‘He is proud of my courage to ask him to be circumcised’: experiences of female partners of male circumcision clients in Iringa region, Tanzania

Erica H. Layer\textsuperscript{a}, Sarah W. Beckham\textsuperscript{a}, Romani B. Momburi\textsuperscript{b}, Maureen Peter\textsuperscript{c}, Editha Laizer\textsuperscript{c} & Caitlin E. Kennedy\textsuperscript{a}

\textsuperscript{a} Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA
\textsuperscript{b} Primary Health Care Institute, Iringa, Tanzania
\textsuperscript{c} Department of Psychiatry, Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania

Published online: 09 Jan 2014.

To cite this article: Erica H. Layer, Sarah W. Beckham, Romani B. Momburi, Maureen Peter, Editha Laizer & Caitlin E. Kennedy (2014) ‘He is proud of my courage to ask him to be circumcised’: experiences of female partners of male circumcision clients in Iringa region, Tanzania, Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, 16:3, 258-272, DOI: 10.1080/13691058.2013.873481

To link to this article: http://dx.doi.org/10.1080/13691058.2013.873481

PLEASE SCROLL DOWN FOR ARTICLE
‘He is proud of my courage to ask him to be circumcised’: experiences of female partners of male circumcision clients in Iringa region, Tanzania

Erica H. Layera*, Sarah W. Beckettb, Romani B. Momburib, Maureen Peterc, Editha Laizerd and Caitlin E. Kennedya

aDepartment of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA; bPrimary Health Care Institute, Iringa, Tanzania; cDepartment of Psychiatry, Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania

(Received 27 March 2013; accepted 5 December 2013)

Male circumcision programmes in Tanzania seek to increase demand among older, married clients who are more likely to have steady female sexual partners. Understanding women’s roles throughout their partners’ circumcision and any resultant changes in relationship dynamics are important considerations as efforts are made to scale up male circumcision. We conducted interviews with 32 wives of male circumcision clients from November 2011 to February 2012 in Iringa, Tanzania. Transcripts were digitally recorded, transcribed and translated into English and codes were developed based on emerging themes. Women were instrumental in convincing their husbands to be circumcised, but early resumption of sexual activity was common and a minority of women reported their husbands’ emotional abuse or risk compensation following circumcision. These findings suggest that married women play a key role in their husbands’ decisions to be circumcised, but women’s needs for information and education are not being met and gender inequalities further decrease women’s abilities to reduce their risk of HIV in this context. Strategies to more meaningfully engage women in male circumcision programmes are needed.

Keywords: HIV/AIDS; male circumcision; women’s role; Tanzania

Introduction

Three randomised controlled trials (RCTs) have shown that male circumcision may reduce the risk of female-to-male HIV transmission by up to 60% (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007). On the basis of this evidence, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) promote male circumcision as an important HIV-prevention strategy in the context of a generalised epidemic and as part of a broader package of combination prevention (WHO 2007). Although considerable debate exists as to whether the HIV-prevention benefits from male circumcision will be replicated outside of the original trial settings, and whether reductions in HIV risk will be sustained over time (Dowsett and Couch 2007; Kalichman, Eaton, and Pinkerton 2007), the implementation of male circumcision programmes is moving ahead. Several sub-Saharan African countries have begun to scale-up male circumcision services and international donors have pledged significant funding to support male circumcision in countries with high HIV prevalence and low rates of male

Tanzania has an HIV prevalence of 5.1% and a male circumcision rate of approximately 72% (Tanzania Commission for AIDS et al. 2013). However, the Iringa region in southern Tanzania has an HIV prevalence of 9.1% within the adult population, nearly double the national average. The male circumcision rate was 30% in 2008, but has increased dramatically since scale-up of male circumcision services began in June 2010. Now at 60%, however, it still has the lowest rate in the country (Tanzania Commission for AIDS et al. 2009, 2013). The Government of Tanzania plans to support the circumcision of 2.8 million men by 2015, including 268,000 men in the Iringa region (National AIDS Control Programme 2010).

Male circumcision will in principle have the most immediate impact on HIV incidence if sexually active men (over the age of 20) are circumcised before they are infected with HIV (WHO 2007). However, attracting these men to services has been a challenge for many male circumcision programmes. To date, a majority of clients in Iringa region have been under the age of 19 years (Plotkin et al. 2013), a trend that has been reported in other male circumcision programmes in sub-Saharan Africa (Herman-Roloff, Bailey, and Agot 2012; Wawer et al. 2012). To reach sexually active men, programmes are developing strategies to increase demand for these older clients (Herman-Roloff, Bailey, and Agot 2012; Plotkin et al. 2013).

Male circumcision, if widely implemented in high-HIV-prevalence, low-circumcision settings, has the potential to significantly reduce new HIV infections among men. If HIV incidence is reduced among men at a population level, this should ultimately reduce HIV incidence among women as well. However, despite the promise of male circumcision programmes, several concerns have been raised about the potential impact of male circumcision on women. First, women may be at increased risk of HIV if sexual intercourse is initiated before the WHO-recommended six-week post-circumcision sexual abstinence period (Wawer 2009; WHO 2007). Early resumption of sexual activity, especially among married men, may be common, potentially placing the wives of HIV-positive men at increased risk of HIV (Herman-Roloff, Bailey, and Agot 2012; Hewett et al. 2012).

A further concern is the possibility of risk compensation, or behavioural disinhibition. If circumcised men feel protected from HIV, they may be less likely to consistently use condoms or may increase their number of sexual partners (Eaton and Kalichman 2009). Two studies from RCT sites in Uganda and Kenya have found little evidence of risk compensation (Gray et al. 2012; Mattson et al. 2008). However, these findings may not be replicable in programmatic settings (Eaton and Kalichman 2009). Several recent studies from outside of RCT sites have reported concerning findings, including the perception that condom use is less important for circumcised men (Westercamp et al. 2012), the misconception that circumcised men are fully protected against HIV (Andersson and Cockcroft 2012) and increased risky sexual behaviour among traditionally circumcised men who feel that their risk of HIV is reduced due to circumcision (Eaton et al. 2011). Mathematical modelling predicts that even small amounts of risk compensation among men could increase HIV incidence in women (Dushoff, Patocs, and Shi 2011).

There is also concern that gender-based violence could increase if men accuse their wives of infidelity during the wound healing process or if women ask their husbands to use condoms once they are circumcised (AIDS Vaccine Advocacy Coalition 2008; Hankins 2007). A multi-country study among HIV-positive women in sub-Saharan
Africa, in settings planning for male circumcision roll out, reported that a majority of
women believed that gender-based violence could increase as a result of male
circumcision scale-up (WHIPT 2010).

As male circumcision programmes increasingly focus on reaching older men, clients
of these services will be more likely to have steady partners and consideration of the effect
of circumcision on these partners is increasingly important. Understanding married
women’s experiences through the process of their husband’s circumcision could provide
valuable insight into the role women play in their partners’ decisions to be circumcised and
could highlight any changes in relationship dynamics that have the potential to negatively
impact women. In addition, relationship dynamics related to male circumcision likely
differ by the HIV status of the partners. Male circumcision is recommended among
HIV-negative men for HIV prevention, however HIV-positive men who want to be
circumcised are not prevented from doing so if medically indicated (WHO 2007). In
couples where the woman is HIV-negative, she may see the circumcision of her
husband as potentially protective for herself if it reduces her husband’s chance of
HIV infection from an outside partner. In couples where the woman is HIV-positive, an
HIV-negative husband may choose to be circumcised to reduce his own risk of HIV within
the partnership. In short, the reasons for circumcision and the dynamics that circumcision
may have within a couple likely differ by HIV status of the partners. An understanding of
these partner dynamics and women’s experiences associated with their husband’s
circumcision could inform circumcision demand-creation efforts, help tailor counselling
messages and approaches within circumcision programmes and better characterise the
wider impact of these programmes on women and communities.

Against this background, the aims of this study were to (1) assess married women’s
roles in influencing their husbands with regard to circumcision, (2) understand the
experiences of married women whose husbands were circumcised in the past year and (3)
explore changes in relationship dynamics between women and their husbands following
male circumcision in Iringa, Tanzania.

**Methods**

This study was conducted in Iringa region, Tanzania between November 2011 and
February 2012. We conducted in-depth interviews (IDIs) with HIV-positive and
HIV-negative married women whose husbands had been circumcised in the previous year
in order to assess women’s experiences generally and to explore any differences in
experiences by HIV serostatus. All participants were at least 18 years old, reported that
they had been married for at least two years and that their husbands had been circumcised
in the previous year. Participants were sampled from women’s groups, HIV support
groups and health centres in urban and rural areas of Iringa region. Specifically, we
attempted to purposefully sample women to achieve variation in the sample by HIV status,
age, length of marriage and urban and rural residence in order to elicit a range of
experiences (Sandelowski 1995). The research team was not affiliated with the male
circumcision programme in Iringa in any way, and data collectors informed participants of
this during recruitment.

We conducted IDIs with 18 HIV-negative women and 14 HIV-positive women. In
order to gain a more in-depth understanding of their experiences, follow-up interviews
were conducted with women whenever possible. We conducted 2 interviews with 15
women and 3 interviews with 3 women, for a total of 53 IDIs. Interviews lasted between 20
and 90 minutes. Participants were compensated for their time with 3000 Tanzanian Shillings (~ USD2) at the end of each interview.

The study team consisted of researchers from the USA and Tanzania. The IDIs were conducted by four bilingual, university-educated Tanzanian women, trained in an intensive two-week course on qualitative research theory and methods, interviewing techniques and human subjects research ethics. The research was approved by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board and the Tanzania National Institute for Medical Research. Oral informed consent was obtained from all participants prior to enrolment.

A semi-structured interview guide was used, which focused on the woman’s relationship with her partner, the decision-making process that her partner went through before being circumcised (including the woman’s role in her partner’s decision), her experience shortly after the circumcision and any changes in relationship dynamics within the couple. Questions in the interview guides were open-ended and probes were used to explore additional topics that arose during interviews.

All IDIs were conducted in Swahili and digitally audio recorded with the permission of the respondents. All data were transcribed in Swahili and fully translated into English. Weekly meetings were held in which the study team discussed findings from the interviews and the lead author read all transcripts as soon as they were available to provide feedback to the data collectors so that emerging themes could be explored in more depth. Memos were also written to capture meaning from each interview and to summarise main themes from the data, which were used to develop initial codes (Charmaz 2006). Codes were added as new themes were identified and a codebook was developed and applied to the interview transcripts. A matrix comparing findings by respondents’ HIV status was created and findings were developed based on themes that emerged during coding and matrix analysis. Summary memos were written for each code and the lead author read all transcripts in their entirety to confirm findings.

Results

Respondents in this study generally ranged in age from their 20s to 50s and represented a range of urban and rural residence. Relationship dynamics surrounding male circumcision were complex and situated within larger contexts of participants’ lives, relationship trajectories and gendered power dynamics. Below, we present the stories of three women to show how the themes discussed are integrated into the life trajectories of these women and their partners. These stories were chosen because they represent the wide range of women’s experiences and illustrate both positive and negative experiences related to their husband’s circumcision. These stories incorporate many of the recurring themes observed by all participants. To ensure participant confidentiality, pseudonyms are used throughout this paper.

Esther’s story

Esther, an HIV-negative woman, first heard about male circumcision through mass media:

I heard about the places that male circumcision was being conducted from the radio. I also heard that male circumcision reduces the risk of getting HIV by 60%, and when I was at the hospital for health services I saw some posters.

After receiving information about the benefits of male circumcision, Esther initiated a conversation with her husband:
I started discussing it with my husband. After I heard that it is easy for uncircumcised men to be infected with diseases, I was shocked and started to convince my husband to be circumcised. I told him he must be circumcised ... because nowadays an uncircumcised man is not a real man. ... I comforted my husband and told him that if he agreed to be circumcised I would stay with him for the rest of my life, take care of him and follow the doctor’s instructions until the wound was healed. If he would not agree I would feel shame.

Esther’s husband agreed to be circumcised and she accompanied him to the hospital. She recalled:

I decided to escort him to the hospital to encourage him. That day my husband received training and was tested for HIV. ... When the results came out it showed that he was HIV-negative. My husband said ‘now I start a new life because I didn’t believe that I could be HIV-negative.’ ... He told me he would not cheat on me by having sexual intercourse outside the marriage.

Following the circumcision, Esther discussed how she supported her husband through the wound-healing process:

I used to stay far away from my husband after he had circumcision to allow him to recover on time. I didn’t want to cause temptation that may make him feel like having sex while the wound was not yet recovered. ... we [did not have sex] for four months.

Despite her husband’s circumcision, Esther still acknowledged the risk of HIV. She said that ‘he can get HIV even if he is circumcised. Men should be faithful to their wives so that they can prevent HIV.’ Esther felt her relationship with her husband had been strengthened since his circumcision. She described how the entire process of circumcision, including the HIV testing and pre-circumcision counselling, helped their relationship:

He feels good and happy now that he is circumcised because he trusts himself and feels safe. The male circumcision campaign helped him to know his HIV status and also circumcised him for free. ... To be honest my husband respects me. When I advised him to be circumcised and I did not run away, he realised that I love him and that’s why I advised him to go. ... He is proud of my courage to ask him to be circumcised.

Maria’s story

Two years ago, Maria was diagnosed with HIV. Her husband, Victor, and their five-year-old daughter were HIV-negative. Despite knowing that he was in a serodiscordant relationship, Victor still refused to use a condom. Maria recalled:

Before we tested we did not use condoms, but after I tested [positive] we started using condoms for like three days. Then he refused ... [he said] ‘Why should I use a condom now while before I was not using condoms ... but I did not get [HIV]? Why should I use it now?’ ... I feel uncomfortable, of course ... but what will I do? If I refuse him he will beat me.

Maria heard about the male circumcision campaign from a car with a loudspeaker driving through her village. She said, ‘They said all men who are not circumcised should go [to be circumcised] to avoid problems like HIV and sexually transmitted diseases.’ After hearing that male circumcision would be offered for free, she started talking with her husband to convince him to be circumcised and ‘begged’ him to go. Victor agreed and Maria went to the hospital with him for the procedure. Maria waited outside of the hospital while Victor went through the procedure and recalled ‘He was just given information alone inside ... he didn’t tell me anything.’

Following Victor’s circumcision, Maria supported him through the wound healing process. The couple slept in different rooms to ‘reduce the sexual feelings that will bring
pain and disturb the stitches.’ After two months, the couple resumed sexual intercourse. Maria recalled that Victor:

... felt fine and safe. If there are diseases he can’t get them. He felt good because he was circumcised ... even when he is having sex he is at peace because he will not get HIV ... even in the radio they mentioned that male circumcision helps to reduce HIV.

However, following his circumcision, Victor began to change. A few months after the circumcision, Maria reported that:

After he was circumcised, he just had sex with me two or three times. Then he started changing ... before he was circumcised he used to take care of me. Not after he was circumcised. He didn’t care anymore ... he now sees that having multiple partners is a normal thing. ... I wonder why he betrayed me. I think even other women like him more now because he is circumcised.

Maria currently lives with her five-year-old daughter. Victor left them for another woman following his circumcision and has not returned.

**Upendo’s story**

Upendo reports being HIV-negative and lives with her husband, Charles, in a small, rural village. One day, she heard a radio announcement advertising the benefits of male circumcision. She said that she heard ‘the risk of HIV for a man who is circumcised is low compared to the man who is uncircumcised.’ Upendo recalled:

I was worried that he [Charles] was not circumcised since it’s easy for uncircumcised men to get HIV. I had so many questions in my head. What if he goes outside marriage and he is not circumcised? He might get infected.

Upendo began to discuss the idea of male circumcision with her husband. At first he refused. ‘He felt shy because of his age. He was 35 years old and not circumcised. He felt like people would laugh at him’, Upendo recalled. After refusing to be circumcised for one year, Charles finally agreed.

Charles refused to let Upendo accompany him to the hospital. Upendo agreed: ‘I think there was no need for me to go with him ... he can just go and come back to tell me about it.’ Once he returned home following his circumcision, Upendo said that Charles became very aggressive and suspicious:

He looked sad and unhappy most of the time [following circumcision] and he was not like that before. When I asked him he told me that he thought I would cheat. He looked angry. ... He just answered me with abuse and anger, ‘I don’t trust you. You will cheat on me. I don’t think you can wait all this time.’ ... I felt very bad but I forgave him. I knew some day he would be healed and we would be okay again.

The couple resumed sexual intercourse after ‘one week and a half’. As Upendo described it, ‘I was just listening to him to know if his wound was healed. He was just angry, saying “Yes, it is healed”.’

Despite the emotional abuse Upendo faced during the wound healing process, she discussed how Charles reduced his risky behaviour in the long term, which she believed was ‘because of the teaching he received from the health centre about HIV transmission.’ She said:

He used to cheat before he was circumcised, but since he went for circumcision and got counselling, he has changed. He was told that being circumcised does not mean you won’t get HIV; you can still get it if you mess around with other women. To be honest, he is not cheating anymore. He was drinking alcohol but now he is not. ... He feels good. He even told me ‘thank you, my wife, for convincing me to go for circumcision.’
Communication with partners about male circumcision

As illustrated by Esther, Upendo and Maria, women described playing an important role in their partners’ decisions to be circumcised. Almost all women in this study discussed how they initiated conversations with their partners about male circumcision and most thought they were the reason that their husbands decided to be circumcised. One recurrent theme was the importance of mass communication, which provided a platform from which women could bring up male circumcision with their partners. Many women said they started to talk to their husbands about circumcision after hearing about the health benefits from mass media such as radio advertisements, billboards and television. Furaha (HIV-negative) stated:

I told him I heard about the male circumcision campaign from a car loudspeaker... I told him it was important for him to be circumcised and he agreed about that. After the encouragement I gave him, the next day my husband went to the hospital for circumcision.

Women described using various strategies to convince their husbands to be circumcised. Some women threatened to move out if their husbands did not get circumcised. Other women began discussing male circumcision while eating a nice meal together or tried to ‘sweet-talk’ their husbands into getting circumcised. Yosepha (HIV-positive) reported:

I kept on influencing him to go [for circumcision] but he refused. Then I decided to punish him by using condoms because I knew he didn’t like using condoms. ... So when the campaign started he decided to go for circumcision.

Support provided during circumcision

While almost every woman reported that she initiated conversation about male circumcision with her husband, less than half accompanied him to the health facility. Women who did not go to the health centre noted that their husbands were able to attend the facility by themselves, that the wife should to stay at home to prepare food for him when he returned, or that her husband did not tell her he was going. Like Upendo, a few women noted that their partners did not allow them to attend the health facility because they were embarrassed to be seen with their wives ‘escorting’ them to circumcision.

Of the women who accompanied their husbands to the health centre for circumcision, most noted that they went to support their husbands through the procedure, as illustrated in Esther’s story. According to Sharon (HIV-negative):

It is important [to accompany him] because he is your husband. When he is sick he needs comfort from his wife. Another important thing is when my husband gets instructions from the doctor after the circumcision. For example, if the husband forgets about his medical prescriptions, his wife will remind him if she went with him for circumcision.

Once at the health facility, women discussed how they waited outside while their husbands went through counselling, HIV testing and the circumcision procedure. One woman attended an information session with her husband and other men waiting to be circumcised. When asked if she had interaction with the counsellor she responded, ‘Oh no, there were a lot of people; we had no chance to ask questions to be honest.’ Most other women said that they were asked to stay outside or that they were not invited to attend any counselling with their husbands. Sharon recalled:

For sure there is no one who told me to come back and get advice like my husband. That day I managed to meet a nurse who happens to be my neighbour, but she also didn’t welcome me back for any counselling or advice.
Post-circumcision wound healing process

Following their husbands’ circumcisions, many women, such as Esther, tried to make their husbands comfortable through the wound healing process. Women described how they spent extra time cooking nice meals, preparing bath water or helping their husbands take medication.

Most women reported a peaceful recovery period. However, like Upendo, a few women were subjected to emotional abuse:

He did not trust me [while his wound was healing]. He thought that I would cheat on him. ... Sometimes when I came back home I would find him angry. If I asked him what was wrong he just yelled ‘Where are you coming from this time? ... You must have someone else outside.’

Resumption of sexual activity

Women were generally aware that sexual intercourse should be avoided during the wound healing process and used various methods to support their husbands during the abstinence period. Like Esther, some women slept in different beds, wore unrevealing clothing or spent time away from home on the family farm so as not to sexually arouse their husbands. However, the length of the required waiting period was not widely known. Only one participant knew that sex should be avoided for the recommended six weeks post-surgery, while many others thought they should wait ‘until a man tells his wife that the wound is healed’. Most participants said that the biggest risks of early resumption of sexual activity following circumcision were delay in wound healing or pain for the man. Doreen (HIV-negative) joked that in order for a man to know if his wound is healed ‘he should test if he has healed by doing it [sex].’

Among participants, the abstinence period following circumcision that was actually practised varied from one week to six months, and half of the study participants reported sexual intercourse before the recommended six week abstinence period. HIV-positive women were just as likely to report early resumption of sexual activity as HIV-negative women. Women gave many explanations for the decision to resume sex. Jane (HIV-negative) described her decision to have sex after only one week in this way:

After seven days the wound dried up ... they told him to stay for two weeks, but when the first week was over, he started to ask for sex. I told him ‘you are probably not healed completely’ but he said he was healed. ... He squeezed his penis; if a wound is still raw on the inside and you squeeze it, you must feel pain. But he squeezed it and did not feel any pain so he knew that he had healed. That is when I agreed to have sex.

In contrast, a few women waited four to six months before having sex. Esther discussed the decision to wait: ‘We stayed for four months before we started having sex again. I was so afraid to make love with my husband when the wound was not yet recovered.’

Changes in relationship dynamics

Condom use post-circumcision

A majority of HIV-negative participants noted that they rarely used condoms in their relationships with their husbands, both before and after circumcision. Most discussed how they were uncomfortable asking their husbands to use condoms. In contrast, about half of the HIV-positive women in this study reported using condoms to prevent transmission to their HIV-negative partner or to prevent re-infection of HIV if both partners were HIV-positive. Three women, including Maria, discussed how they stopped using condoms
after their husbands were circumcised. Lulu (HIV-positive) said, ‘To be honest, we use condoms less. Since we trust each other so now [that he is circumcised] there is no need to use condoms each time we have sexual intercourse.’

**Behaviour change post-circumcision**

Following male circumcision, married women discussed changes in relationship dynamics. Most women, both HIV-positive and HIV-negative, said that their husbands did not change their behaviour. Several participants reported that their partners became more faithful following circumcision. Like Upendo, most women attributed this decrease in risky behaviour to the counselling and HIV testing that they received prior to the procedure. Esther explained:

> I see that many men after being circumcised become faithful to their partners. ... If a man used to make love with many women before being circumcised, after circumcision, education and testing for HIV/AIDS, many men decide to be faithful to their partner especially when the status shows that they are negative.

Among women who reported that their husbands reduced their risky behaviour following circumcision, many discussed how the process of their husbands being circumcised strengthened their relationships and increased trust. Elimina (HIV-negative) noted:

> As I told you before, we trust each other so we are not at risk of getting HIV. I think I am safer now since my husband has been circumcised. Every three months, we have the habit of testing for HIV/AIDS in the hospital. Also, my husband feels that there is no risk for him to get HIV because we trust each other as partners.

HIV-positive women were more likely to report that their husbands engaged in risk compensation following circumcision. One HIV-positive woman suffered emotional abuse during the wound healing process and three HIV-positive women reported that their husbands increased their risky behaviour following circumcision. Two of the three women in this group felt that their husbands started extramarital relationships because they were ‘proud’ to be circumcised. These participants both said that other women are much more likely to have sex with circumcised men compared to uncircumcised men. The social desirability of circumcised men was brought up as a major reason that men choose to be circumcised in general. One woman, Dorothy (HIV-positive) whose husband was also HIV-positive, discussed her experience:

> Like I told you, he has come to change after getting circumcised. It is now that he has this other woman. It means he feels like he is the same as other men now. In the past he was feeling shy because he was not circumcised. ... He was probably ashamed.

**Discussion**

As male circumcision programmes aim to attract older men for services, women will increasingly be involved as the sexual partners of circumcision clients. While previous studies have explored men’s reasons for becoming circumcised and behaviour change following the procedure (Grund and Hennink 2012; Riess et al. 2010), this is the first study to investigate the experiences of women with regular sexual partners who undergo male circumcision and provides unique insight into complex relationship and power dynamics surrounding the circumcision process.

Overwhelmingly, women in this study were supportive of their husbands being circumcised and many reported convincing their partners to go through with the procedure, a finding also reported in Kenya (Lanham et al. 2012). Mass media promoting
male circumcision in Iringa was mentioned as a mechanism through which women were able to initiate a conversation about and provide evidence of the benefits of male circumcision. Women in this study were almost all able to recall at least one fact about male circumcision and said that these messages provided most of their knowledge on male circumcision. While the support and encouragement women provide their husbands is positive, no participants mentioned any potential risks for women or limitations of male circumcision. Of the women who attended the health facility with their husbands, only one attended an information session. None of our study participants received gender-specific information or education and none reported couples counselling.

Half of the study participants reported early resumption of sexual activity. The WHO recommends a 42-day abstinence period to ensure complete wound healing (World Health Organization 2007). Although some participants waited as long as six months to resume sexual intercourse, others waited only one week. Women were aware that sexual activity should be avoided until complete wound healing, however the length of the waiting period was not clearly known. HIV-positive women were just as likely to report early sexual activity as HIV-negative women. These findings are consistent with previous quantitative studies in Kenya and Zambia (Herman-Roloff, Bailey, and Agot 2012; Hewett et al. 2012). Increasing messages and education about the importance of the six-week abstinence period should be prioritised and directed towards both men and women. Our findings also support recommendations for increased couples counselling and support regarding the abstinence period in order to minimise the risk of increased HIV transmission during the wound healing process (Herman-Roloff, Bailey, and Agot 2012).

Following circumcision, most women reported either no change in their husbands’ behaviour or a reduction in risk behaviour. Esther’s story illustrates one of the most commonly cited reasons for a man’s decreased risk behaviour following circumcision: an HIV-negative test result at the time of circumcision. The male circumcision programme in Iringa uses an opt-out HIV testing approach and clients are almost universally tested for HIV before circumcision (USAID 2011). Many women discussed how their husbands were ‘shocked’ to find out their HIV-negative status or ‘did not believe’ they could be free from disease, which led to more protective behaviours. As Upendo described, another commonly mentioned reason for reduction in risk behaviour was attributed to the counselling men receive prior to circumcision. These findings are consistent with previous studies and highlight the importance of male circumcision as one part of a comprehensive HIV-prevention programme, including risk-reduction counselling and high-quality HIV counselling and testing (Grund and Hennink 2012; L’Engle et al. 2011; Riess et al. 2010).

The main difference in study findings between HIV-negative and HIV-positive women was in participants’ accounts of their husbands’ increase in risky behaviour post-circumcision. Four women, all of whom were HIV-positive, reported negative experiences following their husbands’ circumcision, including emotional abuse during the wound healing process, the discontinuation of condom use and reports of the male partner initiating new sexual partnerships. In another manuscript exploring women’s attitudes towards male circumcision in Iringa, we report that for some men male circumcision may be socially and sexually desirable, which may be influencing relationship dynamics (Layer et al. 2013). For example, one woman, whose husband was also HIV-positive, reported that he initiated new partnerships because he no longer felt ashamed of being uncircumcised. This same participant believed that other women would be more willing to have sex with him now that he was circumcised. Of the three HIV-positive women who reported that their husbands initiated extramarital affairs following circumcision, two reported that their husbands were HIV-negative. This desirability associated with
circumcision may encourage circumcised men to take on additional partners outside of their primary relationship, which could be motivated by sero-discordance in a relationship.

Although limited to a minority of our participants, these negative findings are most alarming because they were reported among HIV-positive women. Previous research has shown that HIV-positive women in sub-Saharan Africa are more likely to experience intimate partner violence than HIV-negative women (Campbell et al. 2008; Maman et al. 2002), so understanding if the process of a male partner being circumcised further increases this risk among HIV-positive women will be an important programmatic consideration. These results should be interpreted with caution as they reflect only a small number of individuals. However, the findings also highlight the need for a more complex conceptualisation of risk compensation – including, for example, women’s inability to negotiate condom use post-circumcision, perceptions of the sexual desirability of circumcised men, initiation of extramarital affairs following circumcision and women’s and men’s perception of risk – than is currently being monitored by male circumcision programmes. Future studies should measure the potential negative outcomes with particular consideration of HIV-positive women. Further, as recommended in the UNAIDS/CAPRISA (2007) meeting report on social science aspects of male circumcision, programmes should use operations research to monitor and address negative behaviour changes following male circumcision to minimise risk to women and men.

Underlying these findings is the fact that the process of male circumcision – and the resulting experiences of female partners of circumcision clients – occurs in the context of gender inequality, especially unequal division of power within relationships. While women can initiate conversations and interactions with men about circumcision, they must employ strategies to negotiate these interactions that are consistent with their relative position within the relationship. Indeed, while women were in favour of their husbands being circumcised, they were not simply able to ask their partners to have the procedure. Rather, Esther promised to stay with her husband forever, while other women noted that they planned a nice meal or thought of ways to ‘convince’ the man that circumcision would be good for him. Maria and several other participants were unable to negotiate condom use before or after circumcision. Study participants also reported fear of violence and struggled to manage post-circumcision resumption of sexual activity. These gendered power imbalances must be considered in any intervention involving women, as interventions to increase women’s understanding of male circumcision and engage them more in the process of their husbands’ circumcisions will be limited by the gendered power structures in which these relationships are set.

This study should be viewed through the following limitations. First, women whose partners were circumcised in the past year were recruited for the study. Interviews focused on their experience before and shortly after their husband’s circumcision. Because women were interviewed up to a year after the event, some of the details of their experiences may have been forgotten. A longitudinal approach following women through the stages of their husbands’ circumcision could improve recall. Second, women in this study were recruited on the basis of their self-reported HIV status. Among HIV-negative women or those who did not know their status, all reported that their partners were also HIV-negative. It would have been beneficial to interview HIV-negative women whose partners are HIV-positive, as we did not capture the dynamics of this particular type of sero-discordant partnership in our results.

Overall, women in this study had positive attitudes towards male circumcision and strongly supported their male partners being circumcised as a strategy to protect their
husbands and themselves against HIV and other diseases. Information received by women was obtained largely through mass media and focused on the benefits of male circumcision for the male partner. However, women’s lack of understanding of the risks and limitations of male circumcision was common and unequal power dynamics were evident within partnerships. At the community or facility level, programmes could strengthen communication among couples and help to increase women’s understanding of the partial efficacy of male circumcision and the importance of sexual abstinence during the wound healing process, thus increasing opportunities to meaningfully engage women in the process of their husbands’ circumcision.

**Funding**

This work was supported by the David L. Boren Fellowship, the Johns Hopkins Center for Global Health Field Research Award and the Baker, Reinke & Taylor Award in International Health.

**References**


Résumé
Les programmes de circoncision masculine en Tanzanie cherchent à augmenter la demande parmi les hommes d’âge mûr et mariés qui sont susceptibles d’avoir des partenaires sexuelles régulières. Les rôles joués par les femmes tout au long du processus de la circoncision de leurs partenaires ainsi que tout changement éventuel dans la dynamique des relations, conséquent à la circoncision, sont des points importants à prendre en considération, dans un contexte où tout est fait pour élargir l’accès à la circoncision. Entre novembre 2011 et février 2012, nous avons conduit des entretiens avec 32 femmes mariées à des hommes qui avaient bénéficié de la circoncision à Iringa, en Tanzanie. Les entretiens ont été mémorisés sur des supports numériques, transcrits puis traduits en anglais, et des codes ont été développés à partir des thèmes émergents. Les femmes ont révélé qu’elles avaient joué un rôle déterminant pour convaincre leurs maris de la nécessité de la circoncision. Mais la reprise précoce de l’activité sexuelle avait été courante. Une minorité de femmes ont rapporté qu’elles avaient subi des sévices psychologiques ou une compensation du risque de la part de leurs maris, suite à la circoncision. Ces résultats suggèrent que les femmes mariées ont un impact important sur les décisions prises par leurs maris concernant la circoncision, mais que les besoins des femmes en information et en éducation ne sont pas satisfaits, et que les inégalités de genre accentuent l’incapacité des femmes à réduire leurs risques liés au VIH dans ce contexte. Il est donc nécessaire de développer des stratégies permettant aux femmes de s’impliquer davantage dans les programmes de circoncision.

Resumen
El objetivo de los programas de circuncisión masculina en Tanzania es aumentar la demanda de hombres mayores y casados que suelen tener compañeras sexuales estables. Para poder aumentar la circuncisión masculina, es importante entender el papel que desempeñan las mujeres cuando sus parejas se someten a una circoncisión, así como los cambios resultantes en la dinámica de la relación. Para este estudio, llevamos a cabo entrevistas de noviembre de 2011 a febrero de 2012 en Iringa, Tanzania, con 32 esposas de hombres circuncidados. Las entrevistas se grabaron digitalmente y se
transcribieron y tradujeron al inglés, y se crearon códigos en función de los temas mencionados. Las mujeres fueron decisivas para convencer a sus maridos a someterse a una circuncisión, si bien era habitual una pronta reanudación de las relaciones sexuales y una minoría de mujeres informaron de un abuso emocional por parte de sus maridos o de una compensación del riesgo (incremento de los comportamientos de riesgo) tras la circuncisión. Estos resultados indican que las mujeres casadas desempeñan un papel fundamental para que sus maridos tomen la decisión de ser circuncidados, pero no se da suficiente información y educación a las mujeres. Asimismo en este contexto, las desigualdades de género hacen disminuir aún más la capacidad de las mujeres para reducir su riesgo de contraer el virus del sida. Es necesario crear estrategias para conseguir involucrar más eficazmente a las mujeres en los programas de circuncisión masculina.