GLOBAL JOURNAL OF BIOLOGY, AGRICULTURE & HEALTH SCIENCES
(Published By: Global Institute for Research & Education)
www.gifre.org

ACCEPTABILITY OF MEDICAL MALE CIRCUMCISION WITHIN THE APOSTOLIC MARANGE SECT IN ZIMBABWE; A QUALITATIVE STUDY

Oliver T. Gore[1] (MDS), Manase Kudzai Chiweshe (MSc Sociology and Social Anthropology, PhD Sociology, Post Doctoral Fellow)[2] Manenji Mangundu[3] (MPH, DPhil Student), & Agnes Mangundu[4] (MDS)

[1] Faculty of Gender and Development Studies, Women's University in Africa, Zimbabwe
[2] Faculty of Humanities, Rhodes University, South Africa
[3]College of Human Sciences, Department of Health Studies, University of South Africa (UNISA)
[4]Faculty of Gender and Development Studies, Women's University in Africa, Zimbabwe

Abstract

According to WHO/UNAIDS 2007, it is estimated that male circumcision can reduce female-to-male HIV transmission by 60%, but some faith based organisation may not be practicing male circumcision. Therefore the study assessed the Marange's Apostolic Sect's knowledge and attitudes on male circumcision (MC) as an additional strategy in preventing HIV/AIDS transmission through heterosexual intercourse from women to men. A qualitative study was undertaken using focus group discussions, in depth interviews, and key informant interviews with participants from the Marange apostolic sect. A total sample size of 134 participants were selected using purposive sampling and snowball sampling techniques. The findings indicated lack of knowledge among the Marange apostolic sect members on male circumcision. MC was understood from a religious stand point by the Marange apostolic sect members. A general non-acceptance attitude due to MC being perceived as sinning and promoting adultery was noted. MC was therefore irrelevant as the religious group believed in the absence of HIV within its members due to perceived effective HIV prevention practices within the sect. Barriers to MC uptake including perceived lack of benefits of MC such as sexual pleasure, pain during and after the MC procedure and risk compensation were identified. The study recommended involvement of church leadership in MC programming and in encouraging Marange apostolic sect members to utilize biomedical services, increasing enrolment of sect members into higher education, and HIV prevention awareness programmes including counseling.

Keywords: Male Circumcision; Marange; HIV/AIDS; attitudes.

1.0 Introduction

A larger proportion of men in the world, are not circumcised and yet, medical opinion strongly recommends medical male circumcision as an effective measure for averting or reducing HIV transmission from women to men through heterosexual intercourse. HIV/AIDS is one of the principal causes of high morbidity and mortality in Zimbabwe, which has an HIV prevalence rate of 13.7% (Ministry of Health and Child Welfare and UNICEF 2010). Yet evidence from observational studies conducted in Kenya, South Africa and Uganda that researched on the linkages between male circumcision and HIV infection showed that male circumcision reduces HIV transmission through female to male transmission by 51 to 60 percent (Auvert et, al. 2005, Bailey et, al. 2007, Gray et, al. 2007). The body of evidence in those researches resulted in WHO recommending the use of medical male circumcision (MMC) for countries with high HIV prevalence like Zimbabwe (18%) and low MMC practice (WHO/UNAIDS 2007). Based on the WHO recommendations, the Zimbabwean government through the Ministry of Health and Child Welfare (MOHCW) and National AIDS Council adopted medical male circumcision as an additional strategy for averting HIV infection from women to men (Mavhu et, al. 2011). Medical male circumcision is being implemented through Voluntary Male Circumcision Programme and the current country's strategy plan 2009-2015 focus approaches of scaling up MC.

World Health Organization estimates that 30 percent of males worldwide are circumcised, with prevalence of circumcision varying mostly with religious affiliation and cultures (WHO 2007). In Zimbabwe male circumcision is mostly practiced within minority groups such as the Tonga, Remba and Shangaans, but is not a common practice among the main Shona (Halperin et, al. 2005, Mavhu et, al. 2012). Mathematical modeling in Zimbabwe estimates that 750 000 HIV infections could be prevented when 80% men are circumcised within seven years, and this is likely to save US$3.8 billion over 15 years of the costs that would have been spent on treatment and care costs (USAID 2009). Therefore male circumcision is a cost effective method of averting HIV transmission through heterosexual intercourse from women to men.

A study conducted by Mavhu et al. (2012) on acceptability of male circumcision in Zimbabwe indicated that cultural and religious beliefs affects male circumcision acceptability. Some tribal groups were concerned about the handling of the foreskin after circumcision procedure, others felt that the process should be done by people from the same tribe or religion with them whilst infant male circumcision was totally discarded infant male circumcision by some minority groups (Mavhu et al 2012). Whilst tribal or religious affiliations impact on male circumcision acceptability in Zimbabwe, there is generally lack of consensus amongst Christians on the practice of male circumcision in Africa. WHO (2007) observes that male circumcision is a regular practice amongst the Coptic, Ethiopian, Egyptian and Eritrean Orthodox Churches but it is not practiced by most Christians in Africa. Christians amongst the Luo in Kenya believed that male circumcision should be practiced since Jesus was circumcised, yet others believed that male circumcision was a sin since it changed the way people were created (Bailey 2007). Some Christians in Papua New Guinea considered male

circumcision unacceptable for religious reasons since they felt that HIV prevention was to be found in God specifically by being faithful (Kelly et, al. 2012). There is however absence of literature on MC practices amongst the Marange Apostolic Sect in Zimbabwe.

The Johanne Marange Apostolic Church (Marange) constitutes a significant proportion of the population in Zimbabwe and Southern Africa. The sect has an estimated membership of 1.8 million members from East Africa and Southern Africa, including Zimbabwe, (Sunday Mail, 15-21 July 2012), and an estimated 10 million followers worldwide (Mavunganidze 2006:01). The Marange believe in spiritual healing and are well known for resisting biomedical interventions including treatment, immunizations and HIV testing (Tachiwenyika et, al. 2011, Chakawa 2011). Multiple concurrent sexual partnering is sanctioned through polygamous practices within the sect (Chakawa 2011), and this exposes the sect members to high risk to HIV infections.

2.0 Methods

A qualitative methodology was used to undertake the study with a total number of 134 participants from Harare (Central Business District), Chitungwiza and Seke Districts. Convenience sampling was used to select districts due to its proximity to the researcher considering financial constrains. The researcher, together with 3 enumerators collected the data using focus group discussions, in-depth interviews and key informants. A total number of 11 focus groups (n=10) were conducted with male youth (n=2 groups), and female youth (n=3 groups), and adult men (n=4 groups) and adult women (n=2 groups). In addition to that, 20 in-depth interviews were conducted with adult men (n=8 interviews), adult women (n=5 interviews), male youth (n=4 interviews) and female youth (3 interviews). A total of 4 key informant interviews were conducted with sect leaders.

Purposive sampling was used to identify and select participants. Since the Marange apostolic sects are a closed society, snowball sampling technique was also used (Hancock 2002, Faugier and Sargeant 1997:792). Data collection was stopped after reaching theme saturation -when new categories or themes ceased to emerge from the data (Glaser and Strauss 1967:61); and this was after 11 focus groups and 24 (indepth and key informant) interviews. Data was collected verbatim using audio recorders and hand written notes.

Audio recorded data were transcribed and consequently translated from local language into English before analysis. Completed focus groups and interviews were transcribed and coded up from the beginning of data collection process up until the end. Data was analyzed following principles of Grounded Theory. Texts from the transcripts were coded line by line using open coding to identify indexes before merging them to form categories and codes. Constant comparison of these categories and codes were made, and the codes were refined upon emerging of new data. Sub-themes and themes were then created and these were shown by quoted text.

A total of 9 themes were derived from the qualitative data that was collected and these were knowledge of male circumcision, misconception, religious factors, non-utilisation of biomedical factors, belief in absence of HIV and STIs within the apostolic faith sect, perception on appropriate age for circumcision, inhibiting factors, gender perception and male circumcision being imposed.

Ethical Considerations

Permission to undertake the study was obtained from the Medical Research Council of Zimbabwe, which is the local ethical board. Prior conducting the focus group discussions and interviews, participants were given information sheets that provided full explanation of the research purpose and process, and this was followed by a verbal explanation from the researcher before signing of consent forms. Both information sheets and consent forms were in *Shona*, which is the local language understood by participants. To ensure full understanding of the research, participants were given the opportunity to ask questions, which were consequently responded to by the researcher. This was followed by signing of the consent forms by the participants. The right of participants to refuse to participate was observed. Confidentiality of participants and information were also observed as data were kept safely, as no any other people had access to it except the University Authorities.

3.0 Results

Participants were knowledgeable on the meaning of male circumcision as they have heard about the practice before either from the media or from the Bible. Participants pointed out that male circumcision was not practiced by the Shona but was a practice of the Changaans, Venda, Remba, and Chewa ethnic groups.

Knowledge of male circumcision was strongly linked to Christianity as most participants understood the concept in relation to the bible. A participant pointed out that, *"The bible says Jesus was circumcised, but here in Zimbabwe men are not circumcised"* (adult female, focus group discussion, Mahusekwa). Israelites were the only group that was circumcised but the practice ended with Jesus baptism implying that the practice should no longer be done.

However some youth pointed out that it was their first time hearing about male circumcision. It was noted that, "*I have not heard about that [male circumcision] and I do not think it is possible to cut that [foreskin] (*male youth, in depth interview, Mahusekwa). Those who knew about the practice showed little awareness on procedure of the practice and reasons for circumcising men. Another participant noted that, "*We just hear from radios and I cannot say I have knowledge on that one. I also have not seen it being done. They do not explain it clearly on the radio''* (male youth, focus group discussion, Mahusekwa).

However, participants generally demonstrated lack of knowledge on the procedure of carrying out male circumcision and its benefits. Due to lack of knowledge of male circumcision, several misconceptions were highlighted by participants including that MC procedure results in malfunctioning of the sexual organ, it was difficult to circumcise adults as the veins on their sexual male organs were well developed, and that there were some boys born with penis that were already circumcised. Some participants were of the view that male circumcision was being done for the same purpose with polio immunization, which they thought was for identity purposes. Furthermore, MC was thought to be

done through having sex with virgin girls. It was observed that, "*We marry virgin girls only and this means we break virginity of those women. So you get circumcised during the course of breaking their virginity. The fore skin opens up more as the [sexual] organ penetrates each virgin woman"* (male youth, focus group discussion, Mahusekwa)

Participants generally showed a non acceptance attitude on male circumcision given that it helped preventing HIV transmission. Various reasons were given by participants for their unwillingness to have males from their religious group circumcised. Male circumcision was not acceptable to participants due to religious beliefs. Circumcision was viewed as an old practice done by the Israelites and the practice ended when Jesus died for people's sins. A participant was of the opinion that, *"For the Israelites to be recognized as pure they had to get circumcised. But nowadays because Jesus died for our sins, it is unnecessary to get circumcised. Our religion does not accept that [male circumcision]"* (adult female, focus group discussion, Mahusekwa). Furthermore, it was indicated that male circumcision was replaced by baptism that uses water and Holy Spirit. Others however pointed out that they would accept MC when it came as an instruction from God and not for from anyone. Another participant was of the view that, "*We do not have anything to do with male circumcision. But we will do it when the holy spirits says so because we look upon from the God (*adult male, in depth interview, Chitungwiza).

For some participants MC was construed as sinning. It was pointed out that, *"[Laughs] I do not want that practice at all because I am not an animal. It is God only who circumcises people through giving them a short foreskin on birth"* (church elder, in depth interview, Mahusekwa). Creating a permanent disability to someone was perceived as sinful and thus male circumcision was viewed as a sin as no person had the power to change what God has created. Participants explained that an uncircumcised man was fertile and able to satisfy their women and therefore it was unnecessary and sinful to change that. One of the participants stated, *"So changes on the body do not mean anything. It just like one who wants to change their nose when they were born like that, or to cut one or two of the fingers one has. This is not a good practice at all"* (adult male, focus group discussion, Mahusekwa). Another participant was of the opinion that, *"I do not want my husband and son to have their body parts cut when they were born with all their body parts present"* (adult women, focus group discussion, Mahusekwa).

Some participants instead thought that MC should be replaced by following God's commandments. This would mean that people would not commit adultery and get infected with HIV, which was supposedly the purpose of male circumcision. It was observed that, *"being faithful and getting satisfied with your partner is the only way for HIV prevention not circumcision"* (adult female, focus group discussion, Mahusekwa). It was also stated that, "*We view circumcision as a way of coping with sinning. But the solution is to believe in God and stop sinning. Not committing adultery is the only way to prevent diseases"* (church elder, in depth, Harare). Participants therefore believed that male circumcision was not meant for their religion since they were not committing adultery. One of the participants stated that, "*There are those who are doing those earthly things such as committing adultery. You can tell them those committing adultery to get circumcised"* (adult male, focus group discussion, Mahusekwa).

More pronounced was the negative attitude on male circumcision due to it being done through biomedical services. Participants strongly indicated that they were against the use of medication including anesthesia which they thought was part of the circumcision process. They pointed out that their religion did not allow them to be associated with anything related to modern biomedical services including visiting clinics or hospitals, use of injection and medicines including antiretroviral therapy, surgical procedure and even the use of contraception. One of the participants mentioned that, "*I do not want that kind of circumcision at all. What is it that is done about the wound after removal of the foreskin? Where does that wounded person go? How is he treated? I am refusing to accept that kind of circumcision and I have not seen that practice throughout my life* (adult male focus group discussion, Mahusekwa).

In the event that their religion allows them to carry out the practice, some participants highlighted that they would accept male circumcision when it uses holy water for treatment and not medication. Others however pointed out there was no way the practice would be conducted without the use of medicine which their religion did not allow. They mentioned that cutting of the foreskin was a painful procedure that could not be done naturally. Moreover, wounds would not heal without medicine leading to much pain and ultimately death. A participant noted that, "*We cannot do it [male circumcision]. It is a paining exercise that needs hospitals and anesthesia. There might be others willing to have the practice but who does that [without medication]?* (Male youth, in depth interview, Harare). They stated that it is virtually impossible for them to accept circumcision.

However, other participants indicated they were not totally against the use of biomedical services as they see the need of them. A participant revealed that, *"In some cases if a church member gets sick, he travels to another area where he is not known to get some medication. We all know that we have to seek medication but we cannot do that. We want to maintain our names and reputation which we have built over time"* (male youth, adult male , Harare).

Other participant felt that male circumcision was an unnecessary practice that had lesser benefits than costs due to pain involved. They noted that the practice was meant to prevent HIV infection that had not yet happened. Considering the health risks involved including the wound not healing and the social costs of pushing them to clinics, they perceived it as unworthy while practice. A participant pointed out that, *"We cannot [get circumcised] because a person cannot be treated before getting sick. Just like you have doctors, you get examined first before getting treatment* (church elder, adult male, Mahusekwa). Another participant mentioned that, *"It's fear of pain because circumcision does not have any [negative] effect or anything it disturbs. Men think of having their flesh cut, so they are afraid of that pain. It's about pain only"* (male youth, in depth interview, Harare). Another one pointed out that, *"Men do not want to get circumcised because of pain. They say it's painful"* (Adult female, focus group discussion, Mahusekwa).

Age was also an important factor determining participants' attitudes on sect members. There were mixed feelings on sect members having their male infants circumcised. Some participants pointed out that they wanted their children to be circumcised soon after birth as the wound easily heals, but the procedure would be carried out by their parents. Others however thought that it was unfair to circumcise the newly born boy since he needed to make his choice. A participant observed that, *"When the boy later realize that he is supposed to have a foreskin, what are you going to do? Yet*

somebody have taken advantage of the boy and cut it. He is going to cry and ask God why he is like that yet it's another human who has deformed him. That is only a little innocent boy (male youth, in depth interview, Chitungwiza). Another one however noted, *"Why should the practice start with their children?"* (adult male, focus group discussion, Mahusekwa).

Getting circumcised at adulthood was viewed as undesirable due to the fact that adults were already used to being uncircumcised. Others however were of the view that there were no chances of them getting infected with HIV due to them not engaging into extra marital affairs as they were already old. It was noted that, "*I am too old to do that [getting circumcised]. [Laughs] I have my family and what else do I want?"* (adult male, in depth interview, Chitungwiza). This however was in disagreement with views of women. A female participant was of the view that, *"It is better to circumcise boys soon after birth; it becomes normal to them when they grow up. Men become more promiscuous if circumcision is done at adulthood for HIV prevention,"* adult female, focus group discussion, Mahusekwa).

More over male participants indicated that their wives might not enjoy having sexual intercourse with circumcised husbands as they were used to them being uncircumcised yet the procedure was irreversible. One of the participants stated that, *"Why should I introduce something new in my life and my family? I would not want"* (adult male, focus group discussion, Mahusekwa). To male participants, teenage ages (between 16 and 20 years) were the right stage for circumcision as the boys were able to make their informed decisions to get circumcised. "*They should have their first [sexual] encounters after they are circumcised. It is better that way unlike having sex first when uncircumcised and then having it afterwards [when circumcised]. What if you find less sexual pleasure after being circumcised?"* (adult male, in depth interview, Harare). Some male and female participants however expressed neither negative nor positive attitude on male circumcision as they perceived nothing wrong with the practice. A participant observed that, "*Although we do not look forward to that in our church there is nothing wrong if one wants to get circumcised to protect themselves"* (adult male, focus group discussion, Mahusekwa).

There was a general belief in the absence of HIV and STIs within the religious group. It was stated that, *"In our religion we do not talk about AIDS. It's an unknown phenomenon implying we cannot accept it from that way. There is no AIDS in our church. I do not know how people from our church can contract HIV"* (church elder, in depth interview, Mahusekwa). Participants pointed out that they have their unique and organized practices of HIV prevention, rendering male circumcision an unnecessary measure. It was mentioned that, "*Our church has got systems and measures to deal with issues of HIV protection. Our church is well organized"* (male youth, focus group discussion, Chitungwiza).

The following practices were believed to be effective strategies used by the sect in preventing HIV from affecting church members; intermarriages within the church, virginity tests for young girls, polygamy practices, belief in the use of Holy Spirit to detect adultery, and spiritual healing. As such participants strongly maintained that there was neither HIV nor STIs amongst their religious members. Participants noted the following:

Lack of perceived advantage was another barrier to MC uptake pointed out by participants. Male circumcision was thought neither to increase sexual pleasure nor sexual power during sexual intercourse with women. Though participants thought that male circumcision did not prevent HIV transmission, they were of the view that it was a hygienic practice. Furthermore the hardened penis was thought to cause pain to the woman during sexual intercourse. Another participant mentioned that, *"You find out that one would be assessing the costs and benefits of undergoing that procedure. Being uncircumcised does not disturb fertility and erection of the penis so I do not think there is any benefit from that"* (adult male, focus group discussion, Mahusekwa). Women indicated that they were afraid of adverse events so they did not want their sons and husbands to get circumcised. A participant was of the opinion that, *"We have heard this from the Chewa that other boys were not coming back from the forest [dying] where they go for circumcision. Sometimes nine of them return instead of ten. We fear for our sons"* (adult woman, focus group discussion, Mahusekwa).

Perception of participants on risk compensation was mentioned as a setback for uptake for male circumcision amongst the sect members. Participants highlighted that male circumcision was meant to promote promiscuity as men were likely to engage into risk relationships because they regarded themselves as protected from HIV. A participant mentioned that, *"Circumcision is like condoms because it encourages promiscuity. I do not use those [condoms] with my wives. Condom [use] is like circumcision; it is a culture of promiscuity. Male circumcision is for disease controlling"* (male youth, in depth interview, Harare). Women indicated that they did not want their husbands to get circumcised. It was observed that, *"Some men would regard themselves as bulls and go for sex spree after circumcision and even bring more wives. They want to taste [explore and have sex with] other women because they think they cannot get the disease. These men should get sufficient information that they are not entirely safe.* (adult female, focus group discussion, Mahusekwa).

Men's beliefs on women within the religious sect were highlighted as inhibiting the uptake of male circumcision. Male participants believed that women did not have sexual feelings neither was it necessary to satisfy them. Regarding issue of sexual pleasure, one of the participants stated that, "*It is the man only who has ropa rinotapira [sexual feelings]. The woman is just an instrument [mudziyo] that can be used, a cooking pot where [sweet] things are cooked and removed. It is a demon that causes women to have sexual feelings.*" [church elder, key informant interview, Mahusekwa]. [Please note that this view is strong within the religious group. The female interviewer was refused permission to conduct a focus group discussion with women from the sect by church elders since she did not '*know anything though she was educated'* and neither their wives were aware of anything.] This however contrasts with views of women who thought that MC enhanced sexual pleasure. A female participant stated that, *"There is more fire [increased pleasure] having sexual intercourse with a circumcised men and that is an advantage.''* Other women expressed ignorance pointing out that they have not experienced sex with circumcised men and were satisfied with their uncircumcised

The belief that male circumcision is being imposed on their religion was another obstacle to uptake of male circumcision. There was a generally belief amongst participants that male circumcision was being imposed on them. They were of the opinion that the government did the same when it imposed immunization programmes on them. A participant observed that, "*In most cases the government implements policies that are against our religion because some*

of its policies do not involve Holy Spirit. They are just earthly practices and we do not agree with them. So they will be saying go to hospital, take medication and so forth; and that is our point of disagreement" (male youth, in depth interview, Harare).

4.0 Discussion of major findings

An anticipated finding was a non acceptance attitude of the religious group on male circumcision, though this is in contradiction with previous studies on the general population in Zimbabwe (Mavhu 2011, 2012). The findings of this study however corroborate the findings of previous work in this field. Bailey (2007) asserted low acceptability of MC amongst Christians due to the belief that it was a sin to change the way one was created. Kelly et, al. (2012) also found out that amongst Christians in Papua New Guinea MC was considered unacceptable since they believed that HIV prevention was found in God from being faithful. WHO (2007) also found MC unacceptable amongst Christians in South Africa.

The study noted an unfavourable attitude on MC due to the belief that there was no HIV within the religious group. A possible explanation for this might be the strong belief on the presence of effective systems and practices for HIV prevention within the sect. These findings concur with Kelly et, al. (2012) who noted that being faithful amongst Christians in Papua New Guinea was seen as an HIV prevention way making MC for HIV prevention unneeded. However, these results are discouraging considering the high risk of HIV and STIs contraction due to Maranges' practices that encourage multiple sexual partners, and the sect's non utilization of biomedical services including condoms and HIV testing.

Another unexpected result was the issue of sexual pleasure as a determinant for acceptability of MC. This was probably due to men's belief that women did not have sexual feelings, implying that it was unnecessary for them to get circumcised for purposes of enhancing sexual pleasure for women. Yet the study showed that women favoured circumcision as it was thought to enhance sexual pleasure. Previous studies Peltzer et, al. (2007) highlighted the importance of women in decision making for MC acceptability. An interesting finding was also the presence of a strong belief amongst men and women that MC causes men to engage into more risky sexual behaviour due to the belief that they are protected from getting infections. Prior studies have shown that risk compensation is an inhibiting factor for MC acceptability. Kelly et al (2012) also noted risk compensation as barrier to MC uptake amongst Christians in Papua New Guinea.

Some of the issues emerging from these findings relate specifically to issues of leadership involvement. These findings have important implications for developing strategies to involve religious leadership for the possible acceptability of MC. This also implies that awareness campaigns of MC can be carried out through the sect systems. Another implication of this study is the possibility of designing MC procedures that are easily carried out by personnel from the religion within their religious systems.

Recommendations for further studies

Further studies should focus on developing models which can help linking the Marange and biomedical institutions. In addition to male circumcision, the Marange can benefit other services offered through the modern health delivery systems.

5.0 Conclusion

The study found out that there is low knowledge of MC amongst the Marange. Mavhu et, al. (2011) found out that there is an association between low knowledge of MC and unwillingness to get circumcised. Low knowledge level is likely to have contributed to the religious group's non acceptance attitude on MC.

The Marange generally understood male circumcision concept from a religious point of view. Berger and Luckmann (1966) postulated that through 'inter subjectivism construction' individuals within a society give meaning to the world they live and these meanings are shaped by the society's history and culture. This was evidenced by the Marange's understanding of male circumcision that it was a tradition of Israelites from the Bible and that it was sinful to get circumcised. HIV prevention was therefore through following God's commandments including being faithful to a partner or several partners in polygamous relationships and not from MC. It can therefore be noted that the Marange's construction of MC is vital to their attitude on male circumcision.

A salient point to note is that religious factors contributed to Marange's non acceptance attitude to male circumcision. This is through believing that HIV infections were non-existent within the sect (due to several practices that discourage adultery within the sect) meaning that it was redundant to get circumcised. This however contradicts other previous studies that found out that some Christians were willing to get circumcised since Jesus was circumcised. WHO (2007) observes that amongst Christians MC is practiced by the Coptic, Ethiopian, Egyptian and Eritrean Orthodox Churches and also some other African churches. Non acceptance attitude on MC however corresponds to previous studies (Kelly *et al.* 2012; Bailey 2007; WHO 2007) who revealed that some Christians were against MC. Therefore the Marange are also amongst the Christian groups that are unwilling to accept MC as an HIV prevention measure.

Several barriers for men to get circumcised were identified and these varied with gender. Men mentioned lack of benefits for getting circumcised, pain and health risks associated with the MC procedure. Whilst men thought that women had no sexual feelings that required to be satisfied through men getting circumcised, women were of the view that MC enhanced sexual pleasure. However both men and women were in agreement that MC would lead to increased adultery and therefore it was undesirable. These barriers concur with previous studies (Bailey 2011). These differences in gender perceptions have some implication in when addressing these barriers.

Acknowledgements

The study was funded by the Research Council of Zimbabwe and was carried out through Women's University in Africa (Harare).

Limitations of the Study

A sample was obtained from 3 districts due to financial constrains, and the data might not be that entirely representative.

Author's Contributions

Oliver T. Gore, Manashe K. Chiweshe were involved in the conceptualization, data analysis of the study and drafting of the manuscript while Manenji and Agnes Mangundu were involved in refinement of the methodology and the drafting of the manuscript for publication.

References

1. Auvert B. Taljaard D. Lagarde E. Sobngwi-Tambekou J. Sitta R. and Puren A. (2005) Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Medicine 2, 1112–1122.
2. Bailey R. C. Moses S. Parker C. B. Agot K. Maclean I. Krieger et, al. (2007) Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A randomised controlled trial , Lancet 369: 647-656.
3. Bailey R. C. Herman-Roloff1 A. Otieno N. Agot A. Ndinya-Achola J. (2011) Uncircumcised Men in Kenya One Year After the Launch of the National Male Circumcision Program Volume 6, Issue 5, e19814 Plos 1.
4. Chakawa J. (2010) Marriage via the 'Holy' Spirit: Girl Child Sexual Abuse in the Johanne Marange Apostolic Church in Marange Area of Zimbabwe; Zimbabwe Social Sciences Review Volume 1 Number 2 December 2010
5. Faugier J. and Sargeant M. (1997) Journal of Advanced Nursing 26, 790–797
6. Glaser and Strauss (1967) Glaser BG Strauss AL (1967) The discovery of grounded theory: Strategies for qualitative research New York: Aldine de Gruyter.
7. Gray R. H. Kigozi G. Serwadda D. Makumbi F. Watya S. Nalugoda et, al. (2007) Male Circumcision for HIV prevention in men in Rakai, Uganda: A randomised Trial, Lancet, 369:657-666.
8. Halperin D.T. Fritz K. Mcfarland W. and Woelk G. (2005) Acceptability of adult male circumcision for sexually transmitted disease and HIV prevention in Zimbabwe, Sexually Transmitted Diseases 32, 238–239.
9. Hancock B. (2002) Trend Focus Group for Research and Development in Primary Health Care: An Introduction to Qualitative Research, Nottingham, Trend Focus Group
10. Kelly A. Kupul M. Fitzgerald L. Aeno H. Neo J. Naketrumb R. Siba P. Kaldor P. M. and Vallely A. (2012) "Now we are in a different time; various bad diseases have come." Understanding men's acceptability of male circumcision for HIV prevention in a moderate prevalence setting, BMC Public Health 2012, 12:67 http://www.biomedcentral.com/1471-2458/12/67
11. Mavhu W. Buzdugan R. Langhaug L.F. Hatzold K. Benedikt C. et, al. (2011) Prevalence and factors associated with knowledge of and willingness for male circumcision in rural Zimbabwe, Trop Med Int Health 16:589-597.
12. Mawunganidze T. (2006) 'A critical inquiry into the Sexual Network in Marange: A Case of the Johanne Marange Apostolic Church', Human Science Research Council Vol 1.
13. Mavhu W. Hatzold K. Laver S. M. Sherman J. Tengende B. R. Mangenah C. Langhaug L. F. Cowan F. M. (2012) Acceptability of Early Infant Male Circumcision as an HIV Prevention Intervention in Zimbabwe: A Qualitative, PLos ONE
14. Ministry of Health and Child Care and UNICEF (2010) National Health Strategy 2010-15. Harare, Zimbabwe
15. Peltzer K. Niang C. L. Muula A. S. Bowa K. Okeke L. Boiro H. Chimbwete C. (2007) Editorial review: Male circumcision, gender and HIV prevention in sub-Saharan Africa: a (social science) research agenda Vol. 4 No. 3 November 2007 Journal des Aspects Sociaux du VIH/SIDA
16. Tachiwenyika et, al. (2011) Pan African Medical Journal. 2011 8:7 http://www.panafrican-med-journal.com/content/article/8/7/full/ Paediatrics & Child Health Division,
17. United States Agency for International Development [USAID] (2009) The Potential Cost and Impact of Expanding Male Circumcision in Zimbabwe. USAID, Washington, DC.
18. WHO/UNAIDS (2007) Male Circumcision: context, criteria and culture (Part 1), Joint United Nations Programme on HIV/AIDS, February 26.
19. WHO/UNAIDS (2009) Progress in male circumcision scale up country implementation strategy.
20. World Health Organization (WHO) (2007) Joint United Nations Programme on HIV/AIDS (UNAIDS) Prevention, Geneva