example, in the Zanzibar and parts of the coastal and pastoral communities and region it’s an old traditional practice and an initiation to manhood to perform MC the traditional way.

Normative expectations: In the religious communities (Moslem population), it is often considered a prerequisite for marriage, identity and source of belonging. Woman accepts him because he will fulfil her sexual desires. For example in Iringa region, a study showed that 61% of respondents in one study believed they would be ridiculed by their peer or reference group unless they were circumcised. The desire to ‘belong’ or be a full man, perform better
sexual desires is also likely to be the main factor (factual belief) behind the high rate of adult male circumcisions from non-circumcising communities.

Attitudes /personal normative beliefs: The belief that cutting is a religious requirement or identity and mostly could be done the traditional way using sharp instruments or medical otherwise non-conformity can result into sanctions/punishment is true. A young man in a study in Zanzibar mentioned that, I would likely lose educational support from my family, if I refused to circumcise in this community. Also, in Iringa, circumcised men are given more respect...feel proud and free and can easily approach girls...It was not their tradition, but now it is accepted as normal practice, especially within urban areas.

Factual beliefs: The medicalization of the concept of MC as a positive reinforcement; perception that young males are not infected by HIV. There are also economic reasons -loss of income during the six week post-surgical healing period. All these influence people’s behaviour. Thus, VMMC is relational, economical, hierarchical, historical and context specific. VMMC is not only a social convention but also a social norm. It’s a social norm to control initiation into adulthood and for marriage purpose.

It depends on mutual beliefs, conditional preferences and expectations of the relevant population or customs. This entails that the decision-making process on VMMC is interdependent, on the principle that on religious grounds among some communities, no individual can change the norm on his own but confirm to its expectations.

VMMC is maintained by a deeply rooted social norm. The truth of acceptance by adult males within their communities is a process of “inter-dependent decision” and “reciprocal expectations” by the communities. VMMC prevalence is increasing nationally, especially among younger males, more in urban setting and among educated men. But this reality is yet to be manifested in the rural areas in terms of desired outcomes in behaviours where risky behaviours are high, MC is less and external factors such as access to, availability of, and quality of services are not available.

II. Critical Evaluation of the Work in Tanzania so far

UNICEF programme in Tanzania has always been a mix of support to relevant policy development at national level and practical programming for child survival, protection and development at sub-national level. The programme has always operated on both the mainland and the islands of Zanzibar. In order to achieve tangible results for children, the sub-national programming inevitably has significant activity at community level. Focusing at community level tackling inequities and gaps in access to, and utilisation of, services with the aim of achieving convergence of activities across the various UNICEF programme areas, so as to optimise synergies and enhance results is the focus of priority.

As everything is specific to its peculiarities and context, the different theories, concepts and approaches discussed during the UPenn course make strong use of the principle of social norms (Dooley 2013). It concentrates on creating both personal and collective empirical expectations and normative attitude shifts through collective discussion and with the change of factual beliefs (with good reasons provided about the health risks or practice of male circumcision) and attitudes (disgust at current practices) to build a new social norm of
circumcising in non-circumcising communities, based on common knowledge and cooperative behavior for the public good (less infection of disease i.e. STDs, HIV, healthier lives, hygienic or clean penis).

Once a community has confirmed and agrees to male circumcision, a communal ‘pledge’ or promise can be made that all households will commit to take action. This equates to the rule of commitment or public declarations in the social norm theory, making it much less likely that the group will go back on their promise (C. Bicchieri, 2013). After certification of good practice the belief that we are circumcising because of a cause, the community will mark the event with a public celebration which solidifies the social norm change (G. Mackie, 2013). Natural Leaders often emerge from the triggering event to promote male circumcision for example on religious lines in their community, traditional elders, Moslems and Christians to advocate for the practice. The use of local ‘champions’ or community drivers of change (people who are well respected) this are respected celebrities that can be great advocates for MC to assist with the diffusion of the knowledge of the approach to a bigger number of the population to effect collective behaviour that is seen as change as long as many people belief and are committed that many are changing or practicing MC.

Once circumcision is performed at a facility, a follow-up visits are made by community health workers (CHWs) after triggering, whilst the new norm is still fragile, to reinforce the factual beliefs and normative expectation and to assist with technical concerns/questions (healing process, pain control, enabling environment, HIV prevention) of non-circumcised adult males and policy issues.

III. CHANGE IN PRACTICES

The following steps are proposed to assist in targeting the most significant demand creation or increase in number on voluntary medical male circumcision in Tanzania, to widely disseminate and diffuse the principle of male circumcision in non-circumcising communities or regions with low acceptance of MC and aim for creation of national social norm – that is to say, everyone thinks that everyone should circumcision because of the health benefits that a circumcised male is less of a risky to transmit diseases and will remain hygienic.

a) National Level

In 2009, the Government of Tanzania embarked on scaling up voluntary medical male circumcision (VMMC) services for HIV prevention in 8 priority regions, with the aim of serving 2.8 million boys and men ages 10–34 years by 2013 (THMIS 2012). 340,000 VMMCs had been done by December 2012 countrywide. The majority (85%) of these VMMC clients were under 19 years old (average age, 16 years). This study aimed to identify potential barriers and facilitators to VMMC among older men.

Evidence identifies several areas where more synergetic investment has been done and also is needed to address the challenges in Tanzania. These areas include legal and policy reforms, incentive schemes for increased access to basic services, and ethical codes of conduct for health workers offering the tools for VMMC.
Strategies that have worked well in Tanzania include:

**MC Devices**

A number of development partners are approaching the Ministry of health and social welfare (MOHSW) requesting permission to introduce use of different types of MC devices. The MOHSW has been advised that WHO is going through the process for pre-qualification of MC devices before giving concrete global guidance on their use. The MOHSW is still discussing the possibility to allow some partners to implement demonstration projects for some of the MC devices before WHO prequalification results are out. Although Tanzania has adopted the Models for Optimizing Volume and Efficiency of Male Circumcision Services (MOVE) model, the country is facing human resource challenges in the different regions which limit the full utilisation of this approach.

**VMMC Incentives**

Provision of incentives to VMMC providers may be necessary and productive especially in arrangements where providers work outside their normal official hours. However, the same may be counter-productive as in some cases for Tanzania such as: When funds for incentives of VMMC services are suspended in some cases the staffs that are not on the programme may not be ready to provide support without being included on the incentive scheme. The incentive scheme may not be sustainable and is difficult to integrate into routine health services. However, VMMC should be integrated into the routine health services and verticalisation and use of allowance should be discouraged.

**Operations research**

There is no defined national VMMC operational research agenda in Tanzania especially to explore practices that promote programme improvement. In the absence of an operational research agenda, some key lessons are being lost and opportunities with research institutions are being lost including those for community-based research.

**Communication**

Tanzania has not developed a national VMMC communication strategy which could improve demand creation and resource mobilization and also be used to solidify some of the sensitive social norms. UNICEF together with other UN agencies and development partners will support the development of this strategy. First by identifying the key communication gaps through a bottleneck analysis (situation), stakeholder consultations and community dialogue on the key issues with a strategic focus on aligning national frameworks related to HIV prevention from social norms lens.

**Resource mobilization**

Country Leadership and ownership is strong when government financing is provided to support VMMC services. Regarding outreach for VMMC different forms have been used by government and partners in few regions from role models, to radio programs and edutainment

A recent study in Tanzania (TAMPS 2011) found that the core target group for media campaigns should be young unmarried youth as they are the most open to questioning values
and behaviours. Most importantly, any such campaigns must involve the full participation of people from the reference group and communities that are affected or being targeted by the intervention.

**b) In the field/community:**

Communication and outreach and social mobilization approaches

Communication and Community mobilization are the two main strategies currently used at the social norms level by implementing partners. Empowering education is one of the approaches at the community level: educational sessions will be empowering if they serve not only to impart new knowledge but also to provide a forum for participants to dialogue on the issues of their health, exchange experiences, and help them to reveal and share their complex inner feelings and examine conflicting attitudes towards circumcision (THMIS, 2012). There is also a call for increased advocacy and awareness-raising activities that stimulate discussion and debate within social networks and reference groups within the communities especially using the women as forces of change in order to remove the negative barriers and strengthen demand in the context of VMMC.

Invest more resources in regions where HIV prevalence is high and male circumcision is low. In these regions, conduct a more detailed social ‘mapping’ of open areas where MC is low and HIV prevalence high (using MICS data and local knowledge) and social networks within these zones are powerful and should be considered in the mapping excises. These networks can be based on many reference groupings, for example ethnic, religious, educational or commercial (markets) and this knowledge will be extremely useful for planning the diffusion of information strategies.

Concentrate our community influencers/ motivators such as village chiefs or reference groups that the family members and peers who are circumcised and are used primarily to trigger the adult males in the communities where MC is low and not the tradition or practice. For now, we do not trigger the communities where MC coverage is already over 80%. In each region, select priority or ‘central’ MC communities (those with the most network connections to others) to be triggered first (Muldoon, 2013).
Once MC is achieved, support the natural leaders of the central/hub communities to spread the approach and promote to neighbouring communities, schools, churches etc. This is using the effective channels of community to community diffusion or outreach (Mackie, 2013).

Following the triggering of central villages, the change agents/motivators should move to the more isolated MC communities, or those with the least dense network connections, as these will be subject to the least social influence (gossip) and so will benefit more from factual information sharing (Kohler 2010). In parallel with this, work on the upstream or enabling environment.

In conjunction with the community rural roll-out plan, develop a national advocacy campaign strategy promoting VMMC as a national social norm on several levels – mass media (TV/radio/SMS), road shows, through health centres and village outreach programmes etc. The messaging can be very positive, using the reference group that is already circumcised as a motivating factor to influence the non-circumcised groups and creating dialogue with women to influence their spouses with social expectations that are empirical-dynamic and normative like the ‘Asante Mama’ campaign in Tanzania, thanking mothers for ensuring their kids wash their hands (G.Mackie 2013). Identify and promote national public figures or celebrities as male circumcision champions. This could include regional and district level events where key influential leaders are invited to attend the events like the ‘brothers for life’ campaign that has been targeting intergenerational sex as a means for HIV prevention.

**MEASUREMENTS - MONITORING AND EVALUATION**

Use the existing routine monitoring systems with the guidance from MoH/NACP/partners. Explore Social Media platforms (YAL) for tracking social issues. Select set of indicators as needed to ensure basic data is collected on the intervention, coverage, knowledge, attitudes and associated changes in perceptions and behaviours. Select the facilities for monitoring with the identification by dialoguing with the community members and service providers to be oriented on the on the intervention through different channels (radio) and the monitoring tools to be adopted/or developed so as to be able to track the utilization of services before, during and after.

**CONCLUSION**

This paper argued that social norms are more than just discrete factors that figure into the behavioral of an individual. Instead, norms are more accurately described as variables that affect our perception of every other schema or script daily in life, thereby encouraging an individual to either confirm or disconfirm to the significance of other considerations. While deviance from or compliance with a norm may have its own costs or benefits, an equally important effect of norms is to influence the way individuals understand information, and or practice what they do the way they do so that from the outset the behavioral outcome is weighted in favor of the predominant social norm. Norms therefore play an even larger role in shaping and controlling behavior than most legal norms have argued. The challenge that remains is to engage in the empirical research necessary is to predict how to best change specific norms. Especially where core beliefs are very strong while harmonising the legal, moral and social norms which has been put nicely as preferences, beliefs and social expectation and constraints to affect collective social change (C. Bicchieri, 2013). There is
need to adopt a mixed strategy of both the formal and informal institutions in the community and interpersonal environment, community approaches to include; community leaders, champions, positive social deviants, peer educators, and the social media as well as service delivery approaches which should be appropriate to social norms.

LITERATURE AND REFERENCES

1) C. Bicchieri, 2013. Social norms, social change – Lecture notes from UNICEF course on social norms, July 2013, University of Pennsylvania.


4) The Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12 (THMIS)


