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Towards a gender perspective in qualitative research on voluntary medical male circumcision in east and southern Africa

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Abstract

The World Health Organization endorsed voluntary medical male circumcision (VMMC) in 2007 as an effective method to provide partial protection against heterosexual female-to-male transmission of HIV in regions with high rates of such transmission, and where uptake of VMMC is low. Qualitative research conducted in east and southern Africa has focused on assessing acceptability, barriers to uptake of VMMC and the likelihood of VMMC increasing men's adoption of risky sexual behaviours. Less researched, however, have been the perceptions of women and sexual minorities towards VMMC, even though they are more vulnerable to HIV/AIDS transmission than are heterosexual men. The purpose of this paper is to identify core areas in which a gendered perspective in qualitative research might improve the understanding and framing of VMMC in east and southern Africa. Issues explored in this analysis are risk compensation, the post-circumcision appearance of the penis, inclusion of men who have sex with men as study respondents and the antagonistic relation between VMMC and female genital cutting. If biomedical and social science researchers explore these issues in future qualitative inquiry utilising a gendered perspective, a more thorough understanding of VMMC can be achieved, which could ultimately inform policy and implementation.

Keywords

male circumcision; qualitative research; gender research; female genital mutilation; Africa

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Introduction

Voluntary medical male circumcision

Since 2007, Ministries of Health from various sub-Saharan African countries have included the rollout of voluntary medical male circumcision (VMMC) in national HIV/AIDS strategies (United Nations Programme on HIV/AIDS [UNAIDS], 2013). These efforts follow the endorsement by the World Health Organization (WHO) and UNAIDS of VMMC as a safe and effective HIV prevention procedure used to decrease the chances of female-to-male transmission of HIV. This has been particularly supported in regions where uptake of VMMC is low, and the prevalence of heterosexually transmitted HIV infection is high (WHO/UNAIDS, 2007).

Three randomised control trials (RCT) conducted in Uganda, Kenya and South Africa provided evidence that circumcised men are at a 48–60% reduced risk of becoming infected with HIV (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). A subsequent trial in Uganda was stopped when it was observed that VMMC had no protective effect for women (Wawer et al., 2009). However, the internal validity and generalisability of the 2005–2007 RCT findings have been questioned due to a number of factors. In addition to premature termination and because study sampling was not representative of other African populations, certain confounding factors were not adequately assessed, such as the non-sexual transmission of HIV, and because these trials isolated the effectiveness of the procedure from critical behavioural, social and cultural aspects that contribute to people's vulnerability to HIV infection (Bell, 2014; Siegfried, Muller, Deeks, & Volmink, 2009; Van Howe & Storms, 2011).

In addition to questioning the validity of these RCTs, the bio-physiological mechanisms explaining the benefit of VMMC against HIV transmission need to be further studied (Dinh et al., 2012). WHO/UNAIDS supported the argument that compared to the outer foreskin and glans penis, the inner foreskin mucosa has more accessible HIV-1 target cells (WHO/UNAIDS, 2007). However, advocates of preserving intact tissues, such as the inner foreskin where Langerhans cells secrete langerin (a natural barrier against HIV) (de Witte et al., 2007), contrast with scholars asserting that a high concentration of HIV-target cells in the inner foreskin make a plausible biological explanation to the partial protective effect of VMMC (Hirbod et al., 2010).

Using a gendered approach

The term gender refers to historically developed as well as on-going sociocultural constructions that mould and structure relationships between men and women (Connell, 2012). Gender is embodied in social structures and is multidimensional; it includes economic, power, symbolic and affective relations that shape gendered norms, identities and relations. Gender norms influence how femininity and masculinity are perceived across cultures, and how these evolve in different ways within each culture; these norms can have an effect on how people respond to ill health as well as how they engage in discourse surrounding disease prevention (Peters, van Driel, & Jansen, 2013).

When considering scholarly investigations into disease prevention strategies, a major principle of sex and gender research (Connell, 2012; Johnson, Greaves, & Repta, 2007) suggests that it should not be assumed that women and men are uniform and share the same characteristics within their sex/gender groups. Researchers should not extend the findings derived from one gender group to the other without adequate translational studies. Researchers should also note all multiple variations between individuals of the same sex/gender from the outset of research. One aspect that differentiates individuals within a same sex/gender group is their sexual identity and behaviours. Further, women and sexual minorities should receive equal attention to heterosexual men in the scientific discourse. They should be accurately reflected in study samples, for example. Moreover, in qualitative research the same meanings, values and processes that are explored with heterosexual men should also be addressed with women and sexual minorities.

A gendered perspective is relevant for qualitative research on VMMC (Peters et al., 2013). While VMMC might contribute to decreasing the risk of men becoming infected with HIV via heterosexual intercourse, the degree to which women are protected is not known (WHO/UNAIDS, 2007; Weiss, Hankins, & Dickson, 2009). Indeed, in one RCT conducted in Uganda, VMMC appeared to lead to an increase in cases of HIV-infected women (Wawer et al., 2009). If VMMC campaigns do not reinforce the message that VMMC confers only partial protection against HIV transmission, men may engage in sexual disinhibition and further contribute to an increase in HIV prevalence among their female partners (Dushoff, Patocs, & Shi, 2011; Peters et al., 2013; Van Howe & Storms, 2011).

A gendered approach should investigate how VMMC programmes in sub-Saharan Africa could exacerbate the HIV/AIDS epidemic among women. Female HIV prevalence is higher than male prevalence in most countries (UNAIDS, 2013). A myriad of gender inequality-derived barriers to prevention, diagnosis and treatment make African women highly vulnerable to HIV/AIDS (Dushoff et al., 2011; UNAIDS, 2013). Gender norms can contribute to women having reduced access to services, compromised condom negotiation skills, and less accurate knowledge regarding HIV transmission than do men (UNAIDS, 2013). Sexual minorities, such as men who have sex with men (MSM) and with men and women (MSM/W), are also more vulnerable than heterosexual men, and their access to HIV healthcare is hindered by stigma, homophobia and criminalising legislation (UNAIDS, 2013).

In an effort to try to understand what compromises the uptake of VMMC in sub-Saharan Africa, the sociocultural barriers for its acceptability have been explored in the qualitative literature. Common themes explored in research that include women as study participants are the likelihood of these women to take an intact (uncircumcised) man as a sexual partner (Layer et al., 2013; Tarimo et al., 2012), their perceptions of circumcised men adopting risk compensation (Abbott, Haberland, Mulenga, & Hewett, 2013; Albert et al., 2011; Lukobo & Bailey, 2007; Tarimo et al., 2012), and the extent to which these women play an influencing role in men's acceptance of VMMC (Downs et al., 2013; Lanham, L'Engle, Loolpapit, & Oguma, 2012; Plotkin et al., 2013; Tarimo et al., 2012). Women's attitudes towards having their children circumcised have also been explored (Albert et al., 2011; Downs et al., 2013) although it must be noted that infant male circumcision differs from VMMC, both because it

is involuntary and because the alleged health benefits of VMMC cannot be extrapolated to infant circumcision (Davis, 2001; Lyons, 2013; Svoboda & Darby, 2008).

The qualitative literature on VMMC in east and southern Africa is analysed in this article. The purpose of such analysis is to identify core areas of research that, from a gendered perspective, might provide biomedical and social science researchers new insights into analysing how VMMC programmes are being designed and implemented, and how they may impact their target populations' vulnerability to HIV transmission. Findings from qualitative research carried out with a gendered perspective from the outset could provide evidence-based knowledge to inform policy and implementation, and assist biomedical and social science researchers in further analysing information obtained from quantitative studies.

Methods

Literature review

Systematic reviews, meta-analyses of RCTs and observational studies on VMMC are published elsewhere (Siegfried et al., 2009; Wiysonge et al., 2011). To our knowledge, no review or meta-ethnography of qualitative studies on VMMC in east and southern Africa has been published since the endorsement of VMMC by WHO/UNAIDS. Qualitative research methodologies have been used across scientific disciplines seeking to explore, examine and interpret the meanings and values that people place in phenomena. The methodology for conducting and reporting a meta-analysis of quantitative studies is not transferable to meta-ethnography for a number of practical and epistemological reasons (Britten et al., 2002; Noblit & Hare, 1988). This article draws from the preparation of a meta-ethnography of qualitative studies on VMMC.

For this review, the databases Pubmed/Medline, Cochrane and African Index Medicus were searched from October 2013 until January 2014. The keywords 'male circumcision, qualitative research, surgical procedures, traditional practices and Africa', in combination with the Booleans AND/OR, were used to search for original articles reporting qualitative and mixed research findings. The publication year limit was set from 2007 to 2013. No language limits were set.

Excluded articles were those that did not include qualitative methods, did not discuss issues around VMMC with study participants and those that reported on findings from other study sites than countries in east and southern Africa (excluding South Africa).

Sixteen articles were found to meet the eligibility criteria (Table 1). No formal quality appraisal of the articles eligible for this literature review was made. Simple measures for assessing trustworthiness were preferred. Hence, the following quality criteria were examined: description of study design, study site, sampling method, data collection materials, ethical considerations, explanation of study limitations and future prospects for research (Atkins et al., 2008; Britten et al., 2002; Tong, Flemming, McInnes, Oliver, & Craig, 2012).

Two researchers (G.M.P. and A.G.) read through the abstracts, selected the papers and coded the themes that emerged from the analysis. Meta-ethnography was used to analyse and synthesise the findings (Atkins et al., 2008; Britten et al., 2002; Noblit & Hare, 1988). Five thematic areas are discussed in this paper: risk compensation, stigma towards intact men, female genital cutting (FGC), values given to the foreskin and MSM/W as a study population.

Resulting themes

Risk compensation

Risk compensation is defined as engagement in risky sexual behaviour as a result of a decrease in perceived risk of vulnerability to HIV/STDs transmission (Grund & Hennink, 2012; Layer et al., 2013). Research in Swaziland has suggested that risk compensation may not be a serious concern because only a few respondents reported engaging in increased risk behaviours (Grund & Hennink, 2012). However in other contexts, men and women both manifest concern about risk compensation (Abbott et al., 2013; Albert et al., 2011; Friedland, Apicella, Schenk, Sheehy, & Hewett, 2013).

In a study on knowledge of VMMC in Zambia and Swaziland, Friedland et al. (2013) found that respondents reported that the impact of circumcision on HIV risk for their female partners had not been discussed during counselling. Qualitative research has suggested that during couples counselling, it should be reinforced that VMMC reduces the risk of HIV/STDs (Abbott et al., 2013; Friedland et al., 2013; Grund & Hennink, 2012; Lundsby, Draebel, & Meyrowitsch, 2012). It has also been advised that counsellors emphasise that the extent to which a woman is protected if her partner engages in risk compensation is not known (Lanham et al., 2012) and that VMMC, if followed by sexual disinhibition, may increase the risk of HIV transmission (Dushoff et al., 2011; Wawer et al., 2009). Future qualitative studies should further explore in what ways counselling impacts how men and women perceive the necessity of adhering to key practices for HIV prevention.

For some men from Botswana, an impediment to undergoing VMMC is the fear of having their sexual performance impaired (Sabone et al., 2013). This fear is defined as a 'misperception' that needs to be addressed in order to improve VMMC demand in Botswana (Sabone et al., 2013). On the contrary, in Uganda, Tanzania and Zambia, acceptance of VMMC may be motivated by the belief that circumcision enhances sexual experience (Albert et al., 2011; Friedland et al., 2013; Lundsby et al., 2012; Plotkin et al., 2013). A gendered perspective in biomedical and social science research using qualitative methodologies should investigate whether such motivational messages to undergo VMMC have the effect of encouraging populations of any gender and sexual orientation to adopt risk compensation, due to the belief that having been circumcised or that having a circumcised partner will enhance their sexual experiences.

Engaging in unprotected sex during the healing period is a high-risk behaviour that also increases the risk of HIV transmission (WHO/UNAIDS, 2007). While men are advised against resuming sexual activities before the circumcision scar heals properly, some men have difficulty complying with the abstinence period (Abbott et al., 2013; Friedland et al.,

2013; Plotkin et al., 2013). A gendered approach should also assess how women are counselled on the need to respect the abstinence period, how women's sexual expectations may encourage men to resume sexual intercourse before the circumcision scar heals and how premature recommencement of sexual activity can put women at higher risk for acquiring HIV.

Abbott et al. (2013) studied the influence of knowledge on VMMC among sex workers in Zambia. For future qualitative research, we recommend examining how knowledge on VMMC might influence risk compensation and condom negotiation among women other than self-identified sex workers, such as married women or those who engage in transactional sex but do not self-identify as sex workers.

Inaccurate information spread by mass media may negatively influence perceptions about the partial protection of VMMC (Muzyka, Thompson, Bombak, Driedger, & Lorway, 2012; Wang, Duke, & Schmidb, 2009). For example, messages from Kenyan newspapers like 'male circumcision cuts the risk of HIV transmission by 60 per cent' (Muzyka et al., 2012) may contribute to an assumption among circumcised men and their sexual partners that circumcision is sufficient for protecting them against HIV transmission. We recommend that biomedical and social science researchers adopt a gendered approach to examine how inaccurate messages from mass media – especially those that recommend VMMC as a procedure that provides absolute protection against HIV, or that do not simultaneously emphasise the need for continued condom use – are assimilated and influence engagement in risk compensation by heterosexual men, women and MSM/W.

Stigma towards intact men

In some contexts, some men who refuse to undergo VMMC face the risk of stigmatisation (Mshana et al., 2011; Sabet Sarvestani, Bufumbo, Geiger, & Sienko, 2012; Tarimo et al., 2012). In the generation of stigma against intact men, the role of women's perceptions of VMMC has been explored in certain settings (Downs et al., 2013; Plotkin et al., 2013; Tarimo et al., 2012). Some women regard circumcised partners as more sexually pleasing (Abbott et al., 2013), as other women have reported perceiving intact men as 'uneducated', 'unhygienic' or 'out-of-fashion', and even not-sexually satisfying (Layer et al., 2013; Tarimo et al., 2012). As seen in Zambia, some female sex workers commented that circumcised men were better lovers since they are slower to ejaculate (Abbott et al., 2013). Further, in Tanzania, some women stated that they do not enjoy sex with intact men. Men also expressed concern that women may even refuse to marry the intact ones (Downs et al., 2013; Layer et al., 2013; Tarimo et al., 2012).

The preferences of female partners with regard to the circumcision status of the male may arise from her previous responses to sexual stimuli, her preconceived ideas about VMMC and how the female partner has been socialised (Hankins, 2007). Preferences may also arise from previous sexual experiences with different types of men. However, these studies did not clearly indicate if women who considered circumcised men as more sexually satisfying had engaged in sexual intercourse with both circumcised and intact male partners.

Biomedical and social science researchers need to investigate to what extent these beliefs and preferences, derived from subjective and culturally influenced judgements of a small number of individuals in specific settings, may (1) foster stigmatising (mis)perceptions of either circumcised or intact men; (2) modify traditional sociocultural motivations for men to undergo either ritual or medical circumcision; (3) influence people's sexual partner choices based on expectations about their partner's circumcision status and (4) change the way women and men experience pleasure and erotic attraction. Moreover, research should address how these stigmatising perceptions might change existing masculinity roles: promoting circumcision through psychologically coercive tactics promoted by 'outsider' Western agencies holds the risk of establishing a hierarchical differentiation of men that may interact in unknown ways with existing sociocultural values associated with the circumcision status of men in different groups.

Qualitative research may help to understand how a negative attitude towards intact men originates in a specific setting, and how pressure from mass media and health systems to adopt VMMC can increase stigma against those men who opt not to undergo VMMC. How women's negative perceptions towards intact men are exploited, as a means of motivating men to undergo VMMC, is another aspect worth exploring in future research. Findings from qualitative research that adopts a gendered approach to investigate each of these aspects could be used to inform VMMC campaigns, and pre- and post-VMMC counselling to include messages promoting respect for those men who decline to be circumcised in favour of other HIV prevention methods (e.g. abstinence, faithfulness or condom use).

Female genital cutting

In some cultures, male and female circumcisions are symmetric rites that may be based in similar ontological principles (Johnsdotter, 2012; Kaplan et al., 2013). Female circumcision is an imprecise term that comprises a wide variety of procedures altering the anatomy of the female genitalia (Shell-Duncan, 2001). All such procedures have been described as female genital mutilation (FGM) by those who oppose such alterations (Davis, 2001). In the same document in which WHO/UNAIDS endorses VMMC, it is stated that FGM, the term adopted by the WHO, is a procedure that infringes on 'the physical and psychosexual integrity of women and girls, and is a form of violence against them' (WHO/UNAIDS, 2007, p. 27). As a more neutral term that allows for scholarly discussion without implicitly promoting a specific advocacy agenda, the term FGC has also been proposed (Shell-Duncan, 2001).

FGC is practiced in Kenya, Tanzania and Uganda with a prevalence of 27.1%, 14.6% and 0.6%, respectively, among women aged 15–49 years (Yoder, Wang, & Johansen, 2013). Infibulation, the most severe form of FGC, is not prevalent in our study region; it is practiced only in Kenya by 17% of the 27.1% of women who undergo any type of FGC (UNICEF, 2009).

The studies identified for this review and that were conducted in Kenya (Lanham et al., 2012; Riess, Achieng, Otieno, Ndinya-Achola, & Bailey, 2010), Tanzania (Downs et al., 2013; Layer et al., 2013; Mshana et al., 2011; Plotkin et al., 2013; Siegler, Mbwambo & DiClemente, 2012; Tarimo et al., 2012) or Uganda (Albert et al., 2011; Sabet Sarvestani et

al., 2012) failed to explore how promotion of VMMC might help reinforce the practice of FGC due to the close association between the two procedures in the eyes of both the community and the practitioner. Indeed, since ‘tribal’ circumcisions can have similar health outcomes (Svoboda & Darby, 2008) when performed in non-sterile environments and with untrained practitioners, a shift towards the ‘medicalization’ of male circumcision may contribute to the concomitant ‘medicalization’ of FGC (2008). Bell (2005) has drawn attention to the contradictory policies of the WHO on this point, ‘which seek to medicalize male circumcision on the one hand, oppose the medicalization of female circumcision on the other, while simultaneously basing their opposition to female operations on grounds that could legitimately be used to condemn the male operations’ (p. 131).

For future qualitative research, it is necessary to analyse in these three countries how the concepts of VMMC and FGC are interwoven. This analysis can be improved if researchers from biomedical and social science disciplines review the anthropological literature examining both traditional male circumcision and FGC in the region.

How different groups interpret the efforts of international organisations working to ‘eliminate’ only the female half of their initiation rituals, while promoting the male half in a hospitalised setting, must also be studied. These groups may wonder why ‘health benefits’ are cited for male circumcision but not FGC, when it is only the ‘health benefits’ of the former that have been investigated and only the ‘harms’ of the latter that have been investigated and funded by the same Western agencies (Svoboda & Darby, 2008). The extent to which mass media messages adhere to WHO/UNAIDS recommendations differentiating between VMMC and FGC (Wang et al., 2009), how they might contribute to efforts to eradicate FGC (Hankins, 2007), and how these messages impact people’s perceptions towards both practices are all areas in need of further investigation.

Understanding the foreskin

Some men in east and southern Africa may undergo traditional circumcision, which is performed in a non-medical setting and is perceived as a body alteration that marks the entry to manhood. In some cases, due to the wide variety of traditional types of male circumcision, penile appearance might signal to which linguistic group a man is ascribed (Brown et al., 2001; van Binsbergen, 1992).

Significance of the cosmetic result of circumcision as a research question is highly relevant, as penile appearance can differ substantially depending on whether the method chosen is traditional circumcision or VMMC. Moreover, the cosmetic result can also differ depending on if VMCC is surgically performed, or if a circumcision device is used. The importance men give to the cosmetic appearance of the penis has been measured in quantitative studies evaluating safety and acceptability of PrePex and Shang Ring devices in Kenya (Feldblum et al., 2014) and Uganda (Kigozi et al., 2013), respectively. Research with Colombian MSM reported that not having an aesthetic scar is a barrier to uptake of VMMC (Gonzales et al., 2012).

However, aesthetic appearance is one of the biggest gaps in the qualitative literature on VMMC under review in this article. A missed opportunity of a further exploration of this

topic is seen in a study from Uganda that targeted traditional circumcisers from the ethno-linguistic groups: Sebei, Bagisu, Baamba and Bakonzo (Sabet Sarvestani et al., 2012). The researchers investigated different styles of circumcision techniques with the aim of assessing the risks associated with VMMC by traditional methods, and the levels of protection against HIV that can be linked to different styles of circumcision. Acceptability and preferences for cosmetic appearance in the study participants were not assessed.

It should not be assumed that the aesthetic norms governing penile appearance (whether circumcised or intact) are the same across individuals, ethnic or gender groups. Future qualitative research should explore how significant penile appearance is for both males and females, and take into consideration some of the characteristics that differentiate individuals within a gender group especially with regard to their sexual orientation and sexual behaviour. Beyond informing barriers to uptake of VMMC, this research could also inform how men and women perceive the shape and appearance of the penis post-VMMC, and how this may either conform to or conflict with the erotic and social functions of the foreskin in traditional contexts. Biomedical and social science researchers should emphasise, using gendered-informed qualitative inquiry, an understanding of what the glans penis, scrotum or foreskin mean for populations that traditionally practice types of male genital alteration other than VMMC.

Some ethnic groups confer significance to the foreskin beyond just its aesthetic appearance – conforming to local norms regarding the appearance of genitalia symbolises that the male youth has undergone traditional rites of passage into manhood. Unlike other ethno-linguistic groups in Uganda, as a rite of passage into manhood the Sebei perform a different style of VMMC as traditional male circumcision that involves leaving some of the foreskin intact (Sabet Sarvestani et al., 2012). For the Maasai in Kenya, a buttonhole circumcision technique is performed instead, another type of partial removal that leaves an appendage of foreskin hanging below the penis (Siegler et al., 2012). The cultural and social function that the foreskin holds for certain ethnic and linguistic groups, and how modifying traditional circumcision techniques can impact current masculinity models, should be acknowledged when designing qualitative research on VMMC. It is recommended that researchers from biomedical and social science disciplines immerse themselves in the body of anthropological literature, where the meanings that are associated with traditional circumcision rituals have been explored across multiple ethnic groups in east and southern Africa.

MSM/W as study participants

The studies included in this review did not explore the sexual orientation of their participants. Thus, it is not possible to know how the knowledge and perceptions of MSM/W towards VMMC might act as barriers or opportunities for the uptake of VMMC, and/or influence risk compensation. Heteronormativity, a construct placing the heterosexual family and individuals as the core site for production of kinship, family values, sexual identities and sexuality, should not be the only assumption guiding participant sampling in research on VMMC.

Gender norms and relations place MSM/W in a vulnerable position with respect to HIV/AIDS infection (UNAIDS, 2013). MSM/W in east and southern Africa should also be

enrolled as study participants, as shown in previous research on VMMC conducted in Colombia (Gonzales et al., 2012), Scotland (McDaid, Weiss & Hart, 2010) and India (Schneider et al., 2012). This is crucial expansion of the current research on VMMC uptake, since at present there is insufficient evidence to support the use of VMMC as a HIV prevention tool for MSM/W (Wysong et al., 2011).

Future qualitative research should also consider exploring same-sex sexual practices with the aim of discerning how perceptions of the partial protection of VMMC may lead MSM/W to engage in risk compensation. Not investigating this aspect may be detrimental to the health of women who might be at higher risk of HIV transmission if their partners are MSM/W, but have not been counselled that VMMC might not provide any protection against HIV should they engage in sexual intercourse with other males without using a condom.

Conclusion

Incorporating a gendered perspective in biomedical and social science research for future qualitative studies on VMMC is crucial. VMMC endorsement by WHO/UNAIDS aims to contribute to decreasing the chances of heterosexual men becoming infected with HIV/AIDS, in a geographical context where gender-derived inequalities determine that women and MSM/W are actually more vulnerable than heterosexual men to HIV/AIDS transmission (Peters et al., 2013; UNAIDS, 2013). As some studies have pointed out (Dushoff et al., 2011; Wawer et al., 2009), this vulnerability for women and MSM/W may actually increase as a function of VMMC, perhaps through the mechanism of sexual disinhibition motivated by men's perception of being fully protected against HIV. Findings from qualitative research that consider a gendered approach will be important for health personnel and policy planners in determining whether VMMC is safe for women, or if on the contrary, it should not be recommended as it may increase their chances of becoming infected with HIV.

Biomedical and social science researchers should always include women and explore the sexual orientation of the participants in any qualitative study on VMMC. This would be useful in documenting gender relations, norms and inequalities, and to enhance the framing and understanding of the acceptance and impact of VMMC by relevant men, women and sexual minorities. A gendered approach could reveal the ways in which men and women perceive their gender identities, sexual identities, sexual orientations, social relations, choice of sexual partners, and how they experience pleasure and erotic attraction as a consequence of VMMC.

Finally, a gendered approach in qualitative research would be helpful in understanding some of the dynamics that we have explored in this article, thereby informing policy and implementation development. The messages that are provided to populations in VMMC campaigns and pre- and post-counselling sessions could greatly benefit from a gendered research agenda, with the ultimate goal of protecting men and women from further complications derived from risk compensation and potential risk factors associated with VMMC.

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Table 1

Qualitative studies included in this review.

	First author	Year	Country	Men?	Women?	Objective
1	Abbott	2013	Zambia	No	Yes	Knowledge, experiences and risk compensation related to VMMC among sex workers
2	Albert	2011	Uganda	Yes	Yes	Attitudes related to VMMC to provide information to promote VMMC
3	Downs	2013	Tanzania	Yes	Yes	Reasons and obstacles for low rates of male circumcision among Christians
4	Friedland	2013	Swaziland & Zambia	Yes	No	Understanding VMMC, the need for post-procedure abstinence and strategies for continued HIV risk reduction
5	Grund	2012	Swaziland	Yes	No	Understand men's sexual behaviour and risk compensation post-VMMC
6	Lanham	2012	Kenya	Yes	Yes	Women's understanding of partial HIV protection from VMMC, communication about VMMC
7	Layer	2013	Tanzania	No	Yes	Women's social value placed in VMMC and perceptions on partial protection
8	Lukobo	2007	Zambia	Yes	Yes	Knowledge, attitudes and beliefs and acceptability of VMMC if introduced to local health facilities
9	Lundsby	2012	Zambia	Yes	No	Explore how recently circumcised men adapt and ascribe value to and make sense of VMMC
10	Mshana	2011	Tanzania	Yes	Yes	Integration of traditionally circumcising communities with medical VMMC
11	Plotkin	2013	Tanzania	Yes	Yes	Identify potential barriers and facilitators to VMMC among older men
12	Riess	2010	Kenya	Yes	No	Explore sexual risk perceptions and behaviours and risk compensation
13	Sabet Sarvestani	2012	Uganda	Yes	No	Cultural implications of traditional circumcision to inform VMMC strategies
14	Sabone	2013	Botswana	Yes	No	Examine impediments to generate demand for circumcision among men in Botswana
15	Siegler	2012	Tanzania	Yes	Yes	Improved instrument sanitation practices and acceptability of VMMC in traditionally circumcising communities
16	Tarimo	2012	Tanzania	Yes	No	Perceptions and acceptability of VMMC among police officers