Safe snipping

Medical vs traditional circumcision: changing risky sexual habits

It is now indisputable that male circumcision performed in a medical facility protects against HIV. But there is also evidence that the protective benefits of male circumcision are undermined by 'risk compensation', or a lack of restraint when it comes to sexual behaviour. **KARL PELTZER, LEICKNESS SIMBAYI, MERCY BANYINI** and **QUEEN KEKANA** undertook two studies – among the first of their kind – to investigate whether counselling could limit this phenomenon among both medically circumcised and traditionally circumcised men.

These studies were in response to the urgent need for interventions that could prevent men from taking sexual risks after circumcision. Both studies were conducted among young men: one among those who had medical circumcisions and the other among those who underwent traditional circumcision. The mean age of both groups was 20 to 21.

Both studies were designed as follows: The day before circumcision a sample of 150 men in both studies was randomly chosen – 75 in an experimental group and 75 in a control group. The first group attended a three-hour motivational skills-building session, and the control group a 60-minute health improvement education session, with a brief segment on HIV prevention. Three months later both groups were again assessed on key behavioural issues.

INTERVENTION AMONG MEDICALLY CIRCUMCISED MEN

The results of the three-hour risk-reduction counselling session was positive. For example, when analysed it was found that after three months participants had significantly less (59%) unprotected vaginal intercourse. Knowledge about HIV was high before and after the assessment. It also showed that AIDS-related stigma was reduced by 32,4%.

This study concluded that a relatively brief and focused counselling session can have at least short-term effects on reducing the risky sexual behaviour among men who undergo medical circumcision.

INTERVENTION AMONG TRADITIONALLY CIRCUMCISED MEN

Some research has shown that traditional male circumcision seems to protect men from HIV infection, but a population-based survey among predominantly traditionally circumcised men in South Africa did not have the same positive results.

There are several important differences between traditional circumcision procedures and clinical procedures. These include differences in equipment used and counselling provided to the men before and after surgery.

Another difference is how much of the foreskin is removed. Some traditional circumcision involves only a partial removal of the foreskin, while the medical procedure removes sufficient foreskin that the glans remains fully exposed even on a non-erect penis.

It is not known exactly how much foreskin should be removed to reduce the risk of HIV infection in men, but complete removal seems to be the norm. The practice of partial removal of the skin may help explain why some cultures that practise traditional circumcision still have high rates of HIV prevalence.

> South African men are very resistant to change due to sociocultural values dictating how men should behave.

METHODS OF COUNSELLING

Recruitment was done at a traditional school with the assistance of the traditional attendant. This is a provisional structure far from the community. Initiates stay at the initiation school for almost two months.

The intervention of HIV risk-reduction counselling was provided toward the end of the stay in the traditional school so as to integrate the intervention with other teachings on manhood. The two counsellors were men who had been circumcised according to the same culture; they were told not to divulge anything about what was happening regarding the study as it would seem they were unveiling what was seen as sacred in the community.

INTERVENTION

The three-hour intervention was similar to that used in the medical circumcision study, which included male circumcision risk reduction content through skills building, personal goal setting, and addressing gender roles, particularly exploring meanings of masculinity and reducing adversarial attitudes toward women.

Condom use skills were explored through interactive group activities, and sexual communication skills were rehearsed in response to sexual risk scenarios. Participants provided feedback in behavioural rehearsal enactments and worked toward setting goals for HIV risk reduction. Alcohol use in sexual contexts was specifically discussed in relation to risk situations.

IN A NUTSHELL

- Traditionally performed circumcisions in South Africa may not provide the same level of HIV protection as medically performed circumcisions for several reasons.
- Traditionally performed circumcisions in South Africa include education that may decrease HIV-related stigma.
- Health providers must assess the knowledge, attitudes, and behaviour of men who have undergone traditional circumcision to determine the need for additional HIV-prevention education.
- Men who have undergone medical circumcision may not have had education or support to help them reduce HIV-related risks. Health providers need to assess this deficit and implement plans to educate these men about continued HIV risks.

RESISTANCE TO CHANGE

The intervention did not have any effect on this sample of traditionally circumcised men.

Why? Possibly because the two-month initiation into manhood teachings were more powerful than the one session of HIV risk-reduction counselling toward the end of the traditional initiation period.

However, from previous research in the same ethnic groups, most traditional circumcision providers did not include HIV/STI education and counselling , and most traditionally circumcised men were not aware of the HIV protective effect of male circumcision, although most believed in protective effects of male circumcision against STIs .

Surprising, however, was the finding that there was a decrease in HIV-related stigma.

PERVASIVE MACHO ATTITUDES

The lack of change in male role norms in both these studies is interesting. It suggests that these South African men are very resistant to change due to sociocultural values dictating how men should behave.

Similar resistance has also been noted with another intervention by our research team addressing gender-based violence and HIV risk reduction. There is therefore a need for a multi-level intervention with theory-based behavioural HIV risk reduction counselling targeting men who have undergone circumcision.

Another intervention would target both men and women at the community level to reinforce what the men learned in their counselling groups.

LIMITATIONS

Study limitations include that interventions in the current research were tested in trials with small sample sizes. In addition, the current studies represented an initial efficacy test of an adapted counselling model to male circumcision and therefore had a short follow-up period.

Finally, the study relied on self-report measures of sexual risk and alcohol use behaviours, which might not always be reliable.

CONCLUSIONS

These cluster randomised trials were the first to study a theory-based HIV intervention to reduce risk among circumcised men in South Africa. There is an urgent need for a larger randomised controlled trial to be conducted, followed by operational research as medical circumcision is being rolled out by the Department of Health nationally.

As for traditional circumcision, there is a need to find ways to moderate the social norms and values inculcated during traditional male circumcision rituals. ◂◂

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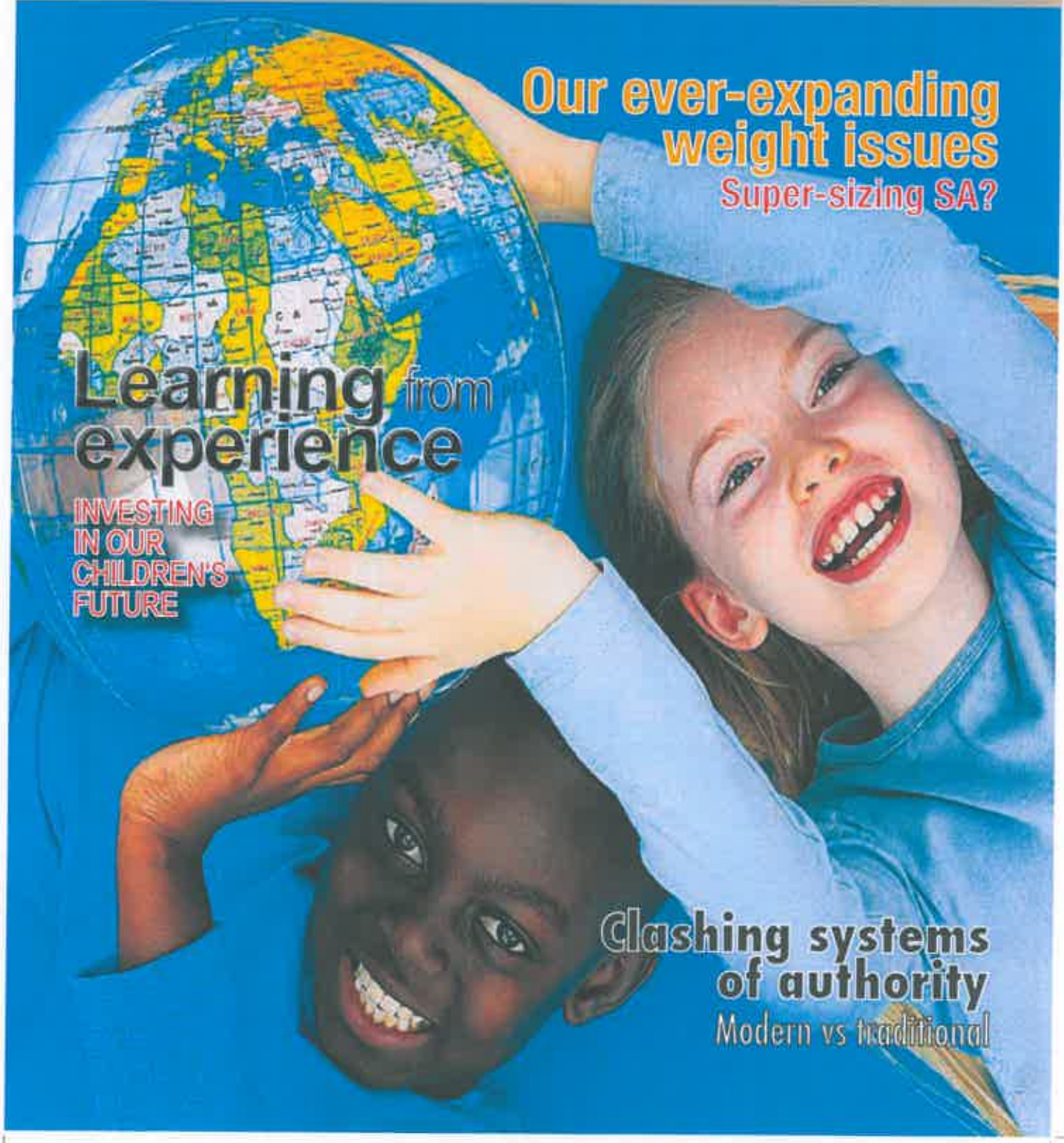

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