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Alfredo F. X. O. Obure
Kenya Medical Research Institute, afxobure@gmail.com

Erick O. Nyambedha
Maseno University, nyambedha@maseno.ac.ke

Boniface O. Oindo
Maseno University, bonifolo@yahoo.com

Hezborn M. N. Kodero
Moi University, hkodero@gmail.com

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Abstract
Male circumcision (MC) is now recommended as an additional HIV preventive measure, yet little is known about factors that may influence its adoption, especially in non-circumcising communities with generalized HIV pandemic. This qualitative study explored factors influencing MC adoption in rural western Kenya. Twenty-four sex specific focus group discussions were conducted with a purposive sample of Luo men and women (15-34 years). Perceived barriers to circumcision were pain and healing complications, actual and opportunity costs, behavioral disinhibition, discrimination, cultural identity, and reduced sexual satisfaction; perceived facilitators were hygiene, HIV/STI risk reduction, ease in condom use, cultural integration, and sexual satisfaction. To enhance MC adoption, community education, and dialogue is needed to address the perceived fears.

Keywords
Male Circumcision, Barriers, Facilitators, Health Promotion, HIV/AIDS, Luo, Kenya, Sub-Saharan Africa, Grounded Theory, and Theoretical Sampling

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Alfredo F. X. O. Obure
Kenya Medical Research Institute/Centers for Disease Control and Prevention Program, Kenya

Erick O. Nyambedha
Department of Sociology and Anthropology, Maseno University, Kenya

Boniface O. Oindo
School of Environment and Earth Sciences, Maseno University, Kenya

Hezborn M. N. Kodero
Department of Psychology, Moi University, Kenya

Male circumcision (MC) is now recommended as an additional HIV preventive measure, yet little is known about factors that may influence its adoption, especially in non-circumcising communities with generalized HIV pandemic. This qualitative study explored factors influencing MC adoption in rural western Kenya. Twenty-four sex specific focus group discussions were conducted with a purposive sample of Luo men and women (15-34 years). Perceived barriers to circumcision were pain and healing complications, actual and opportunity costs, behavioral disinhibition, discrimination, cultural identity, and reduced sexual satisfaction; perceived facilitators were hygiene, HIV/STI risk reduction, ease in condom use, cultural integration, and sexual satisfaction. To enhance MC adoption, community education, and dialogue is needed to address the perceived fears. Key Words: Male Circumcision, Barriers, Facilitators, Health Promotion, HIV/AIDS, Luo, Kenya, Sub-Saharan Africa, Grounded Theory, and Theoretical Sampling

Introduction

Sub-Saharan Africa (SSA), home to 10% of the world's population, remains more heavily affected by HIV and AIDS than any other region of the world (UNAIDS/WHO, 2006). Although availability of antiretroviral therapy for individuals infected with HIV is increasing, many more new infections occur for every additional person started on such treatment (Global HIV Prevention Working Group [GHPWG], 2006). Preventing new infections is the only realistic hope for stemming the HIV pandemic, yet currently available prevention measures have often been unsuccessful in restricting the spread of HIV (GHPWG, 2006; Muula, 2007). HIV testing and counseling, promotion of condom

use, reduction in sexual partners, and treatment for other sexually transmitted infections (STI) are some of the main intervention strategies currently employed by national AIDS control programs. Research evidence from over 40 observational studies (see Weiss, Quigley, & Hayes, 2000) and three randomized control trials (Auvert, Taljaard, Lagarde, Sobngwi-Tambekou, Sitta & Puren, 2005; Bailey, Moses, Parker, Agot, Maclean, Krieger, et al., 2007; Gray, Kigozi, Serwadda, Makumbi, Watya, Nalugoda, et al., 2007) indicates that male circumcision (MC) is an efficacious, partially protective strategy in reducing heterosexual transmission of HIV from women to men. Accordingly, MC is now recommended as an additional HIV preventive strategy (WHO/UNAIDS, 2007). Consequently, several SSA countries are preparing to roll-out projects promoting and providing medicalized MC services.

The prerequisite to any public health promotion process is collecting data and learning about community perceptions of factors that may facilitate or inhibit adoption of the new intervention (Green & Kreuter, 2005). Although acceptability of MC has been studied previously (see Westercamp & Bailey, 2007), most of these studies were conducted before the procedure was included as an additional HIV preventive strategy. These perceptions could have changed with more information and socio-cultural transformations (Rollnick, Mason, & Butler, 2002). There is need for more detailed understanding of factors that may influence promotion of MC in communities that are traditionally non-circumcising, now that it is recommended as an additional HIV preventive measure.

The country's HIV prevalence is 7.8% as shown by estimates from the 2007 Kenya Aids Indicator Survey (KAIS). The Nyanza region in western Kenya, mostly inhabited by the Luo, one of the largest ethnic groups in the country, leads other regions with a 15.3% HIV prevalence (Government of Kenya [GOK], 2008). There are around 40 indigenous ethnic groups in Kenya; the five most populous ones are the Luo, Kikuyu, Kalenjin, Luhya, and Akamba. Unlike the great majority of other ethnic groups in Kenya, the Luo do not traditionally circumcise their males; approximately 90% of Luo men are uncircumcised (Agot, Ndinya-Achola, Kreiss, & Weiss, 2004; Caldwell & Caldwell, 1994). KAIS reports indicated higher HIV prevalence (13.9%) among uncircumcised men compared to 4.1% of circumcised men (GOK). The 2003 Kenya demographic health surveillance provided estimates of HIV prevalence in those aged between 15 and 49 years who identified themselves as Luo at 18% for males and 26% for females (Central Bureau of Statistics [CBS], Ministry of Health [MOH], & ORC Macro, 2003). From new evidence, lack of circumcision is one factor that explains high HIV prevalence among Luos, as compared to other ethnic groups in Kenya. Since preventing HIV infection among men equally protects their sex partners (Agot et al.), high HIV prevalence and low MC levels makes the Luo an ideal community in Kenya for promoting and providing medicalised MC interventions.

Kenya's MOH recently added MC to its HIV/AIDS preventive strategies after a series of consultations with various stakeholders and approved the MC policy in October 2007. Subsequently, MOH has partnered with some NGOs to roll-out a 5-year MC pilot program covering several districts inhabited by the Luo ethnic group in Kenya. However, Luo Council of Elders (LCE) has opposed the move to introduce MC before getting concrete consensus from the community for whom the practice is culturally alien. LCE observed that the community should not be compelled to decide hastily on the highly

emotive cultural issue, fraught with heavy, demeaning, and political undertones (Akoko, 2008). Although there are indications of acceptability of MC (Bailey, Muga, Poulussen, & Abicht, 2002), questions remain unanswered on psychological and socio-cultural underpinnings to adopting the practice as an HIV preventive measure among traditionally non-circumcising communities. To address these questions, we explored psychosocial factors that could influence promotion of MC among the Luo of rural western Kenya.

We (authors of this paper) are of the Luo ethnic group of rural western Kenya. Most of Luo males are not circumcised. Currently there is a global public health debate on how to scale-up MC services in western Kenya, predominantly inhabited by the Luo. As the HIV pandemic continues to devastate many families in our community, we have both personal and research interests in contributing to managing the scourge. Currently there is a debate in our community about MC and socio-cultural implications of promoting it as an HIV preventive measure. We are interested in contributing to this debate through a qualitative inquiry into perceptions of young people in this traditionally non-circumcising community of factors that may influence adoption of MC. Alfredo is a specialist in public health projects planning and management, and has in the past five years been involved in community health research interventions programs. He was the study project's field coordinator, and was directly involved in data collection. Erick is a medical anthropologist and has conducted extensive qualitative research on vulnerability of children of western Kenya in the era of HIV pandemic. Boniface is a specialist in environmental planning, with interest in social aspects of project planning. Hezborn is an educational and community psychologist and has also been actively involved in research in western Kenya on community responses to HIV/AIDS. This paper's cross-disciplinary authorship has facilitated a multi-dimensional approach to addressing the diverse issues that influence promotion of MC as a HIV preventive measure in non-circumcising communities of SSA.

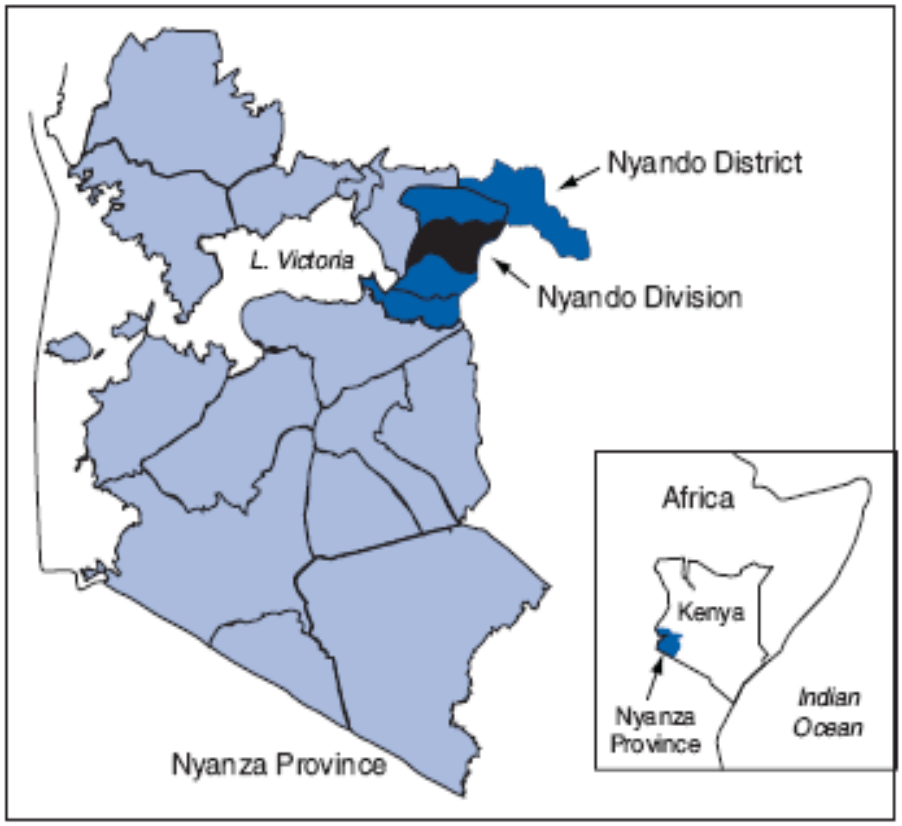
Methods

This is an exploratory qualitative study, founded fundamentally on the doctrine of grounded theory (Strauss & Corbin, 1990). Grounded theory was developed by Glaser and Strauss in the 1960s, and is founded philosophically on symbolic interactionism, which focuses on the meaning that individuals give to interactions with others (Annells, 1996; Blumer, 1969). Using a symbolic interactionism lens, we infer that an individual's behavior is formed by social interactions; individuals are active in this process, and they make conscious decisions about how they will act in a given situation (Ploeg, 1999). The purpose of a grounded theory approach to qualitative research is to discover social-psychological processes. Maxwell (1996) stated that the personal meaning informants place on a particular situation, event, or action is generally a strength of qualitative research.

In this study, the grounded theory method was a means to generate systematically theoretical constructs or concepts that illuminate psychosocial processes relating to MC that are common in the non-circumcising Luo community. This understanding is necessary to design and implement projects to promote the adoption of MC as an HIV preventive measure among the Luo of rural western Kenya.

This study was conducted in six randomly selected villages of Nyando division, an impoverished area in rural western Kenya (see Figure 1). Nyando Division, divided into six administrative locations, has approximately 80,000 people and 15,000 households. Ahero, the capital of Nyando Division, houses the sub-district hospital, which has been identified as the division's referral hospital, where roll-out of MC services can be monitored. Research activities were conducted during February and April of 2008.

Figure 1. Nyando division, in rural western Kenya is the location of the study.



This study received institutional review board approval from Maseno University, Kenya before data collection. Before the group discussions, questions regarding the procedures were addressed and participants provided informed consent. Verbal consent to be audiotape recorded before each group discussion session was also obtained from the participants.

Participants

Participants were out-of-school male and female youths and young adults ranging in age from 15 to 34, with an average age of 23.6 years. Those in this age bracket are a sexually active high risk group for HIV infection, and males in this age set are target for projects promoting MC in Kenya (GOK, 2008). Participants were purposefully selected

based on theoretical sampling and availability (Charmaz, 2006; Ploeg, 1999; Strauss & Corbin, 1990). The goal of theoretical sampling is to enable the researcher to seek out individuals who are able to help answer the research questions and, thus, offer the best chances for creating solid theory (Strauss & Corbin). Participants were therefore recruited through the local provincial administration and from established youth groups in the community. A total of 126 males and 107 females participated in the study.

Data Collection and Analysis

Focus Group Discussions (FGDs) were used for data collection (Bader & Rossi, 1998; Vaughn, Schumm, & Sinagub, 1996). Focus groups are not uncommon in other qualitative research, and are suited to grounded theory (Dick, 2005). An FGD guide was developed and was comprised of a set of open-ended questions aimed at eliciting explorations and debate on reasons for and against MC in the community. The guide covered seven topical areas: history of circumcision in the community; knowledge and beliefs regarding MC; reasons for and against MC; general acceptability of MC in the community; and how adoption of MC can be enhanced as an HIV preventive measure in the community. The guide was translated from English into Luo and back-translated. One of us, Alfredo Obure, led all the discussions with the men and a native female moderator, a sociologist trained in grounded theory methodology, led all the discussions with the women. Two same-sex research assistants took detailed notes during male and female FGDs. Participants were given a choice of participating in the indigenous language, Luo, or in Kiswahili, or English. A total of 24 FGDs were conducted; each session included 6 to 12 participants. Table 1 gives a general description of the FGD participants.

Table 1. **Composition of Focus Group Discussions**

Sex	**Age group**	**Description**	**Number of FGDs conducted**	**Mean number of Participants**
Males	15-24	Young, mostly single	6	10.9
	25-34	Mostly married, self employed	6	10.2
Females	15-24	Young, mostly single	6	8.6
	25-34	Mostly married or with children	6	9.3

Data consisted of proceedings of sessions that were tape-recorded, as well as the moderator and note-takers' notes written during discussions. At the end of each session, major issues raised were summarized by the moderator and participants were asked to give further views. We held debriefing sessions with research assistants to identify emerging issues and wrote memos for further exploration in subsequent FGDs. Memo-writing is the "pivotal intermediate step between data collection and writing drafts of

papers…constitutes a crucial method in grounded theory because it prompts you to analyze your data and codes early in the research process" (Charmaz, 2006, p. 72).

Proceedings of each FGD were transcribed immediately after each session and later translated into English. FGD narratives were imported into the Atlas.ti (version 5.0), software (Scientific Software Development, 2004) for analysis. Each of us read the transcripts several times in their entirety. For the inductive analysis, we used grounded theory procedures described by Charmaz (2006). In the first step we did line-by-line initial open coding for each of the transcripts. In vivo codes were also identified. In the second step, we did a focused coding, in which we used the most significant and/or frequent earlier codes to sift through, synthesize and explain larger segments of the data, and to identify categories. In the third step, themes were identified in order to lend form to the focused codes and help to conceptualize relationships among the substantive codes (Charmaz). Quotations relevant to each focused and theoretical categories were identified from the transcripts for qualitative reporting.

To establish rigor and manage threats to trustworthiness (Padgett, 1998), we employed reflexivity and auditing during the initial analysis. After this initial analysis was completed, the following strategies were employed: triangulation, peer reviewing, and member checking (Bowen, 2005; Padgett). We used data-source triangulation, in which data from the FGD transcripts were augmented with observations during the discussions and with informal interviews with theoretically sampled individuals. In peer reviewing, a colleague with expertise in qualitative methods examined the FGD transcripts, coding sheets (which identified concepts, categories, and themes), and the summary of the findings (Bowen). All leading questions were identified in the transcripts, and data received from those questions eliminated from analysis. The peer review identified the analysis as being completed in a logical and systematic manner and the findings were reasonable and accurate based on field data. Member checks were conducted by telephoning 5 of the FGD participants and checking with them the accuracy of our result summaries and observations (Bowen; Padgett). Crosschecking with these participants helped us maintain reflexivity by encouraging self-awareness and self-correction. This process allowed for participant validation of the findings (Bowen; Padgett).

The results for this study are organized according to two main themes that emerged from data analysis: reasons for circumcision and reasons against circumcision. For each theme, several categories that emerged during data analysis are presented, supported by relevant quotations.

Results

Reasons Against Circumcision

The most frequently mentioned obstacles to promoting MC were culture, pain and healing complications, costs, behavioural disinhibition, stigma and discrimination, and sexual satisfaction factors.

Cultural barriers to male circumcision

Non-circumcision was mentioned by most participants as a significant cultural characteristic that distinguished the Luo from other communities, and some expressed fear that introducing circumcision could cause loss of this cultural identity. A male participant in one of the FGDs described this perception as follows:

> Our people are slow at adopting circumcision because it may threaten our cultural identity...like we are married into others' cultures. Those promoting it should first be sensitive to our ways and know that we are not doing anything wrong by not circumcising our men, and that if we begin to cut our men, we are only improving on how we are doing our things by adopting new technology. We should not feel like we are being forced into a practice that is foreign just because of HIV. (Male, 31 years old)

Some participants described removal of six lower teeth as initiation rite that was associated with the Luo, but which had long been abandoned. One male participant said, "…long time ago, our people used to remove six of their lower teeth to symbolize that they were adults and not children any more… we were born when this practice had been abandoned" (Male, 34 years old).

Some male discussants described a "mini-circumcision" done by young boys, which involved separation of the underside of the foreskin from the penile shaft to avoid pain during penetrative sexual intercourse. A male discussant expressed the following:

> I remember that when we were young, we were being pressured by peers to cut the tendon that connects the skin to the fore-glands…we used hair of a cow or a large soldier ant to cut it at once. I know that even now, the youth in this community are doing it… when they go grazing cows together. That was like a mini-circumcision. (Male, 33 years old)

Many discussants mentioned several labels that were associated with circumcised men or those with shortened prepuces. Terms like rayuom, apum, mwache, jomwa or kimirwa featured prominently. Further exploration of the meaning of these words revealed that they are derogatory terms, often used to refer to men who are circumcised, or whose prepuces are shortened. One male discussant stated: "'Rayuom' is an insult. Someone tells you how different you are from other normal people" (Male, 29 years old).

Some participants expressed a perception that males, who were circumcised or had congenitally shortened prepuces, were embarrassed and experienced isolation. In the words of one male discussant:

> You find that young boys who are circumcised do not wish to take off clothes and shower with peers by the lake or river...You will really be humiliated… you would even wish to bathe with [inner] pants on like a woman… or shower away from peers …I think this causes some feeling of isolation. (Male, 16 years old)

Pain and healing complications

Most participants mentioned that fear of excessive pain during circumcision and healing complications could be a major obstacle to seeking the procedure. A male discussant stated:

> The truth is… let me bring the point home… the truth is… pain… pain… pain… pain is the problem….What we really fear is the pain…for a man as big as I am… just imagine that someone takes a knife and cuts you …the pain is… so much. (Male, 23 years old)

Many discussants held a perception that pain was a key characteristic of circumcision practices in neighboring tribes. The participants said that they had heard of circumcision ceremonies in these communities, in which endurance of pain was an indicator of being a man and an important experience. A female discussant described the situation as follows:

> Their men are so proud when they talk about MC to us. They tell us of how painful the experience is, and that it was proof of manhood to endure the pain; I think this scares our Luo men even more. It is like they want to prove that they are more men than our men. (Female, 17 years old)

Some participants expressed the perception that time to heal and other social complications could also be barriers to men in the community seeking to circumcise. Some discussants expressed a perception that since men were socialized to tolerate pain, they would avoid incidences where they are seen as unable to bear it. For example, a female discussant said:

> When a man who is recently cut sees you, he thinks about sex and the penis erects, even if it has not healed well. This causes more pain. They don't want to be seen crying. They are taught from childhood that men never cry like a woman. (Female, 28 years old)

A few participants proposed that circumcision be performed at a special place, where circumcised men heal before returning to the community. The participants suggested that this place would also allow men to "wear wrappers" as they heal without feeling humiliated. There was a belief among these discussants that wearing wrappers in public would debase masculinity, as the following female participant expressed:

> They need a place to stay until they get well and can put on trousers before being told to go home…so that even if people know that he went for MC, but not that he still covers himself with a wrapper like a woman here at home. (Female, 19 years old)

Participants suggested that more males would circumcise if the procedure was performed in a professional setting and with pain reduced through anesthesia. One female

participant expressed that, "these fears can reduce if the men were told that they would be given strong pain killers during the procedure and as they are healing" (Female, 23 years old).

Actual and opportunity costs

Most discussants observed that apart from the actual cost of the procedure, there are a myriad of additional associated costs that could obstruct circumcision-seeking behavior in the community. These included expenses for wound dressing, medications, and transport costs to visit the health facility. Moreover, circumcision was least among household priorities and its effects long-term. One woman said:

> If there is a cost to circumcision in the hospital, they will ask: why spend money on this thing yet you have lived all these years without it and no one is complaining? It may not be seen as an urgent thing to compete with others' needs for money in the house. (Female, 22 years old)

In addition, there was fear that circumcision may temporarily immobilize economically productive males. Many discussants perceived that this time taken to heal would lead to loss of much needed daily household income. A male participant stated:

> If this man is the breadwinner of his house, and you want to put him down for 2 to 3 weeks, depending on how his body responds to wounds. He is both the driver and the conductor of his family's livelihood. Economically this family will be affected, starved, because the man got circumcised. (Male, 34 years old)

Many discussants mentioned accessibility to the nearest health facility as a barrier to seeking MC. The participants expressed a perception that some people preferring circumcision may not seek it because of transportation expenses to the nearest hospital. As one male participant mentioned:

> Sometimes it is even hard to have these people to pay 20 shillings [about a quarter of a US dollar] for clinical records book. Transport…[to MC hospitals] will be a problem. It will not be accessible to these people with low income. Maybe the NGOs promoting it can have mobile theatres…like mobile voluntary counseling and testing services to perform the procedure or they can have specific days that the procedures are done in nearby facilities. (Male, 34 years old)

In motivating circumcision-seeking behavior, some participants proposed that the service be offered free, in the nearest health facility, and that medicine and hygiene incentives like soap be offered.

Potential for behavioral disinhibition

There was an expressed perception among most participants that promoting MC would lead to a misconception that MC was some "magic bullet" against HIV, which could have an adverse effect on other preventive methods. Some discussants mentioned that male youth may engage in higher HIV risk behaviors like disuse of condoms and increase in multiple sexual partners if they believed that circumcision offers protection from HIV infection. One male participant said:

> It will increase prostitution…will make them more careless…and then as we try to prevent HIV through these projects, we are only increasing it. People will begin to have reckless sex…some youth will even experiment with how it feels to have sex when circumcised…to try it out. That is common, just like a new dress you have just bought…you always want to wear it…or like a man who had married a second wife…you will have more sex with her than the first wife…then the risk of getting infected would be faster than those who are not circumcised…yet you say it reduces infection. (Male, 29 years old)

Some discussants noted that the concept of risk reduction may be interpreted to imply risk elimination, thereby leading to riskier sexual behaviors. A female participant noted:

> You know some of the men would interpret the message [to mean] that MC fully prevents HIV and not reduces the chances of getting it. They will just go spraying fire… this can increase HIV…he would be perceived as the real man…you remember the story [that] AIDS is like a road accident…everyone dies sometime…or the idea that having sex with a virgin cures AIDS…didn't you hear of the cases of defiling young girls to cure AIDS? (Female, 29 years old)

Some discussants expressed a belief that emphasizing circumcision as a strategy to reduce HIV would compromise current HIV protection practices such as condom use. On this issue, a female discussant said:

> Many of these men who are going to come out of circumcision will feel that the sex speed governor has been removed. Now that you are cut, your chances of being infected have reduced…it is like the speed governor has been removed. Men will no longer want to use condoms. They have always disliked it. Sometimes they start using it during the first round or when you have just met…then as you get to familiarize with him, he wants to avoid using it…like trust is already built. (Female, 25 yrs)

Most discussants suggested that there was need for proper counseling, before and after circumcision, in order to educate those seeking the procedure against the perception that MC offers full protection against HIV. One of the participants, a male, expressed:

> I think people should get enough counseling before and after the cut. Currently, people think that a circumcised person takes a long time at playing [sexual intercourse]; so once he get cut, he will rush to try confirming if the thoughts he had earlier are really true. Then he gets involved in risk behavior. You don't know how many girls he will encounter; and how many are infected; again the longer he is going to take [in sexual play],the more likely that he will get HIV. I think counseling the youth first is very important. (Male, 22 years old)

Some discussants suggested that projects promoting MC should emphasize hygiene and other MC benefits rather than on HIV infection reduction. In the words of a male participant:

> It should be clear that we are doing it for hygiene…if you talk about HIV prevention, it is going to make us very reckless…let us forget about emphasizing that it reduces HIV. It should be purely about hygiene and improved genital health. (Male, 27 years old)

Discrimination against uncircumcised men

Another fear mentioned in every focus group was that if MC is promoted to reduce HIV, men who decide to remain uncircumcised would be discriminated against. The common argument was that the uncircumcised men would be labeled as risky or assumed as HIV infected. Some male discussants feared being stereotypically labeled as HIV "walking bombs" by other circumcising tribes, as explained by the following male participant:

> My greatest fear…now that people are being encouraged to circumcise, what would happen to those who still prefer to stay uncircumcised? They will be perceived as walking bombs…like it is a taboo to have an affair with such a man. We are the only community which is not traditionally doing this…others might begin to judge our men as people who are already dead, only awaiting death announcement. (Male, 33 years old)

On the perception that promoting MC in the community could discriminate against uncircumcised men, a female participant said:

> I think that we should be careful how to promote this circumcision among our people. If women are convinced that circumcision reduces HIV…we will tend to discriminate against uncircumcised men. I would encourage my daughters that they would rather go for a circumcised man, whose chances of infection are lower than an uncircumcised one. (Female, 34 years old)

Some discussants expressed a fear that uncircumcised Luo men may be shunned by women and perceived as unwilling to play a role in HIV reduction. One male discussant observed:

> I think our women will begin to run away from us due to stigma that uncircumcised men are dirty and prone to have AIDS. I don't think this is the way to take us. These people must first thoroughly educate the whole community about this, not just to sneak in and separate us from our ladies…we have lived well all those years with our full penises and this circumcision, a foreign practice, may spoil it. (Male, 18 years old)

Some participants expressed the perception that some parents would prevent their daughters from marrying non-circumcised men. A female participant explained this perception as follows:

> I want my daughter to be safe. I [will] definitely tell her only to get involved with a man who is circumcised. At least the man will have had a lower chance of getting HIV. Surely, you cannot lead your daughter to death that you are aware of. At least I will advise her to avoid the uncircumcised men. (Female, 34 years old)

Many of the male participants who expressed a perceived fear of discrimination of uncircumcised men also talked about current concerns of stigma from community members towards persons living with HIV/AIDS. One discussant explained that one of his relatives had to cancel his wedding because a religious leader, who was to officiate at the function, insisted on an "HIV certificate to prove their status before they get married in church" (Male, 32 years old).

Sexual satisfaction barriers

Some discussants supported the theory that non-circumcision enhanced sexual pleasure. The perception was that MC leads to loss of penile sensitivity, which affects a man's sexual pleasure. Few discussants observed that MC could lead to loss of penis size and consequently the loss of male's ability to satisfy women. Inability to satisfy the woman was perceived as a significant failure in the masculinity test. Supporters of non-circumcision observed that the foreskin caused more friction, warmth, and sensation, increased penile size and filled the woman's vagina. This was perceived to enhance pleasure for women and men. Some discussants observed:

> I feel like this fold on the foreskin is a good thing because it creates rings on the penis, and a bigger one at the foot of the rubber. This increases both size and friction. It is like you have a natural and permanent studded condom. (Male, 24 years old)

> I think if circumcised, some part of penis is reduced. So it leaves it short; and you may not satisfy her; you don't reach there. If you are not

> circumcised, the skin rolls back and covers a wider diameter. Then the dick rubs the all ends as it penetrates; this is what makes the woman to start shivering with sweetness. It hits all sides of her river. (Male, 19 years old)

A few discussants expressed a perception that circumcision could lead to excessive sexual desire and tendency to womanize. One participant expressed the following:

> But I think circumcision for men, may have an effect; when you sleep with a woman, when you are circumcised, the rubber gets hardened, so it is not sensitive; but when you are not circumcised, the rubber [prepuce] is sensitive and you get sexual satisfaction faster. The circumcised penis is not sensitive… [and the man] will have several women to fully satisfy him. (Male, 23 years old)

Some participants expressed a perception that increased tendency to womanize was immoral and risky in terms of HIV susceptibility. Sexual satisfaction is further discussed as a facilitator to MC in the following section.

Reasons for Circumcision

Qualitative analysis further revealed that reasons for circumcision expressed in the FGDs were hygiene, reduced risk of STD/HIV infection, ease in condom use, cultural integration, and sexual satisfaction.

MC and perceptions of increased genital hygiene and cleanliness. Most discussants expressed the perception that some men were not capable of maintaining genital hygiene and had bad odour. Penile foreskin was perceived as harboring dirt (ondoyo), making the penis unhygienic and germ-infested. This was perceived as a risk factor for infections. Female discussants were more emphatic about the association of MC and genital hygiene. One of the female discussants said:

> You know some of these men do not care. Some don't bathe even for one week. Some do not wash their genitals well. If not cleaned well, the foreskin stores a lot of dirt. It stinks; germs are hidden in there. When circumcised, automatically it will get clean as they bathe normally or the pants will clean it. Circumcision can give them easy time to keep it clean. (Female, 18 years old)

Many female discussants argued that when they perceive the penis as clean, they have a motivation to explore oral sex. One of the female participants said:

> It is easier to clean the penis of circumcised men. In fact if uncircumcised, after the first round, you feel like vomiting if he asks you to put it in your mouth to stimulate him again…you are not motivated…it feels dirty. (Female, 28 years old)

Perceptions of MC and HIV/STI prevention

Many participants expressed an awareness that MC could help reduce incidence of sexually transmitted infections (STIs) such as syphilis, genital ulcers, and HIV. One male discussant referred to an uncircumcised penis as "soft and fragile…more susceptible to cracks and scratches during in-and-out thrusting of penetrative sex" (Male, 21 years old). In contrast, another participant described a circumcised penis as follows: "it is jua kali [weathered] and does not get cut easily by pubic hair" (Male, 26 years old). However, the cracks and scratches during penetrative sex were seen as providing easy gateways for entry of the HIV virus and other germs into the body. A female discussant expressed the association of MC and reduced HIV/STI risk as follows:

> MC helps reduce STIs because germs causing infections hide under the foreskin; it accommodates many germs. If you sleep with that man without a condom, these germs are transferred to you, and you get infected. Again, the foreskin is fragile and breaks easily and this makes the man to get AIDS from an infected woman. (Female, 34 years old)

Some participants noted that many of the male youths were already secretly seeking circumcision services from the nearest health facility. One male participant, who disclosed, during the group discussion, his intent to get circumcised in the nearby hospital, described this situation as follows:

> To get circumcised or not is an individual's own decision. I don't have to wait for a trumpet to be blown by elders to start protecting myself. If it can at least protect us from these diseases, do I have to ask the village elder for permission? I don't even need to wait for the government to launch it. Some of us here are already getting circumcised. For example, I have an appointment tomorrow and my friends are waiting for the outcome of my operation for them to go for it too. (Male, 19 years old)

MC as making it easier to wear and use condoms consistently

Some discussants suggested that circumcision could improve condom use among males; wearing and using condoms was perceived to be easier among circumcised men than among the uncircumcised men. One male discussant expressed this perception as follows:

> […] the process of putting on a condom is easier among the circumcised men. Some of us have very protracted foreskins…even if on heat [erect], you still have to fold it into position before wearing the condom. (Male, 22 years old)

Another male participant said:

> The foreskin is a speed governor that slows the process of wearing condom, especially when your blood is already hot and you want sex immediately. If circumcised, it does not take you a long time to be sure that you have put in on correctly and it is not toiling to do so. (Male, 34 years old)

Some discussants expressed a perception that some males do not consistently use condoms. While suggesting that MC could make wearing condoms easier, one male discussant narrated his first experience with condom use as follows:

> I think condoms are standard, but MC can promote it. I was so disappointed with myself the first time I tried using it. I had to concentrate more on the thought that it kept loosening during the act [sex]…I could feel it moving…I kept removing myself from her to see the position of the condom. After that incidence, I really avoided using it….You know when you are ripe [erect], sometimes you stop to think… (Male, 21 years old)

A female participant commented that her male sexual partner insisted on abandoning condom use because they have known each other for some time. On the association of MC and condom use, she said:

> He hates condoms and only uses it because I insist on it. He says that we should have trusted each other by now. He says that the condom turns him off [and] that he wants to feel me meat-to-meat. I believe circumcision may make him like condoms because the condom would fit him better. (Female 21 years old)

In addition, some discussants stated that they had notable problems in the use of condoms, and believed that getting circumcised could solve these problems. One male discussant said:

> Circumcision can increase condom use among youth. When a circumcised man wears a condom, it holds the penis at the foot firmly. But for an uncircumcised person, after wearing a condom, even up to the very root of the penis, the foreskin rolls back as you play sex. The condom tends to chuck [dislodge from the penile shaft] with prolonged sex. I think the foreskin interferes with proper use of condoms. It will start making disruptive noise, which makes you lose erection. (Male, 22 years old)

One female discussant referred to the foreskin as an "additional condom" and that wearing a condom among uncircumcised men is like having two condoms. She commented that:

> The fore skin is already a condom on its own; then you wear the real condom…it is like wearing two condoms. As the man plays sex for long, he gets less hardened, and the foreskin and condom begin to move

> together. Sometimes, the man has to get out of the vagina to pull back the condom to the original position before continuing...sometimes it really irritates me. I lose my psyche and [that] makes me hate condoms. (Female, 25 years old)

MC and cultural integration

Discussants mentioned that some men would choose to circumcise in order to be more acceptable to their neighbouring, traditionally circumcising communities. A discussant observed:

> Things are changing at a very high speed [and] time has really overtaken some of these cultural inhibitions about circumcision. As we intermarry and take their women, we are adopting some other cultures from them as they do so from us… it will change…some Luos in town are already secretly taking their kids for circumcision in hospitals…ethnic mix and match…I have even noticed in this discussion; none of us here can speak Luo 100% without mixing with Kiswahili or English…interactions are very high. (Male, 33 years old)

It also emerged that some men were willing to circumcise to be accepted by women from circumcising communities, as expressed in the following quotations from two male participants:

> I got circumcised because it gave me a very easy time with ladies from other tribes. Several tribes prohibit their women sleeping with uncircumcised men. (Male, 30 years old)

> A Luhya [neighboring, circumcising tribe] woman literally took off from me, after she saw my dick…in bed. She said she could not sleep with an uncircumcised man. I immediately went for circumcision just to prove to her that I was a real man. Much later, I lured her and 'worked on her' thoroughly. (Male, 31 years old)

Some discussants observed that Luo boys, who went to neighboring boarding schools, experienced peer isolation because of their non-circumcision statuses. One male discussant said:

> Most of us school in neighboring communities. You cannot shower with them… I would find my own time to shower…Sometimes, even when we went bathing in the river, they would not want us to bathe up-stream...because you are perceived as dirty and the river will flow the dirt to them…It really made me isolated. It would be different if I was circumcised. Our parents should circumcise their sons before they go to boarding schools. (Male, 17 years old)

MC and sexual satisfaction

Most discussants, especially females, expressed a belief that circumcised men had an ability to sustain sexual activity, giving more satisfaction to their partners. For example, a female discussant expressed:

> I think even we ladies, we have this perception that a circumcised man is a sweet man. One that has taste… they can give you several rounds because of their prolonged sex before ejaculation. (Female, 19 years old)

A common explanation for greater sexual satisfaction to women from circumcised men was that the penile glands of circumcised men are well-adapted to touch and has reduced sensitivity, which allows prolonged sex before ejaculation and greater satisfaction to women. A female discussant observed:

> You find that a circumcised man takes a longer time before he ejaculates, so the woman can really enjoy sex. If an uncircumcised man takes only 5 minutes, then he would take longer if circumcised…like 15 or 20 minutes. I think this makes circumcision beneficial, especially in this community where sex is mostly done for the man…to satisfy the man… they fall asleep after the cum and leave you still shivering with heat…but if circumcised, then he will rub inside you for a longer time, then you can both get a cum. (Female, 27 years old)

Further discussions revealed views that uncircumcised penises were prone to abrasions during sex, which caused pain and less enjoyment during subsequent rounds of sex. Positions and theories on the sexual satisfaction effect of MC were quite varied. Largely, this perception of sexual pleasure depends on the frame of mind of the participants, on the experience and style each partner brings to the endeavor, and on the love they have for each other.

Discussion

We found that although the Luo of Kenya are traditionally non-circumcising and consider circumcision as culturally alien, many men and women in this study would welcome MC if the procedure was affordable, accessible, and less painful; if broad-based community dialogue, counseling, and education on the social and health benefits and risks of MC were encouraged; and if it was promoted on the strength of its public health good rather than for HIV prevention only. These results are consistent with other acceptability studies from sub-Saharan Africa suggesting that MC may generally be more acceptable (Bailey et al., 2002; Lukobo & Bailey, 2007; Mattson, Bailey, Muga, Poulussen, & Onyango, 2005; Ngalande, Levy, Kapondo, & Bailey, 2006; Scott, Weiss, & Viljoen, 2005; Westercamp & Bailey, 2007). Most of these studies were, however, conducted before MC was included as an additional HIV preventive measure. This study, conducted after the WHO inclusion of MC into the global anti-HIV armory, confirms previous results about the acceptability of MC among non-circumcising communities.

Consistent with previous qualitative studies on acceptability of MC in sub-Saharan Africa (Bailey et al., 2002; Lukobo & Bailey, 2007; Ngalande et al., 2006), participants in our study identified perceived fear of pain and other healing complications, a belief that MC was culturally alien to their community, fears of discriminating against uncircumcised men, and financial and opportunity costs as men are pulled away from their productive activities during healing. Our results therefore support Westercamp and Bailey's (2007) argument that more men would be willing to get circumcised if MC services were provided safely, inexpensively, with minimal pain and adverse complications, and to the extent that the services are accessible. Our findings further support Bailey and associates' (2002) earlier call for education and counseling programs about the health benefits and risks of MC, in order to allow individuals to make informed decisions and personal choice on MC. Some male participants in our study were already circumcised, while a few of them were considering seeking MC services. This could have a positive influence on the adoption of the practice as those who are already circumcised become role models for others, and as perceived fears and apprehensions are disputed through sharing of experiences between circumcised and uncircumcised men.

As in previous studies, the main reasons for favoring MC were genital hygiene, prevention of STIs, including HIV, cultural integration and acceptance, ease in condom use, and beliefs surrounding the likelihood of enhanced sexual pleasure during intercourse with circumcision. We found that despite general knowledge of recent research evidence supporting the promotion of MC for HIV prevention, some group discussants still held beliefs that circumcision was a culturally alien practice with sociopolitical implications, and that promoting it could dispose Luo men who choose not to circumcise to stigmatization and labeling. If there are relevant socio-cultural issues that are not adequately being attended to, then people may mistrust the public health intentions of MC (Sawires, Dworkin, Fiamma, Peacock, Szekeres, & Coates, 2007). Engaging non-circumcising and circumcising communities in broad-based dialogue on the socio-cultural and public health implications of MC could help defuse current community perceptions and motivate circumcision-seeking behavior.

That circumcision is associated with ease in condom use is noteworthy. Some male discussants lamented that they had problems with wearing and consistently using condoms, and hypothesized that circumcision could enhance ease in wearing and using condoms. Condom use was also mentioned as the most effective HIV preventive measure. Since WHO recommends that MC should always be considered as part of a comprehensive HIV prevention package, which includes providing and promoting correct and consistent use of male and female condoms (WHO/UNAIDS, 2007), this result has significant implications for the co-promotion of MC with existing HIV preventive strategies. As Sawires and others (2007) suggest, a framework is needed that places MC within the context of a broader framework of prevention strategies and that does not isolate the strategy, thereby reinforcing the notion that it has the potential to address the complexities of HIV prevention by itself. However, further empirical evidence is needed on the role on MC in enhancing condom use.

Participants in this study mentioned their concerns, that if MC was perceived as a "magic bullet" against HIV infection there would be an increase in high sexual risk behavior among youth. Furthermore, non-circumcising communities may be labeled by other communities as a "high risk" group. A study in western Kenya (Agot, Kiarie,

Nguyen, Odhiambo, Onyango, & Weiss, 2007) reported that during the first year post-circumcision, men did not engage in more risky sexual behaviors than uncircumcised men, suggesting that any protective effect of MC on HIV acquisition is unlikely to be offset by an adverse behavioral impact. However, participants in our study expressed fear of behavior disinhibition and suggested that MC be promoted for its general public health good, such as improving hygiene and reduced risk of other infections like genital ulcers, rather than purely on the emphasis of HIV prevention. Pertinent questions that still require qualitative exploration are how to educate the community that MC is only partially protective, and how to motivate men and women to continue using the other known HIV preventive strategies, including abstinence, being faithful to one uninfected sexual partner, reduction in number of sexual partners, consistent and correct use of condoms, and prompt and complete treatment of STIs (see Ross, Dick, & Ferguson, 2006). Participants in this study suggested that MC promotional messages that package the intervention as a "fashionable thing to do" could have greater effect to enhance circumcision-seeking behavior. MC acceptability was also projected to increase with culture change as more parents prefer to have their sons circumcised at infancy.

With more information on the protective effect of MC, there is increasing demand for the procedure among traditionally non-circumcision communities. This demand, created through social communication networks and informal influences, occurs against the backdrop of inadequate professional providers of MC services and general unpreparedness of the government healthcare service delivery system. This could be disastrous as many rural people seeking MC may turn to unsafe and unprofessional modes of circumcision. Although, circumcisions are already being offered on a small scale by some NGOs, there is need for the government to move with speed to publish and communicate the necessary in-country policy on MC as the first step in ensuring wider access of the service. Additionally, there is need to consider introducing infant circumcision, especially for communities that are traditionally non-circumcising; this could be an introductory stage to enculturation of the practice among these communities.

Study Limitations

A possible limitation of this study, like for other inquiries founded on grounded theory, is that it relied on the researchers' perspectives and ways of thinking and understanding throughout data analysis. This may impose subjectivity in the analysis (Bowen, 2005; Padgett, 1998). However, to manage this threat to data quality, we maintained rigor throughout the study. Another limitation of this study is that the findings are not generalizable. The intent of grounded theory inquiry is not to allow for generalization, but to develop an account of a phenomenon that identifies its major constructs, their relationships, and the context and process (Charmaz, 2006; Dick, 2005; Strauss & Corbin, 1990). This study has generated a theoretical account of psychosocial factors that influence public health promotion and adoption of MC as a HIV preventive measure, grounded in the experience and perceptions of the non-circumcising Luo people of rural western Kenya.

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Author Note

Dr. Alfredo F.X.O. Obure, MPhil, PhD, is Behavioral Research Scientist with Emory University's Center for Global Safe Water in Kenya, and adjunct Faculty at Great Lakes University of Kisumu. He is also co-investigator with NICHE project, a collaboration of Kenya Medical Research Institute and Centers for Disease Control and Prevention. His current research interest is how to enhance adoption of evidence-based technologies and approaches to improve health and livelihoods of rural-poor communities. Contact: Email: afxobure@gmail.com, Telephone: +254 721 845 363.

Dr. Erick O. Nyambedha, MA, PhD, is Senior Lecturer and Head of Department of Sociology and Anthropology, Maseno University, Kenya. He has done extensive research on vulnerability of children in the context of HIV/AIDS in sub-Saharan Africa. He has also been involved in researching on HIV/AIDS impact on older people in their role as caretakers for orphans. Contact: Email: nyambedha@maseno.ac.ke, Telephone: +254 713 816 189.

Dr. Boniface O. Oindo, MSc, PhD, is Senior Lecturer at School of Environment and Earth Sciences (SEES), and Chairman, SEES Graduate Studies at Maseno University , Kenya. He has conducted research in biodiversity assessment using remote sensing and in rural development. His current research interest is management of community projects. Contact: Email: bonifolo@yahoo.com Telephone: +254 722 677 862.

Dr. Hezborn M.N. Kodero, MEd, PhD, is Senior Lecturer in Educational Psychology, and former Dean, School of Education at Moi University , Kenya. His research interest is human growth and development and community response to HIV/AIDS. He has conducted extensive research on psychosocial impact of HIV/AIDS on orphaned children in western Kenya. Contact: Email: hkodero@gmail.com, Telephone: +254 721 414 793.

Correspondences regarding this article should be addressed to Alfredo Obure at afxobure@gmail.com.

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