THE SOCIO-CULTURAL CONTEXT OF MEN'S SEXUAL BEHAVIOUR DURING POST- VOLUNTARY MEDICAL MALE CIRCUMCISION IN USENGE SUB-LOCATION, BONDO SUB-COUNTY, KENYA

BY

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DECLARATION

This thesis is my original work and has not been presented for any degree award in any university.

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ABSTRACT

Voluntary Medical Male Circumcision (VMMC) is an additional HIV preventive measure that is performed globally. In Kenya, the Ministry of Health added VMMC to its HIV preventive strategies after a series of consultations with various stakeholders and approved the VMMC policy in October, 2007. Majority of the Men in Usenge sub-location belong to the culturally non-circumcising Luo community and the uptake of VMMC in the region is expected to reverse the spread of HIV which is predominantly high in Nyanza as compared to other regions in Kenya. However, there is need for anthropological approach to know more about sexual behaviour of men who have been circumcised and whether the anticipated protective effect of VMMC leads to riskier sexual behaviour or not. This study therefore, sought to explore the socio-cultural context of men's sexual behaviour during post voluntary medical male circumcision in Usenge sub-location, Bondo Sub-County, Siaya County. Specifically, the study found out men's perception on sexual risk factors for HIV/AIDS following medical male circumcision; explored the influence of socio-cultural practices on men's sexual behaviour after circumcision; and examined the effectiveness of post-circumcision HIV/AIDS communication strategies in Usenge sub-location. The study was guided by the Health Belief Model (HBM) developed by Rosenstock (1966) and Becker in (1974) and cultural ecology theory coined by Julian Steward (1902-1972). The study design was cross-sectional. The study population comprised 192 medically circumcised men aged 18-49 years in Usenge sub-location. Study adopted purposive and snowball sampling methods to get 101 participants. The quantitative data were collected by the use of 101 semi-structured questionnaires while the qualitative data were collected using 101 semi-structured questionnaires, 10 in-depth interviews, 10 key informant interviews and 6 focus group discussions. Qualitative data were analyzed using content analysis method and presented in textual descriptions and illustrations using verbatim quotations. The quantitative data were analyzed using descriptive statistics by the aid of Statistical Package for Social Sciences (SPSS) version 19.0 and results presented in tables of frequencies and percentages. The findings showed that majority of participants in the survey were aged 25 to 29 years and most of them engaged in fishing and related activities as an occupation. The results further show that most circumcised men resumed sexual activities before proper healing of the wound to test whether their penises were functioning well. There existed perceptions that VMMC is "a back-up" and "a vaccine" against HIV/AIDS hence inconsistent condoms use during sexual intercourse. Fishermen's migratory patterns, transactional sexual relationships, peer pressure and alcoholism were social practices that influenced circumcised men's sexual behaviour in this study while cultural practices included: widow inheritance and other sexual cleansing ceremonies among the Luo community. There was no condom use during cultural practices that involved sexual intercourse. Local vernacular radio stations and brochures given to circumcised men were identified as communication strategies that had HIV/AIDS prevention messages. Brochures were not considered an effective method of delivering post VMMC messages while radio programmes were considered effective. In conclusion, the study revealed that during cultural practices there was no condom use. However, despite the existence of post VMMC behaviour change communications, circumcised men still engage in risky sexual practices, thus nullifying some of the intended benefits of VMMC. The study recommends the need to include local entertainment-education such as ora-media in the current HIV/AIDS communication strategies since this medium takes into account activities, beliefs and customs of local population. Moreover, policy makers and HIV/AIDS program implementers such as NASCOP and partners to integrate community members' participation in HIV/AIDS prevention programmes to minimize the conflict between cultural beliefs and new health interventions.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
CBS	:	Central Bureau of Statistics
FGDs	:	Focus Group Discussions
GOK	:	Government of Kenya
HBM	:	Health Belief Model
HIV	:	Human Immunodeficiency Virus
IPAR	:	Institute of Policy Analysis and Research
KAIS	:	Kenya AIDS Indicator Survey
KIIs	:	Key Informant Interviews
KNBS	:	Kenya National Bureau of Statistics
KNASP	:	Kenya National AIDS Strategic Plan
MC	:	Male Circumcision
MDGs	:	Millennium Development Goals
MMC	:	Medical Male Circumcision
MoH	:	Ministry of Health
NACC	:	National AIDS Control Council
NASCOP	:	National STI and AIDS Control Programme
SPSS	:	Statistical Package for Social Sciences
SSA	:	Sub-Saharan Africa
STD	:	Sexually Transmitted Disease
UNFPA	:	United Nations Population Fund

UNAIDS	:	The Joint United Nations Programme on AIDS
VMMC	:	Voluntary Medical Male Circumcision
WHO	:	World Health Organization

LIST OF TABLES

DEFINITIONS OF TERMS

Circumcision: a surgical procedure involving the removal of the foreskin of the penis.

Effective communication strategy: communication which takes into account the social and cultural aspects of recipient community.

***Jaboya*:** A Luo word that refers to a female customer or client who is a lover to the fisherman.

Madhar: this is a folk taxonomy among the Luo fishermen meaning a head of fishing crew member of a boat at a given time.

Medical Male Circumcision: the actual procedure of removing the foreskin using qualified health personnel.

Perception: this entails people's worldviews, knowledge and meanings that they attach to phenomena and the definition they offer.

Risk: the probability that a person may acquire HIV infection, usually as a result of specific behaviours that allow HIV transmission to occur.

Risk compensation: individuals increasing their risk behavior due to a real or perceived reduction of risk.

Sexuality: sex or sexual performance/functioning of the body (i.e. *the penis* as a source of sexual pleasure and satisfaction for the man and the woman).

Voluntary Medical Male Circumcision: the fact that the services to circumcise men are based on their own decision or choice.

Wimbo: this is a Luo word that refers to frequent migration by fishermen from original beach to another beach following income opportunities wherever fish stocks are most plentiful.

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) pandemic is one of the most serious health and development problems in the world with approximately 35.3 million people living with HIV by 2012 (UNAIDS, 2013). HIV testing and counseling, promotion of condom use, reduction in number of sexual partners, and treatment for other Sexually Transmitted Infections (STIs) are some of the main intervention strategies that are mainly employed by national AIDS control programs to minimize the spread of HIV/AIDS (UNAIDS,2010). Male Circumcision (MC), one of the oldest surgical procedures (WHO/UNAIDS, 2007a), that involves the removal of the foreskin of the male penis, is currently an additional HIV/AIDS preventive strategy recommended for men. According to World Health Organization's (WHO) 2006 report, 30% of men comprising 665 million were circumcised worldwide, mostly in countries where it is common for religious or cultural reasons (UNAIDS/WHO, 2006). In the United States alone, there were an estimated 1.2 million circumcisions performed shortly after the male child's birth in the hospitals in 2010 (Owings, 2013).

However, several studies in sub-Saharan Africa (SSA) have found that the perception of reduced risk in circumcised men could also have an adverse impact on other HIV risk reduction strategies. Unsafe sexual behaviour by men who misunderstood their own risk for infection could result in increased incidence and prevalence of HIV/AIDS. This may actually underestimate the intended protective effect of circumcision an aspect that this study intends to investigate (Nicoll, 1997; Weiss, Quigley & Hayes, 2000).

SSA is the region worst affected by HIV/AIDS, accounting for about two-thirds of the estimated 34.4 million people living with HIV/AIDS worldwide (WHO/UNAIDS, 2010). Male circumcision is common in many African countries, and is almost universal in North Africa and most of West Africa. More than 550,000 males were circumcised for HIV prevention in the priority countries of SSA by the end of 2010 (WHO/UNAIDS, 2010). In contrast, MC is less common in southern Africa, where self-reported prevalence of MC is around 15% in several countries namely: Botswana, Namibia, Swaziland, Zambia and Zimbabwe although it is higher in Malawi 21%, South Africa 35%, Lesotho 48%, Mozambique 60% among other countries (WHO/UNAIDS, 2007). Moreover, Zambia and South Africa had circumcised over 80,000 and 130,000 men, respectively, by the end of 2010. In Tanzania, the prevalence of male circumcision is estimated at 69.7% with a wider variation among the regions. Some regions have more than 95% circumcision rates and others as low as 20%. Two in three men aged 15-49 years in Tanzania are circumcised and urban men are more likely to be circumcised than rural men at 88% and 60%, due to massive VMMC campaigns in urban areas (Francis, *et al.*, 2012).

Despite the high rates of male circumcision in sub-Saharan Africa, there are signs of an increase in risky sexual behaviour in several countries (UNAIDS, 2013). Recent evidence indicates a significant increase in the number of sexual partners in some countries including Burkina Faso, Congo, Cote d'Ivoire, Ethiopia, Gabon, Guyana, Rwanda, South Africa, Uganda, the United Republic of Tanzania and Zimbabwe, as well as a decline in condom use despite the availability of MC operations (UNAIDS, 2013). Notably, in countries such as: Cameroon, Guinea, Haiti, Lesotho, Malawi, Niger, Rwanda, Senegal, Tanzania, and Zimbabwe, HIV prevalence is higher

among circumcised men (Mishra, *et al.*, 2009). This provokes questions about the nature of VMMC which was previously reported to be an additional protection against HIV.

Evidence from Zambia suggests that a large portion of VMMC clients are not adhering to WHO's recommendations on abstinence period of six weeks in order to allow for complete wound healing. According to a study conducted by the Population Council in 2010, newly circumcised men resumed sex within six-weeks. Of these men, 82% reported at least one unprotected sex act while 37% had sex with two or more partners during the healing period. Furthermore, 46% of the men who resumed sex early did so in the first three weeks following surgery, including 22% in the first week. This exposed circumcised men to HIV/AIDS (Hewett *et al.*, 2011). This implied that the risk of HIV transmission is increased for men during the healing period, due to increased likelihood of tearing or bleeding of the unhealed penis during sexual intercourse (Cassel, Halperin, Shelton, & Stanton, 2006).

Although a global meta-analysis of studies determined that 'behavioural interventions reduce sexual risk behaviour and avert sexually transmitted infections and HIV' (Scott-Sheldon, *et al.*, 2011), many countries lack a comprehensive strategy for rolling out these programmatic approaches. Social-behavioural programmes are often implemented in isolation, uncoordinated, insufficiently tailored to address the needs of the intended population and lacking in rigorous evaluation on a scale necessary for widespread roll-out. It is clear that countries will realize the optimal prevention returns only when a comprehensive set of HIV prevention initiatives is rolled out on a national scale, with sufficient access to, and frequent use of, quality services (Scott-Sheldon, *et al*., 2011; UNAIDS, 2013). The unique magnitude and scope of HIV/AIDS pandemic

therefore calls for unprecedented global, regional and national responses. Policies and programmes are increasingly addressing HIV/AIDS as a development challenge, and this requires a multidimensional national response (WHO/UNAIDS, 2007).

Kenya is one of the global leaders in scaling up Voluntary Medical Male Circumcision (VMMC) for adult males. For instance, over a two-year period between 2008 and 2010, more than 230,000 men have been circumcised with more than 60% of these being adult males in Nyanza region. VMMC reduces the risk of female-to-male HIV transmission by at least 60% (NASCOP, 2011). However, male circumcision does not provide complete protection against HIV infection because circumcised men can still become infected with the virus. Thus, there are concerns that risk compensation may lead to risky behaviour sparked by decreases in perceived risk of HIV infection and this could undermine the protective benefits of male circumcision (Cassell *et al.,* 2006; WHO/UNAIDS, 2007). The association between perception of risk of HIV infection and sexual behaviour remains poorly understood although perception of risk is considered to be the first stage towards behavioural change from risk-taking to safer behaviour (Akwara *et al.,* 2003).

However, the meaning and context of sexuality varies across populations and cultures, and it has been demonstrated that this has a major impact on sexual behaviour (Cassell *et al*., 2006; Akwara *et al.*, 2003). Previous research conducted on HIV/AIDS and male circumcision has adopted a biomedical paradigm on the aetiology of the disease in explaining sexual behaviour of circumcised men while ignoring social, cultural, and economic factors that influence the sexual behaviour (Green, 1999). Therefore, it is important to use anthropological insights in

understanding the variation of sexuality across populations and cultures an aspect that this study endeavors to address.

The Kenya AIDS Epidemic Update of 2011 shows that HIV/AIDS prevalence as at December 2011 was approximately 1.6 million (NACC & NASCOP, 2012). According to KAIS 2012 report, HIV prevalence among adults aged 15 to 64 years decreased nationally from 7.2%, as measured in KAIS 2007 to 5.6% in 2012. While the country's HIV/AIDS prevalence rate is 5.6%, Nyanza Province which is predominantly inhabited by the Luo community had a prevalence rate of approximately 14.9% in 2007 which increased to 15.1% in 2012. There appears to be several reasons for the high HIV prevalence in Nyanza province and among the Luo ethnic group despite the fact that it has recorded a high increase in voluntary medical male circumcision rates between 2007 and 2012 (NACC & NASCOP, 2012). First, the Institute of Policy Analysis and Research (IPAR) (2004) indentified poverty as a causal [as well as consequent] factor for high HIV infection in the region (IPAR, 2004). It is the leading predisposing factor to casual sex and promiscuity. Additionally, the post circumcision period and the perceptions on benefits of MMC on men's sexuality and the 60% protective aspect of MMC perhaps alter risks perceptions and therefore could be leading to a renaissance of HIV infection in Nyanza region. This is yet to be clearly explained by this study.

Secondly, high sexual risk behaviours along the shores of Lake Victoria such as sex-for-fish (*jaboya system*) and carefree lifestyles of the beach community have also been associated with high HIV infection in the region (IPAR, 2004; Nyambedha, 2006). According to IPAR (2004) report, beach culture is conducive to casual and commercial sexual practices, hence playing a

major role in the spread of the scourge, not only among the Luo but in the Lake Victoria gulf in Eastern Africa in general. The peculiar characteristics of the beach community are that men have sex at random and can change partners as they wish and each woman at the beach must have a temporary man friend or husband at any one time, to be assured of fish supplies and other favours. In addition, condom use is very low among them. The consequences of the beach culture are felt not only among the immediate community but also in many neighbouring hinterlands. This is because, as the beach people move to the hinterland to visit spouses and relatives, they carry the virus long with them (IPAR, 2004). While the behaviour of mobile fishermen has been documented (Kwena, Camlin, Shisanya, Mwanzo & Bukusi, 2013), sexual behaviour of circumcised men along the fish landing beaches of Lake Victoria is not known.

Thirdly, the relatively high prevalence of HIV/AIDS among the dominant Luo ethnic group has been associated with risky cultural practices such as widow inheritance (*ter*), polygamy, and other practices that include sex before ceremonies such as harvesting, opening of new home or house, and or marriage of sons (Agot, Kiarie, Nguyen, Odhiambo, Onyango, & Weiss, 2007; Caldwell & Caldwell, 1994; Luke, 2002; IPAR, 2004). Such cultural practices involve unprotected sexual intercourse which may further expose men to HIV/AIDS. However, wife inheritance factors should be considered within the context of other socio-cultural factors since there are some other ethnic groups in Kenya, such as the Maasai that practice women-sharing, but have low HIV prevalence. Moreover, UNAIDS (2013) report on the global AIDS epidemic indicates that, gender inequalities and harmful gender norms continue to contribute to HIV-related vulnerability. Therefore, this study also intends to find out whether circumcised men use other HIV prevention methods during such cultural practices involving sexual intercourse.

Consequently, HIV prevention communication strategies focus their messages and efforts on three aspects of behaviour: using condoms, limiting the number of sexual partners or staying faithful to one partner, and delaying sexual debut for young persons (abstinence) (NASCOP & MoH, 2008). The effectiveness of adult MMC depends, however, on appropriate behavioural responses to this potentially powerful new intervention (WHO/UNAIDS, 2007). Therefore according to Grund, & Hennink (2011), scheduled follow-up visits after medical circumcision are an appropriate opportunity for doctors and counselors to review safer sexual practices with circumcised men though it is not known whether such reviews could lead to behaviour change. Kenyan health educator Mjomba (2009) criticized HIV behaviour change communication in Kenya among circumcised men as essentially validating Eurocentric, literacy-based, didactic and non-participatory approaches (e.g. lectures, brochures and posters). Such an approach basically ignores oral African traditional forms of communication and probably will not reach large sectors of the population. Therefore, an additional research is therefore needed to continue to identify the most effective communication strategies that could help reduce risky post-VMMC behaviour in Kenya.

Although studies in Kenya (Agot *et al*., 2007; Bailey *et al.*, 2007) and in Uganda (Gray *et al*., 2007) as well as Swaziland (Grund, & Hennink, 2010) found that there is lack of risk compensation after circumcision and an increase in safe sex practice, these findings also show that men adopt multiple protective behaviors following circumcision, which suggest that circumcision scale-up is a feasible and effective HIV prevention strategy. However, the foregoing studies had limitations. Firstly, the studies failed to recognize that men's sexual behaviour change can be either protective against HIV whereby circumcised men use other HIV

prevention measures or provide greater risk for HIV transmission when they engage in unprotected sex with multiple opposite sexual partners. Bailey *et al.,* (2007) note that in Kenya, more circumcised men reported two or more sexual partners at six months, and more unprotected intercourse at 24 months.

Secondly, sexual behaviour may not be under an individual's volition but may be dependent upon the social and cultural environment in which one lives. The ability of individuals to be aware of, to initiate, and to sustain safer sexual behaviours may largely depend upon societal sexual norms and practices, and not just self-perceived susceptibility to HIV infection (Akwara, Madise & Hinde, 2003).

Usenge sub-location predominantly consists of the Luo ethnic group who traditionally did not practice male circumcision, and decisions regarding sex and related matters are culturally bestowed upon and dominated by men who are frequently also reluctant to use condoms (Dodoo, 1993, 1998; Ezeh, 1993; Omondi-Odhiambo, 1997). Therefore, this could also diminish some of the intended benefits of VMMC thus the male perspective is critical to understanding sexual and reproductive health behavior, including matters related to HIV/AIDS prevention in a society (Dodoo & van Kandewijk, 1996).

1.1.2 Luo Men's Sexual Practices

The Luo of Kenya is a large Nilotic speaking ethnic group, inhabiting Southern and Central Nyanza, along the eastern shores of Lake Victoria (Nyambedha, 2006). They are part of the migration of Nilotic group over the past four or five centuries from the Bahr-el-Ghazel region of

South Sudan to the present settlement in Western Kenya (Ocholla-Ayayo, 1986). Luo is a patriarchal society and one-third of its families are polygynous (Ocholla-Ayayo, 1980).

Reproduction is a key underlying concern for the Luo (Ocholla-Ayayo, 1980). The Luo communities along Lake Victoria still live and act within the norms that guide sexuality and their behaviour is guided by social or communal values. Communities along the beach have distinct characteristics where men have sex at random due to easy access to daily cash income and thus they can change partners at leisure and condom use is very low (IPAR, 2004).

Transactional sex majorly referred to as *jaboya* system dominates the Lake Victoria region. According to Odek (2006), *jaboya* is a customer or client who is a lover to the fisherman. Traditionally, *jaboya* referred to a male or female customer or a client who was a customer to fishermen in a particular boat and his/her major role was to buy fish from the fishermen to take to the market for sale and sometimes he/she could buy fishing gears for the fishermen. Traditionally, *jaboya* provided the crews with items such as torch for light at night, fishing gears and sometimes small amounts of money for breakfast when there is low fish catch. The relationship was purely business oriented and there were no sexual favours involved.

Currently, the meaning of *jaboya* has been transformed. Due to scarcity of fish stocks there arises competition and the women are forced to engage in sexual activity in exchange for fish from the fishermen. This is referred to as 'sex for fish' (Gordon & Ann, 2005). Women need to befriend the head of the crew of a boat locally known as *madhar* to be assured of getting more fish than other women. Despite the fact that people deny the existence of 'sex for fish', when probed further at the same time, others always confirm the existence of 'sex for fish' along the

beaches. All beaches have different situations and 'settings' to which 'sex for fish', its 'style or mode of engagement' and frequency is linked to.

The fishing community's lifestyle has also been cited as one of the reasons for the high HIV infections (Gordon & Ann, 2005; Nyambedha, 2007). Notably, fishermen along the beaches tend to have multiple sexual partners. This situation is catalyzed by their constant migratory patterns to other beaches facilitated by low fish catch in their current beaches. Fishermen who are circumcised are at risk of HIV infection when they engage in sexual activities with immigrants who constantly move into the beaches in search of work hence engage in prostitution and promiscuity as a mode of living in the fishing beaches (Kwena, *et al.*, 2010).

Furthermore, fishermen in Nyanza, like in many other parts of the world, are highly mobile often staying away from their families for long periods and interacting with many women who trade in fish (Kwena *et al.*, 2010). Additionally, the fisherfolk's frequent movement following income opportunities wherever fish stocks are most plentiful a concept locally known as *wimbo* has also acted as a catalyst to the spread of HIV among the Luo fishermen. In destination beaches, there is loss of sexual inhibition as a result of being in distant places due to mobility. This is greatly enhanced by consumption of alcohol and illicit drugs (Gupta, Vaidehi & Majumder, 2010), which may be normal behaviour in migration destinations and mobility hubs compared to communities of origin. Migrating circumcised Luo fishermen therefore indulge in extra-marital affairs and this exposes them to risk of HIV/AIDS especially when they do not take precaution of using other HIV preventive measures. This study therefore describes the

circumcised men's sexual behaviour particularly in the Lake Victoria socio-cultural context within Usenge Sub-location in Siaya County.

1.2 Statement of the Problem

Voluntary Medical Male Circumcision (VMMC) is a recently adopted HIV preventive measure and is a global phenomenon. Although VMMC reduces HIV transmission by 60 %, it does not eliminate the risk of infection. There is concern that circumcised men believe that they are fully protected, hence may participate in riskier sexual behavior following the procedure, which could lead to increased HIV infection. This kind of behaviour is referred to as risk compensation.

Therefore, understanding the socio-cultural context of risk perception in relation to sexual behaviour is important because it is the first stage towards behavioural change from risk-taking to safer sex. Although health behaviour models acknowledge the centrality of perceived risk in behavioural change. It is still unclear how circumcised men's personal risk assessments relate to their sexual behaviour. The adoption of preventive behaviour is the only protection against the virus until effective medical treatment of AIDS becomes universally available and affordable.

Besides other social and cultural factors propelling HIV spread in Nyanza region, majority of men in Usenge sub-location belong to the traditionally non-circumcising Luo community and the uptake of VMMC in the region is expected to reverse the spread of HIV infection. However, this has not been the case according to the KAIS 2012 report. If circumcised men in Usenge sub-location believe that circumcision offers them protection from HIV infection, then they may engage in risky sexual practices, which could mitigate some of the intended benefits of VMMC. It is therefore not known whether the circumcised Luo men in Usenge sub-Location combine

other HIV preventive measures like use of condoms during cultural practices which involve sexual activities such as widow inheritance (*ter*), polygamy, and other practices which have the potential to increase risk of HIV/AIDS infection. It is therefore necessary to use anthropological approaches to understand how socio-cultural factors influence circumcised Luo men's sexual behaviour which this study aims to address.

Behaviour change communication strategies in Kenya have typically been implemented without regard for local perceptions, knowledge, beliefs or customs relating to sexual relations, marriage, and related areas of human experience. Therefore, there exist post VMMC messages aired on local vernacular radio stations, posters, banners and brochures given to circumcised men to read. However, little is known on whether such media are effective means of conveying behaviour change and whether circumcised men adhere to the messages from such media. To make a mark in the fight against HIV/AIDS in Usenge sub-location there is need to embrace culturally sensitive communication systems in the fight against HIV/AIDS. This therefore calls for a need to examine the effectiveness of post-circumcision HIV/AIDS communication strategies in Usenge sub-location.

1.3 Research Questions

This study aimed at addressing the following research questions:

i. What are men's perceptions about sexual risk factors for HIV/AIDS following medical male circumcision?
ii. How do socio-cultural practices influence men's sexual behaviour after medical male circumcision in Usenge sub-location?
iii. How effective are post-circumcision HIV/AIDS communication strategies in Usenge sub-location?

1.4 Objectives of the Study

The general aim was to investigate the socio-cultural context of men's sexual behaviour during post voluntary medical male circumcision in Usenge sub-location.

The specific objectives were:

i. To find out men's perceptions on sexual risk factors for HIV/AIDS following medical male circumcision in Usenge sub-location.
ii. To explore the influence of socio-cultural practices on men's sexual behaviour after medical male circumcision in Usenge sub-location.
iii. To examine the effectiveness of post-circumcision HIV/AIDS communication strategies in Usenge sub-location.

1.5 Justification of the Study

An examination of people's perceptions of HIV risk is important in understanding how they relate their sexual experiences to the risk of disease infection in their social environment. Success in improving health therefore depends on specific efforts to promote appropriate behaviours and not just on the introduction of new drugs and technologies. Biological and social conditions propel the spread of the HIV virus and the same combine to make HIV prevention education and behaviour changes difficult. As a result, perceived risk of getting AIDS may have important implications for health if the perceptions are rational and lead to a willingness to avoid risky behaviour.

A study on the socio-cultural context of men's sexual behaviour during post VMMC in Usenge sub-location is appropriate in order to provide insights on factors that catalyzed the spread of HIV/AIDS in this region despite VMMC campaigns aimed at reducing HIV/AIDS spread in Nyanza region. This study has elucidated the importance of continually evaluating and updating the knowledge on HIV transmission with regard to what works in prevention so as to better inform and reinforce policy making and implementation.

This study has used anthropological perspectives and approaches such as cultural description of the Luo sexuality to explain how Lake Victoria as a social and cultural environment may facilitate or reduce the spread of HIV/AIDS in the region. Additionally, the findings and recommendations adduced from this study may guide the Ministry of Health and other public health practitioners in Bondo Sub-County and the wider Nyanza region in policy design aimed at

reducing new HIV infections and reversing the socio-economic impact of the pandemic. The findings from this study can also be used to provide civic education in relation to VMMC and also contribute to academic knowledge on issues of sexuality in our society. Furthermore, findings can be used to inform the Ministry of Health on the need to integrate cultural practices in HIV/AIDS prevention programmes and policies in order to minimize the conflict between cultural beliefs and new health interventions to minimize the spread of HIV/AIDS especially among the non-circumcising communities in Kenya.

1.6 Scope and Limitation of the Study

The study focused on Usenge sub-location of Bondo Sub-County and targeted medically circumcised men aged 18-49 years. This category is considered sexually active, and according to KAIS report (2012), was found to be most affected by the HIV/AIDS pandemic in Nyanza region at 15.1% (NASCOP and MoH, 2013). The study looked at men's sexual behaviour post-voluntary medical male circumcision.

Given the nature of the study population namely circumcised men who fall under the category of difficult-to-find information rich cases (Patton, 1987), this study found it equally impossible to adopt a random sampling strategy to obtain respondents since issues of sexuality were considered private. The study, therefore, adopted purposive sampling in which the snow balling and chain sampling strategies were used to identify the respondents. Only circumcised men from Usenge sub-location were interviewed hence the findings from this study cannot be used for generalization in other areas.

One major limitation was that the study touched on men's sexuality, a subject that is considered sensitive, private in most African societies and is not openly discussed hence this could have

affected the validity of the data collected. However, the researcher explained the importance of the study to the respondents built rapport, this made open up and assure them that whatever they said was confidential and would not be used against them. This made the respondents open up and feel more at ease.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter presents the literature reviewed on male circumcision and HIV/AIDS situation in the Luo community, male circumcision and HIV/AIDS reduction, perception on sexual risk factors for HIV/AIDS following medical male circumcision, influence of socio-cultural practices on men's sexual behaviour after medical male circumcision, the effectiveness of the post-circumcision HIV/AIDS communication strategies and theoretical framework used in this study.

2.2 Male Circumcision and HIV/AIDS Situation in the Luo Community

According to KDHS (2009), Nyanza Province had an overall prevalence of approximately 14.9%. Nyanza Province is predominantly occupied by the Luo community and those aged 15-49 years had HIV prevalence of 11% for males and 16% for females (KNBS, 2008). However, the KAIS 2012 report showed that HIV/AIDS prevalence rate in the province increased from 14.9% to 15.1% for people between 15-64 years of age. Further, KAIS (2007) showed that HIV transmission in fishing communities is a particular problem around Lake Victoria, a region mostly inhabited by the Luo accounting for 26% of incidence (NASCOP & MoH, 2008). The scientific evidence accumulated over more than 20 years shows that among the strategies advocated during this period for HIV prevention, male circumcision is one of, if not, the most efficacious epidemiologically, as well as cost-wise (UNAIDS, 2010). The high HIV prevalence and low MC (Adari, 2004; Agot *et al*., 2004; Caldwell & Caldwell, 1994) suggested that the greatest public health impact could result from prioritizing expansion of MC services for younger males, among whom HIV prevalence may still be relatively low but incidence could be high now, or in subsequent years (WHO/UNAIDS, 2007b).

In October 2007, the Government of Kenya approved MC as one of the strategies for preventing HIV infection and consequently embarked on campaigns to encourage non-circumcising communities to undergo MC (NASCOP, 2008). Kenya performed more than 230,000 voluntary medical male circumcision procedures from November 2008 to December 2010, reaching more than 60% of previously uncircumcised adult males in Nyanza Province, where circumcision prevalence is much lower than the national average (NACC and NASCOP, 2012). By October 2009, 50,526 men and boys in Nyanza had been circumcised and had received related HIV prevention services (NACC & NASCOP, 2012). However, in-depth studies that have examined the association between the perception of risk and sexual behaviour change remain inconclusive because of the complexities of the contextual and socio-cultural factors that influence sexual behaviour change (Caldwell, Orubuloye & Caldwell, 1999; Cohen & Trussell, 1996; Gage & Njogu, 1994; Anarfi, 1993). There is therefore is a need to investigate factors influencing men's sexual behaviour change in relation to VMMC.

2.2.1 Male Circumcision and HIV/AIDS Reduction

The recent global finding that circumcision of men substantially reduces the risk of HIV infection is one of the most exciting developments in the history of HIV/AIDS prevention (Cassell, Halperin, Shelton, & Stanton, 2006). The hypothesis that MC might reduce risk of HIV infection was first proposed in 1986 by Fink (Bongaarts *et al.,* 1989; Fink, 1987). Several biological research explanations have been documented to explain how MC may reduce the risk of HIV infection (Weiss *et al.,* 2000). Some of the researched arguments are that removal of the foreskin reduces ability of HIV to penetrate the skin of the penis, and that on the underside of the foreskin are located many special cells such as langerhans cells which are prime targets for HIV

(Morris, 2007; Moses *et al.,* 1998). Other explanations are that uncircumcised penis is more susceptible to minor trauma (small tears in the delicate skin of the inner surface of the foreskin) during sexual intercourse, which could allow a portal entry for HIV (Morris, 2007).

The trials carried out in Kisumu, Kenya and Rakai District, Uganda revealed at least a 53% and 51% reduction in risk of acquiring HIV infection, respectively (Bailey *et al.,* 2007; Grey *et al.,* 2007). These results supported findings published in 2005 from the South Africa Orange Farm Intervention Trial, which demonstrated at least a 60% reduction in HIV infection among men who were circumcised (Auvert *et al.,* 2005).

Since transmission occurs primarily through heterosexual contact in sub-Saharan Africa (Caldwell and Caldwell, 1993) and decisions regarding sex and related matters are culturally bestowed upon and dominated by men who are also frequently reluctant to use condoms (Caldwell, Caldwell, and Quiggin , 1989; Dodoo, 1993, 1998; Ezeh, 1993; Isiugo- Abanihe, 1994; Omondi-Odhiambo, 1997), the male perspective is critical to understanding sexual and reproductive health behavior, including matters related to HIV/AIDS prevention in the region (Dodoo and van Kandewijk, 1996).

2.3 Perceptions on Sexual Risk Factors for HIV/AIDS Following Medical Male Circumcision

Perception entails people's worldviews, knowledge and meanings that they attach to phenomena and the definition they offer (Brown, 1989). The perception of phenomena by a person can be defined as a social judgment about that particular phenomenon. This conceptualization implies that perceptions are learned and, are therefore a product of social interaction (Hare, 1996). The

perception one has about a situation or phenomenon normally guides the actions one takes regarding the situation. This therefore, implies that perception of people about HIV/AIDS has a direct bearing on what they do to deal with it (King, 1962; Knutson, 1965). The concept of risk perception is socially constructed and culturally embedded within groups (Knutson, 1965).

Risk-taking sexual behaviour in sub-Saharan Africa is associated with a number of factors, including gender inequalities that place women in subordinate positions, the belief that men have stronger sexual drives than women, and the notion that men cannot do without sex (Reid, 1999; Kenya, Mulindi, Onsongo, & Gatei, 1998; Cohen & Trussell, 1996; Ocholla-Ayayo & Schwarz, 1991). These beliefs act to exacerbate the spread of Sexually Transmitted Diseases (STDs), including HIV/AIDS. The lack of power to negotiate safer sex among women may be the central obstacle to AIDS prevention in Africa. Sexual behaviour may not be under an individual's volition but may be dependent upon the social and cultural environment in which one lives. The ability of individuals to be aware of, to initiate, and to sustain safer sexual behaviours may largely depend upon societal sexual norms and practices, and not just self-perceived susceptibility to HIV infection (Akwara *et al*., 2003).

Even if circumcision is promoted as only reducing risk and not fully protecting a man from HIV acquisition, men might undergo the procedure and feel less inhibited about engaging in risky sexual behaviour. Such behavioural disinhibition could result in increases rather than reductions in HIV incidence. There is evidence that some circumcised men engage in higher risk behaviours than uncircumcised men. However, the circumcised men are still found to have lower prevalence of HIV infection (Akwara *et al*., 2003). Studies conducted in Kenya and Swaziland (Auvert *et al*., 2005; Bailey *et al*., 2007; Gray *et al*., 2007; Grund, & Hennink, 2010; Riess *et al*., 2010)

both indicated that men described perceived MMC as a 'back-up' protection against HIV/AIDS thus inconsistently indulged in sex without condom use. The data from this study consequently explored the reasons as to why men perceive MMC as a 'back-up' and further explored whether they used condoms during sexual intercourse, within the context of a fishing community.

Currently, VMMC is performed in countries with low MC rates, high HIV prevalence, and where heterosexual sex is the main route of transmission of HIV. The questions remain about whether promoting VMMC as an HIV prevention intervention will result in decreases in HIV incidence. A key concern is that promoting VMMC may lead circumcised men to develop a false sense of complete protection against HIV and engage in risk compensation by halting or decreasing previous protective behaviors such as condom use or partner reduction, causing the protective effects of VMMC to be reduced or negated (Riess *et al*., 2010). For instance, a cross-sectional study conducted in Botswana, Namibia and Swaziland (Andersson & Cockcroft, 2012), showed that the misconception that circumcised men cannot transmit HIV was significantly more common in Swaziland, despite the statement in the MC campaign materials that HIV positive men who are circumcised can transmit HIV. For instance, this misconception led circumcised men to engage in risky sexual behaviour by increasing the number of sexual partners and failed to use condoms shortly after circumcision (Grund, & Hennink, 2010).

VMMC lowers the probability of men contracting HIV and any increase in risk behaviour attributable to this known protection should be considered as risk compensation. Accordingly, sexual risk compensation in the context of MC is characterized by someone knowing that they are less likely to contract HIV and responding to this reduced risk by increasing behaviors

associated with greater risk of HIV transmission, such as not using condoms, increasing the number of sexual partners, increasing the frequency of higher-risk sex (e.g. anal sex versus vaginal sex), or increasing the frequency of sex with high-risk partners (e.g. sex workers) (Riess *et al*., 2010). This study therefore focused on the socio-cultural context of men's sexual behaviour during post VMMC, considering the fact that that the ability of men to be aware of, to initiate, and to sustain safer sexual behaviours may largely depend on societal sexual norms and practices, and not just self-perceived susceptibility to HIV infection. Therefore, there is inadequate information on whether and how societal sexual norms and practices reinforce risky sexual behaviour among those who are circumcised.

Flood, Lust & Latex (2003) did a study in Brazil which qualitatively explored why young heterosexual men did not use condoms. From the study, several themes emerged to account for non-use of condoms among the participants. Condoms were perceived to decrease penile sensation, difficult to use, and inhibited sexual episodes. Moreover, condoms were perceived to interrupt the "heat of the moment" of sexual episodes. This "moment" was defined as passionate, sexually and emotionally intense, and verbally silent, and unable to accommodate awareness or considerations of HIV protection (such as condom use) or of the possible consequences of the episode. Furthermore, young men emphasized the notion of trust indicating the perception that condom use could not be used in stable, regular sexual relationships. Flood *et al* (2003) study focused on adoption of condom use among young men. There is limited information existing to explain sexual behaviour or practices in relation to HIV infection following VMMC in Kenya hence this study attempts to address this knowledge gap.

KAIS (2007) report found that among sexually active, HIV infected participants, less than half had ever used a condom and less than 20 percent used a condom the last time they had sex (NASCOP & MoH, 2008). Other studies (KDHS, 2003; Welsh *et al.,* 2001) have found that many people do not use condoms consistently with their regular partners or spouses due to the perception that they are uninfected and always faithful. Previous studies in Kenya (Buve *et al.,* 2002; KDHS, 2003; Pulerwitz *et al.,* 2006) reported that condoms are often perceived as ineffective, difficult to use, reduce pleasure, and may imply lack of trust in a partner. Additionally, alcohol and substance abuse may also lead young people to forget to use condoms (Kamau, 2006). These results suggest an urgent need to strengthen HIV preventive strategies to prevent new infections. Hence, this study described the social factors that could lead to such perceptions which exposed circumcised men to risk of HIV/AIDS.

2.4 Influence of Socio-cultural Practices on Men's Sexual Behaviour After Medical Male Circumcision

People live and act within specific communities and societies, and their behaviour is guided by social or communal values (Kamaara, 2004). Further, Kamaara (2004), asserted that human sexual behaviour is determined and constrained by factors outside the individual being, and is a product of socio-cultural imposition on the biological factors within the individual being.

Bongaarts (1995) stated that 'sexual behaviour is probably responsible for much of the differences in heterosexual HIV/AIDS epidemics among countries, as well as for the equally large differences among regions and demographic groups within countries'. Various authors have suggested that sexual activity in sub-Saharan Africa appears to be driven largely by socio-cultural beliefs and practices (Caldwell *et al*., 1999; Cohen & Trussell, 1996; Gage & Njogu, 1994; Anarfi, 1993). Risk-taking sexual behaviour may be tolerated in some contexts while in

others it may be strongly disapproved of and regarded as irresponsible or immoral. For example, multiple partnerships for men may be tolerated, while women's infidelity is highly penalized, meaning that aspects of sexual conduct are beyond women's control (Caldwell *et al*., 1999; Fapohunda & Rutenberg, 1999; Ingham & van Zessen, 1997).

Although there is data on sexual behaviour following adult circumcision from the South African randomized controlled trial (Auvert *et al.,* 2005), men were asked about factors associated with numbers of sexual partners and contacts. Circumcised men reported higher risk behaviour for the five reported factors (being married or living as married; at least one sexual contact not protected by a condom; at least one non spousal partner; at least one sexual partnership with only one sexual contact; at least five sexual contacts) during the period 4–12 months after randomization, and four out of five during the period 13–21 months after randomization (Auvert *et al.,* 2005). Effective promotion of sexual behaviour change requires more than just knowing what puts people at risk and who is at risk. It requires understanding why they engage in risky behaviour an aspect that most studies have not addressed. Notably, ignoring the cultural beliefs and attitudes that a societies have about HIV/AIDS is counterproductive to the development of culturally appropriate and effective HIV/AIDS prevention programs. Therefore, focusing on socio-cultural factors provides a much more realistic view of what it takes to get people change their sexual behaviour (Caldwell *et al*., 1999).

2.4.1 Transactional Sexual Relationships in the Fishing Communities along Lake Victoria

Two ecological studies have shown HIV infection rates to be highest in traditionally non-circumcising areas of sub-Saharan Africa (Bongaarts *et al*., 1989; Caldwell & Caldwell, 1994). Nyanza Province has the lowest prevalence of male circumcision (47 percent) and the highest

prevalence of HIV (15.3 percent) in Kenya hence the region was targeted for the roll out of VMMC programmes (NACC & NASCOP, 2012).

Transactional sex involves exchange of sex for money, favours, or gifts. The practice is associated with high risk of contracting HIV and other STIs due to compromised power relations and the tendency to have concurrent, multiple partners as a result. Transactional sex has been shown to be the driving force in the dynamics of HIV in many different sites (Edward & Janet, 2004). The estimated Population Attributable Fraction (PAF) of transactional sex is 84% in Accra and 76% in Cotonou. A recent meta-analysis confirmed the importance of 'paid sex' as a sexual risk factor for heterosexual HIV transmission in sub-Saharan Africa for both women and men (Chen *et al.*, 2007).

Fishing communities that include both fishermen and others who process or trade in fish are among those groups with the highest prevalence of HIV and other STIs (Pickering, Okongo, Ojwiya, Yirrell & Whitworth, 1997; Voeten, Egesah & Habbema, 2004; Kissling *et al.,* 2005; Ng'ayo *et al.,* 2008). Fishing communities which, according to Edward and Janet (2004), are categorized among the highest-risk groups in countries with high overall rates of HIV/AIDS prevalence, the high prevalence is associated with complex interacting causes which may include the mobility of many fisherfolk, the time they spend away from home, easy access to daily cash income in an overall context of poverty, their demographic profile and vulnerability of commercial sex in fishing ports (Edward & Janet, 2004; Kissling, *et al.,* 2005).

The HIV vulnerability of fisherfolk partly stems from the specific dynamics of the occupation and the social interactions that arise out of the fishing industry (Hemrich & Topouzis, 2000). Fishing communities attract young, highly migratory men who spend long periods away from their families and local communities. While away, the social structures and hierarchies that guide sexual norms are no longer observed (Seeley & Allison, 2005). On the fishing beaches, social ties are based on economic relationships and occupational peer-group interactions, providing unrestricted opportunities that determine sexual and behavioural norms (Kissling *et al*., 2005). Transactional sex between men and women is often thought to be a manifestation of poverty, epitomizing differences in economic power between men and women. Men may therefore exploit unequal economic power differentials by demanding sex for any goods or services that women require of them (Kongnyuy, Wiysonge, Mbu, Nana & Kouam, 2006).

Along the fish landing beaches of Lake Victoria, transactional sex is majorly referred to as *jaboya system.* Odek (2006), defines *jaboya* as a female customer or client who is a lover to the fisherman. The practice includes even rich women who fund fishing activities of young men and receive sexual favours in return. Because the catch is not always bountiful and demand for fish is high, the women fishmongers are conditioned to offer sexual favours to fishermen in order to secure a consistent supply of fish for their trade, a practice popularly known as "sex-for-fish" (Nyambedha, 2006). According to IPAR (2004) report, beach culture is conducive to casual and commercial sexual practices, hence playing a major role in the spread of HIV/AIDS, not only among the Luo but in the Lake Victoria gulf in Eastern Africa. The peculiar characteristics of the beach community are that men have sex at random and can change partners at leisure; and each

woman at the beach must have a husband at any one time, to be assured of fish supplies and other favours. In addition, condom use is very low (IPAR, 2004; Grund, & Hennink, 2010).

Moreover, the gendered social dynamics of fishing communities in contexts of poverty bring together several key contextual factors that shape both women's and men's risk for acquiring HIV, such as gender inequality, poverty, migratory processes, and highly differentiated occupational sex segregation (Dworkin & Ehrhardt, 2007). This study therefore investigated fishermen's migratory processes and how these processes contributed to risky sexual behaviour in the destination beaches among circumcised men.

2.4.2 Widow Inheritance and Sexual Cleansing Ceremonies

High prevalence of HIV among the dominant Luo ethnic group has been associated with risky cultural practices such as widow inheritance (*ter*), polygamy, and other practices that include sex before ceremonies such as harvesting, opening of new home or house, and marriage of sons (Caldwell & Caldwell, 1994; Luke, 2002; IPAR, 2004; Agot *et al*., 2007). Widow inheritance is whereby a brother or cousin of the deceased man takes the widow to live with as a sexual partner as well as taking care of the widow and her children .This is due to the belief among the Luo community that upon the death of the husband, both the home and widow become unclean (Whisson, 1964; Nyambedha, 2000; Ogutu, 2007). Widow inheritance acts as a ritual cleansing process to the widow and the home from the bonds of death. Sexual intercourse between the widow and the inheritor is central to this process whereby there has to be an exchange of body fluids to merge the two partners. Indeed, most of the time in wife inheritance, sex takes place without condom use and in the absence of HIV testing and counseling for the adults involved in the practice (Prince, 2004; Gunga, 2009).

Widow inheritance remains a controversial and persistent subject in the Luo community (Prince, 2004; Gunga, 2009). Other study by (Ogutu, 2007) note that, persistence of widow inheritance among the Luo community is as a result of a belief that if one fails to undergo the ritual cleansing, the widow would be hit by *chira,* a curse from the gods leading to a wasting illness that can affect the widow and her children. Due to the fear of *chira,* the widow goes through a "ritual cleansing" (*chodo okola)* which is achieved through obligatory sexual intercourse, performed by *jatiek kwer* if he is from within the clan, or a *jakowiny* when he is an outsider, some of whom are paid (Kimani, 2004; Nyambedha, 2006; Ogutu, 2007).

Notably, there is no limit as to the number of widows a man can inherit at any given time. Consequently, the practice has a lot of potential for transmitting HIV (IPAR, 2004). According to Gunga (2009), the practice of widow inheritance is a way of containing the spread of the disease as the widow is attached to a single male inheritor rather than circulating freely among men in the community. In addition, it is a taboo to reveal HIV/AIDS as the cause of death, more so when the deceased is a relative. The partners of the deceased are then at a high risk of spreading the virus in the course of the rituals associated with mourning the dead, widow inheritance being one of them (IPAR, 2004; Gunga, 2009). Other sexual cleansing practices in the Luo community such as sexual contact between the parents or between one parent and a stranger in the event of marriage of sons; setting up a new homestead and major agricultural activities such as ploughing, sowing and harvesting can also predispose circumcised men to HIV (IPAR, 2004).

Furthermore, while the concept of 'African sexuality' is debatable (Ahlberg, 1994). There is clear ethnographic evidence that African societies do not condone sexual permissiveness. There is evidence that Eastern African communities are preoccupied with controlling sexuality so that all issues surrounding sex, and the self-control that is required in that regard, demonstrate social and moral behaviour. Risk-taking sexual behaviour may be tolerated in some contexts while in others it may be strongly disapproved of and regarded as irresponsible or immoral. For example, multiple partnerships for men may be tolerated, while women's infidelity is highly penalized, meaning that aspects of sexual conduct are beyond women's control (Ingham & van Zessen, 1997; Caldwell, Orubuloye & Caldwell, 1999; Fapohunda & Rutenberg, 1999). HIV prevention projects therefore need to factor in the cultural context and male perceptions of their sexuality and their adoption of HIV risk-reduction strategies. Previous studies identified cultural perceptions and practices as a key barrier to sexual reduction in Nyanza province, Kenya (IPAR, 2004). However, this study used anthropological approaches in understanding whether cultural perceptions among the Luo acted as a catalyst or reduced the rate of HIV in circumcised men.

2.5 The Effectiveness of Post-Circumcision HIV/AIDS Communication Strategies

HIV seems to be on the increase because the messages of behaviour change are not coming out clearly and strongly thereby, failing to impact on people's behaviour (Panos Eastern Africa, 2011). Accurate knowledge about HIV, although critical, on its own, often does not lead to sustained behaviour change. Effective HIV prevention helps individuals perceive whether they might be at risk for HIV, increases the motivations and intentions to reduce risk, and builds the skills required to enable individuals to protect themselves against transmission (Frolich & Vazquez-Alvarez, 2008). Behaviour change communication strategies include initiatives intended for the general population, as well as focused interventions for key sub populations.

Broad-based HIV awareness campaigns have helped equip the Kenyan population with extensive knowledge about HIV (Frolich & Vazquez-Alvarez, 2008).

Although Kenya National AIDS Strategic Plan (KNASP III) prioritizes the development and implementation of focused prevention programmes in fishing communities, relatively few prevention services have been implemented for fishing communities, in which frequent migration for work serves to intensify HIV related vulnerability (Gelmon, Kenya & Oguya, 2009; NACC, 2009a). Majorly, an emphasis on remaining abstinent has been a central feature of many youth-focused HIV prevention programmes in Kenya (Gelmon *et al*., 2009). However, little literature has exposed the impact of abstinence-focused programming in reducing men's risk of HIV infection in Kenya (Gelmon *et al.*, 2009), although a review of studies of abstinence-only programmes in high-income countries did not find them to be effective (Underhill *et al*., 2007). However, in a cross-sectional study conducted in Botswana, Namibia and Swaziland (Andersson & Cockcroft,2012), findings indicated that the misconception that circumcised men cannot transmit HIV infection was significantly more common in Swaziland, despite the mention in the MC campaign materials that HIV-positive men who are circumcised can transmit HIV. Wawer *et al* (2009) therefore argued that stronger efforts are needed to raise awareness that MC does not directly protect women, that circumcised men may be HIV positive, and that HIV positive circumcised men can transmit the infection at least as readily as non-circumcised men (Wawer *et al*., 2009).

Effective HIV prevention communication can help reduce young people's risk of HIV infection. For example, a survey of female upper primary school students in Nyanza found that exposure to

HIV prevention programming in community festivals was associated with increased chances of condom use (Maticka-Tyndale & Tenkorang, 2010). However, the early age of sexual debut and infrequent condom use among young people, documented in periodic national surveys, underscore the reality that many young people in Kenya still lack meaningful access to effective prevention services. Behaviour change interventions are primarily delivered by more than 16,000 organizations that sponsor HIV related programmes in Kenya, though the impact on sexual behaviour change have not been completely exhausted (Gelmon *et al.,* 2009). Recent reviews have identified gaps in the continuum of behavioural interventions. For example, few prevention communication strategies specifically focus on adults over age 25 (Gelmon *et al*., 2009), even though the country's modes-of-transmission study found that older adults in stable relationships account for the largest single share of new HIV infections. This study therefore examined if there were post-circumcision HIV/AIDS preventive communication strategies targeting medically circumcised men and whether these strategies led to responsible or risky sexual behavior among circumcised men.

Although information about male circumcision and HIV infection is available to the population via radio, bill boards, in-door and out-door posters, client's brochures and newspapers among other communication channels in a limited manner (Godlonton, Munthali, & Thornton, 2011). According to Godlonton, Munthali, & Thornton (2011), there is reason to believe that the effects of receiving the information directly and individually from interviewers are stronger than the effects of other media sources. Therefore, even if respondents had access to information from other sources about the relationship between circumcision and HIV infection, previous studies suggested that even among individuals with prior information exposure, comprehension of the

information increases after receiving it directly from a health officer (Moag *et al.,* 1998; Guadagno and Cialdina, 2002; Valley, Thompson *et al*., 2002; Guadagno and Cialdina, 2007).

HIV/AIDS prevention in Africa tend to value literacy or Eurocentric communication approaches such as brochures, posters, radio, newspapers and television more than indigenous modes of communication strategies such as narration *(sigendni*), singing (*wende)* and dancing (*miende)* (Wenje, Nyambedha & Muhoma, 2011). Mounting evidence indicates that these Eurocentric modes of communication have the potential of alienating and disempowering the people they are intended to inform because the communication process does not start from within their experiences and in many cases are incapable of giving full respect to their values. To make a mark in the fight against HIV/AIDS in African countries there is need to embrace culturally sensitive communication systems in the fight against HIV/AIDS. The traditional systems of communication put greater emphasis on getting the audience involved in perceiving HIV/AIDS as their problem rather than a media, government, non government organization or an international agency agenda (Guadagno and Cialdina, 2007; Wenje, Nyambedha & Muhoma, 2011).

Moreover, social-behavioural programmes need to be better coordinated and more strategically focused. Intensified efforts are needed to ensure that social-behavioural programmes are evidence-informed, rigorously evaluated, gender- and youth-sensitive and address key drivers of the epidemic, including concurrence among sexual partners (UNAIDS, 2013). In addition, this study examined the effectiveness of available post-circumcision HIV/AIDS preventive programs available for circumcised men in Usenge location, Bondo Sub-County in Siaya County.

2.6 Theoretical Framework

The study was guided by the Health Belief Model (HBM) and Julian Steward's cultural ecology theory. HBM is one of the first theories of health behaviour originally developed by Rosenstock in 1966 and further developed by Becker in 1974, as a psychological model to explain and predict why individuals engage in health-related actions that may or may not compromise their health. It remains one of the most widely recognized theories in the field of preventive medicine. It was initially used in the 1950's to explain the widespread failure of people to participate in prevention programmes against diseases (vaccination) and later applied to people's responses to diagnosed symptoms of illness and compliance with medical regimens (Rosenstock, Strecher & Becker, 1994). It suggests that health-related behaviours depend on four individual attitudes or perceptions about an illness: 1) the potential seriousness of an illness, 2) the person's feeling of risk from that illness, 3) the benefits they feel they will receive for taking a preventive action and 4) the barriers to taking that action. Rosenstock (1974) was of the opinion that these were actually the determinants of a person's perception of his health condition and the actions he or she was likely to take to move from ill-health to health. This leads to health seeking behaviour and decision making process. For an individual to constantly remain healthy, he must continually take positive decisions and dutifully act upon them (Kaplan, Sallis & Patterson, 1993).

The HBM has been proposed as a framework to conceptualize HIV/AIDS preventive behaviours because of its success in explaining health conditions and health related behaviours (Rosenstock, Stretcher, & Becker, 1994). The HBM is therefore built on these four core components (perceived susceptibility, perceived severity, perceived benefits, and perceived barriers). Evidently since health motivation is the central focus of HBM, the model should be a good fit for

addressing problem behaviours that could evoke health concerns such as high-risk sexual behaviour and the possibility of contracting HIV (Kaplan, Sallis & Patterson, 1993). The inability of the HBM to make tangible provision for a social environment where behaviour takes place has created a gap concerning its application in Africa where traditions are held in high esteem (Odutola, 2005). However, HBM does not explain the importance of the social environment or context where human behaviour occurs in studying human behaviour and the strong influence that the socio-cultural context exerts on decision-making hence the use of cultural ecology theory in this study to address the social-cultural factors that influence men's sexual behaviour.

Cultural ecology was coined by Julian Steward (1902-1972) as a methodology for studying human adaptations to social and physical environments. In his *Theory of Culture Change: The Methodology of Multilinear Evolution* (1955), cultural ecology represents the "ways in which culture change is induced by adaptation to the environment." Steward (1955) argued that to understand people's behaviour an individual has to look at 1) people's technologies & methods used to exploit the environment to get a living from it, 2) how a particular human pattern of behaviour or culture is associated with the environment and 3) assess how much these patterns of behaviour influence other aspects of culture in the society (Steward, 1955). Steward argued that any particular human adaptation is in part historically inherited and involves the technologies, practices, and knowledge that allow people to live in an environment (Steward, 1955).

In applying these theories in the present study, the Health Belief Model, helps to explain men's perception of sexual risks following voluntary medical male circumcision despite the fact that

they are counseled and informed that VMMC is just one way of reducing the spread of HIV/AIDS. Applied to VMMC, men are motivated to undergo VMMC, in large part, because they perceive themselves to be at risk of acquiring HIV and they further believe that being circumcised will reduce their HIV risk. Beliefs about the degree of HIV protection afforded by VMMC termed response efficacy may moderate changes in HIV risk perception after getting circumcised and thereby influence sexual behavior. For example, if a man understands that VMMC is only partially protective against HIV, he may be inclined to practice other HIV protective behaviors. Alternatively, if he thinks that male circumcision is 100% effective at preventing HIV, he may think that he is no longer at risk of HIV infection after VMMC and engage in risky or compensatory sexual behavior. Although there is no substantive evidence, there is apprehension that medically circumcised men will engage in riskier sexual behaviors because they erroneously believe that circumcision completely reduces their risk of HIV infection a phenomenon termed risk compensation or behavioral disinhibition.

In the health belief model, there must be a focus and limit to what to believe and the action to be taken should be specific. Consequently, HBM helped in explaining what factors circumcised men perceived to expose them to risky sexual behaviours after VMMC and whether the risk factors exposed them to HIV/AIDS in Usenge sub-location.

Cultural ecology was used to explore the influence of socio-cultural practices on men's sexual behaviour after medical male circumcision since cultural ecology also interprets cultural practices in terms of their long-term role in helping humans adapt to their environment. Moreover, an ecological perspective focuses on the nature of people's transactions with their

physical and socio-cultural surroundings (Sallis & Owen, 1997). Accordingly, Richard, Potvin, Kishchuk, Prlic, and Green (1996) asserted that understanding health will only be realized "if the context in which people live is taken into account" while "the ecological approach compensates for the limitations of traditional individual approaches often associated with victim blaming."

Moreover, all people belong to a specific culture and a group of people may share the same basic but unique pattern of learned behaviour. As such, each culture has a distinct environmental adaptation, human beings are uniquely reliant on culture as a means of adaptation. . For instance, circumcised men in Usenge sub location majorly reside along Lake Victoria region and villages linked to Lake Victoria fish landing beaches. Therefore, cultural ecology was used to describe how circumcised men rely on their environment for adaptation and how adaptation had an influence on their socio-cultural beliefs which in turn influenced their sexual behaviour positively by using HIV preventive measures or negatively by engaging in riskier sexual behaviour.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodology that was used in this study. It gives a description of the study design, study area, study population, sampling procedures, and methods of data collection. It further explains the methods of data analysis and presentation. In addition, it presents the ethical considerations.

3.2 Study Design

The study design was cross-sectional survey. This aided in achieving a snapshot picture of what was happening in the study area hence was useful in capturing information within a short period of time. Both quantitative and qualitative research techniques were incorporated in the design (Creswell, 2003). The study was conducted in two phases that lasted a month each. The first month involved administering semi-structured questionnaires and conducting in-depth interviews. This was followed by key informant interviews and Focus Group Discussions (FGDs).

3.3 Study Area

The study was carried out in Usenge Sub-Location, Bondo Sub-County of Siaya County in Nyanza Region. Usenge sub-location is situated in West Yimbo location of Usigu division. The sub-location has a projected population of about 21931 out of which 11027 are male and 10904 are female (Central Bureau of Statistics, 2010). The area is mainly inhabited by the Luo. Generally, the population is ethnically heterogeneous since it has immigrants from other tribes in Kenya who do not necessarily speak *Dholuo*. The study area is situated along the fish landing beachline on the shores of Lake Victoria. It is one of the regions with very high HIV prevalence

because of activities related to fishing such as transactional sex which creates a fertile area for HIV/AIDS (GOK, 2002; Republic of Kenya, 2005). Usenge sub-location in Bondo Sub-County had approximately 192 medically circumcised men. However, larger population of men are not circumcised (Central Bureau of Statistics, 2010).

There are several fish landing beaches surrounding the sub-location namely; Usenge, Goye, Uhanya, Anyanga, Nyenye and Misori out of which the study targeted beaches with higher activities related to fishing. Consequently, Usenge, Uhanya and Anyanga beaches were purposively selected for this study. However, out of eighteen villages, eight villages linked to fish landing beaches also formed the study area. These villages included: Usenge area A, Usenge area B, Usalo, Sanda, Uhanya, Rapogi, Anyanga and Kanyibok.

According to Central Bureau of Statistics (CBS) (2010), the main economic activity in the study area is fishing. As the main economic activity, fishing also provides a source of livelihood and some manual jobs for locals. Apart from fishing, the inhabitants also practice subsistence farming while male youths sometimes engage in touting, bicycle and motorcycle taxi business locally known as *boda boda* (Nyambedha, 2000). Notably, some of the youths engaged in water vendoring and *jua kali* industry such as welding. Inhabitants also deal in small-scale businesses such as small retail shops and food kiosks. Usenge sub-location was selected for this study because of its proximity to Lake Victoria and therefore the area falls under the category of very high HIV prevalence areas and rate of VMMC is averagely above national rate (NACC & NASCOP, 2012) and is more likely to report high promiscuity due to transactional sexual relationships and several beaches surrounding the sub-location.

These several beaches attract a mixture of people including men and women, single, young, widows or divorced, because there is business opportunity and high cash flow. Early in the morning after landing at the shores the fishermen have their pockets full of money. It should be noted that the saving culture and, knowledge about it and possibilities for saving is low on the beaches. Additionally, in most beaches, there are no existing options for 'recreation' for the fishermen. They therefore have cash in their pocket, the whole day free and time with nothing to do, which confirms the claim that money goes into sex, alcohol and drugs.

3.4 Study Population

The study population comprised a total of 192 men aged 18 to 49 years who had undergone voluntary medical male circumcision and were residents of Usenge sub-location. Usenge sub-location had been estimated to have a male population of 11027 out of which approximately 192 were medically circumcised (CBS, 2010; Bondo District AIDS/STD Control Records, 2011). The study population also included: eight local community elders who provided information on how socio-cultural practices influenced men's sexual behaviour after circumcision in Usenge sub-location, three beach leaders in the sub-location, the assistant chief, three health professionals in the sub-location and Bondo Sub-County health officer were also targeted as key-informants.

3.5 Sampling Procedure and Sample Size

Usenge sub-location consists of eighteen villages and six fish landing beaches. This study was conducted in three beaches where there were high activity related to fishing after obtaining data from Bondo Sub-County Fisheries Department. Purposive sampling procedure was used to select the three beaches namely: Usenge, Uhanya and Anyanga beaches were purposively selected for

this study. Furthermore, eight villages linked to the selected fish landing beaches such as Usenge area A, Usenge area B, Usalo, Sanda, Uhanya, Rapogi, Anyanga and Kanyibok were also purposively sampled. The study employed purposive and snowball sampling methods to get the medically circumcised men and community elders. However, snowballing can be limited by only focusing on one social network, so the study maintained an appropriate mixture by varying geographical locations and socio-economic activities as areas of recruiting circumcised men. Snow balling was used to determine the next respondent until the desired sample size was reached at the point of saturation of data being collected. Glasser & Strauss (1967) define data saturation as the point at which "no additional data are being found whereby the (researcher) can develop themes of the category." Therefore, the study sample size was 101, which is recommended by Kathuri and Pals (1993) who say that a minimum of 100 and above is recommended for a survey research. This was a sufficient sample as the targeted respondents were difficult to find and had been defined as sexually active and vulnerable to HIV infections (Ross, Dick, & Ferguson, 2006). From the eighteen villages, six community elders were purposively selected for key informant interviews based on their in-depth knowledge of the Luo culture. Other key informants included; three beach leaders from three beaches in the study area, two health professionals in the study area and the Sub-County AIDS/STD control officer.

3.6 Methods and Instruments of Data Collection

This study used data triangulation, in which different methods of data collection and analysis were employed. Specifically, the study used semi-structured questionnaires, In-depth Interviews, Key Informant Interviews, Focus Group Discussions and secondary data.

3.6.1 Survey/Semi-Structured Questionnaires

The researcher used a formal standardized semi-structured questionnaire which included both closed and open ended questions and was administered to 101 circumcised men. This provided both qualitative and quantitative data on socio-demographic characteristics of the respondents, perception about sexual risk factors for HIV/AIDS following medical male circumcision, how socio-cultural practices influence men's sexual behaviour after VMMC and the effectiveness of post-circumcision HIV/AIDS preventive communication strategies. Questionnaires were chosen because they were an inexpensive way to gather data from a potentially large number of respondents. Often, they are the only sufficient way to reach a number of respondents large enough to allow for statistical analysis of the results.

3.6.2 In-depth Interviews/In-depth Interview Guide

In-depth interview technique according to Bernard (1995) is appropriate for sensitive topics. Using in-depth interview guides allowed thorough probing for clarification and detailed understanding of men's perception of their sexual risks following medical male circumcision. In this case, in-depth interviews helped probe sexual practices, especially issues such as condom use after VMMC. It also helped probe change in number of sexual partners before and after VMMC and the effectiveness of the available post VMMC HIV/AIDS communication strategies. The narratives from circumcised men were recorded using a digital sound recorder and later transcribed. Ten in-depth interviews with circumcised men who were identified purposively based on how they responded during the questionnaires survey were conducted. In-depth interviews also offered a confidential environment for participants to discuss personal sexual behaviour and sensitive issues.

3.6.3 Key Informant Interviews/Key Informant Checklists

Key informant interviews were used to collect data from community elders and local health professionals. A key informant is defined as someone who is likely to have knowledge or experience that is relevant to the topic under investigation (Bernard, 1995). Interviews with the 6 community elders were therefore conducted to give a deeper understanding of socio-cultural practices influencing men's sexual behaviour after circumcision. Further, interviews with 3 beach leaders provided an understanding of whether transactional sexual relationships existing in the fishing communities along Lake Victoria threatens the intended benefits of VMMC. In addition, the Sub-County AIDS/STD control officer was also interviewed to give the information on any available post-circumcision communication strategies that target circumcised men in particular and how effective those programmes were. A key informant checklist was used in order to ensure every aspects of the study objectives were covered effectively.

3.6.4 Focus Group Discussion (FGDs)/ Focus Group Discussion Guide

The study utilized six focus group discussions comprising of nine participants each. The participants were selected purposively from the study population based on the principle of homogeneity. Two focus group discussions were conducted with circumcised men who were married with the spouse alive and living together to get their views on adherence to post VMMC abstinence period, socio-cultural practices that could influence their sexual behaviour during post VMMC and their perceptions on sexual risk factors following VMMC. Another two focus group discussions were held with circumcised men who were not married to obtain their views on perceptions on sexual risk factors for HIV/AIDS after VMMC and the last two focus group discussions were held with the community elders to obtain their opinions on socio-cultural practices that could put circumcised men at risk of HIV infection. Membership of this group cut

across the 18 villages. A FGD guide served as a reference tool to ensure that discussions were focused towards achieving the objectives of the study. The guide was translated from English into Dholuo and the responses from the discussants were back-translated to English.

The researcher moderated all discussions and one male research assistant trained by the researcher on the objectives of the study took detailed notes during FGDs. Discussants were given a choice of participating in the sessions in the indigenous language, Dholuo, Kiswahili, or English. Proceedings of sessions were recorded using a digital sound recorder. Discussants were then thanked for their participating in the discussion. The proceedings of each FGD were transcribed (in Dholuo, later translated into English) immediately after each session. This facilitated identification of topics not well covered in previous discussions to be pursued in details in subsequent FGD sessions.

3.6.5 Secondary Data

The study also utilized secondary sources of information that were relevant to the topic of study. Relevant literature related to voluntary medical male circumcision, HIV/AIDS and men's sexual behaviours, among others was obtained from the library, journals and articles, various books and research reports. Secondary data was used to supplement primary data and to put various discussions in context.

3.6.6 Validity and Reliability

Validity and reliability involved a pre-determination of questionnaires to ensure that the questions that were vague were changed or restructured before the actual study. Ten semi-structured questionnaires were administered twice to circumcised men in the village linked to beach and neighbouring the study area at an interval of one week. The aim of this was to

improve on questionnaire reliability through correct wording and appropriate ordering so that questions could be made clear. In addition, the researcher discussed the prepared questionnaires and the interview guides with the supervisors to ensure that they were adequate enough to collect data that would eventually address the objectives of the study. This was meant to cater for the reliability and validity of the data collection instruments.

3.7 Data Analysis and Presentation

Data interpretation began while the field work was in progress. The researcher took note of emerging themes and how they shaped the course of the research. Qualitative data from semi-structured questionnaires, in-depth interviews, key informant interviews and focus group discussions were then analyzed through content analysis method, which involved identifying recurring themes. The process involved going through the qualitative data, sentence by sentence, word by word, identifying recurring themes and coding them (Ritchie & Lewis, 2003). Content analysis helped in capturing the knowledge, perceptions and experiences of the respondents regarding sexual behaviour after voluntary medical male circumcision in the study area. Qualitative data were presented in textual descriptions and illustrations using verbatim quotations. Quantitative data were analyzed using descriptive statistics by the aid of Statistical Package for Social Sciences (SPSS) version 19.0 and results were presented in tables of frequencies and percentages, as shown in the next chapters.

3.8 Ethical Considerations

Permission to proceed with the study and to guarantee respect for human subjects was obtained from Maseno University. Furthermore, ethical clearance was obtained from Maseno University Ethical Review Committee. Research participants were informed of the nature of the study and

that participation in the study was completely voluntary. Informed consent was obtained from all participants and the respondents were assured of confidentiality. Respect for human privacy and dignity was maintained throughout the data collection and analysis process. For qualitative data collected in this study where individual's responses were reported qualitatively, no identifying name tags were used. A summary of the findings were made available to the participants in a results dissemination process through the assistant chief's *baraza* after the study.

CHAPTER FOUR: MEN'S PERCEPTIONS ON SEXUAL RISK FACTORS FOR HIV/AIDS FOLLOWING VOLUNTARY MEDICAL MALE CIRCUMCISION

4.1 Introduction

This chapter presents the results on the socio-demographic characteristics of the study population. It also presents both results on men's perceptions about sexual risk factors for HIV/AIDS following voluntary medical male circumcision in Usenge sub-location, Bondo Sub-County, Siaya County in Western Kenya. The aim of this chapter is to describe men's perceptions on sexual risk factors to HIV/AIDS after VMMC. The chapter therefore, presents results of the study under the following sub-headings:- socio-demographic characteristics of the respondent and perceptions on sexual risk factors for HIV/AIDS following voluntary medical male circumcision. The chapter specifically describes;-compensation for the healing period and inconsistency in condoms use; marital affairs post voluntary medical male circumcision; perceived increase in men's sexuality post VMMC; and finally the summary.

4.2 Socio-Demographic Characteristics of the Respondents

It was important to establish the socio-demographic characteristics of the respondents since in developing countries, being circumcised is primarily influenced by religious and ethnic/cultural reasons in addition to other socio-demographic and economic factors such as education levels, residence, region, wealth status, occupation, age, and marital status. These factors also influences sexual behaviour (Shaffer *et al*., 2007; WHO and UNAIDS 2007; Connolly *et al.*, 2009). In total, 101 men participated in the study.

4.2.1 Age of the Respondents

Majority (42.6%) of circumcised men in this study were aged between 25 to 29 years. This age bracket were also identified by Kenya AIDS Indicator Survey (KAIS) 2007 as an age bracket that had the highest HIV prevalence (NASCOP, 2007). The results in this study also indicated that the rate of circumcision decreases as the age increases. The results are as shown in Table 4.1. According to Akwara *et al.,* (2003), the age of a person is another factor that may influence sexual behaviour and the level of perceived risk of HIV infection. This is because men in their teens are at an increased risk of HIV infection because they often engage in unprotected sexual intercourse (Hulton, Cullen & Khalokho, 2000). Additionally, according to Kenya AIDS Indicator Survey (KAIS) 2012 report, men within the age bracket of 18 to 49 years in Nyanza Province have high HIV/AIDS prevalence which stands at 15.1% (NASCOP, 2013). This study therefore included age as a factor in examining circumcised men's perceptions on sexual risk factors to HIV/AIDS following voluntary medical male circumcision.

Table 4.1 Age of the Respondents

Age	Frequency	Percent
18-24	9	19.8
25-29	43	42.6
30-34	15	14.9
35-39	20	8.9
40-44	9	8.9
45-49	5	5.0
Total	**101**	**100.0**

4.2.2 Marital Status of the Respondents

Results in Table 4.2 show that a majority (58.4%) of the respondents were married. This implied that there was low condom use as had been indicated in previous studies in Kenya. According to previous studies conducted in Kenya by Glen *et al*., (2001) and KAIS (2007), men in stable relationships are less likely to use condoms consistently (NASCOP, 2007). Marital status may also affect sexual behaviour and risk of HIV infection when couples engage in extra-marital affairs. It also influences perception of the risk of HIV infection and sexual behaviour (Akwara *et al.,* 2003). Sexual transmission accounts for an estimated 93% of new HIV infections in Kenya, with heterosexual intercourse representing 77% of incident infections. According to Akwara *et al.,* (2003) often, married men consent in unsafe sexual practices, even if they suspect or know of their partner's extra-marital relations due to the fact that they may be suspected of being unfaithful. This was also supported by Blanc *et al.,* (1996) who stated that on most occasions married couples do not use condoms due to fear of suspicion from the partner. Although HIV cannot be spread through sexual intercourse in stable monogamous relationships between uninfected partners, among married women, the presence and nature of their partners' casual or extramarital sexual practices largely determine the risk of HIV transmission (Akwara *et al.,* 2003).

Table 4.2 Marital Status of the Respondents

Marital Status	Frequency	Percent
Single	32	31.7
Married	59	58.4
Widowed	6	5.9
Separated	4	4.0
Total	101	100.0

However, promotion of condom use and reduction in the number of sexual partners are some of the main intervention strategies that are mainly employed by national AIDS control programs to minimize the spread of HIV/AIDS. Other researches in Kenya have indicated that people in married relationships are less likely to use HIV protective strategies such as condoms (Welsh *et al.*, 2001; KDHS, 2003; IPAR, 2004; NASCOP, 2007; UNAIDS, 2010). This was because of the fear of being suspected of promiscuity by their spouses, which could lead to unwanted consequences such as separation or even divorce.

Furthermore, 31.7% of the respondents in this study were single. Studies in sub-Saharan Africa (SSA) show that young single males do not confine themselves in monogamous relationships (Hogsborg & Aaby, 1992; Welsh *et al.*, 2001; IPAR, 2004; Shelton *et al.*, 2004). Their findings indicated that moderate number of single circumcised men (32 out of 101) such as the ones in this study could further be exposed to HIV/AIDS if they fail to confine themselves in monogamous relationships.

Notably, 5.9% were widowed and a few 4.9% of the respondents in this study were separated. This was an indication that these men were free to re-marry and this could, in some cases, expose them to HIV virus as supported by the excerpt below:

> In Luo culture, a man who is widowed is allowed to re-marry a girl of his choice and in most cases there is no HIV test done. Thus, HIV transmission can either be from the man to new wife or from the new wife to widower. Moreover, separation gives man the chance either to re-marry or to indulge in extra-marital affairs which are a risky sexual behaviour. Circumcised men like me are not exempted from such behaviour (A man, 39 years old).

4.2.3 Educational Status of the Respondents

In terms of education, a majority (57.4%) of the respondents went up to secondary school .This implied that these men had an increased ability to understand HIV prevention information, better access to health services, and reduced social and economic vulnerability that exposes them to risky sexual behaviours. Moreover, 19.8% of the respondents had up to primary level education or less, an indication that they easily receive and process health information while 10.9% of them had up to university level of education. A minority (7.9%) of the respondents never went to school. Due to inadequate information, these men noted that they perceived circumcision as a new HIV 'vaccine' hence exposed to risk of HIV infections. Approximately 4.0% of the respondents mentioned that they attended college such as teachers' training colleges and accountancy colleges. The results are as illustrated in Table 4.3.

Table 4.3 Education Level of the Respondents

Education Level		Frequency	Percent
	Never went to school	8	7.9
	Secondary School	58	57.4
	Primary School	20	19.8
	University	11	10.9
	College	4	4.0
	Total	101	100.0

A key determinant of access to and comprehension of HIV/AIDS knowledge and information is education and these results imply that majority of respondents had at least knowledge on modes of HIV/AIDS transmission. During in-depth interviews, medically circumcised men noted that along Lake Victoria region, there are a large number of men who completed secondary school. However, due to a lot of money that they earn from fishing and activities related to fishing and their poor family backgrounds, these men failed to receive post-secondary education.

For instance, one of the informants noted that:-

> Along the lake region we are assured to get cash daily provided you go fishing…you cannot sleep hungry so, most young men who have finished their secondary education sometimes resort to fishing and activities related to fishing more so those who come from poor family backgrounds that cannot finance their post-secondary education….I am telling you along these beaches most youths resort to fishing rather than education….benefits of education take longer time while fishing brings food on table daily. Thus, circumcised men along these beaches whether learned or not have to adapt to 'beach culture'…..this culture exposes the educated and non-educated circumcised men to HIV/AIDS (Male informant, 36 years old).

Education increases chances of upward mobility and accumulation of wealth. These resources make it easier for an individual to have access to more casual sexual partners. Research in Kenya has shown that education is associated more with high risk behaviour such as casual sex (Glen *et al.,* 2001). According to Fortson (2008), highly educated men are more likely to engage in pre-marital sex, which may increase their susceptibility to HIV infections. In this study, education level was used to assess circumcised men's perceptions on sexual risk factors for HIV/AIDS following medical male circumcision.

4.2.4 Religious Affiliation of the Respondents

Table 4.4 displays religious affiliation of the respondents in the study.

Table 4.4 Religious Affiliation of the Respondents

Religious Affiliation	Frequency	Percent
Catholic	13	12.9
Protestant	85	84.2
No or *other* Religion	3	3.0
Total	101	100.0

A majority (84.2%) of the respondents were Protestants. However, there were religious affiliations such as Nomiya Luo Church (Protestants) that has been advocating for male circumcision. Nomiya Luo Church in Kenya requires male circumcision for membership and this is done after a baby boy is born, then the church leaders count up to 7 days and on the eighth day the child is circumcised (de Walque, 2006). Additionally, there are some religious groups that do not advocate for the use of condoms. Religion has been reported to have an influence on the

use of other HIV prevention measures. Most notably, the Catholic Church and Muslim religion have been publicly vocal about their disapproval of the use of condoms (de Walque, 2006). In this study, some (12.9%) of the respondents were Catholics while minority (3.0%) reported 'no or *other* religion'. Religion as a factor can also be used to assess a link between circumcision and HIV infection since it is usually associated with individual sexual behaviour.

4.2.5 Occupation Characteristics of the Respondents

A majority (50.5%) of the respondents' reported fishing as their occupation. This was an indication that these men had to adapt to beach culture to sustain their livelihood. As shown in Table 4.5, 18.8% of the respondents were involved in motorbike riding locally known as *boda boda* and 13.9% of them were involved in touting. The majority of the respondents were fishermen and 6.9% of them were involved in farming which involved growing of maize, millet and vegetables for family consumption. There were a few respondents (5.9%) who were businessmen and a minority (4.0%) were involved in teaching respectively. The results are as illustrated in Table 4.5.

Table 4.5 Occupation of the Respondents

Occupation	Frequency	Percent
Fishing	51	50.5
Touting	14	13.9
Motorbike Taxi (Boda boda)	19	18.8
Teaching	4	4.0
Farming	7	6.9
Business	6	5.9
Total	101	100.0

Due to proximity to Lake Victoria, most of the respondents in this study were fishermen and this could contribute to high incidences of HIV prevalence in Usenge sub-location because of beach community's culture where there exist carefree lifestyles and men have sex at random and can change partners at leisure (IPAR, 2004). Moreover, KAIS (2007) report showed that HIV transmission in fishing communities is a particular problem around Lake Victoria, a region mostly inhabited by the Luo accounting for 26% of incidence (NASCOP and MoH, 2008).

According to IPAR (2004), the peculiar characteristics of the beach community are that men have sex at random and can change partners leisurely; and each woman at the beach must have a temporary man friend or husband at any one time, to be assured of fish supplies and other favours; and in addition condom use is very low because sometimes sex occurs in a hurry and there is no time to negotiate for condom use.

The consequences of the beach culture are felt not only among the immediate community but also in many neighboring hinterlands. This is because, as the beach people move to the hinterlands to visit spouses and relatives, they carry the HIV virus along with them. Notably, circumcised men in this study who lived along the fish landing beaches had to adapt to the beach culture hence were not exempted from HIV infections if they indulged in unprotected sexual intercourse.

4.3 Perceptions on Sexual Risk Factors for HIV/AIDS Following Voluntary Medical Male Circumcision

The disparity between people's knowledge about HIV/AIDS and the extent to which they take measures to protect themselves is one of the most critical issues for public health. In this study, risk factors were considered to be the behaviour circumcised men engaged in which could predispose them to HIV/AIDS after MMC. For instance, this study focused on the lake region as a social environment and how activities around the lake could influence circumcised men's perceptions on risk factors to HIV/AIDS.

In this study, compensation for the healing period and inconsistency in condom use, increase in extra-marital affairs, and perceived increase in men's sexuality after VMMC were commonly mentioned as risk factors. However, the respondents associated these risk factors to low chances of contracting HIV/AIDS due to the belief that MMC acted as a natural condom and a 'back-up protection' against contracting HIV, the virus that causes AIDS. Therefore, to understand the respondents' perception on the mentioned sexual risk factors for HIV/AIDS following VMMC, inconsistency in condom use, increase in extra-marital affairs and perceived increase in men's

sexuality post VMMC are discussed and linked to the socio-demographic characteristics of the respondents.

A primary prerequisite to any public health promotion process is to collect data and learning about community perceptions of factors that may facilitate or inhibit adoption of the new intervention (Green & Kreuter, 2005). However, the relationship between knowledge about HIV/AIDS and associated sexual behavior especially among circumcised men along fish landing beaches remains a paradox. Despite the high level of awareness about the disease, knowledge of how it spreads, the determination of consequences, and effective means of prevention, risky or unsafe sexual behavior persists (Bertrand & Bakutuvwidi, 1991; Edwards, 1994a, 1994b, 1994c; Adamako Ampofo, 1993, 1995). Since treatment and prevention alternatives in the biomedical arena do not appear to become practical a reality soon, behavioral options remain fundamental to stemming the spread of the disease.

4.3.1 Compensation for the Healing Period and Inconsistency in Condoms Use

The qualitative results from FGDs and key informant interviews conducted in this study revealed that most circumcised men resumed sexual activity before proper healing. One of the commonly mentioned reasons for this behaviour was that the healing period was too long for them and they could not just watch their partners sleeping next to them without getting an erection. Therefore, they resumed sexual intercourse earlier or could wait for the healing period but indulge in sexual activities at a high frequency to compensate for the healing period. However, this study has shown that high sexual frequencies by circumcised men occurred both in married and single men. However, single men mentioned an increase in number of sexual partners occasioned by

peer pressure and praises from their sexual partners during sexual intercourse. This gives them a lee way to have more sexual partners.

Some discussants noted that curiosity to know whether the penis functions well also occasioned early resumption of sexual activity. This was due to the fact that after the removal of the bandage from the penis, the penis looked uglier and circumcised men could not imagine it would function properly. When the penis began healing and the stitches fall off, that was between third and fourth week, the discussants noted that they got curious to confirm whether the penis could function well during sexual intercourse as before. Most frequently mentioned reasons for early resumption of sex before proper healing included compensation for the abstinence period, men having stronger drive for sex than women and post circumcision testing of the penis.

A single circumcised male discussant in one of the FGDs described this as follows:

> Sincerely speaking, most of us here including me did not wait for the recommended healing period (six weeks)…..That thing (penis) looked ugly immediately after removing the bandage, I got worried that may be my penis will not *screw* a woman (meaning having sexual intercourse with a woman) as before…..Yes, I got curious and you know it was the fourth week before my penis healed properly but the stitches had at least fallen…. …I wanted to test whether my penis had stamina as before…I did not use condom, though made my partner wet properly before *the game* (meaning sexual intercourse). Furthermore, condoms decrease penile sensation. After sex my penis took long to heal and I was stressed so much but I was treated in the local clinic (male, 29 years old).

A male discussant added that:

> We rarely use condoms immediately after confirming that the penis is healed and can *screw* a woman properly…you know at the back of our mind we know that we have a larger percentage protection (60%) against HIV infection…..and you know sometimes these ladies are young and clean and I cannot imagine using a condom consistently…..in round one I will use condom but during round two my friend I tell you I will ‘eat her raw’ (meaning he will not use a condom, he will have dry sexual intercourse) because condom reduces pleasure. Moreover, we men have stronger sexual drive than women so you know when you sleep next to her and erection comes you will have to play sex (Male, 27 years old).

The excerpts above show that circumcised men are still at risk. As much as they know the importance of using condoms, circumcised men did not bother to use condoms and other HIV preventive measures. Moreover, in sub-Saharan Africa, an almost universal awareness of the serious consequences of AIDS and of the sexual transmission of HIV co-exists together with reluctance in adopting consequent preventive measures in the form of protected sexual intercourse. These results therefore imply that perception that the circumcised men have a high sexual urge because circumcision makes them *"agile and active"* makes them highly vulnerable to HIV infection because of inconsistency in condom use during sexual intercourse. Furthermore, there was a tendency by circumcised men to associate cleanliness and young age of women with less risk for HIV infection. The concern about possibility of increase in unsafe sexual behaviours among circumcised men has been previously reported (WHO/UNAIDS, 2007b). Delayed resumption of sex after MC potentially reduces the risk of HIV acquisition during the wound healing period. During the healing period, men who engage in sexual activity may be at an increased risk of acquiring HIV infection, though studies on this question remain inconclusive due to failure to address reasons for men resuming sex before the recommended healing period of six weeks (Mehta *et al.*, 2009).

Furthermore, study findings also concurred with Flood *et al* (2003) qualitative study findings which explored why young heterosexual men do not use condoms consistently during sexual intercourse. From Flood *et al* (2003) study, it emerged that condoms were perceived to decrease penile sensation and inhibited sexual intimacy. Moreover, previous studies in Kenya reported that condoms are often perceived as ineffective, reduce pleasure and may imply lack of trust in a sexual partner (Buve *et al.*, 2002; Central Bureau of Statistics (CBS) *et al.*, 2004; Pulerwitz *et*

al., 2006). According to Rosenstock *et al.,* (1994), health-related behaviours depend on perceptions about an illness. Therefore, sexual risk compensation in the context of MMC is characterized by someone knowing that they are less likely to contract HIV and responding to this reduced risk by increasing behaviours associated with greater risk of HIV transmission. Circumcised men along Lake Victoria region are still at risk of HIV infection due to the misconception that MMC provided a false reassurance to men that they were not at risk to get HIV. This can have an adverse effect on other HIV and AIDS preventive methods. However, this could also mean that there have been misconceptions about risk reduction to mean risk elimination, thus contributing to higher incidences of riskier sexual behaviour.

From the key informant interviews, it was confirmed that most circumcised men in Usenge Sub-Location were not waiting for the recommended six weeks healing period. It emerged that circumcised men visited local health professionals secretly to seek treatment especially after resuming sexual activities earlier before proper healing of the wound. In this respect, a male local health officer observed:-

> VMMC is good but my worry is about post VMMC early resumption of sexual activities by men in this region ….last four months I treated/injected (anaesthesitized) seven circumcised men from this area who came here when their penises had sores and wounds … the truth of the matter was that these men indulged in sexual activities before the wound healed properly. One case was worse, there was a married man who visited my clinic when pus was oozing from the penis and forced me to seek help from the medical officers in the dispensary because they had a VMMC surgeon.
>
> Moreover, these men once they indulge in sex before proper healing of the wound they do not go back to the circumcision centers….some resort to private treatment in the local health centers and in mild cases, others resort to painkillers (Clinical Officer, Male, 40 years old).

Following VMMC, abstinence from sex for six weeks is recommended to enable complete wound healing which was not the case as per these study findings. These study findings therefore concurs with studies conducted by Cassell *et al*., (2006); Kalichman, Simbayi & Vermaak, (2007b) which stated that there were concerns that men could not adhere to the post-procedure abstinence recommendation and this could result in a higher risk for HIV infection. Moreover, evidence has shown that VMMC can reduce acquisition of HIV in heterosexual males by approximately 60% (WHO, 2007). Arguably, according to White *et al*., (2008), risk compensation could significantly reduce the impact of VMMC programs and, if it is of sufficient magnitude, has the potential to completely negate the protective effect of circumcision against HIV when circumcised men resume sexual activities before proper healing.

Additionally, these study findings are in disagreement with a study conducted by Agot *et al.,* (2007) whose study findings in Siaya district did not find any significant differences in risky sexual behaviour between circumcised and uncircumcised men. However, the findings of the present study corresponds with studies conducted on association between circumcision status and men's sexual behaviour conducted in Rwanda, Uganda, Kenya, and South Africa by Seed *et al.,* (1995); Tyndall *et al., (*1996); Bailey, Neema, & Othieno, (1999); & Auvert *et al.,* (2005) which reported higher risky behaviours among circumcised men. Some of the circumcised men resumed sexual activity earlier than the expected healing period as has been confirmed by this study.

4.3.2 Marital Affairs Post Medical Male Circumcision

Results on changes in number of circumcised men's sexual partners apart from the regular sexual partner following voluntary medical male circumcision are illustrated in Table 4.6. A majority (52.5%) had between two to four sexual partners three months prior to this study. This indicated an increase in number of sexual partners. Notably, (41.6%) had only one sexual partner. This was an indication of faithfulness to one uninfected sexual partner while (5.9%) had more than five sexual partners following voluntary medical male circumcision, an indication of risky sexual behaviour. The respondents mentioned that after circumcision, there was change in the number of sexual partners. This was due to the perception that women prefer circumcised men to uncircumcised men and thus circumcised men got an opportunity to get as many sexual partners as possible. Further, compensation for post VMMC healing period also facilitated the increase in extra-marital affairs.

Table 4.6 Number of Other Sexual Partners 3 Months Ago after VMMC

No. of Sexual partners	Frequency	Percent
1 Only	42	41.6
2-4	53	52.5
More than 5	6	5.9
Total	101	100.0

In order to further explore whether there was an increase or decrease in circumcised men's number of opposite sexual partners, two FGDs for circumcised married men and another two FGDs for circumcised unmarried men were conducted. During FGDs, a male discussant explained that:-

> In Luo culture, men are allowed to *keyo kothee* (spreading his seeds) meaning having extra marital affairs….so the fact that I am circumcised does not bar me from having an affair in fact after circumcision I have had sex with several women I cannot even remember the total number of women I have slept with in this region and the neighbouring villages….you know men's whereabouts are not questioned by women in our culture thus we can go as far as sleeping in our *girlfriend's* houses.
> Moreover, healing period takes long and you know most men in this region have high libido because of fish and *omena* that we eat. Thus, after circumcision men engage in sexual acts at a high frequency due to high sexual urge and due to the fact that women praise them to be good in bed (Male, 29 years old).

The excerpt above shows that there was an increase in extra-marital affairs. FGDs discussants noted that men are naturally polygamous and that after circumcision, men tended to engage in more extra marital affairs than before due to perception that circumcised men are loved by women. The participants in this study also noted that in traditional Luo community, men were allowed to have extra-marital affairs while women were supposed to be faithful to their husbands. This belief exposed circumcised men to risk of getting HIV which they carry home to their faithful wives. This implied that women married to circumcised men were still at risk of getting HIV. Remarkably, as noted by Ingham & van Zessen, (1997); Caldwell *et al*., (1999); Fapohunda & Rutenberg (1999) risk-taking sexual behaviour may be tolerated in some contexts while in others it may be strongly disapproved of and regarded as irresponsible or immoral. For example, multiple partnerships for men may be tolerated, while women's infidelity is highly penalized, meaning that aspects of sexual conduct are beyond women's control.

Furthermore, in the FGD for circumcised men whose occupation was fishing, it was revealed that most of the crew members had at least one or two female sexual partners in every beach they move to and in most cases they rarely used other HIV preventive measures and do not have time to ask about the HIV status of the partner. This was attributed to the fact that the fishermen receive a lot of money after selling fish and there are no banks in the beaches they migrate to,

hence resort to spending their money on entertaining women as they desire. The fishermen further revealed that after circumcision the numbers of sexual partners they have in the neighbouring beaches have increased as compared to before. When probed further, the they revealed that in addition to spending money on these women, preference for circumcised than uncircumcised men acted as an advantage to men thus they could have a woman in every beach they go to. To support this, a male participant noted;-

> We are mobile and our next destination is determined by the bountiful fish catch in these beaches…you know I cannot stay for a period of three weeks in the cold nights in the islands without warmth from a woman so I must get one. Moreover, these women love circumcised men and money so the more they praise me to be good in bed or good at sex the more I befriend many of them but in different beaches. Money is not a problem the lake is my bank so I spend all the money I have to pay for these women's upkeep depending on which beach I am on. However, the behavior patterns among circumcised men who are fishermen in this region can facilitate HIV transmission…..for instance, I don't bother to ask these women their HIV status and I rarely use condoms so to some extent I feel to be at risk while sometimes I am confident that I have a hardened dick so I just *work on them mercilessly* (meaning having sex with several women) but my wife has to remain faithful until I go back home (Male participant, 39 years old).

The study findings showed that circumcised men who were fishermen moved from one beach to another in search of where fish stocks were bountiful. In the destination beaches or islands, they get a lot of money which they use to entertain women and later have sexual relationships. These men stay in these beaches for a shorter period thus do not bother to know their new sexual partner's HIV status which may expose them to HIV infections. The above verbatim quotation corroborates findings from studies conducted by (Allison & Seeley, 2004b; Seeley & Allison, 2007; Mojola, 2011) whose findings on fishing communities in East Africa's freshwater lakes were attributed to a mobile occupation, and fisherfolk's frequent movement in pursuit of income opportunities wherever fish stocks are most plentiful. This frequent and prolonged mobility often leads fishermen to establish relationships with women at various fish landing sites for domestic

support, sexual satisfaction, and to secure trading ties. According to Nunan (2010), while traveling frequently among broad geographic sexual networks, circumcised men of shoreline communities encounter numerous opportunities for HIV infection.

Men's multiple sexual partnerships contribute to the spread of HIV in sub-Saharan Africa (Caldwell *et al*., 1999; Fapohunda & Rutenberg, 1999). The finding from the present study supports Lagarde *et al.,* (2003) findings which found a strong association between the reported number of life partners and circumcision status. The proportion of circumcised men was significantly higher among those who reported more than four lifetime non-spousal partners than among those who reported between one to four. Consistent and correct use of condoms is one of the key strategies of the national HIV/AIDS prevention programmes, together with abstinence and being faithful to one sexual partner (ABCs of prevention) thus from these study findings, circumcised men along Lake Victoria region are still at risk of HIV/AIDS infection due to multiple sexual partners where condom use was also low.

4.3.3 Perceived Increase in Men's Sexuality After VMMC

FGDs discussants believed that circumcision increases sexual vitality or energy in men and allows them to have sexual intercourse for much longer than uncircumcised men. The main reason given for this by most participants was that circumcision renders the glans penis (or front of the penis as they described it) less sensitive and allows a man to prolong sexual intercourse before he ejaculates. During in-depth interviews, almost all respondents thought that loss of penile sensitivity was a good thing because it allowed both men and women to enjoy sex for longer periods. A few respondents made reference to the notion of 'balancing sexual satisfaction'

between a man and a woman in explaining the perceived association between prolonged sex and pleasure.

A male participant observed:

> "You know … the main reason why I choose to get circumcised was to increase my sexual pleasure and to lower the chances of getting HIV virus that causes AIDS. Today the head of my penis has become quite strong and a bit hardened… meaning that it is not sensitive like that of someone who is not circumcised. ……since the penis is hardened and its sensitivity is reduced, I take longer time to ejaculate and my woman praises me for a good work. In fact, the hardened head of my penis is my guard against HIV….so I rub inside her for a longer time until both of us reach climax of orgasm (Male respondent, 28 years old).

The sentiment above implied that perception that circumcision increases men's sexuality put men at risk to HIV because in such occasions they do not use condoms. Heterosexual transmission is responsible for the vast majority of new HIV infections, particularly in sub- Saharan Africa, where the HIV pandemic already has had the greatest impact (UNAIDS, 2012). The results of three Randomized Controlled Trials (RCTs) in Kenya, Uganda and South Africa have demonstrated that MMC significantly reduces acquisition of heterosexually transmitted HIV among men (Weiss, Quigley & Hayes, 2000). However, a key finding of the research in Usenge sub-location was that circumcised men believed that besides the fact that MMC lowered chances of acquisition of heterosexually transmitted HIV, MMC had other additional positive effects such as sexual functioning/performance and pleasure in men. Although protection against HIV was found to be the most significant reason for accepting VMMC for HIV prevention, perceptions about the positive and negative effects of male circumcision on sexuality were found to be an important consideration among the majority of male respondents in this study. In fact, in all the one hundred and one semi-structured questionnaire interviews and the six male focus

group discussions in this study, (27.8%) mentioned that they accepted VMMC due to the perceptions that it enhanced sexual performance as shown in Table 4.7.

Table 4.7 Main Reason for Getting Circumcised

Main Reasons for getting circumcised	Frequency	Percent
Wanted to prevent STIs/HIV	53	52.5
Wanted to Keep my Penis Clean	10	10.8
Persuaded by/Insistence by my Partner	2	3.0
Wanted to Increase Sexual Pleasure/Performance	29	27.8
Peer Pressure	6	5.9
Total	101	100.0

Additionally, during in-depth interviews, almost all male respondents attributed MMC to loss of penile sensitivity which enhances sexual performance by making the 'game last longer' meaning taking longer time to ejaculate. Moreover, inconsistency in condom use was also mentioned by most of the respondents due to the perception that they wanted to prove to their partners how sexually good they were as compared to before they were circumcised. For instance, a male respondent expressed:

> A circumcised man takes a longer time before he ejaculates this is due to loss of penile sensitivity, so the woman can really enjoy sex….but uncircumcised men will ejaculate faster because the head of penis is very sensitive to vaginal heat and their penises are prone to abrasions during sex hence they do not enjoy sex or satisfy their women. The truth is that I rarely use condom or I can use condom in round one but not the subsequent rounds of sex you know my penis is hardened so there is no escape route for HIV virus that causes AIDS (Male, 38 years old).

These results are in agreement with previous studies (Bailey *et al.,* 2002; Lagarde *et al.,* 2003; Ngalande, Kapondo & Bailey, 2006; Lukobo & Bailey, 2007). These studies reported that most participants perceived circumcised men to have a good sexual drive and great sexual pleasure during sex. However, Bailey *et al.,* (2002) reported that perception of sexual pleasure and performance resulting from MC depends on the frame of mind of the participants, on the experience and style each partner brings to endeavor, and on the love they have for each other. The socio-psychological literature on health-related behaviour emphasizes the perception of being at risk of HIV infection as being one of the necessary conditions for preventive behaviour to be adopted.

4.4 Summary

This chapter has presented results on socio-demographic characteristics of the respondents and men's perceptions on sexual risk factors for HIV/AIDS following medical circumcision. Results show that majority of participants in the survey were aged 25 to 29 years (58.4%). Additionally, 50.5% of them engaged in fishing and related activities. Majority of participants in this study had to adapt to beach culture for their livelihood, a factor that altered circumcised men's sexual behaviour where HIV/AIDS was regarded as any other disease. The results further showed that most circumcised men in this study resumed sexual activities before proper healing of the wound to test whether their penises were functioning well. The results also show that there exists a perception that MMC is "a back-up" and "a vaccine" against HIV/AIDS hence circumcised men inconsistently used condoms during sexual intercourse. It also emerged that majority of circumcised men did not adhere to the post-procedure abstinence recommendation and this could result in a higher risk for HIV infection and mitigate the intended benefits of VMMC. Indulgence in extramarital affairs following MMC was linked to Luo culture where men's promiscuity is

tolerated. Though extramarital affairs supported by Luo culture, acted as a risk factor to HIV/AIDS since majority of circumcised men in this study reported inconsistent condom use. Furthermore, the results in this study showed that there was a perception that MMC enhanced men's sexual performance hence men further indulged in extramarital affairs. These results have major implications in the process of the design of HIV/AIDS preventive measures necessary for checking the spread of the disease among different population sub-groups especially circumcised men along the Lake Victoria region in Kenya.

CHAPTER FIVE: THE INFLUENCE OF SOCIO-CULTURAL PRACTICES ON MEN'S SEXUAL BEHAVIOUR AFTER VOLUNTARY MEDICAL MALE CIRCUMCISION

5.1 Introduction

This chapter presents data emerging from qualitative inquiry on the influence of socio-cultural practices on men's sexual behaviour after voluntary medical male circumcision in Usenge sub-location. This chapter has three sections. Section one presents data on circumcised men's views on the influence of social factors on their sexual behaviour after voluntary medical circumcision. Section two presents results on cultural practices that influence men's sexual behaviour after voluntary medical circumcision from community elders', local health professionals' and beach leaders' points of view. Section three is a summary of the major results presented and discussed in this chapter.

5.2 Social Practices that Influence Men's Sexual Behaviour after Voluntary Medical Male Circumcision

Results from in-depth interviews, FGDs and key informant interviews revealed that the social practices that influenced men's sexual behaviour after VMMC were; fishermen's migratory patterns; transactional sexual relationships; peer pressure and alcoholism. These social practices were expressed as factors that influence men's sexual behaviour after voluntary medical male circumcision.

5.2.1 Fishermen's Migratory Patterns

The occupation of a majority of the respondents in this study (50.5%) was fishing as shown in Table 4.5 in chapter 4. Results from in-depth interviews, key informant interviews and FGDs conducted in this study revealed that mobility of fishermen contributed to the spread of HIV at least in part through high risk sexual behaviors of migrant and mobile individuals. The beach leaders who were key informants mentioned that fishermen's migratory pattern in search of bountiful fish catch is locally known as *wimbo*. *Wimbo* is the migratory pattern by fishermen in pursuit of income opportunities wherever fish stocks are most plentiful. The migratory patterns are majorly between one beach to another and these beaches are majorly situated away from one's home beach. *Wimbo* as a migratory pattern is only found along the lake region and it influences circumcised men's sexual behaviour in a number of ways.

One beach leader for instance narrated that:-

> In every society, there are values and norms guiding issues of sex and human behaviour. Circumcised men along Lake Victoria, who are fishermen, migrate to other beaches in search of huge fish catch and from my experience some of these men stay for long in the destination beaches like for weeks, months or even a year. When in the destination beaches, their sexual behaviour changes in order to adapt to the new environment. These men get a lot of money which they do not remit to their families back at home…some consume a lot of alcohol and majority get new sexual partners. That is the beach culture. However, men who migrate in these beaches are targeted by women whose husbands migrated to other beaches and they get married temporarily until the time their husbands come back from *wimbo*. Beyond any reasonable doubt with the kind of sexual relationships in these beaches, our circumcised men rarely use condoms and on most occasions after adapting to the new environment, these men tend to have multiple sexual partners….surely curbing this is very difficult because I cannot follow these men and women every time (Beach leader, 49 years old).

Another beach leader had this to say:

> Sex for fish is a common practice along the lake region. Circumcision targeted non-circumcising communities with relatively high incidences of HIV/AIDS. Usenge sub-location is one of such areas…our circumcised men still face the risk of contracting HIV/AIDS because circumcision does not alter beach culture…in my opinion we still

> need to come up with ways of educating these men on the importance of condom use when on shore and offshore (Beach leader, 55 years old).

First and foremost, the excerpts above indicate that *wimbo* as a migratory pattern as acted as a catalyst to the spread of HIV among circumcised Luo fishermen. Once they arrive at destination beaches, there is always loss of sexual inhibition as a result of being in distant places. Men in this study noted that they get new sexual partners and this is kept secret. While the mobile partner is away from the reach of the real partner, family and community norms and social monitoring, the non-mobile partner is freed from the protective watch of the spouse and vice versa. This implied that social constraints on sexual behaviour which apply at home, did not apply at fish landing sites and beaches in other areas. Furthermore, it emerged that circumcised men's sexual behaviour changed immediately they migrated to other beaches. This was due to need to adapt to the new environment. This implied there were modification on norms and values guiding sexual activities when these men migrated to new environments in the islands and other fish landing beaches. This is supported by Steward's (1955) arguments that culture change can be induced by adaptating to the environment. Additionally, it was also noted that women whose husbands had migrated to other beaches targeted men who land in these beaches and they temporarily get them until their husbands come back from seasonal fish camps.

During FGD with fishermen, a discussant observed;

> Fishing is a good occupation… we get a lot of cash and women are at our disposal. Sincerely, during *wimbo*, we become unfaithful to our spouses, we get new girlfriends in the destination beaches or islands and the relationship may be terminated when fish catch goes down and we move to the next beach where we also get new girlfriends. In my crew for instance, almost all men are circumcised but I tell you these men's sexual behaviour in the destination beaches is a risky one. They, change women like dresses and am very sure that these men do not use condoms because our main objective during *wimbo* is fishing in addition we don't even bother to know the HIV status of these women this is a risky behaviour but we cannot change it since it is the beach culture (male, 27 years old).

The sentiment above shows that circumcised men who were fishermen had at least one or two sexual partners in every beach they move to and in most cases they rarely used condoms and other HIV preventive measures. During all FGDs with circumcised men, it was commonly mentioned that circumcised men do not bother to know the status of their new sexual partners in the destination islands and beaches because sometimes they stay in these islands for a week or a month depending on the time that the fish catch goes down and sometimes they seduce these women using money and fish.

The study findings revealed that when men went for *wimbo* they stayed away from their families for long. This concurs with findings from a study conducted in Kenya by Kwena *et al.,* (2013) on short-term mobility and the risk of HIV infection among married couples in the fishing communities along Lake Victoria. The study revealed that fishermen in Nyanza, like in many other parts of the world, are highly mobile in search of huge fish catch.

Often, these men stay away from their families for long periods and interact with many women who trade in fish and in the destination beaches and islands condom use is very low. This implies that fishermen's migratory patterns along Lake Victoria region exposes circumcised men to risky sexual behaviour and this could mitigate some of the intended benefits of VMMC. Additionally, study findings from Kissling *et al.,* (2005) and Seeley & Allison (2005) also revealed that fishing communities are at high risk of HIV infection due to the mobility of fishermen and fish traders, the need for and availability of cash, and the congregation of numerous people at fishing harbours and other trading places. According to Ward & Plourde (2006), several aspects of mobility, such as opportunities to participate in transactional sex, isolation from communities of

home and origin, and the desire for unique experiences, all enhance the likelihood of casual sexual experiences while at the migration destinations.

Mobility is not itself a risk factor for HIV. However, mobility may place individuals in situations that increase their vulnerability to HIV, disrupting familial bonds, encouraging the abuse of alcohol or other substances, and facilitating a culture of risk-taking (NACC &NASCOP, 2012). Arguably, these findings are also supported by Steward's (1955) arguments which stated that in order to understand people's behaviour, an individual is required to look at how a particular human pattern of behaviour or culture is associated with the environment and to assess how much these patterns of behaviour influence other aspects of culture in that society. Steward (1955) noted that, culture in a similar environment may have similar characteristics and that on most occasions all adaptations in these environments are short lived and are constantly adjusting to changing environments. Research among fishing communities around Lake Victoria indicated that 30% or more of fisherfolk were infected with HIV, a level of infection higher than those documented among fishing communities in other countries (Kissling *et al.*, 2005). Characteristics of fishing communities that increase their vulnerability to HIV include the migratory nature of fishing work, the social marginalization of fisherfolk, high rates of STIs, the ready availability of commercial sex, and widespread alcohol use (Fraser, Greenstreet, Fryer & Piet 2008; Kissling *et al.*, 2005). A study by (Gelmon, Kenya & Oguya, 2009) on modes-of-transmission of HIV in Kenya concluded that fishing communities may account for 25% of all new HIV infections in Nyanza region, the area of the country with the highest HIV burden.

5.2.2 Transactional Sexual Relationships

Results from in-depth interviews and FGDs conducted in this study revealed that transactional sexual relationships along the beaches could lead to rapid spread of HIV/AIDS in Usenge sub-location especially when the circumcised fishermen perceive circumcision as a 'natural condom'.

During FGDs, most discussants expressed that high sexual risk behaviours along the shores of Lake Victoria such as transactional sexual relationships also known as sex-for-fish (*jaboya*) and the carefree lifestyles of the beach community could expose circumcised men to HIV/AIDS. Moreover, there was a consensus that several socio-economic factors including poverty, and competition among women who are involved in fish trade were factors fueling the sex for fish practice along fish landing beaches in this study as exemplified in the following excerpt.

A discussant observed;-

> Sex for fish is rampant when fishermen go for *wimbo* than when they are in their home beaches. Traditionally, *Jaboya is* a Luo word which referred owner of the boat or to a male or female customer to the fisherman who buy fish and when there is low fish catch he or she buys paraffin and other worn fishing gears that may be needed. Today *jaboya* means a female customer who gets fish from the fishermen in exchange for sex. Due to poverty and competition for the scarce fish among women, sex plays a central role in getting fish….women engage in sexual relationships with *madhar* and other fishermen in order to get fish. When fishermen bring fish to the shore, there is always a group of buyers waiting. But for one to get the fish, there must be extra attention which is always a sexual favour. Women fishmongers get fish and the fisherman get sex this relationship is symbiotic in nature. This is the extra-marital affair in our beaches which can expose our circumcised men to HIV/AIDS. My worry is that fishermen who are circumcised including me believe so much in the hardened penis and that we cannot contract HIV. Moreover, these fishermen exchange women like cloths, I am telling you if it goes this way we will still die and Nyanza province will still lead in rates of HIV/AIDS infection (Male, 35 years old).

As shown in the excerpt above, sex for fish was rampant during *wimbo* than when the fishermen were at home beaches. During such transactional sexual relationships, women who were lovers to the fishermen received extra attention and got more fish supply than others. Moreover, accompanied with other factors along the beaches, the rate of HIV still rises due to false belief by circumcised men that they are immune from HIV/AIDS and indulge in extramarital affairs at a higher rate. Therefore, fish landing beach lines on the shores of Lake Victoria will still experience high rates of HIV infections despite the fact that MMC targeted men along lake region.

The excerpt above means that *jaboya* system emerged due to poverty and stiff competition among fishmongers for the scarce fish (Craig, 2004; Nyambedha, 2006). According to Craig (2004), women fish traders engage in sexual relationship with the fishermen in order to attain rights to their daily catch. When the fishermen bring fish to shore, a specific woman fishmonger has exclusive rights to buy his fish on the condition that she maintains continuous sexual relations with the *Jaboya* (Craig, 2004). This practice of *jaboya* system has been associated with the spread of HIV along the fish landing beaches (Craig, 2004; Nyambedha, 2006). Similarly, other studies have revealed that fishing communities are categorized among the highest-risk groups in countries with high overall rates of HIV/AIDS prevalence, the high prevalence is associated with complex interacting causes which may include the mobility of many fisherfolk, the time they spend away from home, easy access to daily cash income in an overall context of poverty, their demographic profile and vulnerability of commercial sex in fishing ports (Edward & Janet, 2004; Kissling, Edward, Janet *et al*., 2005).

Additionally, Craig (2004) noted that some fishermen maintain relations with multiple women continuously, depending on the amount of fish caught and the nature of these relationships is temporary, where the relationships often last for short periods and when the men move to new beaches, new relationships are established (Craig, 2004). According to Edward & Janet (2004), transactional sex has been shown to be the driving force in the dynamics of HIV in many different sites ranging from fish landing beaches to the mainland. Fishing communities are therefore often among the highest-risk groups in countries with high overall rates of HIV/AIDS prevalence. For instance, the estimated Population Attributable Fraction (PAF) of transactional sex is 84% in Accra and 76% in Cotonou. A recent meta-analysis confirmed the importance of 'paid sex' as a sexual risk factor for heterosexual HIV transmission in sub-Saharan Africa for both women and men (Chen *et al*., 2007). This implies that fishermen who are circumcised are still at risk of HIV/AIDS just like other men who are not circumcised due to low condom use.

Results from in-depth interviews with circumcised men also revealed that the migratory nature of fishermen forces them to adapt to the culture of the destination beach where every boat must have a customer who buys and transports fish to the market. Majorly, the customers in the destination beaches are women who, in the long run, become sexual partners to the fishermen. However, fishermen are likely to have sex with local women when they bring their catch to the mainland. This also acted as a bridge for spreading the HIV virus to the general population. Such lifestyle of people involved in the fish trade could be one of the reasons for the high prevalence rates in the region. Additionally, according to the circumcised fishermen, in scenarios where fishermen have a sexual relationship with married women, sexual intercourse takes place in the bushes near the lake or in the boat. As much as this is a common behaviour among other

fishermen, circumcised men who are fishermen are not left out. The informants also noted that low condom use during sex- for- fish relationship had acted as another catalyst for the rates of HIV infections a long Lake Victoria region as shown in the excerpt.

An informant noted:-

> When we go for *wimbo* we have to get a new *jaboya* in most cases they are women. The woman is either befriended by *madhar* or a crew member and in some cases the woman befriends the boat owner. The relationship becomes purely sexual and in return the woman is given fish. One year ago just after I had been circumcised, I was *madhar* in a boat and our *jaboya* was a married woman whose husband was not rich and very strict on her movements. She became my girl friend. I remember we did sex in the bush *the green lodging* at the lake shore while in another scenario we did it in the boat when other crew members had left me behind to anchor the boat…….there was no time for condom in fact I did not have it. In my opinion, fishermen sometimes carry HIV/AIDS from the islands to their spouses (Male, respondent 31years old).

This study revealed that circumcised men befriend at least a woman in their destination beaches. However, sometimes, sexual intercourse happened in a hurry and circumcised men could contract HIV which upon their return they carried back home to their spouses. This study therefore confirms that sexual intercourse normally occurred in bushes at the shore and this is an ongoing behaviour among fishermen. This depicts low condom use in such context hence exposing men to HIV. The above verbatim quotation corroborates findings by studies conducted in fishing communities in Southern Malawi MacPherson, *et al.,* (2012) and in Kenya by Kwena *et al.,* (2010) whose findings showed that individuals living in fishing communities in low-income countries are particularly vulnerable to HIV infection. One of the key drivers of HIV in fishing communities is transactional sex. In the fishing industry, this takes the form of ‘‘fish-for-sex’’ networks where female fish traders exchange sex with fishermen for access to or more favourable prices of fish. MacPherson, *et al* (2012) noted that sometimes sexual intercourse happens in a hurry.

5.2.3 Peer Pressure and Alcohol Consumption

Discussants in all FGDs mentioned peer pressure and alcoholism as other social factors that influence circumcised men's sexual behaviour during post VMMC. In this study, peers were defined by the discussants as the individuals with whom a child, adolescent or an adult identifies, who are usually but not always of the same age-group. On the other hand, peer pressure was identified by the discussants to occur when the individual experiences implicit or explicit persuasion, sometimes amounting to coercion, to adopt similar values, beliefs, and goals, or to participate in the same activities as those in the peer group. Some discussants explained that there was increasing interest in circumcision among boys and young Luo men because they did not want to be ridiculed by their peers.

A discussant noted:

> Majority of youths in this region opted for VMMC because of ridicule from their peers. For example, my friends kept on calling me *japien* so I went for circumcision and later on the ridicule stopped (Male, 20 years old).

Although peers had an influence on acceptability of circumcised peers in Usenge sub-location, pressure from the peers influenced circumcised men's sexual behaviour following VMMC. Narrations and stories from circumcised men influenced their peers' sexual behaviour both positively and negatively in which negative effects could lead to risky sexual behaviour. In the present study, benefits of VMMC such as: enhanced protection from HIV and STIs, improved hygiene, decreased risk of penile cancer, and improved sexual satisfaction for men and their sex partners, were mentioned as affecting circumcised men's sexual behaviour. Majority of the discussants noted that they indulge in risky sexual behaviour due to peer pressure which makes them highly sexually active in order to be socially recognized. When age mates talk of how sweet it is to have sex without a condom and how ladies hiss during sexual intercourse, then their

peers who are circumcised tend to practice the same and in some cases, they increase the numbers of female sexual partners to explore whether it is true. Discussants also noted that the circumcised penis was considered by others to enter smoothly and directly and this makes women love them more.

A discussant stated:

> Men should be encouraged to circumcise because they will be clean and have less chance of getting infected with AIDS. However, our sexual behaviour do change because of what our peers tell us……for instance, when I heard how my peers described how playing sex without condom is sweet after circumcision, I practically did the same she was hissing and held me tighter telling me to do it… since that day I have five girlfriends in this village. They always praise my circumcised penis as the sweetest ever (Male, 27 years old).

Another discussant added that:

> Peers influence an individual's behaviour positively and negatively. When with your peers you can find yourself adopting a behaviour that you were not born with…..I see young boys influencing one another in all dimensions. VMMC is good but the rate at which immorality has increased among circumcised men who I know is worrying. I believe the social grouping such as fishermen, *bodaboda* and touts in this area has led to an increase in such risky sexual behaviour. Most of us learn from our peers. Thus, any behaviour accepted by the peers will be adopted equally by other peers (Male, 35 years old).

The verbatim quotations above indicate that people changed their sexual behaviour due to peer pressure and social groupings. The discussants explained that they went for VMMC because of ridicule from peers. However, peer pressure influenced the discussants' sexual behaviour positively by advocating for condom use and negatively by encouraging them to have more sexual partners. This implied that circumcised men increased sexual partners due to peer pressure. The excerpts above support research done by Varga (2003) among males in South Africa and by Nzioka (1996; 2001) in Kenya which showed that males respond to peer pressure and become highly sexually active in order to be socially recognized as physically mature or appropriately masculine. The findings in this study shows that circumcision makes Luo youth

more acceptable to their peers and sexual partners from other communities, an aspect that allows them to expand their social and sexual networks, thus exposing them to greater risk of HIV/AIDS. Multiple studies in sub-Saharan Africa, suggest that youth have sex for the first time because of social pressures and environmental conditions (Zulu, Dodoo & Ezeh, 2002; Maticka-Tyndale *at al.*, 2005).

Majority of participants in all the FGDs implicated alcohol consumption as having a causal role in a variety of sexual processes and outcomes. In fact, alcohol was widely regarded as a very effective formula for loosening sexual inhibitions. The main message from the FGDs was therefore that alcohol consumption could foster and enhance sexual activities in circumcised men. According to all discussants in the FGDs, there are a range of alcoholic beverages, including those that were brewed locally and those brewed in factories, in the study area. Locally made brew included a wide range of products distilled and fermented from locally-produced crops. Drinks were able to have an intoxicating effect regardless of the alcoholic content were considered to be alcohol. This also included beverages that were commonly consumed in homes. Minority of the discussants believed that drinking alcohol such as Guinness beer increased the likelihood of sexual activity, enhanced sexual experience, and promoted riskier sexual behavior. Results further show that circumcised men were less likely to use condoms when drunk.

A circumcised male stated:

> Alcohol gives us courage to seduce ladies. At night, we can seduce a lady then have sex with her only to realize in the morning that you did not use a condom ….as much as we are circumcised we get worried about our status after messing at night. We drink alcohol because we have a lot of cash from the lake, *boda boda*, and businesses that we do in this area. I love Guinness beer because it increases my sexual performance (Male, 33 years old).

Another participant added that:

> It is true that when under the influence of alcohol even cowards can seduce a woman and sleep with her just like that. Some of us here get shocked next day when they learn that they had sex with a lady alleged to be HIV positive…..most of us do not bother to go for HIV test after such acts reason being our penises are natural condom and that what we do unknowingly under influence of the liquor has no much consequences in our lives. I believe alcoholism exposes circumcised men to risk of HIV/AIDS especially the cheap liquor sold in this area because beer is expensive (Male, 28 years old).

The excerpt above indicates that alcohol was widely regarded as a very effective formula for loosening sexual inhibitions and that circumcised men under influence of alcohol indulged in risky sexual behaviour. As much as alcohol was associated with interference to proper decision making, alcohol such as Guinness was associated with increase in sexual pleasure and majority of discussants noted that they did not use condoms consistently. The above study findings corroborate Kafuko & Bukuluki (2008), qualitative research findings in Uganda on knowledge, attitudes and practices concerning alcohol. According to Kafuko & Bukuluki (2008) alcohol use was associated with risky sexual behaviour including unprotected sex, casual sex, multiple partners and sexual violence among men. Alcohol use impaired judgement, lowered inhibitions and gave people the boldness to do what they would not ordinarily do. This was usually done without regard for the consequences of one's actions. Both men and women were seen as likely to sleep with someone they would not have slept with if they had not taken alcohol (Kafuko & Bukuluki, 2008).

This study finding similarly, concurs with Cooper (2006) findings on whether drinking promotes risky sexual behaviour or not. Cooper's results indicated that the belief that alcohol causally disinhibits sexual behaviour is firmly ingrained in people's perceptions. Most people believe that drinking increases the likelihood of sexual activity, enhances sexual experience, and promotes

riskier sexual behavior (Cooper, 2006). IPAR (2004) also identified alcoholism and drug abuse as some of the factors exacerbating the spread of HIV/AIDS in Nyanza. According to IPAR (2004) findings, some drugs and alcohol increase the desire for sex, impair reasoning and increases the likelihood of engaging in sexual contacts. Illicit brew intake is particularly high because the bottled beer is too costly for the majority of drunkards to buy (IPAR, 2004). Alcohol intake before or during sexual intercourse may contribute to risky sexual behaviour (NACC &NASCOP, 2012). In a 36-month study of agricultural workers in rural Kenya, study participants who consumed alcohol during sexual intercourse were 2.4 times more likely to become infected with HIV (Shaffer *et al*., 2007).

In this study, the results show that circumcised men are less likely to use condoms while under the influence of alcohol. They recognized this as a potential driver for HIV infection. While under the influence of alcohol, circumcised men are not cautious and do not remember to use condoms. They are taken up by the heat of the moment and do not think about the possible consequences of their actions at that time. However, not all alcohol drinking led to risky sexual behaviour.

5.3 Influence of Cultural Practices on Men's Sexual Behaviour after Voluntary Medical Male Circumcision

Since it is often not enough to talk about sex and reducing HIV/AIDS without understanding the context of cultures and traditions, this study explored the influencing of cultural practices on men's sexual behaviour post-VMMC. Results from in-depth interviews, FGDs and Key Informant Interviews (KIIs) conducted in this study revealed that the cultural practices that

influenced men's sexual behaviour post VMMC were; wife inheritance and sexual cleansing ceremonies.

5.3.1 Widow Inheritance and Other Sexual Cleansing Ceremonies

Results from FGDs and KIIs conducted in this study revealed that wife inheritance and sexual cleansing ceremonies were the major cultural practices that could positively and negatively influence men's sexual behaviour following VMMC. Among the Luo community, widow inheritance is referred to as *ter.* During FGDs with Luo community elders, it was revealed that Luo women are believed to acquire contagious cultural impurity known as *okola* after the death of their husbands that is perceived as dangerous to other people. To neutralize this impure state, a sexual cleansing rite is observed. According to the elders, widow inheritance acts as a ritual cleansing process to the widow and the home from the bonds of death. Sexual intercourse between the widow and the inheritor is central to this process whereby there has to be an exchange of body fluids to merge the two partners. On most occasions, during wife inheritance, sex took place without condom use and in the absence of HIV testing and counseling for the adults involved in the practice. An elder noted:

> When we talk of male circumcision, condom use and recent HIV/AIDS reduction strategies adopted in our society, then we are talking about alien practices in our culture. Widow inheritance is part of our culture and no matter what we cannot do away with it. When a husband dies it is our belief that the woman and the homestead are considered unclean until she undergoes some sexual cleansing. Sexual cleansing is referred to as *ter* and the cleanser is generally called *jater*. There must be sex without any form of barrier….there has to be exchange of body fluids between the widow and *jater*, this is to acs as a ritual cleansing process to the widow and the home from the bonds of death. One *jater* can cleanse as many women as possible so there can be easy transfer of HIV from one village to another or within the same village. Additionally, there is no condom use and in most cases, there is no HIV test conducted. I have been *jater* and I know what happens there (Village elder, 59 years old).

Another elder added:

> Cleansing rituals existed in the Old Testament and widow inheritance was allowed. In Luo society, ritual cleansing cannot be successful if a barrier is placed between the performers. During such cleansing the ghost of the deceased is separated from a Luo widow so body fluids must mix. Thus, circumcised men in this region have to adhere to our cultural beliefs and I know that as much as we stick to our traditions, these men are still at risk of HIV/AIDS (male, 56 years old).

The above narrations show that widow inheritance is still practiced in the Luo community. Beliefs that women are unclean after death of their husbands emerged as a central issue that facilitated wife inheritance. However, the circumcised men are not exempted from such cultural practices. During inheritance, there is no HIV test done and condom use is not tolerated. Circumcised men noted that professional inheritors could easily transfer HIV from one village to another. The above excerpts are in agreement with findings from other studies. According to Prince (2004) and (Gunga, 2009), widow inheritance is still a controversial subject and is still persistent in the Luo community. Other studies (Prince, 2004; Ogutu, 2007; Gunga, 2009) also noted that, persistence of widow inheritance among the Luo community is as a result of a belief that if one fails to go through the ritual cleansing, the widow will be hit by *chira*, a curse from gods leading to a wasting illness that can affect the widow and her children. Due to the fear of the effects of *chira,* the widow therefore goes through a "ritual cleansing" (*chodo okola)* which is achieved through obligatory sexual intercourse, performed by *jatiek kwer* if the ritual cleanser is from within the clan, or a *jakowiny* when he is an outsider, some of whom are paid (Kimani, 2004; Nyambedha, 2006; Ogutu, 2007).

Notably, there is no limit as to the number of widows a man can inherit at any given time. Hence the practice has a lot of potential for transmitting HIV (IPAR, 2004). Furthermore, the practice of widow inheritance is seen as a way of containing the spread of the disease as the widow is attached to a single male inheritor rather than circulating freely among men in the community (Gunga, 2009). In addition, it is a taboo to reveal HIV/AIDS as the cause of death, more so when the deceased is a relative. The partners of the deceased are therefore at a high risk of spreading the virus in the course of the rituals associated with mourning the dead, widow inheritance being one of them (Gunga, 2009; IPAR, 2004). Results from a study conducted by Luginaah, Elkins, Maticka-Tyndale, Landry & Mathui, (2005) in Siaya Sub-County revealed that women were expected to observe a cleansing ritual, which had a sexual component, before being re-incorporated into society following the death of their husbands. This ritual endangered widows' and the inheritors' lives through possible infection with HIV/AIDS. Widow inheritance, whether as a traditional or modern practice among Luo community, has a sexual component except in the case of old women who may no longer bear children and/or have no interest in sex, the practice was symbolic (Ogutu, 2007; Nyongesa & Oluoch, 2013). Additionally, in Zambia, the practice is the same since someone must have penetrative sexual intercourse with the spouse of the deceased in order to exorcise the spirit of the dead from the living partner and in most occasions, there is no use of any protection (Malungo, 1999).

Though the widow inheritance was done to ensure social and economic support for the widow and her children, changes in the practice due to the emergence of HIV/AIDS have led to the inclusion of professional wife inheritors to carry out the process. In addition, women are treated as property to be passed on from one man to the other hence no limit to the number of widows a

professional inheritor can cleanse (Nyongesa & Oluoch, 2013). Arguably, with such kind of sexual cleansing practice, among the Luo of western Kenya, the widespread practice of widow inheritance is also a cultural behaviour that is most often blamed for the continuing spread of HIV/AIDS (Luke, 2002; Ambasa-Shisanya, 2007). Circumcised men are not excluded from such cultural practices. This implies that the intended goals of circumcision in lowering the rate of HIV infection in Nyanza region may not be achieved if new ways of integrating cultural practices in such programmes are not considered. Consequently, rates of HIV/AIDS infections may continue to rise in Nyanza region.

Qualitative results from key informant interviews with a senior health officer and the local health professionals indicated the fear that widow inheritance still acts as a barrier towards safe sexual behaviour among circumcised Luo men. The central argument that was commonly mentioned during key informant interviews was the absence of counseling sessions for the parties involved to know their HIV status and absence of condom use during fulfillment of cultural rites.

A senior health officer stated that:

> Voluntary Medical Male Circumcision (VMMC) is an additional HIV/AIDS preventive measure. However, risky cultural practices such as widow inheritance act as an impediment to goals of VMMC. VMMC targeted non-circumcising communities which had a higher percentage of HIV/AIDS infection rates. In Kenya, Nyanza region, dominated by the Luo ethnic group who value their cultural traditions was targeted with VMMC programmes. My fear is that the government has not come up with a way of integrating cultural practices in HIV/AIDS prevention programmes to minimize the spread of HIV/AIDS among the Luo ethnic group. Circumcised men cannot fail to fulfill cultural rites such as widow inheritance as per the society's requirement. Thus, they are still at risk of getting infected with HIV virus that causes AIDS (Male, 39 years old).

The information from the health officer above imply that risky cultural practices are still an impediment to sexual behaviour change in circumcised men in this study. According to study findings reported by Ambasa-Shisanya (2007) in Siaya, it emerged that when a professional cleanser is infected, he could transmit HIV to many widows. Alternatively, widows whose husbands were HIV positive could easily transmit the virus to their ritual performers and other social partners because in most cases there are no counseling and testing sessions before performing such rituals. This could expose circumcised men to HIV because most of them do not use condoms in such rituals and it had been reported that HIV transmission in sub-Saharan Africa mostly occurs among heterosexual partners (UNAIDS and WHO, 2007; UNAIDS, 2009; WHO *et al*., 2011). Therefore, arguably, if rituals that involve sex could be fulfilled symbolically among the Luo community, then the high HIV/AIDS prevalence in the Luo community could be reduced.

5.3.1.1 Other Sexual Cleansing Ceremonies in the Luo Community

Apart from widow inheritance among the Luo, it clearly emerged from this study that there existed other cultural practices that involved sexual intercourse. The commonly mentioned practices during FGDs with the community elders included: the construction of a new home or house, at the beginning of land preparation and planting season, when a son or daughter gets married and the first day when offspring get back to their houses after burying a parent.

Results from FGDs showed that there was sexual intercourse during major agricultural activities such as ploughing, sowing and harvesting. The homestead owner (*wuon dala)* had to be the first in such activities which was accompanied by sexual intercourse. During such major agricultural activities, sons and daughters in the home were informed in advance to abstain from sex until

after *wuon dala* allowed them to do so in order to avoid *chira* befalling them. Notably, just like widow inheritance, sexual intercourse took place without any form of HIV preventive measures such as condoms. As noted earlier in this chapter, men who stayed away from their families for a long time could carry HIV/AIDS back home to the women or, in some cases, the woman could infect the man in cases of infidelity by the woman when the man was away.

In addition, the discussants also mentioned that having sex was important during the construction of a new home or house. On that very night the husband and wife had sex and on most occasions, there is no condom use and no HIV tests were conducted. The significance of sex was to allow sons to have sex in the new home in future. The community elders referred to this as *yawo rangach*. Moreover, other sex related ceremonies mentioned included when a son or daughter gets married and the first day when offspring get back to their houses after burying a parent.

A FGD discussant noted that:

> I know male circumcision was introduced as an HIV preventive measure. However, sex which is said to be the main route in the transmission of HIV is at the centre of our culture…most of our cultural practices involve sexual intercourse. For instance, when a man builds a house or new homestead, during ploughing, planting, weeding and harvesting there is sexual intercourse between the man and his wife (s). Mostly, there is no use of condoms. Moreover, when a man or the wife's parent passes away, after the burial there is always sexual intercourse.
>
> Circumcised men's sexual behaviours are guided by the norms and values of the society, thus they may or may not use condoms or other protection during sex related ceremonies (Male village elder, 58 years old).

Another elder added that:

> When establishing a new home or building a new house that night, the couples sleep in that house and have sexual intercourse. But if one of the partners is sick or both are elderly and have ceased to engage in sex (*wuok e ria*), they sleep in this house and the husband lays his hands on her or he crosses his legs over the wife's thighs. From then it is assumed the rituals are fulfilled. For young circumcised men they just have to play sex and I think with the rampant rate of HIV/AIDS in Nyanza region, something may be

> done…sex can be symbolically done without penetration. The disadvantage is that the youths of today are too hot blooded they cannot exercise self control and there are no strict rules governing sexuality, young men of today can have one wife but with several sexual partners (Male elder, 47 years old).

The study findings revealed that the discussants were aware that VMMC was introduced as an additional HIV preventive measure. However, VMMC in the Luo community faces a lot of challenges. For instance, cultural practices involving sexual intercourse have pre-existed in the Luo community thus any Luo male, whether circumcised or not, may be exposed to HIV/AIDS when they indulge in such cultural practices that demand for unprotected sexual intercourse. Additionally, the study revealed that men's sexual behaviours are guided by the norms and values of the society. However, in some cases there was symbolic sexual intercourse especially when the couples are elderly or one of the partners is sick. These findings are in agreement with studies conducted by (Prince, 2004; Ogutu, 2007) which noted that sex is deeply rooted in the Luo cultural practices. For instance, (Mboya, 1965; Prince, 2004) noted that sex plays a part in the construction of a new home or house, where on that very night the husband and wife play sex. Sexual ritual is performed because sons will also build their houses in this home and may play sex before the parents and that is regarded as culturally improper and can bring *chira* to the children (Mboya, 1965; Ocholla-Ayayo, 1976; Prince, 2004; Ogutu, 2007). Further, Prince (2004) argued that, sexual intercourse opened the house for habitation, allowing the couples to enter it and for new life to emerge from it and opening the pathway for future generations and on most occasions there was no use of protective devices such as condoms. Circumcised men who indulged in such cultural practices may be exposed to HIV/AIDS if the partner is HIV positive.

Additionally, other sex rituals were performed at the beginning of land preparation and planting season, when a son or daughter got married and the first day when offspring got back to their houses after burying a parent (Mboya, 1938; OchollaAyayo, 1986; Prince, 2004). These cultural practices are still prevalent in the Luo community (Prince, 2004; Ogutu, 2007; Ambasa-Shisanya, 2007). This study found that in almost all cultural practices in the Luo community involving sexual intercourse, no condoms were used hence this could expose circumcised men to HIV/AIDS because of adherence to cultural values and beliefs. This concurs with arguments by Akwara *et al* (2003) that sexual behaviour may not be under an individual's volition but may be dependent upon the social and cultural environment in which one lives. The ability of individuals to be aware of, to initiate, and to sustain safer sexual behaviours may largely depend upon societal sexual norms and practices, and not just self-perceived susceptibility to HIV infection (Akwara *et al*., 2003).

5.4 Summary

This chapter has presented results on the influence of socio-cultural practices on men's sexual behaviour after voluntary medical male circumcision. Results show that fishermen's migratory patterns, transactional sexual relationships, peer pressure and alcoholism were social practices that influenced circumcised men's sexual behaviour in this study. Fishermen's migratory pattern is locally known as *wimbo.* During *wimbo,* the non-mobile partner is freed from the protective watch of the spouse and vice versa and there was deviation from community sexuality norms. Vulnerability of fisheries livelihoods systems to HIV/AIDS stemmed from the socioeconomic dynamics of the fisheries trade and lifestyle, and in particular the fishermen's high mobility, their long absence from home and their cash incomes which are then often spent in the trading centres on casual sex and alcohol. Men's sexual behaviour had to change to adapt to the culture of the

new beach. Furthermore, ridicule and the pressure from peers to be socially recognized and that men are to be highly sexually active and appropriately masculine exposed circumcised men to HIV/AIDS. Alcohol use was associated with risky sexual behaviour including unprotected sex, casual sex, multiple partners and sexual violence among men. Alcohol use impaired judgement, lowered inhibitions and gave circumcised men the boldness to do what they would not ordinarily do. This was done without regard for the consequences of one's actions.

Cultural practices that influenced circumcised men's sexual behaviour after VMMC included, widow inheritance and other sexual cleansing ceremonies among the Luo community such as: the construction of a new home or house, at the beginning of land preparation and planting season, when a son or daughter gets married and the first day when offspring get back to their houses after burying a parent. These cultural practices involved sexual intercourse without use of any HIV/AIDS protection methods. This implied that circumcised men might still indulge in risky sexual behaviour due to cultural practices which include sexual intercourse as the climax of every ceremony. Cultural practices should be integrated in HIV/AIDS prevention programmes to minimize the spread of HIV/AIDS especially among the non-circumcising communities in Kenya.

CHAPTER SIX: THE EFFECTIVENESS OF POST-CIRCUMCISION HIV/AIDS COMMUNICATION STRATEGIES

This chapter presents and discusses data emerging from inquiry on the effectiveness of post-circumcision HIV/AIDS communication strategies in Usenge sub-location. The chapter has three sections. Section one presents data on effectiveness of voluntary medical male circumcision communication strategies aired on local vernacular radio stations. Section two presents results on the effectiveness of brochures issued to circumcised men. While section three entails a summary of the major results presented and discussed in this chapter.

6.1 Effectiveness of Voluntary Medical Male Circumcision Communication Strategies Aired on Local Vernacular Radio Stations

Majority of participants (63.4%) in this study revealed that they got a lot of information from brochures issued to circumcised men after VMMC. This implied that majority had access to post VMMC messages immediately after circumcision and they got information on how to take care of the wound and safe sexual behaviour after VMMC. However, a small percentage (36.6%) got post VMMC messages from radios. Local vernacular radio stations airing post VMMC programmes targeted the general population. Majority of circumcised men in this study did not listen to radios due to the nature of their occupation, that is fishing which involves migration away from their homes as discussed in the chapter five. This implied that most men did not get post VMMC HIV preventive messages over the radios. Results are as shown in Table 6.1

Table 6.1 Source of Information by Circumcised Men on Post VMMC Safe Sexual Acts

Source of Information on post VMMC safe sexual Acts	Frequency	Percent
Brochures	64	63.4
Radio	37	36.6
Total	101	100.0

Results from FGDs, in-depth interviews and key informant interviews conducted in this study also revealed that there was HIV/AIDS prevention programmes aired on local vernacular radio stations that targeted circumcised men. The main local vernacular radio stations mentioned in this study that aired the VMMC programmes included: Radio Lake Victoria FM, Radio Nam Lolwe FM and Ramogi FM. In this study, effective communication strategies included information that enhanced greater public enlightenment, focusing on the removal of socio-cultural obstacles and informational barriers hindering adoption of safe sexual practices, the improvement in the public's awareness regarding the HIV/AIDS epidemic and catalyzing community-based responses to HIV/AIDS. In a nutshell, that is a communication strategy which takes into account the social and cultural aspect of the recipient community.

Themes emerging from FGDs and in-depth interviews with circumcised men revealed that majority were aware of the post VMMC programmes aired on local vernacular radio stations. Informants from in-depth interviews explained that there was an abundance of health education messages in local vernacular radio stations campaigns that attempted to reach out to people to

convey safe sexual behaviour messages before and after VMMC in the hope that if properly understood and utilized effectively by being adhered to, people's lives could be improved. The messages from such programmes target the general population and some of the circumcised men conceptualize them as other advertisements. However, Behaviour Change Communication (BCC) was identified to dominate the programmes aired on local vernacular radio stations. Informants also noted that there was great evidence existing for the ability of such campaigns to increase knowledge and raise awareness of HIV/AIDS after VMMC. However, from FGD discussions, there was little evidence that the BCC campaigns aired on local vernacular radio stations were able to change unsafe sexual behaviour. They noted that human behaviour is complex, and behavior change under any circumstance could be difficult to achieve and maintain. During in-depth interviews, the informants noted that they were aware of other HIV prevention programmes such as being faithful to one uninfected partner, consistent condom use and abstinence but this did not translate to sexual behaviour change of the people because of perceptions that VMMC is a 'back up' for HIV prevention as has been discussed in the previous chapters. Moreover, the in-depth interview informants and FGD discussants noted that communication programmes such as those aired on vernacular radio stations should reinforce preventive behaviour towards the spread of HIV infections through institutional and individual behaviour and social change approaches.

An informant explained:

> It is true that HIV/AIDS messages aired on our local vernacular radio stations advocate for behaviour change. However, the post VMMC messages are conducted in a way that they target the whole population and some men miss them. I listen to such programmes every Monday and at least I have known that VMMC is an additional HIV preventive measure thus I use condoms consistently during *mpango wa kando* (meaning extramarital

> affairs). The truth is very few circumcised men take time to listen to such programmes but they are very effective if we add to what we were taught before MMC (Male, 33 years old).

A discussant also added that:-

> I am aware of other HIV/AIDS preventive measures. Our local radio stations should bear in mind that it doesn't mean that the post VMMC reaches every circumcised man. Moreover, some circumcised men may listen to such programmes but that does not necessarily translate to adoption of safe sexual practices, this is very tricky. Additionally, the message emphasizes that VMMC minimizes chances of contracting HIV/AIDS by 60% and that being circumcised is not a guarantee that circumcised men cannot contract HIV/AIDS. The messages emphasize the use of other HIV prevention methods such as being faithful to one partner whose HIV status is known to the man, reduction in number of sexual partners and consistent use of condoms during sexual intercourse. The messages do not reach everybody for instance men who go for *jua kali* do not have time to listen to radios (Male discussant, 40 years old).

Key informant interviews with senior and local health officers also concurred with FGDs and in-depth interviews findings that post VMMC programmes aired on local vernacular radio stations did not reach every circumcised man and that the messages were very educative. However, it does not mean that those who listened to such messages would adopt safe sexual practices. This is because sexual behaviour may not be under an individual's volition but may be dependent upon the social and cultural environment in which one lives. Additionally, the senior health officer noted that messages aired passed through radio are very effective because men who listen keenly to such messages are aware of other HIV/AIDS preventive methods and in some cases these men call back the radio stations to seek clarification on unclear messages. The officer further noted that such messages reach a larger population.

A senior health officer stated that:

> There are post VMMC preventive programmes aired on our local radio stations such as Ramogi FM, Lake Victoria FM and Nam Lolwe FM. My worry is that such educative messages do not reach all circumcised men for instance circumcised men who are *boda boda* and fishermen are always mobile so there is little time to listen to radio programmes. However, radio is an effective medium of reaching a larger population. I believe that such messages are effective because circumcised men who listen to these programmes keenly are educated on other HIV preventive methods. It is worth noting that the message does not necessarily lead to adoption of safe sexual behaviour as some people might think. (Male, 39 years old).

Some discussants also explained that the vernacular radio stations had messages informing circumcised men on sexual behaviour after VMMC. The informative messages in the advertisement in local radio stations included: information on benefits of VMMC, the disadvantages of the fore skin and importance of using other HIV preventive methods after VMMC. Furthermore, radio programmes informed men that VMMC did not fully offer protection against HIV/AIDS. During such programmes, circumcised men are encouraged to use other HIV/AIDS prevention methods.

A discussant explained:

> I listen to Radio Lake Victoria… they have an advertisement that they air out after every one hour or so. The message in the advertisement is very informative and keen listeners like me have learnt a lot. It taught me that VMMC is an additional HIVAIDS preventive measure and I should continue using other HIV preventive methods such as correct and consistent use of condoms. To make HIV prevention message reach home, I propose we fund the dormant youth groups to help in peer counseling or related discussions on youth sexual and reproductive health (male discussant, 23 years old).

The above excerpts show that the available post VMMC programmes aired on local vernacular radio stations targeted the general population including circumcised men and on most occasions, they are effective but circumcised men perceived them normally as other advertisements aired on

radio daily. Circumcised men who listened to such programmes could therefore not be very keen on take home messages which were all about behaviour change.

Discussants in all FGDs stressed the need for male youth centers where issues of sexual and reproductive health services could be discussed among the youths. The discussants observed that there was only one active youth group which occasionally conducted reproductive health promotion advertisements while the discussants felt that other dormant youth groups could be funded to facilitate their involvement in peer counseling or related discussions on youth sexual and reproductive health. Further, these youths could be used in community mobilizations and awareness creation on male reproductive health and not for HIV prevention alone.

These study findings are consistent with a study by Panos Eastern Africa (2011) which found that HIV seems to be on the increase because the message of behaviour change is not coming out clearly and strongly, failing to impact on people's behaviour. However, a successful and effective health behaviour communication must reach the audience, attract the audiences' attention, present an understandable message, promote change, and produce a change in behaviour for better health (Hubley, 1993). Some of these aspects have not been addressed in the post VMMC programmes aired on local radio stations. The foregoing findings are also supported by UNAIDS (2010) report on combination of HIV prevention methods. The report noted that national prevention programmes are too often made up of a collection of disconnected interventions, and these often lack clear milestones, clearly articulated causal pathways and clear connections with other programmes that contribute to achieving the same prevention targets (UNAIDS, 2010). However, UNAIDS (2010) Global Report argued that "positive behavior

change can alter the course of the HIV pandemic". Thus, communication campaigns have become a cornerstone of global HIV prevention efforts. Typically, these campaigns disseminate health messages that are designed to increase public knowledge about HIV and they utilize a variety of strategies and channels to disseminate these messages, generally combining mass media to reinforce messages under a unified platform (UNAIDS, 2010).

Arguably, according to Health Belief Model (HBM), circumcised men can change their sexual behaviour if they perceive benefits of other HIV preventive measures such as starting to use condoms correctly and consistently to avoid HIV infections. HBM argues that individuals weigh the benefits of a health intervention, in this case VMMC, against the perceived costs and barriers to change. Therefore, for change to occur, benefits must outweigh costs (Rosenstock, Strecher & Becker, 1994). The main aim of post VMMC programmes aired on local radio stations are to change circumcised men's personal beliefs that VMMC acts as a "magic bullet" against HIV/AIDS in order to promote change in adopting safe sexual behaviour. This is due to the fact that health motivation is the central focus of HBM, thus, the model was fit for addressing the circumcised men's sexual behaviours that could evoke health concerns like high-risk sexual behaviour and the possibility of contracting HIV.

6.2 Effectiveness of Brochures Issued to Circumcised Men

Majority (63.4%) of circumcised men in this study explained that there were brochures issued to them before and after VMMC. During pre-VMMC counseling, brochures were given to men to inform men on what VMMC is all about, the benefits of VMMC to men, benefits of VMMC in women, informed consent, duration of healing and risks associated with circumcision. After undergoing circumcision, men were given brochures to take home and read. The main objective

of the post VMMC brochure was to educate circumcised men on how to take care of the wound after VMMC including dressing of the wound on the third day after circumcision and adherence to safe sexual behaviour.

There was consensus in all FGDs with circumcised men that majority of circumcised men do not take time to consistently read the brochures issued after VMMC. It was noted that some circumcised men threw away the brochures and others read it once and kept them. However, most circumcised men were not reading the brochures consistently therefore, pre-VMMC counseling sessions were mentioned to have an effective message on post VMMC care of the wound and sexual behaviour. The discussants also noted that some circumcised men who were illiterate did not see the need of such brochures thus they relied on messages they got from counseling sessions. This confirmed that circumcised men preferred pre-VMMC counseling sessions since getting the information from the counselors increased the comprehension of the information on post VMMC sexual behaviour when received directly from a health officer.

A discussant explained:

> We were given the brochures to read before VMMC. The main message in the pre-VMMC brochures were the benefits of VMMC to men and women, informed consent, healing period and risks associated to circumcision. However, the doctors gave us some brochures to read after circumcision……these brochures to me are not that important because I lost mine one day after operation and what helped me was the information I got during pre and post VMMC counseling sessions (Male, 31 years old).

Another discussant added that:

> Brochures may be effective to those who have gone to school like you….I never went to school so those brochures were of no use. In fact I was given one but threw it away just a distance from circumcision centre. Counseling sessions are very important to those who have not gone to school like me. However, I cannot tell whether all of us here adhered to the information in those brochures (Male, 43 years old).

Key informant interviews with local health professionals in the study area revealed that all circumcised men were given brochures before and after VMMC counseling and after the operation they were given brochures containing all the information said during counseling sessions. Analysis of key informant interviews showed that the brochures were not very effective ways to pass post VMMC messages since some circumcised men were illiterate and they did not see the importance of brochures. Thus, local health professionals emphasized that on continual behaviour change communication as an effective way of telling men what VMMC is all about. In most cases, this could translate to sexual behaviour change either positively when men adhere to safe sexual practices or negatively when circumcised men indulge in risky sexual practices. This depended on how circumcised men interpreted such information.

A senior health officer noted that:

> Circumcised men are counseled before and after circumcision. However, a brochure is given to every circumcised man to read on his own time and they are expected to adhere to the messages in the brochures. These brochures are not very effective because some circumcised men are illiterate and some throw them away……I am happy these clients get the first hand information from our counselors and such messages gives clients freedom to make an informed choice regarding sexual behaviour (Senior health officer, 39 years old).

The excerpt above shows that brochures contained the necessary post VMMC messages that could motivate circumcised men to adopt and continue practicing safe behaviours. Moreover, these findings are in agreement with Kinyeki's (2012) arguments that booklets provides post operative care instructions to clients as well as additional HIV prevention messages. All these basics highlight the need for adherence to safer sexual behaviour, because male circumcision does not provide 100% protection against HIV.

Notably, from this study it emerged that pre and post VMMC counseling sessions were effective methods of passing post VMMC HIV/AIDS preventive methods to circumcised men. The UNAIDS (2011) report argued that illiteracy, especially people who do not know how to read or write, or inherited languages like English can have a barrier for any health promotion message. Notably, as quoted by the study by Senegal *et al*., (2007), "to avoid barriers for any health promotion, it is crucial to give voice to people and to understand how they conceptualize male circumcision within their own philosophical systems, social dynamics, gender relations, and symbolic meanings of learning and transmitting knowledge". This might help in the development of effective health communication strategies. This implies that the centrality of culture cannot be ignored in any discussion on HIV/AIDS. An understanding of people's culture helps in designing communication programs that focus on the manner in which knowledge can be introduced into a cultural system. Such understanding fosters the ability to enable the community to rethink their approaches towards issues regarding sexuality and human relationships.

According to the Information, Education, and Communication (IEC) model, clear information presented in an appropriate format and language would persuade those at risk to protect themselves from the HIV virus (United Nations Population Fund [UNFPA], 2001). Despite over two decades of communication efforts, however, HIV rates have continued to rise globally. It has become increasingly clear that improved knowledge and education do not always lead to positive behavioral changes. Another effective way of passing post VMMC messages to circumcised men could be the use of entertainment-education approach. This had been identified by (UNFPA, 2001) as most effective way of disseminating information through the media by combining entertainment and education. Such entertainment and education could be delivered through

organizations advocating for behaviour change. Further, learning from elders rather than from peers has deep roots in African culture and tradition. Inclusion of traditional opinion leaders in a communication strategy will ideally complement and improve upon the peer education efforts of other HIV programmes in the region.

6.3 Summary

This chapter has presented results on effectiveness of post-voluntary medical male circumcision communication strategies. Results show that majority of circumcised men are issued with brochures to read. The brochures had information on pre and post VMMC messages on importance of VMMC and abstinence period after VMMC. However, brochures were not an effective method of delivering post VMMC message because: some circumcised men threw away the brochures and others read it once and kept them and some circumcised men who had low level of education did not see the need for such brochures. Discussants therefore suggested that post VMMC messages could be effective if delivered through peer groups advocating for behaviour change and also inclusion of traditional opinion leaders in communication strategies for HIV programmes in the region.

The study also revealed that there were HIV/AIDS prevention programmes aired on local vernacular radio stations that targeted circumcised men. Behaviour Change Communication (BCC) was identified to dominate the programmes. However, the study revealed that human behaviour is complex and safe sexual behaviour change under any circumstance could be difficult to achieve and maintain. The findings also show that post VMMC programmes aired on local vernacular radio stations were effective. As much as communication campaigns have become a cornerstone of global HIV prevention efforts, the government should integrate

entertainment-education approach to deliver post VMMC messages. Entertainment-education strategies are based on the idea that self-efficacy will lead to expected results. The approach fits well in the entertainment for education purpose of storytelling, songs, and other community-based activities that are indigenous to Africa and this could be done through the local youth groups. The approach has been used successfully in many reproductive health programmes in sub-Saharan Africa as evidenced from evaluation studies.

CHAPTER SEVEN: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This chapter presents the summary regarding the main empirical findings presented and discussed in this thesis. It further presents conclusions of these findings and their relevance to understanding the socio-cultural context of men's sexual behaviour during post voluntary medical male circumcision within the context of traditionally non-circumcising communities on the shores of Lake Victoria. Recommendations and implications for further research are also presented.

7.2 Summary of the Findings

HIV/AIDS remains a major cross-cutting crisis in Kenya that encompasses virtually every sector of modern life, as well as traditional customs. Prevention of new infections is the only realistic hope for stemming the HIV pandemic. Against the backdrop of compelling research evidence, VMMC is now recommended as an additional measure to reduce HIV infection among men. There were many factors that influence men's sexual behaviour after voluntary medical male circumcision that can hinder some of the intended benefits of VMMC especially among traditionally non-circumcising communities such as the Luo.

The first objective of this study was to investigate men's perceptions on sexual risk factors for HIV/AIDS following medical male circumcision. The findings show that most circumcised men in the study area resumed sexual activities before proper healing of the wound to test whether their penises functioned well. This was as a result of failure to adhere to the post-VMMC abstinence recommendation period. The results also show that there exists a perception that MMC is "a back-up" and "a vaccine" against HIV/AIDS. Further, the results in this study show

that there was a perception that MMC enhanced men's sexual performance hence men indulged in further extramarital affairs.

The second objective of this study was to explore the influence of socio-cultural practices on men's sexual behaviour after medical male circumcision. To achieve this objective, social and cultural practices were identified. Results show that fishermen's migratory patterns, transactional sexual relationships, peer pressure and alcohol consumption were social practices that influenced circumcised men's sexual behaviour in this study. Fishermen's high mobility locally known as *wimbo*, their long absence from home and their cash incomes which are then often spent in the trading centres on casual sex and alcohol influenced men's sexual behaviour hence exposing them to risk of HIV/AIDS. Men's sexual behaviour had to change to adapt to the new beach culture. However, alcohol use was associated with risky sexual behaviour including unprotected sex, casual sex, multiple partners and sexual violence among men. Alcohol use impaired judgement, lowered inhibitions and gave circumcised men the boldness to do what they would not ordinarily have done when sober. This was done without regard for the consequences of one's actions.

Cultural practices that influenced circumcised men's sexual behaviour after VMMC included; widow inheritance and other sexual cleansing ceremonies among the Luo community such as: the construction of a new home or house, at the beginning of land preparation and planting season, when a son or daughter gets married and the first day when offspring get back to their houses after burying a parent. These cultural practices involved sexual intercourse and there were no use of any form of HIV/AIDS protection hence exposed circumcised men equally to HIV/AIDS.

The third objective of this study was to examine the effectiveness of post-circumcision HIV/AIDS communication strategies. Results show that majority of circumcised men were issued with brochures to read. The brochures had information on pre and post VMMC messages on importance of VMMC and abstinence period after VMMC. However, brochures were not an effective method of delivering post VMMC messages because some circumcised men threw away the brochures and others read it once and kept them while some circumcised men with low levels of education did not see the need for such brochures. Additionally, post VMMC programmes aired on local vernacular radio stations were effective because they had behaviour change messages for both educated men and those who had low levels of education. Notably, the study confirms that pre and post VMMC counseling sessions are effective methods of passing post VMMC HIV/AIDS preventive methods to circumcised men since the effects of receiving the information directly and individually from counselors are stronger than the effects of other media sources.

Ultimately, this study confirms that the health belief model can be effectively used to explain and predict why individuals engage in health-related actions that may or may not compromise their health while cultural ecology theory is effective in understanding behaviour of an individual by looking at how a particular human pattern of behaviour or culture is associated with environment and how much these patterns of behaviour influence other aspects of culture in the society. The two theories were therefore important in investigating the socio-cultural context of men's sexual behaviour during post voluntary medical male circumcision.

7.3 Conclusion

Despite the fact that VMMC was adopted in Kenya as an additional HIV/AIDS preventive measure, this study confirms that circumcised men in Usenge sub-location still perceive circumcision as a "back-up" and "a vaccine" against HIV infection. They therefore engage in risky sexual practices, thus hindering some of the intended benefits of VMMC.

Socio-cultural factors such as fishermen's migratory patterns, transactional sexual relationships, peer pressure, alcohol consumption, widow inheritance and other sexual cleansing ceremonies among the Luo community influenced circumcised men's sexual behaviour. This study confirms that circumcised men's ability to initiate and sustain safer sexual behaviours largely depended upon societal sexual norms and practices, and not just self-perceived susceptibility to HIV infection. The existing socio-cultural practices identified in this study still exposed circumcised men to HIV/AIDS because they indulge in sexual activities without using condom or any other form of protection due to perception that they are fully protected against HIV.

Furthermore, this study confirms that Behaviour Change Communication (BCC) which was identified to dominate the programmes however, did not change behaviour of circumcised men to adopt safe sexual behaviours because human behaviour is complex and safe sexual behavior change under any circumstance could be difficult to achieve and maintain. Pre and post VMMC counseling sessions are therefore very important because the information that an individual receives directly and individually from counselors have stronger effects than the effects of other media sources. However, post VMMC programmes aired on local vernacular radio stations were

effective because men with low education could get messages on behaviour change following VMMC.

The study findings have major implications in the process of the design of HIV/AIDS preventive measures necessary for checking the spread of the disease among populations along Lake Victoria region since there existed a misconception about risk reduction to mean risk elimination, thus contributing to higher incidences of riskier sexual behaviour.

7.4 Recommendations

On the basis of findings adduced from this study, several recommendations have been made to inform successful implementation for the intended benefits of VMMC. Implications to national policy have also been identified and highlighted. This section presents the major recommendations arising from this study.

There is a need for enhanced follow up community-wide education and promotional activities that target circumcised men in order to change their perceptions about VMMC. These promotional activities should motivate circumcised men to adopt correct and consistent use of other HIV prevention strategies especially condoms. This study recommends that the current national guidelines for provision of VMMC incorporate a policy whereby there will be forums where community members including women participate in dialogues on issues of reproductive health to ward off misconceptions about VMMC and that circumcised men are protected against HIV.

Engaging circumcised men in broad-based dialogue on socio-cultural and public health implications of VMMC could help address the importance of MMC as an additional HIV/AIDS prevention measure and not a permanent solution to HIV/AIDS among the Luo community. Arguably, there is also a need to integrate community members' participation in HIV/AIDS prevention programmes to minimize the conflict between cultural beliefs and new health interventions aiming to minimize the spread of HIV/AIDS especially among the non-circumcising communities in Kenya.

The study strongly recommends use of local youth groups as avenues through which post VMMC promotional messages can be passed to the community. Youth engagement in such dialogue can be done through the establishment of network of peer groups, village educators and volunteers who are influential people in the local communities. Further, there is need for inclusion of traditional opinion leaders in grass roots communication strategies since this might ideally complement and improve upon the peer education efforts of other HIV programmes in the region.

Since entertainment-education approach is another effective way of passing post VMMC messages to circumcised men, the Ministry of Health should consider developing policies aimed at promoting the use of ora-media approach particularly those targeting rural communities as it is the media which takes into account activities, beliefs and customs of the local population in creation of HIV/AIDS awareness. Live oral-drama ought to be picked up by the government to impact on the emotional outlook of the population against the HIV/AIDS pandemic in the country.

7.5 Areas for Further Research

There is need for further studies on perception of risk to HIV/AIDS by women married to circumcised men along fish landing beaches in Lake Victoria.

There is a need for a study on Luo cultural dynamics and trends with a view to determining how VMMC can be integrated and sustained into the community's cultural system.

There is need for studies on socio-cultural impacts of integration of youth groups and community elders in grassroot behaviour change communications.

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APPENDICES

APPENDIX I: Semi-structured questionnaire for circumcised men

My name is …….., a post graduate student from Maseno University, department of Sociology and Anthropology. I am carrying out a study on ***the socio-cultural context of men's sexual behaviour during post-voluntary medical male circumcision in Usenge sub-location, Bondo Sub-County, Kenya*** and you have been sampled as one of the respondents. I would like to assure you that everything we shall talk about will be kept confidential. I request that you allow me to interview you. Do you agree?

Yes_____ (if Yes, tick and continue)

No_____ (if No, X and stop)

Number of interviewee……Date…… Venue……..…. Signature……

A. Socio-demographic information

1. Age of the respondent (*Tick where appropriate*).

   a. 18-24…… c. 25-29…… d. 30-34……

   e. 35-39…… f. 40-44…… g. 45-49…….

2. Marital status of the respondent (*Tick where appropriate*).

   a. Single……. b. Married……. c. Widowed…….

   d. Separated……..

3. Education level of the respondent (*Tick where appropriate*).

   a. None…… b. Primary school…….. c. Secondary school…..

   d. College/tertiary (*specify*)…….. e. University…….

4. Religious affiliation of the respondent (*Tick where appropriate*).

a. Catholic…….. b. Protestant…… c. Muslim……

d. Others……. e. No religion……

5. Occupation of the respondent?……

a. Fishing/ fish mongering…….. b. Touting……..

c. Motorbike taxi (*boda boda*)…….. d. Teaching……..

d. Farming…… e. Business…….

f. Others (*Specify*)……. G. Student……...

B. **Perceptions on sexual risk factors for HIV/AIDS following medical male circumcision**

1. Which of the following is the reason you got circumcised? (*Tick one*)

a. I wanted to prevent STIs/HIV infection……..

b. I wanted to increase my sexual pleasure……..

c. My partner persuaded me/ insisted that I get circumcised…….

d. I wanted to keep my penis clean…….

e. Peer pressure……

f. Other (*specify*)……

2. In your opinion, does medical male circumcision prevent one from contracting HIV?

a. Yes…….. b. No……

3. Can a circumcised person transmit HIV to another person?

a. Yes…….. b. No……...

4. As an individual do you think it is possible for you to get HIV/AIDS?

a. Yes…… b. No…….

5. If Yes, what are the chances?

   a. Low……. b. Moderate……. c. High……

6. If No, in 4 above what are the reasons? (*Allow the respondent to narrate and note down*).

……
……
……
……
……

7. What is the reason for your answer in 5 above? (*Tick one*)

   a. Abstinence___ **b.** Faithfulness to single faithful partner____ **c.** Always uses condom during intercourse_____ **d.** Circumcision protects me from getting HIV/AIDS_____ **e.** Living away from spouse_____ **f**. Inconsistent condom use_____ **g.** Multiple sex partners_____ **h**. Unprotected sex_____ **i**. Wife inheritor___ **j.** Widow cleanser_____

8. Apart from your wife/ wives do you have other sexual partners? (*For married men only*)

   1) Yes___ 2) No___

9. If Yes, how many did you have intercourse with in the last 3 months?

   1) 1 only___ 2) 2-4_____ 3) More than 5___

10. In such sexual relationships did you use a condom?

    1. Yes_____ 2. No_____

11. If Yes, what would be the reason (s)? (*Allow the respondent to narrate*).

……
……

……
……
……
……

12. If No in 10 above, what would be the main reason? (*Tick one*)

    1. Circumcision protects me from getting HIV/AIDS_____
    2. My religion do not support use of a condom_____
    3. Using a male condom reduces sexual pleasure_____

13. Do you think circumcision act as a vaccine against HIV/AIDS?

    1) Yes___ 2) No__

14. If **Yes** in 13 above, give reason (s) (*Allow the respondent to narrate and record)*……
……
……
……
……
……
..

C. The influencing Socio-cultural practices on men's sexual behaviour after medical circumcision.

1. What are some of the cultural practices that put circumcised men at risk to HIV infection? (*Tick one*)

    a. Polygamy_____ b. Wife inheritance_____ c. Non-circumcision____

    d. Unprotected sex_____ e. Sex related ceremonies_____

2. Do you usually use condom during cultural practices involving sexual intercourse?

a. Yes…… b. No……..

3. What are some of the social HIV risk behaviours among circumcised Luo men? (*Tick one*)

   a. Transactional sexual relationships / *Jaboya system*_____

   b. Having several intimate sexual partners_____

   c. Alcoholism _____

   d. Daily cash income from their occupation_____

   e. Others
   (*specify*)_____
   _____

4. Do you usually use condom in such social practices involving sexual intercourse?

   a) Yes____ b) No_____

5. Does Voluntary Medical Male Circumcision change men's perceptions on HIV/AIDS? (tick one)

   a. Yes_____ b. No_____

B. Effectiveness of Post-circumcision HIV/AIDS communication strategies.

1. Did you get information on how to adhere to safe sexual acts?

   a. Yes_____ b. No_____

2. If Yes in 1 above where do you get this information from? *(Tick one*)

a. Brochures given after circumcision to read_____ b. Radio_____

d.) Newspapers_____ d.) Chief's barazas___ e.) From peers_____

e.) Post-circumcision education_____

f.) Others sources (Respondent to *Specify*)_____

3. Was the information relevant/adequate to you? a) Yes_____ b) No_____
4. What did you learn from such source of information?.....

……
……
……

5. If No in 3 above then what are the reasons? (*Allow the respondent to narrate*).

……
……
……

6. In your opinion, what should the government do to ensure that circumcised men get post-circumcision information on adherence to safe sexual practices? (*Allow the respondent to narrate*).....
.....
..... ……

****END OF INTERVIEW****

This is the end of the interview. Thank you very much for your cooperation.

APPENDIX II: Key Informant Interview Guide for: village elders, Beach Leaders and local health professionals

Topic of Study: The Socio-Cultural Context of Men's Sexual Behaviour During Post VMMC in Usenge Sub-Location, Bondo Sub County, Kenya.

HIV risk behavior among Luo and Perception to HIV/AIDS.

1. What are the community's perceptions about male circumcision and HIV prevention?
2. What are the circumcised Men's perceptions about HIV/AIDS? Do they think that people who are circumcised are protected from HIV/AIDS? Why? How?
3. What are some of the risky sexual behavior that Luo males may engage in because they are circumcised?
4. Does sexual behavior for circumcised men change after circumcision? How? Probe: Number of sexual partners, condom use, other sexual practices, sexual performance.

Socio-cultural factors affecting men's sexual behavior after VMMC

1. What are some of the cultural practices in this community that may put circumcised Luo males at risk of HIV infection?

2. What are some of the social practices in this community that may put circumcised Luo males at risk of HIV infection?

Post-circumcision HIV/AIDS communication strategies available.

1. What efforts are you/your office making to combat HIV/AIDS in this community?

2. What are some of the post-circumcision HIV/AIDS communication strategies available targeting circumcised men and how accessible/ effective are they to circumcised men?

3. In your opinion, what should the government do to ensure that circumcised men get post- circumcision information on adherence to safe sexual practices?

This is the end of the interview. Thank you very much for your cooperation.

APPENDIX III: In-depth Interview Guide for Medically Circumcised Men

Introductory statement:

My name is Stephen Okumu, a post graduate student from Maseno University, department of Sociology and Anthropology. I am carrying out a study on ***the socio-cultural context of men's sexual behaviour during post-voluntary medical male circumcision in Usenge sub-location, Bondo Sub-County, Kenya*** and you have been sampled as one of the respondents. I would like to assure you that everything we shall talk about will be kept confidential. I request that you allow me to interview you. Do you agree?

I agree [ ] I don't agree [ ] Signature_____ (*If agree*)

Areas to be covered:

1. Condom use after VMMC and Perception of Luo males on circumcision
2. Change in number of sexual partners before and after VMMC.
3. Socio-cultural factors affecting men's sexual behavior after VMMC.

1. What are the importance of using condom after VMMC? (*probe further*)
2. What do Luo males think about VMMC in relation to their sexual activities?
3. What are the changes in the number of opposite sexual partners before and after VMMC? (*Allow for narration*)
4. What are some of the social factors influencing men's sexual behavior after VMMC? (*allow the respondent to narrate*)
5. What are some of cultural factors influencing men's sexual behavior after VMMC? (*allow the respondent to narrate and probe further*)
6. In your opinion, what should the government do to ensure that circumcised men get post- circumcision information on adherence to safe sexual practices?

APPENDIX IV: Focus Group Discussion Guide for (Medically Circumcised men both single and married, and community elders).

Introductory Statement:

My name is Stephen Okumu, a post graduate student from Maseno University, department of Sociology and Anthropology. I am carrying out a study on ***the socio-cultural context of men's sexual behaviour during post-voluntary medical male circumcision in Usenge sub-location, Bondo Sub-County, Kenya*** and you have been sampled as one of the respondents. I would like to assure you that everything we shall talk about will be kept confidential. Do you agree to participate?

I agree [ ] I don't agree [ ] Signature_____ (*If agree*)

1. What crosses your mind when you hear about VMMC?

2. In your opinion, do you fear that your sex life might have put you in danger of contracting AIDS after VMMC? Why? Probe.

3. How long do you wait for the wound to heal before resuming sexual activities? Probe on the importance of healing period and men's sexual behavior during this period?

4. What is your exposure to HIV/AIDS since you went for VMMC? Why?

5, What is the situation of extra-marital affairs among circumcised men? Probe on condom use in such sexual affairs?

6. Are you using condom after VMMC? (Probe reasons for or against condom use & consistency in condom use)

7. What are your perceptions on condom use post VMMC?

8. In your opinions, between married and single circumcised men who indulges in high sexual acts after VMMC. (Give reasons)

9. What are some of the factors that can facilitate the spread of HIV/AIDS to circumcised men?

10. What are some of the social practices in this community that put circumcised Luo males at risk to HIV infection?

11. What are some of the cultural practices in this community that put circumcised Luo males at risk to HIV infection?

12. After VMMC did you get civic education on how to adhere to safe sexual practices? If **YES** what did you learn? Probe to know the source of such information and whether they were effective

13. In your own opinions what do you think can be done to ensure that circumcised men get effective information on adherence to safe sexual behavior after VMMC?

This is the end of the Discussion. Thank you very much for your cooperation.