FACTORS INFLUENCING MEN'S UPTAKE OF MEDICAL MALE CIRCUMCISION (MMC) AT UNTUNJAMBILI AREA UNDER ILEMBE DISTRICT IN KWAZULU-NATAL

by

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submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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February 2015

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DECLARATION

I declare that **FACTORS INFLUENCING MEN'S UPTAKE OF MEDICAL MALE CIRCUMCISION (MMC) AT UNTUNJAMBILI AREA UNDER ILEMBE DISTRICT IN KWAZULU-NATAL** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

28 February 2015

……

PROMISE NHLANHLA SANGWENI **DATE**

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ABSTRACT

Since the re-introduction of MMC in the KwaZulu-Natal Province, South Africa in 2010, the target population is hardly reached. The purpose of this study was to explore factors influencing men's uptake of MMC at uNtunjambili area under iLembe District in KwaZulu-Natal and to develop guidelines for support of health care practitioners (HCPs) to promote MMC uptake in the area. A qualitative research design, which is exploratory-descriptive and contextual in nature was used, in which 9 uncircumcised men were selected by convenience sampling at uNtunjambili Hospital OPD. In-depth unstructured face-to-face interviews were used to collect data. The research revealed the following factors as promoting the uptake of MMC, namely: protective function against HIV/AIDS and other STI's; maintenance of hygiene; sexual pleasure; person performing the procedure; taking MMC to the people and providing the community with awareness about MMC and also factors hindering the uptake of MMC namely: fear; personal factors; lack of proper public education; influence of culture; and natural circumcision. After reviewing these research findings, the researcher drew the following conclusions: that men in the area of uNtunjambili are not in favour of MMC notwithstanding the fact that the Department of Health (DOH) has gone out of its way to spare resources for MMC; and on the other hand, HCP's were found to be not doing enough to sell the MMC programme and ultimately, the guidelines were developed to support HCPs to promote the uptake of MMC at uNtunjambili area.

KEYWORDS

Factor; influence; uptake; circumcision; medical male circumcision; men.

ACKNOWLEDGEMENTS

I would like to acknowledge the following people, who supported me during the pursuit of this study:

- My supervisor, Prof TR Mavundla at UNISA, for being kind and always available to share his knowledge with me. I will always be inspired and motivated by your support, guidance and intellect. You guided me from “Zero” to “Hero.”

- UNISA library staff, for always being available to support with library searches.

- Untunjambili Hospital staff and participants who provided me with necessary information.

- Dr EM Mncwango, for assisting me with the editing of the final product.

- Mrs Rina Coetzer, for formatting, printing, binding and submitting the dissertation.

- Prof ZZ Nkosi, my previous supervisor and an encouraging friend, who motivated me to register for the Master’s Degree.

A very special thanks to:

- My wife, Sizakele Sangweni, for love, patience and support during the completion of this study.

- My two handsome sons, Mlungisi and S’phelele, for being good sons and always encouraging me to do more, as they are also looking up to me.

- Last, but not least, Almighty God, my Lord and Creator, for giving me good health, power, wisdom, courage and perseverance to successfully complete the study.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AFSA	AIDS Foundation South Africa
ART	Antiretroviral Therapy
BBC	British Broadcasting Corporation
CCGs	Community Care Givers
CHWs	Community Health Workers
CEO	Chief Executive Officer
DM	District Manager
DOH	Department of Health
HCT	HIV Counselling and Testing
HCPs	Health Care Practitioners
HBM	Health Belief Model
HIV	Human Immunodeficiency virus
KZN	KwaZulu-Natal
MC	Medical Circumcision
MDGs	Millennium Development Goals
MMC	Medical Male Circumcision
MOH	Ministry of Health
NGO	Non-Governmental Organisation
OPD	Out Patient Department
OSS	Operation Sukuma Sakhe
PICT	Provider Initiated Counselling and Testing
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
RHRU	Research Health and HIV Research Unit
SA	South Africa
SANAC	South African National AIDS Council
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
TMC	Traditional Male Circumcision
TMMC	Traditional Medical Male Circumcision Coordinator
TpB	Theory of planned Behaviour
TRA	Theory of Reasoned Action
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNISA	University of South Africa
UNICEF	United Nations Children's Fund
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Circumcision is the surgical removal of the foreskin (prepuce) from the penis and the practice is widely performed on boys and young men in Africa and other parts of the world (Mandova, Mutonhori & Mudzanire 2013:584). According to Maposa (2008), cited in Mandova et al (2013:584), circumcision is practised in many African communities like Rwanda, South Africa, Mozambique, and Zimbabwe. In addition, circumcision is practised in many cultures around the world for various reasons including ritual, religious, medical and for cosmetic purposes (Goshme 2012:18; Mavundla, Netswera, Bottoman & Toth 2009:395).

The World Health Organization (WHO) estimates that 30% of all males aged 15 years and older in the world are circumcised and further suggests that out of these, 70% are Muslims residing predominantly in Asia, Middle East and North Africa while 13% are non-Muslim and non-Jewish men living in the United States of America (USA), and 0.8% of these are Jewish (WHO/UNAIDS 2007:7). The WHO proposed a framework that seeks to contribute to the achievement of Millennium Development Goal (MDG) 6, which aims to ensure that the world has halted the spread of HIV by 2015 (WHO 2012a:2). This is also in line with WHO and UNAIDS recommendations that Medical Male Circumcision (MMC) should be used as an additional important HIV prevention strategy for HIV prevention, particularly in settings with high HIV prevalence and low levels of male circumcision (Kenya National AIDS and STI Control Programme 2011:3; WHO 2012a:7; WHO/UNAIDS 2011:7).

In South Africa, HIV/AIDS epidemic is taken seriously and MMC has been adopted in order to reduce the rate of HIV transmission and this is demonstrated by its highest office of Deputy President in government chairing the South African National AIDS Council (SANAC), the Ministry of Health's (MOH) involvement and the MMC focal person in the MOH (WHO/UNAIDS 2010:8). A national multi-sectoral taskforce on MMC

is chaired by the Chief Director of HIV and AIDS and Provincial and District MMC Taskforce are under the leadership of the Provincial heads of health and they spearhead and coordinate the safe male circumcision campaign (WHO/UNAIDS 2010:8). This move shows how committed South African government is, in the fight against HIV/AIDS.

Although the KwaZulu-Natal Province, where the study was conducted, once practised circumcision as a rite of passage before the times of King Shaka Zulu, this practice was disturbed in the Zulu tradition in the 19th century by King Shaka Zulu himself who believed it robbed him of many warriors at a time (Friedman, Rose & Titus 2011:17). It is for this reason that in KwaZulu-Natal Province, the MMC programme was re-introduced in May 2010 after discussions between His Majesty, Zulu King, King Goodwill Zwelithini Zulu, the then Premier Dr Zweli Mkhize, the KZN Department of Health, and traditional leaders, who took the decision to implement a male circumcision programme as a prevention strategy against HIV and AIDS in an HIV stricken Province (AFSA 2011:7). This initiative has not gone unchallenged by Zulu men who still believe they do not need to perform circumcision as it has not been part of their culture for decades.

In this study the researcher explored factors that influence the uptake of MMC by men at Untunjambili area under iLembe District in KwaZulu-Natal as a strategy used in the prevention of spread of HIV/AIDS. In this chapter, the researcher introduces the phenomenon under investigation (uptake of MMC), presents the background to the problem, and also gives a summary of research design and methods for data gathering.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

UNAIDS estimates that 34 million [31 600 000–35 200 000] people were living with HIV globally at the end of 2010 versus 28.6 million [26 700 000–30 900 000] in 2001 – a 17% increase (WHO/UNAIDS/UNICEF 2011:19). Sub-Saharan Africa (SSA) continues to bear a disproportionate share of the global HIV burden when taking into account the fact that in mid-2010 about 68% of all people living with HIV resided in SSA, a region with only 12% of the global population (WHO/UNAIDS/UNICEF 2011:24). In March 2007 following the release of compelling evidence from three randomised, controlled clinical trials, WHO and UNAIDS issued recommendations that male circumcision be

considered as part of a comprehensive HIV prevention package (WHO/UNAIDS 2011:7; WHO/UNAIDS/UNICEF 2011:63).The clinical trials, conducted in Kenya, South Africa and Uganda, showed that male circumcision reduced the risk of heterosexually acquired HIV infection in men by about 60% (AFSA 2011:7; Kenya National AIDS and STI Programme Report 2011:3; KZN Department of Health 2010:1; Research Health and HIV Research Unit (RHRU) 2010:3; UNAIDS 2000:70; WHO/UNAIDS/UNICEF 2011:63; WHO 2012a:7). This has compelled world countries to look for other ways of preventing the spread of HIV epidemic consequently in 2007, WHO recommended that male circumcision be included in the HIV prevention package (WHO/UNAIDS/UNICEF 2011:63; WHO 2012a:7).

According to WHO/UNAIDS/UNICEF (2011:63), expanding the coverage of Voluntary Medical Male Circumcision (VMMC) to 80% of 15–49 year old men within 5 years could avoid around 3.5 million people becoming newly infected with HIV in the Eastern and Southern Africa. Thirteen (13) Southern and Eastern African countries with high HIV prevalence, low levels of male circumcision and generalised heterosexual epidemics have been identified as priority countries for male circumcision scale-up. These are: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe (WHO/UNAIDS 2011:7). These countries have been engaged in developing programmes for the implementation of male circumcision and are at various stages of programme scale-up. The 2011 Political Declaration on HIV/AIDS emphasises the importance of “decisive, inclusive and accountable leadership to revitalise and intensify the comprehensive global HIV and AIDS response” (WHO/UNAIDS 2011:13). South Africa is no exception to this commitment.

In South Africa, HIV and AIDS have escalated to such an extent that the government has been forced to do whatever it can to make the situation more manageable. In the past decade the number of people infected with HIV in South Africa (SA) has risen dramatically with the population of ±48.5 million having HIV prevalence of ±18.1% and MC prevalence of ±35% (WHO/UNAIDS 2010:8). KwaZulu-Natal (KZN) has consistently recorded the highest prevalence since 1990 and in 2008 the HIV prevalence in the Province was 38.7% compared with the National prevalence of 29.3% (KZN Department of Health strategic plan 2011-14:72). It is also noted that by the end of 2011, more than

1.3 million VMMCs had been performed for HIV prevention, with near doubling of the number from 2010 to 2011(WHO 2012b:2).

According to RHRU (2010:23), it is difficult to determine the trends in MMC in South Africa, given that no routine statistics were kept in the past, and further mentions that it is not widely practised in SA, except amongst certain ethnic groups (largely Xhosas and Sothos) and for religious reasons amongst the Muslim and Jewish communities. RHRU (2010:23) further points out that the only available MC data is from 2003, as presented by the South African Demographic Health Survey (SADHS), the overall rate of MMC in men 15-59 of age years was 44.7%. Provincial rates further reveal that KwaZulu-Natal (KZN) is among the least circumcising Provinces despite its high rate of HIV infection and that is demonstrated in the following provincial MMC statistics : Gauteng Province (GP): 25%; KwaZulu-Natal Province (KZN): 27%; Eastern Cape Province (EC): 44%; Western Cape Province (WC): 68%; and Free State Province (FS): 71% (RHRU 2010:23).

This background of study leads to the formulation of the research problem statement.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Since the re-introduction of MMC in the KZN Province in 2010, the target population is hardly reached. According to the WHO (2010:8), the target population is set between 14 and 49 years of age. The observation has been that only younger boys are participating in the MMC programme instead of sexually active men. In the opinion of the researcher, only boys as young as 12 years have been observed participating in the programme while older men seem to be dodging circumcision. Untunjambili Hospital District Health Information System (DHIS) data for the period April 2013 reveals that 65 men between the ages 15 to 49 years were circumcised while 82 boys that were circumcised at the same period were between 4 months to14 years of age and the same picture continued in May 2013 where 35 men between ages 15 to 49 years were circumcised while 33 men were between 4 months and 14 years who were circumcised at the same period.

In the District where this study was conducted, older men between ages 20 and 40 seldom come for the MMC at health facilities in iLembe District in KwaZulu-Natal as depicted in the Untunjambili Hospital DHIS data mentioned earlier. The primary aim of

MMC is to reduce the spread of HIV infection among sexually active individuals. This primary aim of the KZN Department of Health seems to be defeated because circumcising only younger boys now does not reduce the spread of HIV infection immediately, but it can only ensure that they are protected in future when they become sexually active. This statement of the problem leads to the following research questions:

1.4 RESEARCH QUESTIONS

Research questions are specific queries researchers want to answer in addressing the problem (Polit & Beck 2012:73). In this study, the researcher wished to answer the following research questions, namely:

- What factors influence the uptake of MMC by men at uNtunjambili area under iLembe District in KZN?
- What could be done by health care practitioners (HCPs) to promote the uptake of MMC by men at uNtunjambili area under iLembe District in KZN?

1.5 RESEARCH OBJECTIVES OF THE STUDY

In order to answer the research questions mentioned by the researcher in this study, the researcher formulated the research objectives two-fold in the following manner:

- To explore men's perceptions of MMC at uNtunjambili area under iLembe District in KwaZulu-Natal (Phase 1).
- To develop guidelines to promote the uptake of MMC by men at uNtunjambili area under ILembe District in KZN (Phase 2).

1.6 PARADIGMATIC PERSPECTIVE OF RESEARCH

According to Polit and Beck (2012:11), paradigm is a world view, a general perspective on the complexities of the world. Paradigms for human enquiry are often characterised in terms of the ways in which they respond to basic philosophical questions such as, what is nature of reality (Ontologic) and what is the relationship between the enquirer and those studied? (Epistemologic) (Polit & Beck 2012:11).

According to Polit and Beck (2012:11), a disciplined inquiry in nursing has been conducted mainly within two broad paradigms, positivism and constructivism. While positivism reflects a broader cultural phenomenon that, in the humanities, is referred to as modernism, which emphasises the rational and the scientific, constructivist paradigm (often called naturalistic paradigm) began as a countermovement to positivism and it further assumes that knowledge is maximised when distance between the enquirer and those under study is minimised. According to Polit and Beck (2012:12), the voices and interpretations of study participants are crucial to understanding the phenomenon of interest, and subjective interactions are primary ways to access them.

Men's perceptions of factors influencing their uptake of MMC are in essence irreducible and unquantifiable. According to Polit and Beck (2012:15), human beings are used directly as the instrument through which information is gathered, humans are extremely intelligent and sensitive. Qualitative approach will further help the researcher to follow a systematic approach to capture men's subjective accounts of their perceptions through flexible and unstructured methods of enquiry.

The research was conducted in a naturalistic setting without disturbing men's natural context, e.g. those attending the Untunjambili Hospital Out Patient Department were interviewed in this way. There was no means to control over the setting (Polit & Beck 2012:49). The researcher established a strong relationship with the participants by visiting them before and during data collection. The researcher did not pre-select specific research variables to be studied but instead data that emerged during data collection prompted the researcher to probe even further to explore ideas that participants communicate with him (Lincoln & Guba 1985:102).

1.7 DEFINITION OF KEY CONCEPTS

In this section the researcher presents the terms used throughout this dissertation as outlined below:

1.7.1 Factor

Factor is an element or cause that contributes to a result (*Collins Concise Dictionary* 2004:514).

1.7.2 Influence

Influence is an effect of one person or thing on another (*Collins Concise Dictionary* 2004:747).

1.7.3 Uptake

Uptake is the act of accepting something on offer (*Collins Concise Dictionary* 2004:1654).

1.7.4 Circumcision

Circumcision is an act involving the removal of the foreskin of a male and to perform such an operation as a religious rite on someone (*Collins Concise Dictionary* 2004:271, Silverman 2004; Mavundla et al 2009; Peltzer & Kanta 2009).

1.7.5 Medical male circumcision (MMC)

Medical Male Circumcision (MMC) means the total removal of man's foreskin/ prepuce after testing negative to an HIV test in an attempt to reduce medical conditions e.g. paraphymosis, STIs, HIV/ AIDS etc (Friedman et al 2011:6).

1.7.6 Men

Men are adult male human beings and it is in its plural form (*Collins Concise Dictionary* 2004:904). WHO describes MMC target men as males aged between 18 and 49 years.

1.8 RESEARCH DESIGN

The researcher in this study used a generic qualitative research design as it involved collecting descriptions from men about their perceptions about MMC. Therefore, a qualitative research design, which is explorative, descriptive and contextual was used in this study.

1.9 RESEARCH METHODS

Research methods are techniques researchers use to structure a study and to gather and analyse information relevant to the question (Polit & Beck 2012:12). In this study, the methods section is dealt with in two phases as detailed below.

1.9.1 Phase 1: The exploration of factors influencing the uptake of MMC

The first phase is empirical research to explore the experiences of uncircumcised men between ages 18 and 49 years that make them to delay undergoing circumcision at uNtunjambili area under iLembe District in KwaZulu-Natal. This phase was achieved by adhering to qualitative research methods mentioned in sub-sections below.

1.9.1.1 Population

Population is the entire group of persons or objects that are of interest to the researcher, or, in other words, that meets the criteria the researcher is interested in studying (Brink 1999:123). The target population in this study was uncircumcised men aged between 18 and 49 years in the community of Untunjambili area under iLembe District in KwaZulu-Natal.

1.9.1.2 Sample and sampling

Sample is a part or fraction of a whole, or a subset of the population selected by the researcher to participate in a research project (Brink 1999:124; Polit & Beck 2012:59; Burns & Grove 2009:721).

Sampling is the process of selecting the sample from the population in order to obtain information regarding the phenomenon in a way that represents the population of interest (Brink 1999:128). There are two sampling techniques namely probability and non-probability sampling. Polit and Beck (2012:275) further unpacks these sampling techniques namely probability sampling that involves random selection of elements while non-probability sampling involves non-random methods. As this is a qualitative research, the researcher did not attempt to select a sample that is representative of the population and therefore generalisation was out of question. In this study, a non-

probability sampling approach i.e. convenience sampling was used whereby accidental or availability sampling and involves choosing readily available people or objects for the study. The latter was relevant since the researcher intended to interview men that attend Untunjambili Hospital OPD. All participants were screened whether circumcised or not before selected for actual interview and only one of those approached, was found to have already been circumcised.

1.9.1.3 Data collection

Data collection is defined as the precise, systematic gathering of information relevant to research purpose or the specific objectives and questions of the study (Burns & Grove 2009:695). An unstructured data collection approach was used and the researcher intended to use the interview as the principal method of data collection and an audiotape was used to record the interviews.

Three open ended questions were asked and these were followed by more specific probing questions that depended on the answers obtained on the former questions. The participant was not confined to pre-specified response options but was allowed to answer using his or her own words. This exercise yielded narrative data which were subjected to qualitative, non-numerical data analysis. The open-ended interviews were conducted in a manner that clarifies rather than directs.

1.9.1.4 Data analysis

Since this is a qualitative research, statistics were not used to analyse the data. Qualitative data analysis steps were used. Data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms (Brink 1999:170). Burns and Grove (2009:695) maintain that data analysis is conducted to reduce, organise and give meaning to data and it was done concurrently with the data collection.

The audio-taped raw data were transcribed. The researcher read the transcript of each interview several times to get an understanding of the whole experience. The researcher re-read the transcript of each interview to discriminate between meaning units.

The next step was to formulate transformed meaning units where participants' everyday expressions and language were transformed into expressions of meaning that carry more general and transferable insights. As most qualitative research methods, the researcher proceeded through the process of analysis, i.e. breaking up narratives into smaller parts (coding), inductive reasoning, i.e. clustering many related concepts into a manageable number of categories (categorising) (Polit & Beck 2012:558−559).

Synthesis was also done, that involves probing the data for common themes and establishing patterns of relationships shared by particular phenomena. Each theme and its layers and layers of underlying, and interrelated concepts, were used to describe the phenomenon under investigation, accounting for its complexities. Lastly, the researcher indicated the value of the essential structures for understanding the variations of the lived experiences. The researcher went back to initial transcribed interviews to check how the participants' specific experiences are understood in the light of the constituents of the general structure.

The researcher considered research findings in dialogue with the literature and current research in order to offer critique, possible applications and further directions for research.

1.9.2 Phase 2: Guidelines to promote the uptake of MMC by men at Untunjambili under iLembe District in KwaZulu-Natal

Once participants' experiences about the uptake of MMC were explored and described, the researcher used deductive reasoning to formulate guidelines to support the uptake of MMC at Untunjambili area under iLembe District in KwaZulu-Natal. The guidelines that will be developed will guide HCPs to plan successful MMC camps and improve MMC uptake in general.

1.10 MEASURES FOR ENSURING TRUSTWORTHINESS

Lincoln and Guba's model (1985:290) applies the criteria of truth value, applicability, consistency and neutrality as follows:

Truth value is the criterion that was met by enhancing the credibility of the study. The applicability is the criterion that was met by enhancing transferability of the study. Consistency is the criterion that was met by enhancing dependability of the study. Lastly, neutrality is the criterion that was met by enhancing confirmability of the study. The measures for ensuring trustworthiness are described in detail in the methodology chapter (see chapter 3) for a comprehensive description of this model.

1.11 ETHICAL CONSIDERATION

Ethical consideration briefly means that the researcher must carry out the research competently, manage resources honestly, acknowledge fairly those who contributed guidance or assistance, communicate results accurately, and consider the consequences of the research for society (Bottoman, Mavundla, Forenc & Toth 2009:30). As humans are used as participants, care must be exercised to ensure that their rights are protected (Polit & Beck 2012:150). In this way, their right to autonomy, self-determination, full disclosure, risks and benefits, anonymity and confidentiality should be respected (see Annexure F).

Apart from the rights of participants that should always be respected, most hospitals, universities and other institutions have set up independent committees to review proposed research and to examine and monitor the ethical standards of intended or on-going research. Before undertaking any study, researchers must submit research plans to Institutional Review Board, and must also go through formal training on ethical conduct and certification process (Polit & Beck 2012:166). In this study, the researcher sought permission from relevant authorities before participants were interviewed. Ethical clearance was requested and granted by UNISA before the study was commenced (see Annexure A). Local authorities and the KwaZulu-Natal Department of Health were approached about this research and permission was sought and received from them before interviews were set with participants (see Annexures B, C, D and E). Besides ensuring that institutions have review boards to review proposed research, it was important to explore the scope of the study.

1.12 SCOPE

The scope of the study is defined as the parameters under which the study will be operating and sometimes affect the end result and conclusions that can be drawn (Simon & Goes 2013:1). The scope of this study is limited to the factors influencing men's uptake of Medical Male Circumcision (MMC) at uNtunjambili area under iLembe District in KwaZulu-Natal. The researcher never included any other men for the purpose of this study other than uncircumcised men of ages between 18 and 49 years.

1.13 STRUCTURE OF THE DISSERTATION

This study is divided into six chapters, as follows:

Chapter 1: Study outline

Chapter 2: Literature review

Chapter 3: Research design and methods

Chapter 4: Discussion of research findings and literature control

Chapter 5: Guidelines for support of health care practitioners (HCPs) to promote the MMC uptake at uNtunjambili area under ILembe District in KwaZulu-Natal

Chapter 6: Discussion, limitations, recommendations, and conclusion

1.14 CONCLUSION

This study aspires to uncover more unknown facts about MMC, more especially in the province of KwaZulu-Natal, where men were previously not participating in circumcision of any form for a long time in the past. Findings of the study will also assist the HCPs to plan successful MMC camps with the full participation of local men, more especially those targeted by MMC guidelines, i.e. those between the ages15 and 49 year.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

According to Brink, Van der Walt and Van Rensburg (2012:79), the researcher reviews the literature in some detail, but as a rule does not report on the whole of the literature review. Brink et al (2012:80), on the other hand, further expand that it is not appropriate for the researcher to try to include everything, but should rather report on the portions of the review that are presumed to be relevant. Researchers typically conduct research within the context of existing knowledge by undertaking a thorough literature review (Polit & Beck 2012:94). The researcher tried to do exactly that in this chapter. The purpose of a literature review for this project was to find out what has been studied, the gaps in the studies, how dependable the studies are and to present the findings of what has been studied. In this chapter, the researcher provides an overview of literature that looks at global view of HIV/AIDS, and extent of HIV in Sub Saharan Africa and in South Africa, medical aspects of Medical Male Circumcision (MMC), MMC as an HIV prevention strategy, factors influencing its uptake and factors that hinder its uptake.

Scientific trials have shown that Male Circumcision (MC) can reduce a man's risk of becoming infected with HIV during heterosexual intercourse by up to 60 per cent (AIDS Foundation South Africa (AFSA) 2011:7; Kenya National AIDS and STI Programme Report 2011:3; KZN Department of Health 2010:1; Research Health and HIV Research Unit (RHRU) 2010:3; UNAIDS 2000:70; WHO/UNAIDS/UNICEF 2011:63; WHO 2012a:7). These findings have led to the decision by UNAIDS and WHO to recommend circumcision as an important new element of HIV prevention. WHO/UNAIDS/UNICEF (2011:19) suggests that expanding the coverage of Voluntary Medical Male Circumcision (VMMC) to 80% of 15 to 49 year old men within 5 years could avoid around 3.5 million people becoming newly infected with HIV in Eastern and Southern Africa, representing cost saving of about US $ 16.6 billion between 2011 and 2025.

2.2 GLOBAL VIEW OF HIV/AIDS EPIDEMIC

At the end of 2010, an estimated 34 million people [31 600 000–35 200 000] were living with HIV globally, including 3.4 million [3 000 000–3 800 000] children less than 15 years (WHO/UNAIDS/UNICEF 2011:11; UNAIDS 2011:6).

According to WHO/UNAIDS/UNICEF (2011:11) and UNAIDS (2010:16), globally the annual number of people newly infected with HIV continues to decline, although there is stark regional variation. In sub-Saharan Africa, where most people newly infected with HIV live, an estimated 1.9 million [1 700 000–2 100 000] people became infected in 2010. Between 2001 and 2009, the incidence of HIV infection has declined in 33 countries, 22 of them in sub-Saharan Africa and in that region which continues to have the majority of the people newly infected with HIV (WHO/UNAIDS/UNICEF 2011:13; UNAIDS 2011:7). This was a 16% fewer than the estimated 2.2 million [2 100 000–2 400 000] people newly infected with HIV in 2001 and 26% fewer than the annual number of people newly infected in 1997 (WHO/UNAIDS/UNICEF 2011:13; UNAIDS 2011:7).

This decline can be attributed to a number of factors, inter alia, availability of Antiretroviral Therapy (ART), positive developments among children due to successes of Prevention of Mother to Child Transmission of HIV infection (PMTCT) programme, etc. WHO/UNAIDS/UNICEF (2011:19) elaborates that as the HIV treatment expands, the number of people living with HIV is also rising and it is also worth noticing that half of those infected, are women. AFSA (2011:16) also attests that women continue to bear the burden of the HIV/AIDS epidemic. This may be due to the fact that people continue to live a risky sexual life despite health information they have on HIV prevention and women continue to be the target by the patriarchal system that exists in our communities that suppresses them from having anything to say when it comes to sexual matters. Goshme (2012:14) concludes that the current HIV prevention strategy using MMC will have tremendous impact if implemented according to plan.

2.3 HIV/AIDS IN SUB-SAHAN AFRICA

Sub-Saharan Africa (SSA) remains disproportionately affected by the global HIV burden and in mid-2010, about 68% of all people living with HIV resided in SSA, a region with

only 12% of the global population (WHO/UNAIDS/UNICEF 2011:24). Kennedy (2012:18) suggests that 6 million new HIV infections and 3 million deaths could be prevented in 20 years if all men in SSA became circumcised.

According to WHO/UNAIDS/UNICEF (2011:24), 1.9 million people who became infected with HIV in 2010 in SSA represented 70% of all the people who acquired HIV infection globally. However, the number of people newly infected in this region is decreasing and about 16% fewer people acquired HIV infection in 2010 than in 2001 (with an estimated 2.2 million [21 600–24 100 000] in 2010 (12% more than in 2001) (WHO/UNAIDS/ UNICEF 2011:24).

More women than men in SSA were living with HIV in 2010, women comprised of 59% [56−63%] of the people living with HIV in that region (very close to the same proportion as a decade ago) (WHO/UNAIDS/UNICEF 2011:24). The epidemics in SSA vary considerably, however, with Southern Africa most severely affected, i.e.an estimated 11.1 million [10 600 000–11 600 000] people were living with HIV in Southern Africa in 2009, 31% more than the 8.6 million [8 100 000–9 100 000] people living with HIV in the region a decade earlier (WHO/UNAIDS/UNICEF 2011:24).

The overall burden that HIV/AIDS placed on SSA is unprecedented and HIV/AIDS is now the most common cause of death in the region (Goshme 2012:14).

2.4 HIV/AIDS IN SOUTH AFRICA

Kennedy (2012:22) maintains that South Africa has the world's largest HIV positive population, but only 35% of their men are circumcised. According to WHO/UNAIDS (2010:8), in 2010 the population in South Africa (SA) was ±48.5 million and the HIV prevalence was 18.1% which is a huge per cent that SA contributes globally. Kennedy (2012:22) further unveiled that South African government has been criticised for moving too slowly in developing a national circumcision strategy and by December 2009 the country had a draft policy, but no mechanisms for training, quality assurance or monitoring and evaluation.

WHO/UNAIDS (2007:22) suggests that an estimated 2.1 million adults were newly infected with HIV in 2007, of whom two thirds live in SSA. The prevalence is highest in

Southern Africa where 15% of adults are living with HIV (WHO/UNAIDS 2007:22). South Africa remains the number one country affected by this epidemic and the Province of KwaZulu-Natal (KZN) is leading with people infected with HIV and it is worth mentioning that it is also the less circumcising province in South Africa as mentioned earlier.

2.5 HIV/AIDS PREVENTION STRATEGIES

South Africa has been robust in the fight against HIV/AIDS despite the previous HIV/AIDS denialism in 2000 by the then South Africa's President Thabo Mbeki and Minister of Health, Manto Tshabalala Msimang, as they joined Presidential AIDS Advisory Panel to deny that HIV causes AIDS, while contradicted by conclusive medical and scientific evidence that HIV does cause HIV. Consequently, South Africa was one of the last countries in the region to begin such treatment campaign, and the roll-out has been much slower than planned.

As a result, Bengo, Chalulu, Chinkumba, Kazembe, Maleta, Masiye and Mathanga (2010:72) argue that male circumcision is on the increase due to information on the health benefits (including HIV/ AIDS prevention) and mostly practised on demand in the private sector that can be very costly.

2.5.1 Male circumcision in countries in SSA with high burden of HIV

WHO, UNAIDS and UNICEF (2011:63) reveal three randomised trials conducted in SSA to study the efficacy of MMC for preventing HIV acquisition among heterosexual HIV negative men, and this study showed a strong protective effect, with approximately 60% reduction in the risk of acquiring HIV. WHO and UNAIDS further identified 13 priority countries for scale-up of VMMC: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. US Presidential Emergency Plan for AIDS Relief (PEPFAR) supports activities to implement MMC in these 13 countries and also in Ethiopia, making the total of 14 priority countries (WHO & UNAIDS 2011:7).

A population-based study in a South African township has also shown reduced HIV prevalence and incidence at the community level three years after male circumcision

services began to be rolled out. In 2007, WHO and UNAIDS recommended including male circumcision as an additional HIV prevention programme component in settings with high HIV prevalence and low levels of male circumcision (WHO & UNAIDS 2011:7). Recent studies have also revealed indirect or potential benefits of male circumcision for women, who may be less exposed to HIV infection and HIV prevalence among men is reduced and one modelling study suggested that male circumcision has the potential to reduce, in the long term, the rate of heterosexual transmission from males to females by 46% (WHO, UNAIDS & UNICEF 2011:63).

WHO and UNAIDS (2011:7) state that all priority countries have adopted the minimum package of male circumcision services recommended by WHO and UNAIDS, including management of sexually transmitted infections, HIV testing and counselling (HCT), condom promotion and safer sex education. In 2010, the reported uptake of HIV testing and counselling ranged between 56% and 98% among men receiving male circumcision across all priority countries, demonstrating how male circumcision services can be leveraged as an important entry point to provide men with an opportunity to learn their HIV serostatus (WHO, UNAIDS & UNICEF 2011:65). All this evidence suffices to say male circumcision can play an important role in HIV prevention.

2.6 MEDICAL ASPECTS OF CIRCUMCISION

Masumbuko, Ipyana, Alexander and Ainory (2013:4) describe medical aspect of circumcision as that of preventing diseases, e.g. HIV, cervical and penile cancer, urinary tract infection (UTI) in childhood and prevention of inflammation of the penis (balanitis). Since circumcision is a controversial topic that provokes strong arguments for and against the practice, it becomes relevant to discuss the medical aspect of circumcision at this juncture as it is known to reduce chances of penile carcinoma and other sexually transmitted infections (STIs) as follows:

2.6.1 Penile carcinoma

WHO, UNAIDS and UNICEF (2011:63) uncover that the female partners of circumcised HIV-negative men had a lower prevalence of high-risk human papillomavirus (HPV) than did the female partners of uncircumcised men, a pattern that may lead to a reduction in cervical cancer among women whose partners are circumcised in addition

to a lower incidence of penile cancer. Coll (2005:283) also attests that the association between circumcision and carcinoma of the penis has long been known. Worldwide this cancer accounts for 2% of all male genito-urinary malignancies in males in communities where infant circumcision is not commonly practised. Coll (2005:283) further assumes that there is yet an unidentified, carcinogen in the smegma of the uncircumcised penis, which means that there is suspicion that there could be a cancer causing agent in the whitish dirt that usually collects in an uncircumcised penis.

2.6.2 Sexually Transmitted Infections (STIs), genital hygiene and male circumcision

There is a belief that circumcised men have less chances of getting sexually transmitted infections (including syphilis, chancroid and HPV) and HIV (Kennedy 2012:34). In March 2007, following the release of compelling evidence from three randomised, controlled trials, WHO and UNAIDS issued recommendations that male circumcision be considered as part of a comprehensive HIV prevention package. The clinical trials, conducted in Kenya, South Africa and Uganda, showed that male circumcision reduced the risk of heterosexually acquired HIV infection and other STIs (WHO 2012b:7). The World Health Organization recommends male circumcision alongside condom usage and fewer sexual partners as a prevention of heterosexually acquired HIV (WHO 2012a:7).

Male circumcision improves hygiene since it makes it easier to keep the penis clean and dry at all times, it also decreases the risk of UTI and can help to prevent phimosis, a condition that results from scar tissue that makes a tight opening in the foreskin and prevents exposure of the head of the penis and normal retraction of the foreskin (Kennedy 2012:34; Masumbuko et al 2013:4).

2.7 CIRCUMCISION AND HIV

UNAIDS (2000:70) suggests that researchers have been debating the relationship between male circumcision and HIV and several studies indicated that circumcised men are less likely to become infected with HIV than uncircumcised men. It has also been suspected that male circumcision might reduce rates of HIV transmission during sex but for a very long time it has been unclear whether this is solely the effect of circumcision

itself or other factors may also play a role. Masumbuko et al (2013:4) mention that males who are circumcised have a lower risk of HIV than those who are not circumcised, but also areas with high rate of circumcision have lower prevalence of HIV. It has been established that uncircumcised males are 2−3 times more likely to be infected with HIV than their circumcised counterparts.

Avert (2014) reveals that in three trials conducted in SSA, which together involved more than 11 000 previously uncircumcised men, the results were as follows:

Table 2.1 Conclusive evidence that male circumcision reduces the risk of men from becoming infected with HIV through heterosexual sex

LOCATION	PARTICIPANTS	REPORT PUBLISHED	RESULT IN CIRCUMCISED MEN
SOUTH AFRICA	3,274	July 2005	60% fewer infections
KENYA	2,784	February 2007	53% fewer infections
UGANDA	4,996	February 2007	51% fewer infections

(Adapted from Avert 2014)

Avert (2014) further boasts that the circumcision trials in Kenya and Uganda were halted on 12 December 2006, after an expert committee decided that to continue with them would be unethical as there was already such clear evidence that circumcision reduces the risk of HIV infection.

2.7.1 The effect of circumcision on female to male sexual HIV transmission

AFSA (2011:16) suggests that male circumcision is effective in reducing sexual transmission of HIV from women to men. Ncayiyana (2011:775), unveiled in the Randomised Controlled intervention Trial (RCT) conducted at Orange Farm in Gauteng that circumcision significantly reduced the risk of female to male transmission of HIV. The published conclusion of South African study is more circumspect, declaring simply that male circumcision provides a degree of protection against acquiring HIV infection, equivalent to what a vaccine of high efficacy would have achieved. Ncayiyana (2011:775) further contested the comparison of MMC to a vaccine in that, these trials were conducted in a wide variety of population and environments, and a large diversity

of research conditions. Kennedy (2012:34) concurred with the trials that male circumcision lead to decreased risk of female to male sexual transmission of HIV, reducing the risk of transmission by 60−70%. In 2005 and 2006 randomised clinical trials in 3 African countries demonstrated that VMMC reduces the risk of female to male sexual transmission by 60% (WHO & UNAIDS 2011:7). Most recently, population-based data from on-going research in Orange Farm, South Africa have shown lower HIV prevalence and incidence (55% and 65% lower respectively) among circumcised men than uncircumcised men (Ncayiyana 2011:775; WHO & UNAIDS 2011:7).

This suffices to say VMMC is an exceptional HIV prevention method, in that it offers life-long substantial (albeit partial) protection against female to male sexual transmission of HIV and other STIs (Ncayiyana 2011:775).

2.7.2 Male circumcision versus condom use

Even though MMC has been praised for its role in HIV prevention, it may not be the solution to the global HIV epidemic. The WHO recommends male circumcision alongside condom usage and fewer sexual partners as a prevention of heterosexually acquired HIV (WHO 2012a:7). This means that it is not a matter of relying on MMC only to prevent HIV but also condoms must be used over and above that. Kennedy (2012:36) warns that while both condoms and circumcision reduce the risk of HIV infection, circumcision, unlike condoms, does not prevent pregnancy.

AFSA (2011:16) suggests that communities and, particularly men opting for MMC and their partners, require careful and balanced information and education materials that address the need for condom use and discuss the change in power balance to the extent that male circumcision may reduce women's ability to negotiate condom use. It is also imperative that male circumcision be seen as complementary to other ways of reducing risk of HIV infection, and not as a 'magic bullet' for HIV prevention.

According to UNAIDS (2000:64), it is especially important for young people to use condoms in high prevalence countries where they are likely to encounter an HIV infected partner at the start of their sex life. Even though most young people use condoms, unfortunately for KwaZulu-Natal (KZN), where the probability of encountering an infected partner is probably as high as anywhere in the world, the rates of condom

use among young people were three times lower than those elsewhere in the country (UNAIDS 2000:64). Kennedy (2012:35−36) warns that circumcision is much less effective than condom use at preventing HIV transmission and further concludes that if a condom is used correctly every time a person has sex, it provides highly effective protection against HIV infection whereas circumcision only prevents about 60% of infection.

2.7.2.1 Effectiveness

Circumcision only prevents around 50% of infections (Avert 2014). This means that even if a man is circumcised, he must still abstain, be faithful or use condoms to substantially cut the risk of infection. Garenne (2008:7) adds that as MMC can reduce HIV by only 50%, this reduction in risk of contracting HIV is likely to have only a small demographic effect and other preventive means must be used to reduce HIV further. Apart from its low effectiveness level, circumcision procedure can also have its hazards.

2.7.2.2 Hazards of the procedure

Avert (2014) compares circumcision with other methods of preventing HIV transmission during sex, e.g. condoms, and warns that circumcision requires medical intervention and, therefore, needs to be carried out by a well-trained health professional. To carry out the procedure safely requires considerable resources; otherwise it can be risky and the health care practitioners have to stick to strict Infection and Prevention Control guidelines. This means that if the tools are not sterilised before each use then they can transmit infections and side effects of poorly performed circumcision can include serious bleeding and damage to the rest of the penis. Also, newly circumcised men must wait for few weeks for their wounds to heal before having sex (Avert 2014). If they do not, they are likely to face an increased risk of HIV infection through broken skin.

2.8 MMC AS AN HIV PREVENTION STRATEGY IN SOUTH AFRICA

South African Department of Health in April 2010 officially added MMC to its HIV response as a key prevention strategy and this followed WHO and UNAIDS's recommendations that male circumcision be considered as part of a comprehensive HIV prevention package in 2007 (Chaps 2014). The clinical trials, conducted in Kenya,

South Africa and Uganda South Africa have an overall target of more than 5 million men by 2016 in order to reach the desired uptake level of 80%. Recent marketing activities indicate that MMC services are gaining momentum with an increase in demand at all the sites that offer the service. On average, CHAPS clinics perform up to 50 circumcisions per day (Chaps 2014).

It is important to note that even though the KZN DOH started MMC roll-out on the highest gear, MMC figures are dropping day by day due to various factors.

2.9 FACTORS INFLUENCING UPTAKE OF MMC

A multitude of factors may facilitate the uptake of MMC as follows: (1) acceptability of the procedure, (2) culture, (3) religion, (4) disease prevention, particularly HIV/ and STI, (5) maintenance of hygiene, (6) sexual pleasure, (7) peer pressure and, (8) knowledge about use or health education, as major ones.

2.9.1 Acceptability of MMC

The acceptability of MMC has been studied among men and women in different parts of SSA countries (Botswana, Zimbabwe, South Africa, Tanzania, Kenya), showing results ranging from 45% to 81% (Halperin, Fritz, McFarland & Woelk 2005:238−239; Kebaabetswe, Lockman, Mogwe, Mandevu, Thior, Essex & Shapiro 2003:217; Mattson, Bailey, Muga, Poulussen & Onyango 2005:192; Scott, Weiss & Viljoen 2005:304−313; Nnko, Washija, Urassa & Boerma 2001:214−218). A cross sectional study conducted by Kebaabetswe et al (2003:217) to determine the acceptability of MC in Botswana revealed that MC appears to be highly acceptable. Among 238 uncircumcised men 145 (61%) stated that they would definitely or probably get circumcised themselves if it were offered free of charge and in a hospital setting; the response increased to 192 (81%) after five minutes informational session. This suggests that health education is a powerful instrument in encouraging people to engage in any form of health seeking behaviour. A similar cluster design survey conducted on acceptability of adolescent MC and their parents in two large villages of Botswana, showed a high acceptability rate 75% (95%) CI (Jayeoba, Dryden-Petersen, Okui, Smeaton, Magetse, Makori, Modikwa, Mogodi, Plank & Lockman 2012:340-349).

Some men will have personal reasons for rejecting circumcision, even if their culture allows it. It will be important to also explore this factor, taking into account the fact that circumcision has not been part of the Zulu culture for decades since it was abolished by King Shaka Zulu in the 19th century (Avert 2014). Apart from acceptability of MMC by some people, culture also plays a role in promoting it.

2.9.2 Culture

RHRU (2010:13) affirms that MMC has strong cultural connotations in SA, hence the need to deliver services in a manner that is culturally sensitive. Cultural perceptions of circumcision complicate efforts to improve access to safe and voluntary MMC services in SSA. WHO (2007:4) states that circumcision has been practised for non-religious reasons for many thousands of years in SSA and among many ethnic groups. In majority of the cultures, circumcision is an integral part of a rite to passage to manhood, although originally it may have been a test of bravery and endurance (WHO 2007:4). Circumcision is also associated with factors such as masculinity, social cohesion with the boys of the same age who become circumcised at the same time, self-identity and spirituality (RHRU 2010:13). This factor becomes very important in this study where boys of the same age usually come in numbers for circumcision.

Goshme (2012:21) mentions that the social status accorded to MC is of crucial significance in traditionally circumcising communities, because being circumcised is the only possible way of attaining manhood. In many African societies and among certain ethnic groups, MC is carried out for cultural reasons, as an initiation ritual and a rite of passage from childhood into manhood (Bottoman et al 2009:29; Grant, Brown, Michen, Manuthu & Njeru 2004:189−196; RHRU 2010:13). In South Africa, among the Xhosa tribes, cultural male circumcision is performed on young adults as a rite of passage from childhood to manhood through the removal of the foreskin. For Xhosa males, it is important to undergo this transformation, because one must complete the ritual according to tradition to be considered a man (Bottoman et al 2009:29). Among Xhosa in South Africa men who have not been circumcised can suffer extreme forms of punishment, including bullying and beatings (RHRU 2010:13). Similarly, for the Yao in Malawi or Lunda and Luvale tribes in Zambia, or the Bagisu in Uganda it is unacceptable to remain uncircumcised (Bailey, Muga, Poulussen & Abicht 2002:27−40; Lukobo & Bailey 2007:471−477; Nnko et al 2001:214−218). Although the history of MC

in Botswana is documented as far back as 1874 (Mosothwane 1909:144−165), data on the prevalence of traditional MC are currently inadequate and require further study (WHO 2009:9). Brooks, Etzel, Klosinski, Leibowitz, Sawires, Szekeres, Weston and Coates (2010:1203−1206) and Wilcken, Miiro-Nakayima, Hizaamu, Keil and Balaba-Byansi (2010:209), highlight the importance of culture as a significant predictor for circumcision as whether men are currently circumcised depends largely on the culture they are brought up in.

According to the WHO (2007:4−5), ethnicity also plays a role in circumcision where it has been done for non-religious reasons for many thousands of years in SSA, and many ethnic groups around the world, e.g.Dogon and Dowayo of West Africa and Xhosa of South Africa view the foreskin as the feminine element of the penis, removal of which (along with passing certain tests) makes a man out of the child. Eastern Cape (EC)'s Xhosa speakers, who traditionally circumcise, have relatively low HIV prevalence rates (11%) compared to KwaZulu-Natal's Zulu speakers (16%) who do not. Promoters of male circumcision to fight HIV have to reckon with the Zulu belief that partial circumcision whereby the frenulum underneath the glans penis is cut (ukuqhatha/ukugweda) that leads to better sex, while Xhosas believe in full circumcision (Mail & Guardian 2009, 22nd September). The Mail and Guardian (2009, 22nd September) further quotes an article in the latest issue of the South African Medical Journal that reports that interviews in a rural community in KwaZulu-Natal revealed "rich traditional understandings" of male circumcision. In this article people had strong negative views on circumcision that involved removal of the foreskin and "these perceptions seem to originate in historical tensions between Zulus and the Xhosas regarding male circumcision", they said. This article further suggests that there is a need to distinguish between medical male circumcision, and its benefits, and 'ukugweda' whose HIV benefits were unknown. The article continues to suggest that, "For successful uptake of these contexts, strategies to overcome historically negative cultural perceptions of male circumcision among Zulus, as well as positive associations of partial circumcision with enhanced sexual pleasure, are required", they said.

RHRU (2010:11) reveals that MMC remains a course for concern in South Africa, due to strong cultural values regarding circumcision status and practices. According to SADHS, 2003, the vast majority of those who are circumcised in South Africa are African men (50.4%); fewer than 25% of Coloureds, Indians and White males are

circumcised. The largest ethnic group, the Zulus, have generally not practiced it since the early 19th century, when it was abandoned due to protracted warfare (RHRU 2010:11). AFSA (2011:14) quotes Dr Kanta advising that culture changes and this factor may be important when persuading communities who were not circumcising in the past to consider MMC for health benefits. While culture can serve as a motivator for MMC, religion also proved to be another important factor that can promote MMC.

2.9.3 Religion

According to RHRU (2010:12), South Africa is predominantly a Christian country where most males, about (76.7%) are affiliated to Christian churches. In Jewish religion, male infants are traditionally circumcised on their eighth day of life, provided there is no medical contra-indication and this is done as a covenant between Abraham and God that " This is my covenant, which ye shall keep, between me and you and thy seed after thee: every male among you shall be circumcised" (Genesis 17:10). WHO (2007:3) affirms that male circumcision continues to be almost universally practised among Jewish people. For example, almost all new born Jewish males in Israel, an estimated 99% of Jewish men in United Kingdom of Great Britain and Northern Ireland and 98% of Jewish men in the United States of America are circumcised.

On the other hand, the Bible, in the New Testament states that "in Christ Jesus, neither circumcision nor uncircumcision counts for anything" (Galatians 5:6). In 1442 the Roman Catholic Church stated that circumcision was unnecessary (RHRU 2010:12). Focus group discussions on MMC in SSA found no clear consensus on compatibility of MMC with Christian beliefs and some Christian churches in South Africa oppose the practice, viewing it as a pagan ritual, while others require circumcision for membership (RHRU 2010:12).

According to WHO (2007:3), Muslims are the largest religious group to practise male circumcision as part of their Abrahamic faith, Muslims practise circumcision as a confirmation of their relationship with God and this practice is also known as "tahera" - meaning purification. It is important to mention that there is no mention of circumcision in the Qur'an and it is only obligatory among one of six Islamic schools of law and other schools regard it as traditional (sunnah) and strongly encourage it (WHO 2007:3). The

latter states that it is essential for a man to be circumcised to lawfully make the hajj (pilgrimage) to Mecca, one of the five pillars of Islamic belief.

The WHO (2007:4) mentions that Hinduism and Buddhism appear to be neutral towards circumcision, while the Coptic Christians in Egypt and the Ethiopian Orthodox Christians practise two of the oldest surviving forms of Christianity and retain many of the features of early Christianity, including male circumcision (to take one instance, 97% of Orthodox men in Ethiopia are circumcised). Nazareth Baptist Church in South Africa, popularly known as Shembe, is no exception to this. Similarly, even though most Christians are opposed to circumcision, others, including the Nomiya Church in Kenya and Nazareth Baptist Church in South Africa, require circumcision for membership and in most focus groups interviewed in Malawi and Zambia, most mentioned similar beliefs that Christians should practise circumcision since Jesus himself was circumcised and the Bible teaches the practice. AFSA (2011:8) mentions that the Department of Health in South Africa does not have statistics on how many are being circumcised. Even though circumcision is not prescribed in other forms of Christianity, for example, St Paul wrote: In Christ Jesus neither circumcision nor uncircumcision counts for anything (Galatians 5:6).

The WHO (2007:4−5) uncovers that in some West African countries, circumcision prevalence tends to be lower among those of traditional religion than among Christians (66% vs. 93% in Burkina Faso, 68% vs. 95% in Ghana). Although religion and ethnicity can be a strong determinant within an ethnic group, e.g. among the Mole-Dagbani in Ghana 97% of Muslims are circumcised, 78% of Christians, 43% of those with traditional religion and 52% of those with no religion. (WHO 2007:5). Apart from religion, disease prevention against HIV and STIs may motivate men to consider MMC.

2.9.4 Disease prevention, particularly HIV and STIs

WHO/UNAIDS (2011:7) states that by reducing the number of men who are living with HIV, scale-up VMMC should also confer other substantial health benefits. Medical circumcision (MC) has shown to reduce urinary tract infections in infants and children, ulcerative sexually transmitted infections (STIs), human papilloma virus, which causes cervical cancer in women, and bacterial vaginosis and trichomonas in the female partners of circumcised men (WHO/UNAIDS 2011:7).

VMMC provides men only partial protection from HIV acquisition and should always be understood as such, but one element of a comprehensive HIV prevention package (WHO 2012b:7; WHO/UNAIDS 2011:12). Therefore, it will be situated within a minimum package of services (including HIV testing and counselling, safer sex education, STI management and condom promotion) and comprehensive continuum of HIV prevention strategies. Also, it will be appropriately linked to other programmes and services such as male reproductive health services and care, and treatment for HIV positive men.

RHRU (2010:3) revealed that findings from male circumcision trials conducted in South Africa and Uganda showed that circumcision offers men partial protection against human papillomavirus and herpes simplex virus type 2. Hygiene as a mechanism of protection from STIs was mentioned by a great number of participants (Bailey & Westercamp 2007:341−355). It was held that germs, dirt, bacteria, and viruses had a greater opportunity to proliferate in the warm moist environment beneath the foreskin. Participants also expressed a belief that it would be easier to detect rashes and or ulcerations with the foreskin removed allowing for earlier treatment. The foreskin was also perceived as a portal of entry for sexually transmitted infections as the tissue is considered prone to traumatic injury during sexual intercourse. Conversely, a minority in Zambia reported that the circumcised penis was “always dry”, susceptible to cracking”, and that this state provided a portal of entry for bacteria (Bailey & Westercamp 2007:341−355).

Bailey and Westercamp (2007:341−355) unveiled that 70% of Botswana study participants willing to circumcise their male child listed protection from STIs and HIV among their reasons for doing so. In Nyanza Province, Kenya, 79% of uncircumcised men and 81% of women believed that it was easier for uncircumcised men to acquire STIs compared to circumcised men. The belief dropped to 43% and 60%, respectively, concerning the acquisition of AIDS. In Swaziland, 81% of participants stated that MC reduced the risk of STIs and 18% believed that MC reduced the risk of HIV. In Tanzania STIs were considered more infective in uncircumcised men, with ulcers healing faster in those who are circumcised (Bailey & Westercamp 2007:341−355). Nearly all commercial sex workers believed that there exists a strong association between willingness to be circumcised and perceived health benefits.

2.9.5 Maintenance of hygiene

Penile hygiene was universally recognised as being extremely important and was viewed as a major benefit of circumcision (Bailey & Westercamp 2007:341−355). A great majority of participants, both male and female from multiple studies, agreed that it was much easier for a circumcised man to maintain cleanliness. The majority of participants, including women, believed that it was worrisome that men do not maintain proper hygiene because women were primarily providers of water, poor penile hygiene was often seen as a woman's failing. In both Zambia and Malawi, women were considered responsible for cleaning their partners' penises after sexual intercourse and, additionally, in these populations linked their own risk of STIs to their partners' genital hygiene. Ease of maintaining proper penile hygiene proved a major factor in women's acceptability of circumcision (Bailey & Westercamp 2007:341−355). While maintenance of hygiene of one's penis would serve as a motivator for one to consider MMC, sexual pleasure tends to be a strongest motivator of MMC.

2.9.6 Sexual pleasure

According to Goshme (2012:24), how circumcision is perceived to influence sexual drive, sexual performance, and sexual pleasure for the man himself or for his partner is likely to influence decision making around MC. Participants in many studies believed that circumcision enhances sexual pleasure (Bailey & Westercamp 2007:341−355). Dr Dino Rech, CHAPS CEO also revealed that research has shown that MMC improves sexual performance due to decreased sensation in the penis that can delay ejaculation (SA FM, 2014, *Health Talk Interview*, 28 May 2014, 19h00 to 20h00). While BBC News (2009, 7th December) disputes this claim that foreskin has large proportion of sensitive nerve endings, this has led to critics to say that circumcised men experience less pleasure during sex, although there is no conclusive proof for this.

Most studies assessed three factors association with sexual activity based on circumcision status: sexual performance, sexual pleasure for men, and sexual pleasure for women. Fifty per cent of circumcised and thirty per cent of uncircumcised participants in South Africa believed that MC increased sexual performance, while only twenty one per cent and fourteen per cent, respectively, believed that MC decreased

sexual pleasure. Other studies found that a high proportion of men and a majority of women believed that circumcised men enjoyed sex more than uncircumcised men. About half of female participants reported preference for circumcised men (Bailey & Westercamp 2007:341−355). Many had no preference. Perceived improvement of sexual attraction and performance can also motivate demand for circumcision (RHRU 2010:14). RHRU (2010:14) further quotes a study conducted in Westonaria district, South Africa that about half of the men said that women preferred circumcised partners. A study in South Africa found that men were 8 times more likely to prefer circumcision if they believed that circumcised men enjoyed sex more, and 6 times more likely to prefer circumcision if they believed that women enjoy sex more with circumcised men. Other studies did not find consensus about circumcision status and sexual pleasure on the part of the man or woman. For some, circumcision was irrelevant to pleasure, as pleasure was more related to emotional attachment and past sexual experience. Attitudes about circumcision and pleasure may be different in areas where dry sex is practised (Bailey & Westercamp 2007:341−355). Apart from sexual pleasure, peer pressure would motivate men to consider MMC.

2.9.7 Peer pressure

Lagarde, Puren, Reathe and Bertan (2003:89−95) uncover that approximately half of the non-circumcised men agreed that MC proves manhood and earns respect from peers. The social pressure posed is a very common facilitator of MC uptake, especially among young men. According to Herman-Roloff, Otieno, Agot, Ndiya-Achola and Bailey (2011:e19814), in a Kenyan study, many participants remarked that if a man from non-Luo ethnic group chose to be circumcised, he might be able to mix freely with women and men, in politics, professional and personal setting. In a similar study conducted in South Africa. Mavundla, Netswera, Toth, Bottoman and Tenge (2010:931−941) revealed that uninitiated men experienced great pressure by family, friends and community to get circumcised. Peers tend to incite one another as promoters of MMC while knowledge about MMC will prompt men to circumcise.

2.9.8 Knowledge about use or health education

Goshme (2012:25) states that knowledge is power and, therefore, knowing facts on the pros and cons of any intervention will have a long term positive influence. Goshme

(2012:25) further unveiled that male circumcision was high among the general population in China. Yang, Wei, Jiang, Deng, Qin, Yan, Wang, Zhong, Wang, Ruan, Zou, Xie, Wei, Xu and Liang (2012:e30198) uncovered that more health education campaigns about positive health effects are necessary to increase MC rate in China. Dushoff, Patocs and Shi (2011:e28608) similarly emphasised that MC programme should be paired with education in order to sustain both short and long term effects. As much as all these factors can act as motivators of MMC, the following factors would act as deterrents to MMC.

2.10 BARRIERS TO ACCEPTABILITY OF MMC

Factors that can act as barriers to acceptability of MMC are: surgical complications, culture and religion, cost, fear of positive HIV test, potential for behavioural inhibition, improper communication about MMC, health service accessibility, age at circumcision, place and person performing MMC procedure, the role of women in circumcision and other reasons not to circumcise.

2.10.1 Surgical complications

Goshme (2012:27) proposes that when circumcision is provided in medical or non-medical settings post-surgical complications are common. BBC News (2014:11 June 2014) shares that opponents of MMC argue that potential post-operative complications, such as excessive bleeding and infections overshadow any possible benefits and some refer to circumcision as genital mutilation. To settle this claim, half (50%) of the traditional surgeons reported that they had not had any complications with male circumcision in the past three years, while eight (28.6%) reported complications with one initiate and six (21.3%) with two and more initiates (Kanta, Peltzer, Petros & Nqeketo 2008:346−345). Tang (2014:e85051) mentions fear of pain associated with the operation and local anaesthesia, as well as fear of complications, lengthy healing and sexual abstinence period, perceived threats to masculinity and perceived costs.

On SA FM interview with Dr Dino Rech, CHAPS CEO, a caller from Durban verbalised that he and his son experienced complications post MMC and were in and out of hospitals and they almost lost their penises at 39 years and 16 years, respectively, after they had their MMC in one private hospital in SA and he proposed that MMC be

discontinued because it has many complications (SA FM 2014, *Health Talk Interview*, 28 May 2014, 19h00 to 20h00). Dr Dino Rech responded by saying that in public hospitals where his NGO works, they ensure that there are teams responsible for the monitoring of complications and reporting of adverse events following MMC, but he could not advocate for private hospitals where CHAPS is not working (SA FM 2014, *Health Talk Interview*, 28 May 2014, 19h00 to 20h00). Amongst other complications, pain, bleeding, delayed wound healing, infection, amputation of penis and even death were mentioned as serious complications.

2.10.1.1 Pain

Apprehension about pain during and after the procedure was reported to be a major barrier to MMC acceptability in most studies (Bailey & Westercamp 2007:341−355). Participants belonging to non-circumcising ethnic groups were familiar with the circumcision practices in neighbouring circumcising tribes where pain was a key characteristic of the procedure. As a rite of passage to becoming a man, the endurance of the pain from circumcision is often an integral aspect of the ceremony. For example, out of 108 circumcised participants in South Africa, 42.6% described the traditional procedure as “very painful”, 34.4% as “mildly painful”, and 18.5% as “not painful”. General fear of pain regarding circumcision was the concern mentioned most often and men expressed concern over pain, specifically during the VMMC procedure, but they also feared pain during recovery due to potentially poor suturing or a surgical mishap resulting in deformity (Thomsen 2014:e98221). A few men thought that pain could result from a lack of follow-up wound assessment by VMMC health providers.

AFSA (2011:15) quoted Dr Kanta stating that it is not true that if you undergo MMC, you do not feel pain but there will be numbness for few hours, but 6−7 hours afterwards you will feel the pain. When you get an erection you feel pain, and the only time you won’t feel pain is when you are healed completely. This information is important, more especially, when giving health messages to uncircumcised men in order to avoid false reassurance. Over and above pains resulting from MMC procedure, bleeding was also mentioned as a deterrent to MMC.

2.10.1.2 Bleeding

Excessive bleeding was the major concern and this fear was heightened if the procedure was to be performed by traditional circumciser outside the hospital setting (Bailey & Westercamp 2007:341−355).

Herman-Roloff et al (2011:e19814) uncovered that post MMC adverse events, mainly bleeding, are common barriers to MMC uptake. In a study conducted in South Africa, men circumcised in traditional settings reported to have more complications such as bleeding, penile injury and local infections (Lagarde et al 2003:89−95). A study conducted in Kenya also found more adverse events (35%) among operations conducted in traditional settings than (18%) those that were conducted in medical settings, suggesting that quite a number of procedures are performed by poorly trained practitioners (Bailey & Egesah 2006:19). Lukobo and Bailey (2007:471−477) advised that manpower, surgical instruments, expendable supplies and safety of surgery need to be clearly addressed in proper communication. While addressing the issue of bleeding following circumcision is important, addressing the issue of handling delayed wound healing is of paramount importance.

2.10.1.3 Delayed wound healing

More often than not MMC wounds get delayed healing, especially when there is infection.

In a study conducted in Kisumu, Kenya, the perception was that long healing period following circumcision procedure can act as a barrier to circumcision (Westercamp, Agot, Ndiya-Achola & Bailey 2012:157-166). Herman-Roloff et al (2011:e19814) concluded that delayed wound healing and prolonged time away from work are common barriers to MMC uptake among men. King Shaka, in the 19th century ancient Zululand, also prohibited circumcision among Zulus, mentioning the same reasons that it deprived him of warriors for months while healing. Delayed wound healing is closely associated with infected circumcision incision wound.

2.10.1.4 Wound infection

Wound infections were also mentioned as one reason that can deter men from undergoing MC.

Using the same knife for several boys was believed to be common in traditional settings and a source of infections, including HIV (Bailey & Westercamp 2007:341−355). Mavundla et al (2009:396) confirm that in South Africa in areas where Xhosa male circumcision is practised, there have been reports of botched circumcision and hospital admissions due to various reasons, ranging from poorly performed operations to gangrenous penises, as a result of infection. Mavundla et al (2009:396) further indicate that during circumcision seasons, there is an increase in morbidity and mortality rates among the young due to infected circumcision wounds.

Uptake of MMC can be negatively affected by fear of death from infected wounds, more especially when the whole population is watching news of the public broadcaster, like SABC, with the footage of botched circumcisions in the Eastern Cape and Mpumalanga Provinces. While delayed wound healing is portrayed by many as a main factor that can deter men from considering circumcision, culture and religion can also deter some men from undergoing circumcision.

2.10.2 Culture and religion

While culture and religion can motivate men to circumcise if their cultures or religions favour this practice, they can also equally deter men from considering MMC if their cultures and religions are against this practice. BBC 2009 cites that lack of circumcision was mentioned as an element of the ethnic identity of those who do not circumcise traditionally. However, remaining with one's foreskin is not considered crucial to one's own ethnic identity. It serves as an ethnic marker primarily used by others. In both Botswana and Swaziland studies, only 2% of participants, for example, felt that circumcision would lead to disapproval by their community (Bailey & Westercamp 2007:341−355), although in Botswana 22% mentioned "cultural reasons" as a factor in their decision not to circumcise their male child. It is fundamentally different from belonging to an ethnic group that does practise traditional circumcision. For the Yao in Malawi, for example, or the Lunda and Luvale tribes in Zambia, or the Bagisu in

Uganda, it is unacceptable to remain uncircumcised, to the extent that forced circumcisions of older boys are not uncommon. In some ethnic groups in which circumcision is not commonly practised, disapproval of circumcision is evident in the existence of a derogatory term for a circumcised man or a man with a congenitally shortened prepuce, and these terms include “rayuom” in DhoLuo and “njilwa” in the Sukuma language and “isiveza” in IsiZulu language. In more ethnically diverse areas, circumcision among traditionally non-circumcising peoples could be held as a positive, increasing a man’s chances of being accepted by the women of the surrounding circumcising groups (Bailey & Westercamp 2007:341−355).

Religion is a major determinant of circumcision acceptability. MC is universally associated with Islam and is also considered fundamental to some minority Christian and animist sects while there is no clear consensus on compatibility of MC with Christian beliefs. Great variability in perceptions of Christian churches’ positions on MC was described by different study populations, ranging from condemning MC as a pagan practice to viewing MC as consistent with Christian tradition according to the Bible and Jesus’ circumcision status (Bailey & Westercamp 2007:341−355). In South Africa 38% of circumcised and 32% of uncircumcised study participants described circumcision as “forbidden” by their religion.

Bailey and Westercamp (2007:341−355) further suggest that before MC is promoted in a country, it would be prudent to consult and collaborate with religious leaders to learn the stance of the various churches regarding MC. In many cases, churches can act as helpful advocates or obstructive opponents and may have significant influence on acceptability of MC. Apart from religion and culture as deterrents of circumcision, cost of circumcision has also been mentioned as a hindrance to it.

2.10.3 Cost

According to RHRU (2010:13), MMC was only available through private sector providers and was not covered by medical aids, those who elected to have the procedure would have to pay between R600 to R1700 to have the procedure at a day clinic or doctor’s surgery and this cost would be prohibitive to the vast majority of potential candidates., The cost is exorbitant in South African private hospitals ranging between R10 000 and R12 000 per circumcision procedure. The cost of the procedure was a significant barrier

to MC acceptability by participants in many studies and it was found that scaling-up MMC in SA will require an expansion of service provision to meet an expected dramatic increase in the demand (Bailey & Westercamp 2007:341−355; RHRU 2010:4). Some participants expressed that if circumcision were pr**o**moted by the government, it should be provided at health clinics and hospitals for free or at reduced cost. Others recognised the need to pay for services because a free circumcision was viewed as being of potentially poor quality. Male and female participants in Zambia believed that, if the MC procedure were free or extremely inexpensive, more men would be willing to get circumcised. In one study as many as 34% of participants who initially stated that their preference was to remain uncircumcised changed their minds when the proposed cost of the procedure was set at US$3.00. This means that there is a mentality that for a good service, one needs to pay. In South Africa, it has been reported many times that most men avoid using freely available state condoms because they are of poor quality. Cost of traditional circumcision was considered to be high in many areas and there is gradual shift from traditional to medical circumcision in part for the reason that traditional circumcision is often expensive due to the costs of food, drink, special clothing and other items required during a sometimes prolonged celebration (Bailey & Westercamp 2007:341−355).

Bengo et al (2010:75) revealed that a normal charge for male circumcision is between K 200 and K 300 per child, however, orphans and the poor are exempted from paying. Apart from monetary payment, parents of circumcised children also give a chicken to the chief and the Nakanga (circumciser), i.e. 2 chickens in total and there are also costs associated with Jando (coming out ceremony). Bengo et al (2010:72) suggest that the marginal cost of providing male circumcision is around MK 1,200 in Kenya, although those presently practising circumcision spend more than this in indirect costs. In the study to check willingness to pay for male circumcision in Kenya, two thirds in both urban and rural areas indicated willingness to pay up to MK 1,000 for circumcision with a quarter preferring not to pay anything for it, and just over 5% were willing to pay more than MK 1,000 for circumcision (Bengo et al 2010:75).

Bengo et al (2010:72) conclude that male circumcision will have to be provided at a subsidised cost to increase the intake. Apart from the cost involved in circumcision, fear of positive HIV results could also deter men from circumcising.

2.10.4 Fear of positive HIV results and of rejection

Mdunge (2011:59), in the study conducted on the poor uptake of HCT in Pimville, South Africa, discovered that eight participants expressed the view that their own fear of testing HIV positive emanated from their (current and/or previous) risky sexual behaviours and that these acted as the major barrier to using HCT. Mdunge (2011:59) further uncovered that it was not the fear of the test per se that was the barrier, but rather the perceived consequences of such result. According to her, the most feared consequences of a positive test result for all the eight men was possible rejection by loved ones or by the community. Tang (2014:e850510) attested to this by quoting a qualitative finding that suggested that the fear of an HIV test is indeed a major barrier to VMMC uptake and went on to mention that in a focus discussion group, participants verbalised that potential VMMC clients were opting not to be circumcised because they are required to first undertake an HIV test. One uncircumcised man responded “They are saying before you are circumcised you must first get a blood test. That’s what is chasing most people away”.

The truth of the matter is that in order for one to undergo MMC, one needs to have undergone HCT and must have tested HIV negative for MMC to be performed immediately. If the HIV test is positive, this does not stop one from undergoing MMC, but one will need to wait for CD4 count and treatment of other opportunistic conditions before MMC could be performed. In other words, an HIV test is a “gateway” for MMC to be done. This factor will also be explored further since before MMC is conducted in SA, an HIV test is a precondition. Apart from fears associated with the fear of an HIV test, potential for disinhibition was also uncovered as a deterrent to circumcision.

2.10.5 Potential for behavioural disinhibition or false sense of security

Bailey and Westercamp (2007:341−355) mentions that if men and their partners believe that circumcision offers protection from HIV infection, they may be less inhibited (disinhibited) in their sexual activities and engage in higher HIV risk behaviours, thereby mitigating a partially protective effect of MC. Goshme (2012:26) also points out that there is false sense of security that accompanies MC, which could result in increasing promiscuity. This was also attested to by Lagarde et al (2003:89−95), that a high proportion of circumcised men can safely have sex with many women. Some

circumcised men believe they are immune to infection and may engage in more sexual risk-taking behaviours, such as having sex without condoms and having multiple partners (Kennedy 2012:37). Circumcised men demonstrated slightly higher levels of risk-taking behaviour, specifically greater numbers of sexual contacts in the South African randomised control trial (RTC) (May 2014:36).

Bailey and Westercamp (2007:341−355) maintain that the perception that MC provides full protection against HIV and STIs was found to be generally rare, but it was expressed by few study participants in South Africa and in Nyanza, Kenya. A survey conducted by Soul City in ten countries in Africa, including South Africa found that "multiple and concurrent sexual partnership, associated with low consistent condom use and low levels of MMC, were pervasive in the 10 countries in which the study was done (RHRU 2010:22). Dr Dino Rech from CHAPS came with a different view in an interview with SA FM that research shows that people who were reckless before MMC are likely to continue to do so even post MMC (SA FM 2014, *Health Talk Interview*, 28 May 2014, 19h00 to 20h00).

Bailey and Westercamp (2007:341−355) also quote a concern about the possibility of behavioural disinhibition in focus group in Kenya, Malawi and Zambia that was inevitably expressed and most participants did seem to appreciate the concept of risk reduction as opposed to risk elimination. Similarly, in Swaziland, 87% of study participants advocated having only one partner and 94% promoted condom use for circumcised men. There is some evidence of behavioural disinhibition among circumcised men, e.g. in a study conducted in South Africa where it was found that there is a significant association between circumcision status and the higher reported number of non-spousal lifetime partners. Circumcised men in Uganda were found to engage in more HIV risk behaviours than uncircumcised men. In addition to reporting more extramarital partners in the previous year (1.13 vs. 0.62, $P \leq 0.01$), circumcised men had an overall higher "risk profile". A few respondents in another South African study expressed the belief that MC potentially encouraged adultery as newly circumcised men were curious to test the new shape of the penis (Bailey & Westercamp 2007:341−355). According to Herman-Roloff et al (2011:e19814), some men are motivated to seek MC services because they want to have sex without a condom and/ or increase their number of sexual partners. One study in Botswana found that participants felt that circumcision before age of six years may help to avoid a change in

sexual behaviour associated with sense of increased protection due to circumcision. Bailey and Westercamp (2007:341−355) further unveil that men attending beer halls in Harare, Zimbabwe were aware of the partial protection against HIV provided by MC, and had a good understanding of the limitations and the concept of risk reduction.

Garenne (2008:8) argues that there are dangers associated with mass circumcision campaigns. Firstly, at population level, shifting from ABC strategies which are from experience, the most likely to change the course of the epidemic, to a strategy which has no chance of doing so, seems to be a serious mistake. Secondly, at the individual level, giving the impression that medical circumcision “protects” against HIV transmission may have adverse effects: by giving a false sense of protection, it may induce riskier behaviours, and ultimately increase transmission. Kennedy (2012:36) maintains that even if a man has been circumcised, he must still abstain, be faithful or use condoms to substantially cut the risk of infection. Ncayiyana (2011:776) warns that there is a real risk that the roll-out of circumcision will dilute the standard prevention messages and undermine the gains already made in respect of condom use and behaviour modification. May (2014:39−41) also affirms that circumcision does not remove the need to use condoms to prevent HIV infection and the need for the ABC message remains as strong now as ever, and further concludes that whether a man is circumcised or not, on-going long term HIV prevention strategies are needed. While potential for behavioural disinhibition or false sense of security was perceived as an unacceptable thing that may follow MMC, improper communication about MMC could also serve as a main deterrent to MMC uptake.

2.10.6 Improper communication about MMC

Goshme (2012:29) argues that miscommunication could also hinder the uptake of MC. Development of appropriate and effective messages should involve participation by community members, advocates and other stakeholders before being implemented (Brooks et al (2010:1203−1206).This fact was also supported by Bailey and Westercamp (2007:341−355) that information campaigns may be effective in increasing acceptability of MC.

PEPFAR and USAID (2014:43) proposed a service guide for site operations that proposes effective messages in order to create demand and provide community with

accurate and complete information about VMMC. PEPFAR and USAID (2014:43) further suggested that communities should be provided with all information necessary for informed consent among eligible men, including correcting misconceptions that people hold against MMC. While improper communication about MMC proves to be a deterrent to MMC uptake, poor health service accessibility would also deter men from undergoing circumcision.

2.10.7 Health service accessibility

Goshme (2012:29) shares his experience in Botswana where there were limited centres where MMC was rolled out, e.g. it was scaled up initially in 34 hospitals, 8 clinics and 17 private clinics with an intention to raise it in phased manner. The picture for South Africa may be more or less the same.

The WHO (2009:12) uncovers that MMC at facility level remained low and factors like unequal distribution of health facilities per population, low after hour services and variable utilisation of services affect quality and access. This factor will need to be explored even further in this study where MMC facilities are very limited, not to mention the shortage of personnel trained on MMC since the mass roll out of MMC programme in South Africa in 2010. Apart from limited health service centres, age will determine whether to circumcise or not.

2.10.8 Age at circumcision

There has been an argument as to what age is most preferable for MMC. According to Goshme (2012:30), among a number of studies where acceptability studies have been undertaken, only in Botswana 55% of respondents favoured circumcision in infancy and early childhood (Kebaabetswe et al 2003:214−218). Practitioners interviewed in Kenya and Malawi preferred not to perform neonatal circumcision due to small size of the penis and foreskin potentially leading to higher rates of errors and complications. These practitioners preferred to perform the operation at 8−12 years (Bailey et al 2002:27−40). In an SA FM interview one man revealed that he sent his 1 year old son to a private hospital for MMC and later he discovered that his penis remained underdeveloped post MMC, and Dr Dino Rech responded by saying he could not say it was MMC before 10

years as he prefers MMC from CHAPS to be done preferably after 10 years and before puberty (SA FM, 2014, *Health Talk Interview*, 28 May 2014, 19h00 to 20h00).

In other studies, most participants favoured circumcision between 8−16 years with very few saying over 18 years is the best (Bailey et al 2002:27−40; Lukobo & Bailey 2007:471−477; AFSA 2011:26). In another study, ages 7−13 were thought to be best since the boy could make the decision for himself, understand the significance of the event and take care of the wound himself, the wound also heals faster than if done post puberty when boys start to be sexually active (Bailey et al 2002:27−40; Lukobo & Bailey 2007:471−477; Ngalande, Levy, Kapondo & Bailey 2006:377−385). While age at circumcision deters men from undergoing MMC, place and person performing MMC procedure would deter men from undergoing circumcisions, more especially if a person performing circumcision is not well qualified and if the place is not a hospital to some men that can act as a deterrent to MMC.

2.10.9 Place and person performing MMC procedure

Goshme (2012:30) argues that whilst the age at which one is circumcised is important, the place and person performing the procedure plays a major role in influencing the uptake of MMC.

Goshme (2012:20) further uncovers that in areas where traditional circumcision is uncommon, the preference is overwhelmingly for a medical practitioner to be the provider. Similarly, Scott, Weiss and Viljoen (2005:304−313) in a South African study revealed that about 77% of Zulu speaking prefer medical circumcision to traditional circumcision. A number of studies revealed fear of infection, bleeding, excessive pain, and possible mutilation at the hands of traditional circumcisers as the main reasons (Kebaabetswe et al 2003:2013−2218; Largade et al 2003: 89–95; Lukobo and Bailey 2007:471–477). While the person performing the MMC procedure and place where the procedure takes place can also serve as a deterrent to MMC, the role of women in circumcision cannot be ignored.

2.10.10 The role of women in circumcision

AFSA (2011:26) confirms that the role of women in relation to traditional circumcision is circumscribed and there are taboos limiting the information women (and outsiders) receive about circumcision practices. Due to the secretive nature of the teachings conducted during the initiation, it is not clear exactly what messages boys are being taught regarding gender equality and concepts of masculinity.

According to AFSA (2011:29), decisions about circumcision are made entirely by men even when it comes to women taking care of their sons, partners and brothers after circumcision. Surely, women have a role to play in circumcision as mothers or sisters of initiates who suffer botched circumcision that lead to mutilation or death (AFSA 2011:27). Even in the Eastern Cape where Traditional Medical Male Circumcision (TMC) is widely practised, traditional leaders were unhappy with the fact that an initiate should undergo a medical examination before circumcision and the medical officers might be women or uncircumcised males (Kepe 2009:732).This factor may also be very important to explore during this study to check if participation of women in MMC has a role in deterring men from undertaking MMC or not.

2.10.11 Other reasons not to circumcise

Other barriers to circumcision, mentioned by participants, were lack of access to health care, required time away from work, loss of penile sensitivity, reduction in penis size, decreased ability to satisfy women, excessive sexual desire, increased promiscuity, and the perception of circumcision as old-fashioned (Bailey & Westercamp 2007:341−355).

2.11 CONCLUSION

The literature review revealed that one needs to know factors promoting the uptake of MMC and those hindering it as a point of departure in order to be able to plan and implement an effective MMC programme. Most studies revealed that there is a multitude of factors influencing MMC uptake. In the next chapter (chapter 3), the researcher will discuss research design and methodology.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter discusses the research design and methodology used in the study. It further discusses population, sampling procedures and data collection methods, data analysis, ethical considerations described, discussed and implemented. This study is dealt with in two phases, namely:

3.2 RESEARCH PURPOSE

In line with chapter 1, the purpose of the study was twofold and is dealt with in the following manner:

3.2.1 Purpose for phase 1

The purpose of phase 1 is dealt with in chapter 4 and the manner to attain it, is as follows:

- To explore men's perceptions of MMC at uNtunjambili area under iLembe District in KwaZulu-Natal Province.

3.2.2 Purpose for phase 2

The purpose of phase 2 is dealt with in chapter 5 and the manner it is attained is as follows:

- To develop guidelines to promote the uptake of MMC by men at uNtunjambili area under iLembe District in KwaZulu-Natal Province.

The aforementioned purposes can only be achieved through the use of appropriate research design and methods as indicated below.

3.3 RESEARCH DESIGN

Polit and Beck (2012:58) define research design as the overall plan for obtaining answers to the research questions. Research designs indicate how often data will be collected, what types of comparisons will be made, and where the study will take place. The research design is the architectural backbone of the study. Brink et al (2012:120) mention that researchers who wish to explore the meaning, or describe and provide an in-depth understanding of human experiences must opt for a qualitative method.

3.3.1 Qualitative research

The goal of qualitative research is understanding rather than explanation and prediction. Brink et al (2012:121) further warn that the researcher who wants to obtain an insider's perspective, needs to stand back and let the research participant's voice be heard.

The research designs of most quantitative studies are highly structured, while the research designs in qualitative studies are fluid (Polit & Hungler 1995:160). Qualitative research focuses on meaning, experience and understanding and, therefore, these designs give the researcher the opportunity to interact with the individuals or groups whose experiences the researcher wants to understand.

Therefore, in this study, it was appropriate to follow the qualitative research design, which is exploratory-descriptive and contextual in nature so as to be able to capture factors influencing MMC at uNtunjambili area under iLembe District in KwaZulu-Natal.

3.3.2 Exploratory-descriptive design

This is conducted to address an issue or problem in need of a solution and, or understanding (Grove, Burns & Gray 2013:27). Exploratory-descriptive qualitative studies are reported by addressing each research question and providing the pertinent findings (Grove et al 2013:287). Qualitative nurse researchers explore an issue or

problem area using varied qualitative techniques with the intent of describing the topic of interest and promoting understanding.

According to Grove et al (2013:66−67), exploratory-descriptive qualitative research is conducted with a purpose of exploring and describing a topic of interest but, has not identified a specific qualitative methodology. The goal is to create a program or an intervention to benefit the population. Exploratory-descriptive researchers identify a specific lack of knowledge that can be addressed only through seeking the viewpoints of the people most affected. The researcher reports data without transforming the data into abstract concepts or constructs. In this study, an exploratory-descriptive design was achieved in the following manner:

- By exploring the views of men in the community of uNtunjambili area under iLembe District in KwaZulu-Natal.
- By describing such views as articulated by men in the community of uNtunjambili area under iLembe District in KwaZulu-Natal.
- By describing guidelines to promote the uptake of MMC in the community of uNtunjambili area under iLembe District in KwaZulu-Natal.

3.3.3 Contextual study

Qualitative research is expected to be contextual. Botes (1995:16) describes a contextual study as findings valid within the time-space and value context, where the study was conducted. Context specific study is one of central features of naturalistic inquiry, which refers to the specific environment of field in which the study is conducted and information is derived (De Poy & Gilpin 1998:304). Contextualisation refers to the placement of data into a local area where data were collected due to the fact that it is not advisable to generalise research findings of qualitative research.

This study is bound to the context of exploring the factors influencing the uptake of MMC by men and developing the guidelines for guiding and supporting HCPs to promote the uptake of MMC by men at Untunjambili area under ILembe District in KwaZulu-Natal.

3.4 RESEARCH METHOD

Research methods are techniques researchers use to structure a study and to gather and analyse information relevant to the question (Polit & Beck 2012:12). In this study various research methods were applied by the researcher with the aim of understating factors influencing MMC uptake by men in the community of uNtunjambili area under iLembe District in KwaZulu-Natal from undergoing MMC as promoted by the Department of Health (DOH) in the province. These methods are detailed below.

3.4.1 Population

Botma, Greeff, Mulaudzi and Wright (2010:6) define study population as either healthy participants or patients and they expound by saying although participants may be healthy they may belong to a group that is dependent and / or vulnerable. Brink et al (2012:131) define population as the entire group of persons or objects that is of interest to the researcher, in other words, that meets the criteria that the researcher is interested in studying. Grove et al (2013:44) also define the population as all the elements (individuals, objects, or substances) that meet certain criteria for inclusion in a given universe.

The target population for this study was uncircumcised men aged between 18 and 49 years in the community of uNtunjambili area under iLembe District in KwaZulu-Natal.

3.4.2 Sampling

Sampling is the process of selecting the sample from the population in order to obtain information regarding the phenomenon in a way that represents the population of interest (Brink 1999:128). Botma et al (2010:13) maintain that sampling should be based on reasons directly related to the research and not because people are easily accessible.

According to Polit and Beck (2012:275) mention is made of two sampling methods, namely: probability and non-probability sampling. They are further unpacked as probability sampling that involves random selection of elements while non-probability sampling involves non-random methods.

As this is a qualitative research, the researcher did not attempt to select a sample that is representative of the population and therefore generalisation was out of question.

3.4.2.1 Non-probability sampling

This type of sampling may or may not accurately represent the population (Brink, Van der Walt and Van Rensburg 2012:139). It is usually more convenient and economical, and allows the study populations when they are not amenable to probability sampling, or when the researcher is unable to locate the entire population.

In this study a non-probability sampling approach was used and it was convenience sampling involving choosing readily available people or objects for the study. The researcher interviewed men aged between 18 and 49 years that attend Untunjambili Hospital OPD.

3.4.3 Data collection

Data collection is defined as the precise, systematic gathering of information relevant to research purpose or the specific objectives and questions of the study (Burns & Grove 2009:695). Data collection occurs simultaneously with data analysis in qualitative studies and it is a mechanical process that can be completely planned before it is started and the researcher as a whole person is completely involved in perceiving, reacting, interacting, reflecting, attaching meaning, and recording.

According to Brink et al (2012:57), the researcher collects the data according to the pre-established plan. This is when the researcher explains the study to the participants and to obtain written, informed consent. Data collection varies according to the study design. Research also demands that each piece of data collected has a purpose that is related to the study goal and is not collected as a 'nice to know' data. "Data analysis refers to a process which entails an effort to formally identify themes and to construct hypotheses (ideas) as they are suggested (emerge) from the data and an attempt to demonstrate support for those themes and hypotheses" (Bogdan & Taylor 1975, cited in Tesch 1990:113). In this study the researcher made use of in-depth interviews to collect data.

3.4.3.1 Interviews

The researcher used an in-depth unstructured face to face interviews as the primary tool for gathering data for this study. Brink et al (2012:157) define interviews as the method of data collection in which an interviewer obtains responses from the participants in a face-to-face encounter, through a telephone call or by electronic means. Interviews are frequently used in exploratory and descriptive research, and in case studies. Data collection interviews are generally classified as either structured or unstructured. In this study the interviewing process was unstructured as mentioned earlier in the paragraph (see Annexure G).

The researcher used interviews as they are the best way of exploring factors influencing MMC at Untunjambili area. In this study, the researcher adopted an unstructured in-depth face to face interview which is more free-flowing, with its structure being limited only by the focus of the research. Two or three open ended questions were asked and followed by more specific probing questions that depended on the answers obtained on the former questions. The participant was not confined to pre-specified response options but was allowed to answer using his or her own words. All participants were asked the following questions:

- What are your views about MMC?
- Why have you not taken up an opportunity to perform MMC up to now?
- What could be done by policy makers or health care practitioners to make MMC more appealing to men?

According to Grove et al (2013:424), interviews have the following advantages and disadvantages namely:

(1) Advantages

- Interviews are flexible techniques that can allow the researchers to explore greater depth of meaning than they can obtain with other techniques.
- In interviews, interpersonal skills are used to encourage the subject's cooperation and elicit more information.

- The response rate to interviews is higher than the response rate to questionnaires.
- Interviews allow researchers to collect data from participants who are unable or unlikely to complete questionnaires, such as very ill subjects or subjects whose reading, writing, and ability to express themselves are marginal.
- Interviews are a form of self-report, and researcher must assume that the information provided is accurate.

(2) Disadvantages

- Interviewing requires much more time than questionnaires and scales, and is costly.
- Because of time and cost, sample size is usually limited.
- Response may be biased.

In this study, unstructured interviews yielded rich data as participants were able to respond and raise their views based on their experience without the influence of the researcher. In order to facilitate discussion during interviews, the researcher employed facilitative communication techniques as discussed in the sub-heading below.

3.4.3.2 Facilitative communication skills

The researcher used the following facilitative communication skills in conducting interviews to help explore men's perceptions on MMC at Untunjambili area under iLembe District in KwaZulu-Natal: probing, reflecting, clarifying, paraphrasing and summarising (Wilson & Kneisl 1988:232; Uys & Middleton 2004:154).

- ***Probing.*** Probing was used to explore problems and to disclose information about a person in the empathetic atmosphere of a therapeutic relationship, it is necessary to understand the problem better. The researcher used probing to elicit more information from participants, with phrases like: "tell me more"; "I wonder, let's talk about …"

- ***Reflecting.*** Besides probing, the researcher also used reflecting. Reflecting involves two dimensions, namely reflecting content and feelings. According to Wilson and Kneisl (1988:231), reflecting content is repeating the client's verbal or non-verbal message for the client's benefit. This means the researcher repeats the client's statements. This affords the client a chance to hear and think over what he or she said. Reflecting feelings means validating what the participants imply. The researcher reflected the feelings portrayed by the participants during interviews.

- ***Clarifying.*** Clarifying is an attempt to understand the basis of the nature of clients' statements. Clarification is necessary when a participant's communication is not to the point. The researcher used statements such as "you are feeling anxious now, what's that like for you?"

- ***Paraphrasing.*** Here the researcher assimilates and restate what the researcher heard the clients say. Paraphrasing tests what the researcher understands of what participants are trying to communicate.

- ***Summarising.*** The researcher synthesises what has been communicated in an interview and highlights the major affective and cognitive themes. The response is important at the end of a session for both researcher and participant because it helps the participant recall areas discussed.

3.4.3.3 Preparation for an interview

The researcher made appointments with the Traditional Medical Male Circumcision Coordinators (TMMCs) as they are the people who know where and how to get hold of qualifying men. Untunjambili Hospital Out Patient Department (see annexure E: a letter requesting permission to utilise this hospital/ facility) was contacted beforehand so that the interview space was secured for the interviews to be conducted without hassles. It was also the responsibility of the researcher to confirm with all stakeholders before the appointment.

The open-ended interview was used to encourage the participants to provide as much information as possible and follow-up interviews were conducted to confirm answers

given to some questions. The voice recorder was prepared beforehand to digitally record interviews and the permission was sought from the concerned participants before doing so.

3.4.3.4 Pre-testing the interview instrument

Brink et al (2012:174) state that in order to test the practical aspects of a research study, the researcher can conduct a pilot study or pre-test. It is done by including a few individuals who meet the inclusion criteria, but who will not form part of the sample and data collected during this process are not included in the main study. Its purpose is to investigate the feasibility of the proposed study and to detect possible flaws in the methodology of the proposed study. It is necessary to determine whether questions and directions are clear to participants and whether they understand what is required from them. The pilot study is sometimes viewed as part of the planning phase, as it may bring about changes before the actual data collection commences. In this study two pilot interviews were conducted by the researcher. As in other qualitative studies, such interviews were not discarded but they formed part of the entire study analysis.

3.5 DATA ANALYSIS

According to Brink et al (2012:57), before starting to analyse or process data, the researcher must examine them for completeness and accuracy. At this stage, the researcher organised the data in an orderly, coherent fashion so that he could discern patterns and relationships. Since this was a qualitative research, statistics were not used to analyse the data. Researchers must be open to the possibility of seeing contradictory or alternative explanations.

Qualitative data analysis steps were used. Data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms (Brink 1999:170). The recorded interviews were transcribed verbatim and analysed according to Creswell's (1994:155) eight-step descriptive method as follows:

1) ***Get a sense of the whole.*** The researcher read all transcriptions carefully and jotted down some ideas as they came to mind.

2) ***Pick an interview.*** The researcher then selected the shortest, most interesting interview and went through it asking, what is this about? The researcher thought about the underlying meaning and wrote down any thoughts in the margin.
3) ***Make a list of topics.*** When this task had been completed for several informants, the researcher made a list of all topics, and formed these topics into columns that could be arranged as major topics.
4) ***Code.*** The researcher took the list and went back to the data, then abbreviated the topics and codes and wrote codes next to the appropriate segment of the text.
5) ***Categorise.*** The researcher found the most descriptive wording and converted it into categories, and reduced the total list of categories by grouping related topics together.
6) ***Arrange abbreviations alphabetically.*** The researcher made a final decision on the abbreviation for each category and sorted these codes alphabetically.
7) ***Analyse.*** The researcher assembled data material belonging to each category in one place and performed preliminary analysis.
8) ***Record.*** When necessary, the researcher recorded the existing data.

3.5.1 Measures to ensure trustworthiness

Brink et al (2012:126) state that methods for establishing reliability and validity in qualitative research are not the same as those used in quantitative research. It suffices to say the criteria for measuring reliability and validity of quantitative research instruments are not appropriate in qualitative approaches. In fact, qualitative researchers tend to reject the terms ‘reliability’ and ‘validity’.

As this is a qualitative study, there are many different ways of establishing trustworthiness e.g. member check, interview corroboration, peer debriefing, prolonged engagement, negative case analysis, bracketing, to mention but a few (Lincoln & Guba 1985:290). Botma et al (2010:232) unveil that trustworthiness has four epistemological standards: truth value, applicability, consistency and neutrality. For each of these four standards there are specific stipulated strategies and criteria to adhere to ensure rigour in the research. Lincoln and Guba’s model (1985:290) also applies the criteria of truth value, applicability, consistency and neutrality as follows:

3.5.1.1 Truth value

Truth value determines whether the researcher has established confidence in truth of the findings with the participants and the context in which the research was undertaken (Botma, et al 2010:233; Krefting 1991:215). They further suggest that truth value is usually obtained from the discovery of human experiences as lived and perceived by the participants. Truth value or credibility means that the researcher reports the perspectives of the participants as clearly as possible (Botma et al 2010:292). Truth value is obtained by using the strategy of credibility and this includes activities that increase the probability that credible findings will be produced. Various authors suggest that credibility will be established through prolonged engagement with the subject matter or allowing participants to validate that the reported findings represent their experiences. In this study, the researcher applied credibility through the following:

- ***Prolonged engagement***

According to Krefting (1991:217) prolonged engagement entails spending an extended period of time with informants, so as to allow the establishment of rapport and to enable participants to become accustomed to the researcher. According to him, failure to allow for this relationship building will lead to bias, since participants will be likely to give socially acceptable responses, rather than their actual personal experiences.

In this study, the researcher has been working in the area of uNtunjambili for the past 3 years. This made it easier for him to establish that relation with his participants and the fact that the interviews were not conducted in a hurry. The researcher was able to know better his participants during the interview and this was achieved by interviewing only one or two participants a day and there was no attempt made to rush the interviews. The interview was allowed to continue to the point of saturation and repeated themes and no new information was produced (Grove et al 2013:371; Brink et al 2012:173). Prolonged engagement was done concurrently with persistent observation as described below:

- ***Persistent observation***

According to *Krefting* (1991:218), persistent observation provides measure of the extent to which the researcher has sampled all possible situations, including different social settings, while Brink et al (2012:172) describe persistent observation as when the researcher looks for multiple influences through a process of continual and tentative analysis, and determines what counts and what does not. In this study, this was achieved by choosing uNtunjambili Hospital OPD as a study site, and which is a referral hospital for a number of its Satellite Clinics, and knowing that doing interviews during the lunch hour would not disturb patients but instead seemed very positive in that while waiting for doctors who are on lunch, the researcher could use the opportunity to interview them. While persistent observation was found to be very important in this study, peer debriefing also seemed to be paramount.

- ***Peer debriefing***

According to Brink (2012:172), peer debriefing is seeking the ears of others who have similar status or are colleagues, not novice or juniors. Krefting (1991:219) expands that researcher must discuss the research process and findings with impartial colleagues who have experience with qualitative methods. In this study the researcher achieved this easily since his supervisor is an expert when it comes to qualitative research. While peer debriefing or examination proved very significant, the researcher credibility was also considered as one crucial factor.

- ***Researcher credibility***

According to Polit and Beck (2004:434), researcher credibility refers to the faith that can be placed in the researcher based on his or her qualifications, experience, reflexivity, among other aspects. This point proves to be important when taking into cognisance the fact that in qualitative research the researcher serves as a data collection and analysis instrument.

In this study this was achieved since the researcher has done some courses in research including the “Principles and Methods of Health Research” which was a prerequisite for a Master’s degree the researcher is currently pursuing. The researcher has also worked

for the research organisation before. Therefore, research is not a new subject to him. The researcher also attended a week long course in qualitative methods hosted by UNISA in Durban in 2013, and this helped a lot to boost his credibility. Researcher credibility helped the researcher to incorporate triangulation to this study.

- ***Triangulation***

Brink et al (2012:128) describe triangulation as the use of various methods to collect data from sources to ensure confirmability of the findings. Methodological triangulation is the use of multiple methods to study a single topic (Brink et al 2012:99). In this study, the researcher, over and above face-to-face interviews, used observation, and in addition to field notes, audiotaping was also used. These other methods would assist in repeated reviews of original raw data by researcher and other peer researchers. While triangulation allowed for multiple methods to collect and interpret data, reflexivity was also achieved.

- ***Reflexivity***

Krefting (1991:218) defines reflexivity as an assessment of the influence of the investigator's own background, perceptions, and interests on the qualitative research process. The researcher ensured he jotted down personal field notes and audiotaped the interviews, and this allowed him to capture possible researcher influences during the stage of data analysis. Both jotting down personal field notes and audiotaped interviews ensured reflexivity the same way they ensure triangulation. Apart from trying to achieve credibility through reflexivity, the researcher also tried to reach applicability.

3.5.1.2 Applicability

Applicability refers to the degree to which the findings can be applied to different contexts and groups (Botma et al 2010:233; Lincoln & Guba 1985; Krefting 1991:216). It is the ability to generalise the findings to larger populations, by using the strategy of transferability. In other words transferability refers to the probability that findings will have meaning to others in similar situations. The criteria are selection of sources or sampling; comparison of sample to demographic data; saturation of data; and thick/ dense description.

In this study the researcher did not want to generalise findings to another setting since this is a qualitative research and the sample was not enough for the sample to be representative of the entire population. The researcher had an obligation to enhance transferability by presenting detailed descriptive data about the research setting or context as well as about the transactions and processes observed during the inquiry (Polit & Beck 2004:436; Krefting 1991: 216). While Polit and Beck (2004:435) are of the view that transferability is, to some extent, an issue of sampling and design rather than the soundness of the data itself, the researcher used the following strategies to ensure transferability, i.e. thick descriptions and saturation.

- ***Thick descriptions***

Brink et al (2012:173) describe thick descriptions as the collection and provision of sufficient detailed descriptions of data within a given context, and the reportage on them. The researcher used thick descriptions to ensure that anyone interested in transferring the research findings will have an adequate base of information data and this is in line with Lincoln and Guba's (1985:278) view that to enable anyone to transfer research findings, evidence should be accumulated about contextual similarities. In this study, detailed descriptions of the study setting, the research design, and the results were given to create a clear image of the situation in the reader's mind.

Apart from thick descriptions, the researcher also ensured that he continued collecting data up to the point of saturation.

- ***Data saturation***

Data saturation occurs when additional participants provide no new information and when themes that emerge become repetitive (Brink et al 2012:173). In this study the researcher collected the data up to the point of saturation using open-ended questions with probes in order to ensure the information obtained is rich.

While data saturation was done successfully, sampling that was used did not favour applicability.

- ***Sampling***

Polit and Beck (2004:435) regard sampling as another strategy that can be used to enhance transferability. In this study convenience sampling was used and the inclusion criteria to ensure the inclusion of only information-rich participants was not possible since participants who visited uNtunjambili Hospital OPD were interviewed. The description of the interviewed participants was another strategy that was used by the researcher.

- ***A demographic description of the participants***

The detailed description of study participants is furnished in table 4.1 of this dissertation to give all readers a full perspective of the situation and also enhance transferability.

Apart from ensuring transferability, the researcher also worked hard to ensure consistency.

3.5.1.3 Consistency

Consistency considers whether the findings will be consistent if the enquiry was replicated with the same participants and in a similar context (Botma et al 2010:233; Krefting 1991: 216; Lincoln and Guba 1985:290).The strategy of dependability is used, which implies the following criteria: a dependable audit, i.e. the detailed description of how the researcher collected data and the kind of data collected. In quantitative research consistency would be termed “reliability”. This is quite different in qualitative research where variability is always possible, since the researcher and participants are the main instruments that are assessed for consistency. In consistency, the question that is asked is how dependable are the results?

Dependability is met once the researcher has determined the credibility of the findings. In this study strategies used to ensure credibility, as well as applicability, as described earlier, were also used to ensure the dependability of the study. Apart from maintaining dependability, the researcher also tried to maintain neutrality.

3.5.1.4 Neutrality

Neutrality entails freedom from bias during the research process and results description, and refers to the degree to which the findings are a function solely of the informants and conditions of the research, and not of other biases, motives or perspectives (Botma et al 2010:233). According to Lincoln and Guba (1985:290), the criterion of neutrality is a measure of the extent to which the findings of a study are free from bias. There should be congruency between two or more independent people about accuracy, relevance and meaning of data. Here the strategy of confirmability is used, and the criteria applied are confirmability audit, triangulation, and reflexivity. By leaving an audit trail, the researcher illustrates as clearly as possible the evidence and thought processes that have led to the conclusions.

In this study, the researcher maintained neutrality by allowing confirmability audit by other researchers to compare if findings were functions solely of participants and not of other biases. An inquiry audit is a scrutiny of the data and relevant supporting documents by an external reviewer for verification (Polit & Beck 2012:435). This involves the external auditor going through an audit trail and being able to follow and understand the research process and progression (Krefting 1991:221). The audit trail in this study consisted of the field notes that were collected, the audio tapes, and the drafts of research proposal and write-up. On the one hand, the researcher tried to maintain trustworthiness while, on the other hand, the researcher tried to respect the participants' rights under the ethical consideration.

3.6 ETHICAL CONSIDERATION

The researcher must be well conversant with the ethical principles of conducting research involving human beings (Botma et al 2010:56). The researcher must ensure that the research that is being conducted will not be harmful to participants. Insensitive and intrusive questions that may undermine the participant's autonomy must be avoided.

3.6.1 Autonomy and self-determination

According to Polit and Beck (2012:154), humans should be treated as autonomous beings, capable of controlling their actions and self-determination means that prospective participants can voluntarily decide whether to take part in a study, without the risk of prejudicial treatment. Autonomy is allowing participants to voluntarily choose to participate or not (Grove, Burns & Gray 2013:164). In addition, subjects have the right to withdraw from the study at any time without a penalty. Conducting research ethically requires that research subjects' right to self-determination not be violated and that persons with diminished autonomy, e.g. minors, mentally impaired and unconscious patients, have additional protection during the conduct of studies.

In this study, self-determination was maintained since subjects were treated as autonomous agents as they were told about their right to voluntarily choose to participate or withdraw at any given time. While autonomy and self-determination were treated as important, the researcher also put emphasis on full disclosure and informed consent.

3.6.2 Full disclosure and informed consent

People's right to make informed, voluntary decisions about study participation requires full disclosure (Polit & Beck 2012:150). Full disclosure ensures that the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibilities, and likely risks and benefits. According to Grove et al (2013:177), informed consent has four elements: (1) disclosure of essential information; (2) comprehension; (3) competence; and (4) voluntarism.

Informing is the transmission of essential ideas and content from the investigator to the prospective subject (Grove et al 2013:176−177). Consent is the prospective subject's agreement to participate in a study as a subject, which the subject reaches after assimilating essential information. This means that the person involved should be legally capable to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching or other ulterior form of constraint or coercion; and should have sufficient

knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.

In this study, enough information was given to participants and the consent was obtained before they were interviewed in order to ensure that they signed an informed consent (see Annexure F). Apart from informed consent, risks and benefits were also well handled in this study.

3.6.3 Risks and benefits

Polit and Beck (2008:17) explain that researcher has a duty to protect the participants and make sure that the benefit of conducting research outweighs the risk, while Grove et al (2013:175) suggest that researchers and reviewers of research must examine the balance of benefits and risks in a study. To determine this balance or benefit-risk ratio, you must (1) predict the outcome of your study; (2) assess the actual and potential benefits and risks on the basis of this outcome; and then (3) maximise the benefits and minimise the risks. The assessment of risks and benefits that individual participants might experience should be shared with them so that they can evaluate whether it is in their best interest to participate (Polit & Beck 2012:150).

In this study, risk benefit analysis was done so that participants participated in the study knowing very well the advantages and disadvantages, risks and benefits of participating and no attempt was made to give them false hopes and promises. Notwithstanding the importance of handling risks and benefits meticulously, the researcher also ensured that anonymity and confidentiality were maintained at all costs.

3.6.4 Anonymity and confidentiality

According to Grove et al (2013:172), anonymity exists if the subject's identity cannot be linked, even by the researcher, with his or her responses and the researcher is unable to contact the subjects for additional information without special approval while confidentiality is the researcher's management of private information shared with others without the authorisation of the subject. Confidentiality is grounded in the following premises: (1) individuals share information to have secrets; (2) one can choose with whom to share personal information; (3) people who accept information in confidence

have an obligation to maintain confidentiality; and (4) professionals, such as researchers, have a duty to maintain confidentiality that goes beyond ordinary loyalty.

Anonymity is the most secure means of protecting confidentiality, occurs when the researcher cannot link participants to their data (Polit & Beck 2012:162). According to Botma et al (2010:50), confidentiality and anonymity are ensured in accordance with the following criteria: (1) protection of the participants' identity; (2) the researcher ensures privacy, worth and dignity of the participants and; (3) the researcher ensures that no linking between the individual identity of participants or organisations to the research data can be made.

The researcher tried to maintain anonymity and confidentiality throughout the study by ensuring that information provided by participants was not publicly reported in a way which identifies them. While trying to ensure anonymity and confidentiality, it was equally important to ensure that the researcher was competent to carry out a credible research.

3.6.5 Competence of the researcher

The researcher attended a course on research methodology hosted by UNISA in Durban Regional Offices. This research was conducted under the strict supervision of the Supervisor who also happened to have interest in qualitative research and was guiding the researcher throughout the study.

Brink et al (2012:34) put more emphasis on the importance of honesty and integrity when conducting research, the responsibilities of the researcher, sharing and utilising data, truthful reporting of results, conflict of interest and assigning authorship on scientific publications describing the research. A competent researcher is needed to carry out a credible research but this research was in no way without limitations.

3.6.6 Limitations of the study

According to Grove et al (2013:598), limitations are restrictions or problems that may decrease the generalisability of the findings, while Simon and Goes (2013:1) define limitations as matters and occurrences which are out of the researcher's control that

limit the extensity to which a study can go, and sometimes affect the end result and conclusions that can be drawn. Every study, no matter how well it is conducted and constructed, has limitations.

This study had its own limitations too, e.g. the sampling method used, was convenience sampling. This method has a limitation of participants not turning up due to various factors and also caution should be exercised in generalising the findings of the study to other contexts in KwaZulu-Natal since only a small size of study population in only one hospital was interviewed. So, the findings are contextualised to the region where the study was conducted. The data collection phase coincided with the very cold winter season at Untunjambili area and this forced most participants to stay at home due to chilly weathers on this side of KZN. Men are also known to be poor attenders of clinics and hospitals as they associate this with weakness. This did not go unnoticed in this study.

3.7 CONCLUSION

The research design and methodology, including research population, sampling, data collection and analysis, the ethical principles that protect the study participants' rights and trustworthiness, and the reasons for using qualitative approach to conduct research were described in this chapter. The ethical principles that govern the study participants' rights as well as the researcher's integrity were also discussed. The qualitative data based on the narratives on the findings of the study will be analysed and discussed in chapter 4.

CHAPTER 4

DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

In the previous chapter the researcher discussed the research methodology which was followed in the conducting of this study. In this chapter research findings are presented, including supporting literature. The main purpose of the study was to explore men's perceptions of MMC at Untunjambili area under iLembe District in KwaZulu-Natal Province. Data were collected using in-depth individual interviews and transcribed verbatim. Two main themes emerged from data obtained from individual interviews namely: factors promoting the uptake of MMC and factors hindering the uptake of MMC. The study was subjected to measures for ensuring trustworthiness to ensure authenticity of research findings. These findings are presented below. The findings are discussed in the light of available literature in order to verify the findings.

4.2 FIELDWORK EXPERIENCE BY THE RESEARCHER

Polit and Beck (2012:728) define fieldwork as activities undertaken by qualitative researchers to collect data from the field, that is, in natural settings, while Blunner (1969:37), (cited in Wilson 1993:218) defines fieldwork as getting close to the people involved in it, seeing it in a variety of situations they meet, noting their problems and observing how they handle them, being party to their conversations and watching their way of life as it flows along.

The researcher was an employee where the study was conducted and no major problems were experienced since staff and patients knew him. It all started with the researcher requesting for permission from the Hospital management, stating the purpose of the study (see Annexure E). The permission was given by the Chairperson of Health Research Committee in KZN DOH, Acting District Manager and Hospital CEO respectively (see Annexures B, C and D). They all expressed exhilaration with the study

since they were concerned with the poor uptake of MMC in the area. They were all looking forward to receiving findings of the study and guidelines that will be ultimately developed to promote the uptake of MMC by men in the area based on findings and literature control.

All participants were selected using convenience sampling whereby accidental or availability sampling technique was used, which involved choosing readily available people for the study, i.e. uncircumcised men between ages 18 and 49 years attending Untunjambili Hospital OPD. Most of the research participants were willing to share their controversial views with the researcher, presumably because he was also in their age group.

While participants were in the OPD queue, they were identified and all those who were willing to participate were approached and the purpose of the research was explained, their rights were explained, inter alia, anonymity and confidentiality and voluntary participation and the right to withdraw at any given time was unpacked. Lastly, all participants were made to sign the consent form stipulating that they would participate voluntarily and no duress was used to force them to join the study.

Each interview lasted between 15 and 20 minutes and this did not disturb participants a lot since the researcher managed to interview them while queuing. All interviews were recorded using a voice recorder, and later, transcribed verbatim. No real names of participants were used except that pseudonyms were allocated to them to ensure anonymity is maintained throughout the study. The private room for interviews was prepared beforehand and it was free of disturbances and interruptions, such as noise, telephones ringing, etc.

On the first day of entering the field, the researcher was reminded of the reality that most men do not attend clinics or hospitals and this was evident at Untunjambili Hospital OPD where very few men were observed queuing to be seen or accompanying others to be seen by nurses and, or doctors. Initially the plan was to interview men who had come to OPD to be seen by nurses or doctors but later it transpired that others had accompanied others but they still met the inclusion criteria.

Before the researcher could collect data, a pilot study of three participants was conducted to refine the interviewing skills of the researcher and to ascertain if the interview questions were well formulated and to reformulate as the need arose. As this is a qualitative study, findings of the pilot study formed part of the bigger study and the supervisor was consulted before going ahead with the entire process of data collection. While conducting the interviews, the researcher discovered that it was not easy at all with his first interview since his interviewing skills were put into test for the first time, although he observed an improvement with subsequent interviews. He also noted that it took longer than expected to conclude the first interview since some participants had to be probed to deliver more of their views. It later transpired that there was no sufficient space in the OPD and the venue that was used for interview purposes, was the office of the OPD Operational Manager and at times the interview could be disturbed by staff going in and out of the office. The most suitable time for the interviews was during lunch hours when most staff members were away.

Most men who were interviewed were more than prepared to participate in the study. The majority of those who were approached by the researcher consented to participate in the study. After the purpose of the study had been explained, the participants wanted to be assured of their anonymity and confidentiality. Their anxiety was allayed that their true names would not be used or published anywhere in the study, but only pseudonyms would be used, and they were also convinced that their anonymity and confidentiality would be maintained. Others questioned the use of a tape recorder for the interview as it was viewed as encroaching on their anonymity and confidentiality, but they were reassured that the recorded voice messages were important for the researcher to transcribe the interviews verbatim after data collection and that data would not be used for other purposes other than the research project.

The researcher gave all prospective participants a written assurance that research ethics would be observed (see Annexure F). It was also explained to the participants that ethical issues, such as the right to participate voluntarily and the right to withdraw at any given time, would be ensured at all times. They were also assured of protection from harm and confidentiality in that no information would be divulged to other people or other outsiders, unless they (the participants) had consented to that.

Data transcription was done at the end of each interview and at least one interview was conducted per day. The audio tapes were very crucial during transcription of data. The questions were asked using IsiZulu and the researcher did not find any difficulty in translating the collected data into English as he is used to translating materials from IsiZulu to English.

The data analysis showed that a variety of ideas were voiced out. The themes that emerged during data collection and analysis are discussed in section 4.4 of this chapter.

4.3 SAMPLE DESCRIPTION

The sample was drawn from the population of uncircumcised men aged between 18 and 49 years in Untunjambili area under iLembe District in KwaZulu-Natal. The researcher interviewed nine (9) participants for this study. Out of the nine interviewed, only one was married, while four were single, and were in relationships, one was single and cohabitating, and three were single. Out of the nine participants, one was an FET student, three had passed grade 12 and there were five high school drop outs. Out of the nine participants, three were employed, while six were unemployed. All the participants were African Zulu men who were in their twenties, thirties and forties and were all uncircumcised.

The researcher continued to interview individuals until no new information was reached, i.e. data saturation. According to Grove et al (2013: 371), data saturation occurs when additional sampling provides no new information, only redundancy of previously collected data. In this study, data saturation was reached at the ninth participant when the researcher felt that participants repeatedly gave more or less the same information and no new information emerged during the interview.

Table 4.1 The demographic description of the study participants

PARTICIPANT	AGE	MARITAL STATUS	EMPLOYMENT	EDUCATIONAL LEVEL	RACE	ETHNICITY
P1	27	Single – in a relationship	Unemployed	FET student	African	Zulu
P2	35	Single	Unemployed	Grade 10	African	Zulu
P3	32	Single-cohabitating	Labourer	Grade 12	African	Zulu
P4	30	Single – in a relationship	Unemployed	Grade 10	African	Zulu
P5	43	Married	Clerical	Grade 12	African	Zulu
P6	42	Single	Unemployed	Grade 11	African	Zulu
P7	23	Single – in a relationship	Security Guard	Grade 10	African	Zulu
P8	32	Single	Unemployed	Grade 11	African	Zulu
P9	33	Single – in a relationship	Unemployed	Grade 12	African	Zulu

4.4 THEMES EMERGING FROM THE DATA

Two themes emerged during data analysis, namely: factors promoting uptake of MMC, and factors hindering the uptake of MMC. These themes were further subdivided into categories and sub-categories during data analysis. The table 4.2 represents the themes, their categories and their sub-categories that emerged from data analysis.

Table 4.2 Themes related to factors influencing the uptake of MMC and hindering the uptake of MMC

THEMES	CATEGORIES	SUB-CATEGORIES
4.2.1 Factors promoting uptake of MMC	4.2.1.1 Protective function of MMC against HIV/ AIDS and other STIs 4.2.1.2 Maintenance of hygiene 4.2.1.3 Sexual pleasure 4.2.1.4 Person performing the procedure 4.2.1.5 Taking MMC to the people 4.2.1.6 Providing the community with awareness about MMC	
4.2.2 Factors hindering the uptake of MMC	4.2.2.1 Fear	• Fear of pain • Fear of death • Fear of HIV test • Fear linked to delayed wound healing

THEMES	CATEGORIES	SUB-CATEGORIES
	4.2.2.2 Personal Factors	• Age at circumcision • Lack of role models • Procrastination and lack of volition • Fertility • Faithfulness
	4.2.2.3 Lack of proper public education 4.2.2.4 Influence of culture 4.2.2.5 Natural circumcision	

4.4.1 Factors promoting uptake of MMC

During data collection and analysis, participants reported some factors they believe encourage them to undergo MMC. Things like MMC is important for its protective function against HIV/AIDS and other STIs, maintenance of hygiene, sexual pleasure, person performing the procedure, taking MMC to the people and providing the community with awareness about MMC were all mentioned by men interviewed as factors that influence the uptake of MMC at Untunjambili area.

4.4.1.1 Protective function of MMC against HIV/AIDS and other STIs

Participants mentioned that the protective effect of MMC against HIV and STIs is what will make them to consider MMC. This is what they had to say when asked why they are supporting MMC.

> "…I am for this circumcision. It is the right thing to do as it protects you from diseases so that you do not get them early and easily."

When probed as to what diseases he was referring to? The response was:

> "…The HIV virus."; "…Especially STDs. What I have seen is that it is easier to get these diseases if you are not circumcised."

> "…So that they are safe although that does not mean 100% safe but chances are lower."

> "…but people must know that even if you are circumcised you still get diseases more especially if you did not get a bath immediately after sex, but chances are lesser."

In support of this position, Goshme (2012:22), revealed a strong association between ulcerative STIs, particularly chancroid, syphilis and HIV, and lack of circumcision. This is also congruent with WHO, UNAIDS & UNICEF (2011:65), that rapidly identifying and treating STIs are important elements in controlling HIV, since STIs synergistically increase the risk of HIV transmission. MMC also offers protection against other STIs, further reduces the risk of HIV acquisition and transmission (Tobian, Serwadda, Quinn, Kigozi, Gravitt, Laeyendecker, Charvat, Ssempijja, Riedesel, Oliver, Nowak, Moulton, Chen, Raynolds, Wawer & Gray 2009:1296−1309; Kebaabetswe et al 2003:216). In a study conducted in Botswana, Kebaabetswe et al (2003:214) uncovered that male circumcision is known to be protective against HIV acquisition. The study went on to reveal that the majority of men who would consider circumcision cited the prevention of sexually transmitted diseases, including HIV, for favouring circumcision. This was consistent with what was uncovered by other studies, but for some, getting circumcised means better personal hygiene.

4.4.1.2 Maintenance of personal hygiene

In addition to the protective function of MMC, research participants also identified personal hygiene as one of the factors that promote the uptake of MMC in the study setting. They mentioned that removal of the foreskin keeps a man clean. This is what participants had to say about the promotion of personal hygiene:

> "…It becomes clean since foreskin is removed."

> "They also teach us that the foreskin which is excised carries dirt or germs."

Goshme (2012:23) mentions that improved genital hygiene is something that is almost universally equated with MMC in both traditionally circumcising and non-circumcising communities in Africa. Penile hygiene is universally recognised as being extremely important and is viewed as a major benefit of circumcision (Bailey et al 2002:27−40; Ngalande et al 2006:377−385). Based on these findings it means that circumcised

males find it easy to maintain penile hygiene while to some sexual pleasure would serve as a motivator for MMC.

4.4.1.3 Sexual pleasure

In this theme the researcher further identified enhanced sexual pleasure as another reason that helps promote the uptake of male circumcision among men. In this study, participants revealed that their women express greater sexual appreciation when their partners are circumcised and others also indicated that men also experience greater sexual pleasure with circumcision. This is what men had to say about greater sexual pleasure when one is circumcised:

> "…Those already circumcised say their women experience more sexual pleasure."

> "…I heard but I am not sure that when you have been circumcised, you do not get sexual pleasure but it is the female partner that gets it although others say it is the circumcised men that get more sexual pleasure during sexual intercourse."

Goshme (2012:24) mentions that the perception of the influence of circumcision on sexual drive, sexual performance, and sexual pleasure for the man himself or for his partner is likely to influence MC uptake. George, Strauss, Chirawu, Rhodes, Frohlich, Montagne and Govender (2014:181) suggest that a perceived increase in sexual pleasure for boys having undergone circumcision also mustered support for the procedure. Some of the interviewed men also attested to this, while Obure, Nyambedha, Oindo and Kodero (2009:676) on the other hand, expressed that non-circumcision does enhance sexual pleasure, which sounds like they agree with the perspective that was mentioned by one participant that:

> "…circumcised men do not get sexual satisfaction but only the female partner."

Apart from sexual pleasure to men or sexual partner, a person performing the MMC procedure would instil confidence on uncircumcised men.

4.4.1.4 Person performing the procedure

Another factor that was found to promote the uptake of male circumcision in this study setting was the fact that circumcision is performed by a qualified nurse or medical practitioner as opposed to that conducted in a 'bush circumcision school' where it is performed by lay men. This helps with fast healing of the wound and reduces chances of infections and death of initiates, which is a major problem for circumcision performed for cultural reasons. This is what men mentioned in support of this position:

> "…This circumcision is safe and it is a better thing than that one done in the bush because this one is done by professionals."

> "…No. 1, my view says it is the right thing to do since it is done in a professional way that is safe and not the traditional way it used to be. It is also right because before you are circumcised you are taught as to how to conduct yourself as a man, that it is important not to be promiscuous…"

> "…It is ok since there are doctors and everything and if the wound does not heal you will have trained people to look after you…"

According to Goshme (2012:30), the person performing the procedure plays a major role in influencing MMC uptake. According to this study, in areas where traditional circumcision is uncommon, the preference is overwhelmingly for a medical practitioner to be the provider. It is critical for the KZN province to ensure that all healthcare workers performing circumcision are appropriately trained so that adverse events are minimised and identified promptly and managed by the appropriate specialised units so that no death or permanent disability occurs as a result of male medical circumcision (Friedman et al 2011:16−17).

This was congruent with what was uncovered in a South African study, that about 77% of Zulu speaking men prefer medical circumcision over traditional circumcision (Scott et al 2005:304−313). As a nation that has not been engaging in any form of traditional circumcision in a long time, Zulus are likely to opt for a medical circumcision conducted by well trained professionals while taking MMC to the community would mean improving accessibility to health service to most men.

4.4.1.5 Taking MMC to the people

In addition to the person performing the procedure as one factor revealed in this study, another factor that would promote MMC was identified as taking MMC to the people. It was also mentioned as another factor that will entice men to consider MMC. This factor was evident in one meeting with TMMCs, it was mentioned that there is poor transportation of men from the community to the hospital, and vice versa. When asked what health care practitioners can do to improve the uptake of MMC, participants had this to say:

> "…I do not know the things like budget since there is always an outcry that there is not enough budget, but if there can be things like mobile visits to various communities so that circumcision can be done near their homes so that people are not always collected to the hospital like the mobile clinics do."

This is in keeping with what was revealed by George et al (2014:182) that mobile VMMC camps received positive reviews as boys felt a positive and safe environment was created which allayed their fears of undergoing the procedure. Fear is allayed because most men are circumcised in their environment near their homes. This factor is also closely related to health service accessibility that may be unequal distribution of health facilities per population, low after hour services and variable utilisation of services affect quality and access (WHO 2009:12). If MMC is performed at Untunjambili Hospital only, there are problems as this was also attested to by Untunjambili Hospital transport officer that at times they have to collect many boys to and from their homes with bakkies and double cab vehicles which are not suitable for this purpose, since there is no bus at Untunjambili Hospital and the one that was borrowed from Emergency Medical Services (EMS) was taken back and they are now no longer prepared to lend it out. Apart from taking MMC to the people, the researcher unveiled that providing the community with awareness about MMC would also serve as a motivator for MMC.

4.4.1.6 Providing the community with awareness about MMC

Apart from taking MMC to the people, providing the community with awareness about MMC will also promote the uptake of MMC. This was mentioned by some participants

when asked what the health workers and policy makers can do to improve the uptake of MMC. This is what they had to say:

> "…May be also the issue of awareness as you know most men do not visit health institutions like this one, but frequently visit entertainment areas like taverns and "Shisanyama" where they braai meat as these are areas where most men go…"

> "…They must start by giving you counselling and tell you everything about it…"

> "…They must sit down with you and make you understand so that you do not have fear…"

> "…Hospitals must have people that they send to the community to tell communities about the importance of circumcision and to explain that it is not only for the young ones…"

Community Health Workers (CHWs), now popularly known as Community Care Givers (CCGs) or "Onompilo", are highly multiskilled cadres in KZN DOH and in their training are able to manage different health problems in their field. The use of CCGs as foot soldiers in the Department of Health in KwaZulu-Natal has proven to be more effective to disseminate health messages to the community and promoting health and prevention of diseases. This was also confirmed by CCGs when approached at the Operation Sukuma Sakhe (OSS) meeting on 04 June 2014 that they do not know anything about this MMC programme. This was identified as a knowledge gap since CCGs are known to be very knowledgeable when it comes to health issues and they visit communities daily. Therefore, they could be used to provide the community with more information on MMC. Health awareness and the use of the other media, e.g. radio, IsiZulu and English newspapers are also ways that can be used to reach out to communities as it was suggested during interviews by participants that:

> "…the isiZulu newspapers as they can be read by many people. And even English newspapers".

> "There is lack of information on MMC since I said older people think MMC is for younger ones but if we were all given information that misconception could have been corrected."

> "To tell communities about the importance of circumcision and to explain that it is not only for young ones."

According to Goshme (2012:30), miscommunication could hinder the uptake of MMC, more especially dramatic complications and even when communicating risks and benefits of a new intervention. It was noted that anecdotes, rumour, and misinformation can have greater impact than scientific evidence. This was also congruent with the findings in the study conducted in Botswana that unveiled that before the information session, uncircumcised men from Lebatse and Serowe were less likely than other participants to want to become circumcised themselves, and these sites remained as the only predictors for this response after the information session. This revealed that information awareness plays a vital role in convincing men to consider MMC (Kebaabetswe et al 2003:214−217). This was also consistent with what was uncovered by a similar study in KwaZulu-Natal, South Africa, that revealed that information disseminated by providers of circumcision services was generally well received by participants (George et al 2014:182). In the latter study, participants mentioned that following the information session about male circumcision, even larger proportion of participants stated that they would definitely or probably circumcise a male child. This further underscores that providing information to the communities will increase the uptake of MMC.

Providing the community with information or awareness remains a very critical thing, more especially when selling a new health intervention, like MMC. Marketing of these services must not stop even if it is believed it is known by the community since even 'the most popular washing powder' in South Africa is still being advertised today so as to generate demand of such a service (Evans et al 2014:7). Besides uncovering the factors that motivates MMC, the researcher also unveiled deterrents to MMC as follows:

4.4.2 Factors hindering the uptake of MMC

Apart from factors promoting the uptake of male circumcision, the researcher also identified factors that hinder the uptake of MMC. Hindrances are those factors that make it impossible for men to undergo MMC. In this study the following factors were mentioned as hindering the uptake of MMC, namely: (1) fear; (2) personal factors; (3)

lack of proper public education; (4) influence of culture; and (5) natural circumcision. These factors are comprehensively discussed in categories below.

4.4.2.1 Fear

The researcher identified fear as one of the factors hindering the uptake of MMC in the area where this study was conducted. According to *Collins Concise Dictionary* (2004:524), fear is an unpleasant distressing emotion caused by impending danger, pain or etc. Rumours about death of boys in certain bush circumcision schools aroused a state of fear among men when they thought about undergoing circumcision.

In this study the researcher identified four sub-categories associated with fear among men from undergoing MMC. These included (1) fear of pain, (2) fear of death, (3) fear of HIV test and (4) fear associated with delayed wound healing. The category of fear is comprehensively discussed here by presenting its sub-categories in the discussions below.

- ***Fear of pain***

The participants in this study were more worried about pain. The pain was associated with delayed wound healing and it made men to stay away from undergoing MMC. This was evident in some of the answers given by some participants as follows:

> "…and that we are afraid of, is pains ..."

> "May be since the part that is done circumcision in "the men's home", i.e. penis. This part is sensitive if the issue of feeling pains needs to be addressed."

> "…if males experience a drop (penile discharge) they complain of pains and they imagine that if they are cut in their penises, they think pain will be worse than that from drop (penile discharge)."

> When asked what the participant thinks can be done to promote the uptake of MMC, this is what they had to say:

> "To make people understand that there will be lesser pains."

Majority of studies conducted previously also identified pain as a major factor prohibiting men and boys from undergoing circumcision. Fear of pain during and after MMC surgical procedure is reported to be the major barrier for acceptability of circumcision (Goshme 2012:27; Scott et al 2005:304−313). Kebaabetswe et al (2003:214) also expanded that apprehension about pain during and after the procedure was reported to be the major barrier to male circumcision acceptability in most studies. It was also observed in one study that, pain appeared to be the single most disturbing factor about male circumcision. Pain could be exacerbated by irritation of the wound by drops of urine, penile erection, and pressure from bed linen (Sabone, Magowe, Busang, Moalose, Bingaman & Mwambona 2013:3). Evans et al (2014:3) mention that general fear of pain regarding circumcision was the concern mentioned most often specifically during VMMC procedure but they also fear pain during recovery due to potentially poor suturing or surgical mishap resulting in a deformity. Fear of potential damage that could result from botched surgery and fear of the pain discouraged men from making circumcision a priority (Pierotti & Thornton 2012:17). Many respondents in the latter study described their fears in vivid imaginary, suggesting that they had spent time visualising the worst scenarios.

This is a very important factor and uncircumcised men must get reassurance that the procedure will be less painful. Evans et al (2014:3) suggest that newly circumcised men must follow post-circumcision instructions by taking prescribed painkillers and urinating when waking up with a morning erection. Fearing pains that may follow MMC procedure is one factor while fearing death is another factor mentioned as a deterrent to MMC.

- ***Fear of death***

Apart from the fear of pain, research participants also indicated that they were afraid of death due to mistakes that might happen during the circumcision incision. This is what they had to say about fear of death:

> "…we as boys are afraid that a certain ligament can be cut in the penis and you can end up dying and …"

> "I may be unlucky and be called to die."

Mavundla et al (2009:396) confirmed that in South Africa in areas where Xhosa male circumcision is practised, there has been reports of botched circumcision and hospital admissions due to various reasons ranging from poorly performed operations to gangrenous penises, as a result of infection. Mavundla et al (2009:396) further indicate that during circumcision seasons, there is an increase in morbidity and mortality rates among young men and boys. Scott et al (2005:304−313) in their study conducted among the Zulu men around KwaHlabisa and Mtubatuba in KwaZulu-Natal on the other hand, echoed fear of pain and death as major predictors of circumcision.

Participants in this study also verbalised such fear that they are afraid as they watch in televisions people dying following circumcisions that did not go well and reassurance is needed that this MMC will be performed by highly trained professionals.

- ***Fear of HIV test***

In addition to fear of death, men also resonated the fear of undergoing an HIV test as another worrying factor in most sexually active men.This is what various participants had to say:

> "…may be that has an impact but testing for HIV is also important and I do not know what to do to make people understand it better."

> "…even with the issue of HIV testing it was very difficult for me when I first tested but I had no choice since I was unwell. It was not easy…"

Mayaki (2012:44) uncovers in his study that other participants do not use VCT services because they are afraid of the test. This factor was also mentioned by Hartzol, Mavhu, Jasi, Chatora, Cowan, Taruberekera, Mugurung, Ahanda and Njeuhmeli (2014:e85051) when suggesting that fear of an HIV test is a major barrier to VMMC uptake because men are required to first undertake an HIV test before circumcision. Sabone et al (2013:4) also reverberated the similar sentiments that there is a general consensus among the study participants in their study in Botswana that the requirement that those who sought circumcision must first go for HIV testing was deterring many men from circumcising. Participants in the latter study noted that men are by nature very private

people and that they usually do not like their personal lives to be exposed to public scrutiny.

It is equally important to inform the uncircumcised men that testing positive to an HIV test does not necessarily mean that they will not qualify for MMC but further tests like the CD4 count can be done and some men can still qualify if the CD4 count is still high enough.

- ***Fear associated with delayed wound healing***

Besides the fear of HIV test, men also spoke at length about delayed wound healing as one of the reasons that made them not to undergo MMC. This was also mentioned by some of the participants that:

> "…and at times it takes longer to heal…"

> "You find that you have long been done but it does not heal."

> "…I have heard young boys saying it takes longer to heal…"

> "I have been driving tractors so I thought it was going to delay my wound healing since tractors can disturb the circumcised area…"

> "I was thinking of doing it but I thought it could be better if I did it during winter months since my wounds heal faster in winter. I need to do it since I have a problem when I penetrate during sex, I experience cracks in my penis. I will consider it during winter months."

This was consistent with Peltzer, Nqeketo, Petros and Kanta's (2008:64) findings that improving the quality of MMC services could reduce healing times and thus reduce the risk of HIV infection in those who resume sexual activity soon after circumcision. Herman-Roloff et al (2011:e19814) also revealed that delayed wound healing and prolonged time away from work are common barriers of MMC uptake among men. This was also consistent with what was asked by one participant:

> "…If you have certain diseases can you still go on with circumcision?"

The fear raised here by this participant shows that he understands that having diseases such as HIV/ AIDS and Diabetes Mellitus will cause one's wounds not to heal faster. If men and parents believe that circumcision leads to high rates of complications then uptake of MC is likely to be slow (Lukobo & Bailey 2007:471−477). It is important to make uncircumcised men aware that there are instructions to be followed after one has undergone circumcision in order for the wound to heal faster. Apart from the fear of HIV test as mentioned as one factor that hinders MMC, personal factors were also mentioned as deterrents of MMC uptake.

4.4.2.2 Personal factors

Collins Concise Dictionary (2004:1119) defines personal as belonging to or intended for a particular person and no-one else. These factors were also mentioned in this study. They were also echoed in similar studies that social and personal barriers to obtaining VMMC among adult men included shame associated with seeking services co-located with younger boys and perceived inappropriateness of VMMC after puberty, particularly after marriage and after having children (Plotkin, Castor, Mziray, Kuver, Mpunya, Luvanda, Hellar, Curran, Lukobo-Durell, Ashengo & Mahler 2013:108−116).

Some of these personal factors that were mentioned by participants were age at circumcision, lack of role models, procrastination and lack of volition, fertility and faithfulness. They are further unpacked below.

- ***Age at circumcision***

This factor was seen by most men as a deterrent to performing MMC because there has been an impression that has been created in the area of Untunjambili that only younger boys must be circumcised. There was also a general concern from the participants about the approach used by Untunjambili Hospital in recruiting men for MMC. This is what they had to say during their interviews:

> "…Especially the health workers, I think they only target mostly younger ages and they do not show the importance of circumcising in all age groups like

ourselves in the 40s to encourage us. They say they want boys and not males to go for circumcision…"

"The emphasis should not be on age since it looks like it is for a particular age group only."

"Yes. It is what I say if you look at the age gap. As I was born in the 70's when I am among the young boys as young as 12 or 14 years that will cause an embarrassment. If they can say this time we are targeting these age groups. They must not mix ages. Even myself when I am among the people of my same age group, I will be more comfortable. It will not be the same as when I am among my "sons"."

"…I thought it was the programme for school kids…"

"…It is because the bus comes near our homes and takes only school children. It comes to collect school boys with the consent letters from teachers…"

"…No. I thought I must not interfere with the programme for the kids. I thought older ones are not acceptable because I saw the bus was coming to collect only school kids…"

"…Older people think it is for younger ones…"

The impression created here is that this MMC is targeting only younger boys. When one MMC coordinator was asked as to why only younger boys are targeted in schools, the response was that they are "easy targets" because they accept MMC readily without fear of HIV/ AIDS and the peer pressure in them influences more boys to come forward for MMC so they act as self-recruiters. This was a motivating factor for MMC coordinators since their salary is dependent on how many men they recruited for MMC. Goshme (2012:30) suggests that the ages at which males become circumcised will have an effect on how rapidly MMC interventions may impact the HIV epidemic in any given area. The latter can be defeated if only younger boys are circumcised, leaving out older men who are already sexually active. Apart from personal factors, lack of people who serve as role models was also mentioned as one factor that would hinder MMC uptake.

- ***Lack of role models***

Collins Concise Dictionary (2004:1300) defines role model as a person regarded by others, especially younger people, as a good example to follow. This factor was mentioned by participants that they are not circumcised because no one in their homes is circumcised. This is what they had to say in this regard:

> "…and at home my brother was against it because he read about it. At home as we speak there is no one who is circumcised."

This was congruent with the study that was conducted in KwaZulu-Natal on barriers and facilitators of VMMC that uncovered that VMMC service providers targeting adolescent boys should not underestimate the importance of the involvement of families, intimate partners, peers and the community in general in a young man's decision to undergo VMMC (George, Strauss, Chirawu, Rhodes, Frohlich, Montagne & Govender 2014:185). This latter study revealed that immediate families have a significant influence on a young man's decision, since boys are largely still in the care of parents or guardians. Siblings, especially brothers, were also found to share experiences and views about the importance of VMMC. This was consistent with the response of one participant quoted earlier.

This factor should be taken into consideration, more especially when dealing with the boys or men from the non-circumcising family or community, like the one studied here, i.e. Zulus, that they may not get support at home, more especially if their father figures are not circumcised themselves. While lack of role model proved to be a barrier to MMC, procrastination and lack of volition was also found to be a deterrent to MMC uptake.

- ***Procrastination and lack of volition***

Collins Concise Dictionary (2004:1195) defines procrastination as an act of delaying an action that must be done until later, often because it is unpleasant or boring, while volition is the act of exercising will power or cognitive process by which an individual decides on and commits to a particular course. As they say 'procrastination is the thief

of time', different participants concurred with that. When asked why they are not circumcised up to now, some participants had this to say:

> "…The honourable one. I will say there is procrastination due to life issues and other problems in life…"

> "…I had already made arrangements to go for circumcision but I got held up at work since I was relocated to work on another site. I need circumcision. I do not have a problem…"

> "…I have not been staying here at Untunjambili area but the job I have been doing, I have been driving tractors. So, I thought it was going to delay my wound healing since tractors can disturb the circumcised area…"

Pierotti and Thornton (2012:14) confirmed that opting to get circumcised in an adult male is a big decision, even with the potential benefits of the surgery. The period of inaction is explained as taking people's time to accept a new practice. Once men have decided to be performed circumcision, no time should be wasted before circumcision is performed as they might later change their minds. Besides procrastination and lack of volition, fertility was also mentioned as a barrier to MMC uptake.

- ***Fertility***

Collins Concise Dictionary (2004:1529) defines fertility as the natural capacity to produce offspring. This means that others admire that they can get kids even if they are not circumcised. This factor was mentioned as a hindrance to uptake of MMC by some participants when asked why men are not considering MMC. He said:

> "The older ones are saying they are able to get children even if they are not circumcised…"

This was contrary to what was uncovered in one study that saw infertility as a deterrent to MMC that infertility may arise as a result of circumcision and they questioned if there would be children after circumcision (Hartzol et al 2014:4). Fertility and faithfulness were equally perceived as deterrents to MMC uptake.

- ***Faithfulness***

Collins Concise Dictionary (2004:516) defines faithfulness as maintaining sexual loyalty to one's lover or spouse. Some men believe there is no need for them to undergo circumcision, more especially if they remain truthful to their partners and there is no risk of sexual infections. This is what they had to say:

> "…I am married and I saw no need since I am faithful to my wife and she is faithful to me, and most boys do it because they are not faithful..."

Hartzol et al (2014:6) mention that older men in married relationships reported that they did not want to be circumcised because they were at low risk of HIV infection, while Pierotti and Thornton (2012:13) on the other hand, expanded this by stating that remaining faithful to one partner is also not seen as adequate protection from HIV because many men feel unable to trust their partners. In this study, it was revealed that men still believe that circumcision can protect if the partner is not faithful. Apart from faithfulness, lack of proper public education was also unveiled as a factor that could hinder MMC uptake.

4.4.2.3 Lack of proper public education

Some men feel they do not know much about circumcision henceforth, and that will deter them from undergoing circumcision. Lack of proper public education was articulated by some participants, too, in this study, as follows:

> "…Since parents may say "I do not want my child to go there". We must try to convince them. May be they can try to bring together parents and their children so that they can all learn why circumcision is so important so that parents will know and understand. They also hear bad things about it and they say "…my child's life can be lost". Because they also hear all bad things about MMC like that some boys die while undergoing circumcision. So that they see that it is important but ways of doing it can be improved."

> "…May be also the issue of awareness as you know most men do not visit a lot in areas like this …"

UNAIDS (2008:13) proposes that communication and advocacy that is well co-ordinated and strategic can effectively support an increased uptake of the procedure in Eastern and Southern Africa and ensure maximum benefits from expanding access to male circumcision. While lack of proper public education was confirmed by many as a barrier to circumcision, influence of culture was also mentioned as a deterrent to MMC uptake.

4.4.2.4 Influence of culture

Collins Concise Dictionary (2004:356) defines culture as the total of the inherited ideas, beliefs, values and knowledge which constitute the shared bases of social action, symbols and meanings that are passed from one generation to another with in a specific community of people. While culture is usually mentioned as one factor that influences the uptake of MMC in some communities, the following is the excerpt of what they said:

> "When I was growing up as I was born in the 70s, it was not in the culture of the Zulus to circumcise."

It also transpired in one school boy when they were interviewed randomly before actual data collection when asked why they are not circumcised, he responded that:

> "It is not our culture to circumcise as Zulus. It is a Xhosa culture."

On the other hand culture is not only a significant positive predictor for MMC, in some cultures and traditions the perception is different, to be circumcised was mentioned as an element of the ethnic identity of those who do not circumcise traditionally (Goshme 2012:21). This was also congruent with the study conducted in Western Kenya that 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 cultural identity (Obure, Nyambedha, Oindo & Kodero 2009:671; PEPFAR & USAID 2014:2).

Partial circumcision was also mentioned by one man interviewed as the only type of circumcision that is relevant in his culture as a Zulu man and this is how he responded when asked as to why he was not circumcised:

> "…there was this thing of cutting the frenulum underneath the glans penis "ukuqhatha" and because we were not enlightened, I told myself that it is one and the same thing as to circumcise. And even when this MMC came I told myself that there is no need since I did "ukuqhatha."

This was consistent with what was uncovered in the study in Kenya that 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 (Obure et al 2009:671).

Most Zulus still believe it is not in their culture to circumcise since they relinquished it in the 19th century during the times of King Shaka Zulu who believed it robbed him of many warriors at a time (BBC News 2009, 7th December; Friedman et al 2011:17). Some only accept "partial circumcision" or "ukuqhatha" as the only type of circumcision that is part of their culture, while others feel they were circumcised naturally and do not need to circumcise at all.

4.4.2.5 Natural circumcision

Natural circumcision is when the foreskin that does not completely cover the penis and the tip is not covered. It is not revealing the entire head but just tip, enough to see the whole and a little more. This was mentioned by a participant that:

> "I think it is not all people who have long foreskin. Like myself, I have a very short foreskin, but…"

> "I will say it (glans penis) is half exposed and I think something was going to be excised but I had that feeling that I am safer. Others are born with longer foreskin."

> "…Others think they are circumcised when they are not circumcised at all like myself."

This participant believed having a shorter foreskin is tantamount to having full circumcision. This is consistent with a Mail and Guardian statement that, with partial circumcision, the foreskin is not removed, but an elastic band of tissue under the penis

glans is cut, allowing the foreskin to move easily back and forth and this allows sperm to move freely and to enhance pleasure for men and women (Mail & Guardian, Sapa, 2009. 22nd September).

4.5 CONCLUSION

In this chapter, the researcher has analysed what transpired from the participants who were interviewed in this study. The findings of this study revealed the following factors as promoting the uptake of MMC, namely: protective function against HIV/AIDS and other STIs; maintenance of hygiene; sexual pleasure; person performing the procedure; taking MMC to the people and providing the community with awareness about MMC, and also factors hindering the uptake of MMC, namely: fear; personal factors; lack of proper public education; influence of culture; and natural circumcision.

In the next chapter (chapter 5) the researcher will outline guidelines that can help to improve MMC uptake at uNtunjambili area.

CHAPTER 5

GUIDELINES FOR SUPPORT OF HEALTH CARE PRACTITIONERS (HCPs) TO PROMOTE MMC UPTAKE AT UNTUNJAMBILI AREA UNDER ILEMBE DISTRICT IN KWAZULU-NATAL

5.1 INTRODUCTION

Chapter 4 discussed the study findings with reference to literature control. The understanding gained from in-depth individual interviews and literature control was used as the basis for the development of guidelines to support HCPs to promote MMC uptake at uNtunjambili area under iLembe District in KwaZulu-Natal.

The main purpose of this study was to promote the uptake of MMC at uNtunjambili area. The researcher applied a deductive reasoning strategy in order to deduce guidelines from the findings and literature used by the researcher during fieldwork to control findings. The literature reviewed in this study revealed that one needs to know factors promoting the uptake of MMC and those hindering the uptake of MMC as a point of departure in order to be able to plan and implement an effective MMC programme. The findings of this study revealed the following factors as promoting the uptake of MMC, namely (1) protective function against HIV/AIDS and other STIs; (2) maintenance of hygiene; (3) sexual pleasure; (4) person performing the procedure; (5) taking MMC to the people and (6) providing the community with awareness about MMC, and factors hindering the uptake of MMC as (1) fear; (2) personal factors; (3) lack of proper public education; (4) influence of culture; and (5) natural circumcision. The latter will also be considered when developing guidelines for supporting HCPs to promote MMC uptake at Untunjambili area.

In this chapter, the researcher developed guidelines for support of HCPs to promote the uptake of MMC.

5.2 PROCESS OF DEVELOPING THE GUIDELINES

The guidelines were developed based on the findings that emerged during the analysis of the data collected from in-depth interviews with uncircumcised men. The first step in the development of guidelines was the consideration of the survey list as proposed by Dickoff, James and Wiedenbach (1968:245).

5.3 APPLICATION OF THE SURVEY LIST IN THE DEVELOPMENT OF GUIDELINES

In this study, in order for the researcher to develop the guidelines to support HCPs promotion of MMC uptake at uNtunjambili area, the survey list proposed by Dickoff et al (1968:245) was used as a framework (figure 5.1).

The survey list proposed by Dickoff et al (1968:245) has six aspects of activities. These are: (1) the purpose or terminus that is about the endpoint of the activities, (2) the agent that looks at "who or what" performs the activity, (3) recipient that deals with "who or what" the recipient of the activity is, (4) framework (context) that addresses aspects of setting the activity is performed, (5) dynamics that deal with what the energy sources or motivating factors of the activity are, and, (6) the procedures and these are the guiding procedures, techniques or protocols of the activity. These components of the survey list are discussed in detail in figure 5.1 below.

5.3.1 Purpose or terminus

Collins Concise Dictionary (2004:1216) defines purpose as the reason for which a thing exists or is created. Dickoff et al (1968:245) refer to the purpose as the categories of activities, and goals that someone engages in while terminus is the endpoint of the activity or works each resulting to the final goal or outcome (Dickoff et al 1968:422). In this study the purpose or the final goal was to promote MMC uptake at uNtunjambili area by developing guidelines for supporting HCPs in the process through:

- Promoting enhancement of community awareness about MMC.
- Improving health service accessibility.

- Advancing dynamic partnership among government agencies and other key stakeholder groups.
- Strengthening the “Hlola manje − know your status” campaign.
- Supporting supplementation of MMC camps with routine day to day MMC services.
- Supporting health care practitioners to host user-friendly MMC camps that accommodate both working men and school boys.

5.3.2 Agent

Collins Concise Dictionary (2004:25) defines an agent as a person who acts on behalf of another person, business, government, etc. According to the survey list of Dickoff et al (1968:245) an agent is a person who has adequate awareness and capacity to carry out certain activities. In this study the agents are HCPs who are trained in MMC and traditional MMC coordinators (TMMCs) who work hard to promote the MMC uptake at uNtunjambili area.

5.3.3 Recipient

Collins Concise Dictionary (2004:1251) defines a recipient as a person who or thing that receives something. According to Dickoff et al (1968:245), a recipient is a receiver of the activity designed by the agent. In this study, recipients are uncircumcised male clients or patients at uNtunjambili area, the community of uNtunjambili area and the community leaders who support men to undergo circumcision under the guidance of HCPs.

5.3.4 Framework or context

Collins Concise Dictionary (2004:567) defines a framework as a structural plan or basis of a project, while context refers to the circumstances that are relevant to an event (*Collins Concise Dictionary* 2004:319). Watson, Broemeling and Wong (2009:38) identified various contexts, inter alia social, cultural, political, legislative or regulatory, economic and physical environment that influence the health service delivery in the community. According to Watson et al (2009:38), context together with the input from the environment, directly determines the output of the health service activity. In health

service delivery the context is very important and influences input, activities, output, and outcomes.

Watson, Broemeling, Reid and Black (2004:3) look at efficient service delivery and effective outcomes in the health care system in relation to the environment or the context in which the health care delivery takes place, inputs (human, material, information), activities such as clinical care, and outputs (immediate result of activities) and final outcomes which benefit both the individual patient and community are necessary. The external environment such as social, physical and economic contexts, and the participation and characteristics of the community influence inputs, activities, outputs and outcomes. The context or setting in this study refers to the Untunjambili area where boys and men undergo circumcision.

5.3.5 Dynamics

Collins Concise Dictionary (2004:452) defines dynamics as those forces that produce change in any field or system. According to the survey list, dynamics refers to the factors which encourage the activities. In this study the dynamics are those factors which promote the MMC uptake by men at uNtunjambili area. In this study, the researcher identified the following areas as important for HCPs to promote the MMC uptake by men, namely: (1) Protective function of MMC against HIV/AIDS and other STIs; (2) Maintenance of personal hygiene; (3) Sexual pleasure; (4) Person performing the procedure; (5) Taking MMC to the people and; (6) Providing the community with awareness about MMC. The dynamics identified here are important to improve the MMC uptake at uNtunjambili area.

5.3.6 Procedures

Collins Concise Dictionary (2004:1194) defines procedures as methods of doing or producing something. In this study the procedures refer to the guidelines proposed to support HCPs to promote MMC uptake at uNtunjambili area.

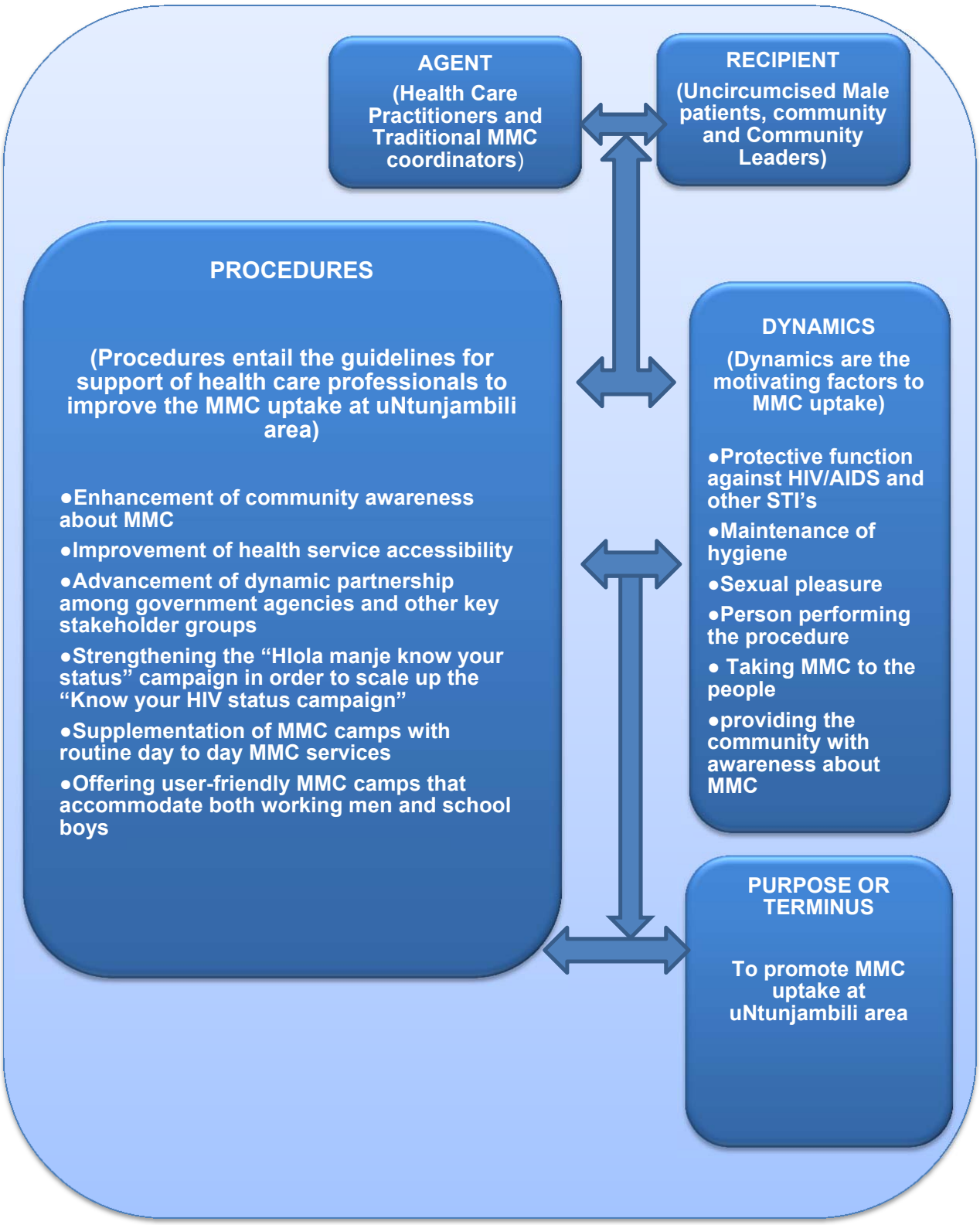

Figure 5.1 Framework for support of health care practitioners to promote MMC uptake at uNtunjambili area

5.4 FORMULATION OF GUIDELINES FOR SUPPORT FOR HCPs TO IMPROVE MMC UPTAKE AT UNTUNJAMBILI AREA

The guidelines were developed to support HCPs to improve the uptake of MMC in uNtunjambili area and consequently reduce HIV transmission to uninfected men. Findings from the study revealed factors that will promote the uptake of MMC, namely, protective function of MMC against HIV/AIDS and other STIs, maintenance of personal hygiene, sexual pleasure, person performing the procedure, taking MMC to the people and providing the community with awareness about MMC, and factors hindering MMC uptake, namely, fear of pain, fear of death, fear of HIV test and fear of delayed wound healing, personal factors like age at circumcision, lack of role model, procrastination and lack of volition, fertility, faithfulness, lack of proper public education, influence of culture and natural circumcision. The hindrances mentioned here will have a negative influence on the uptake of MMC. The researcher intended to address these hindrances to improve the uptake of MMC. These guidelines provide enabling and a resource rich information for uncircumcised men requiring MMC.

In this study, the researcher identified the following areas as important for health care practitioners to promote the MMC uptake by men, namely: (1) Enhancement of community awareness about MMC, (2) Improvement of health service accessibility, (3) Advancement of dynamic partnership among government agencies and other key stakeholder groups, (4) Strengthen the “Hlola manje know your status” campaign in order to scale up the “Know your HIV status campaign”, (5) Supplementation of MMC camps with routine day to day MMC services, and (6) Offering user-friendly MMC camps that accommodate both working men and school boys. The guidelines are developed based on activities indicated in Dickoff et al (1968:243) survey list. After reviewing the research findings, the researcher drew the following conclusions and developed the guidelines.

5.4.1 Guideline to promote enhancement of community awareness about MMC

The sole purpose of this guideline is to promote community awareness about MMC at uNtunjambili area. This guideline was developed in response to the research finding that revealed that uNtunjambili community lacks information on MMC and staff

occasionally give health education if at all they do give health education on the benefits of MMC.

To formulate this guideline, the researcher summarised the findings related to community awareness about MMC. See the box 5.1 for the summary of findings that were used by the researcher to deduce the guidelines in this section.

BOX 5.1 Summary of conclusion statements for poor community awareness on MMC

- Lack of a dedicated MMC team that renders MMC services on a full-time basis.
- No health education plan targeting boys and men to consider MMC.
- Confining MMC to only certain professionals in the hospital leaving out foot soldiers of the DOH like CCGs who have regular contacts with the community on the ground.
- Lack of a vibrant MMC advertising campaign at uNtunjambili Hospital and community at large as Kebaabetswe et al (2003:214−217) articulated that information and awareness play a vital role in convincing men to consider MMC.
- Pre-conceived ideas and misconceptions about MMC as it was noted that anecdotes, rumour, and misinformation can have greater impact in hindering men from undergoing MMC than scientific evidence (Goshme 2012:30).

Based on the above summary in Box 5.1, the researcher came up with guidelines below.

GUIDELINE 1: To promote enhancement of community awareness about MMC.

OUTCOME: To have a knowledgeable community on MMC programme.

RATIONALE: To improve the awareness and sustainability of the MMC programme in order to reduce HIV transmission in uninfected men. No health programme can be sustained by the NGO alone and the government will need to learn skills so as to prepare itself for the future full running of the programme.

Recommended activities and procedures for implementation of the guideline

(1) To recruit team solely responsible for MMC at uNtunjambili area

- Appoint a Professional nurse, Enrolled nurse and Enrolled Nurse auxiliary to run the programme. The DOH staff must play a leading role in MMC programme and not to allow stakeholders such as NGOs to dictate everything on MMC programme.
- Rope in other health extension workers such as CCGs to assist during the community mobilisation and during the day of the camp.
- Involve TMMCs in all MMC campaigns and empower them on benefits of MMC. This is very important because these TMCs are usually not trained or well oriented on their job description.
- Invite the traditional and religious leaders, more especially those that are not opposed to MMC to be always available during the camps so as to display that local leadership is in support of MMC to attract more community members to come forth.

(2) To train more HCPs on MMC procedures

- Training on MMC must involve training on both Forceps Guided method and Tara Klamp MMC method so as to be self-sufficient and to be able to give a choice to boys and men.
- Train CCGs on MMC as they can be used to motivate communities to embrace MMC programme. CCGs as foot solders of KZN Department of Health have much information on health issues and they visit communities almost on daily basis, As a result, they must be given information on MMC so that they can undertake an aggressive mass mobilisation to health educate communities about the benefits of MMC.
- Train TMMCs both for DOH and NGO since the knowledge gap was identified in one meeting that TMMCs, more especially the NGO ones, were never trained on MMC programme, but were only told to recruit boys and men for MMC.

(3) To institute a vibrant advertising campaign of the MMC programme

- Promote daily health education, inter alia, on health programmes, including on MMC. HCPs themselves must plan their health education sessions on MMC for the community visiting the hospital and clinics as this was also mentioned by participants that they believe MMC is not promoted enough in hospitals and clinics as they get heath education on other health topics.
- Build good working relationships with local radio stations and local newspapers in order to get a slot to advertise in their media. Marketing of these services must not stop even if it is believed that it is known by the community, since even 'the most popular washing powder' in South Africa is still advertised today so as to generate a constant demand of such a service (Evans et al 2014:7). The local language, i.e. isiZulu must be used when developing pamphlets and posters for advertising and they must be made available when providing information on MMC to boys, men and community at large.
- Use circumcised boys and men as role models to motivate uncircumcised boys and men to consider MMC so that they provide first-hand information on their experiences on MMC and the benefits thereof. Male health care workers working in the MMC programme, on the other hand, must be exemplary and consider performing MMC so that they do not sell the programme they do not have understanding of.
- The TMMCs must stop associating MMC with boys as if it is for boys only, but they must create an awareness that both boys and men can benefit from it. This factor was mentioned during data collection and it has created an impression that circumcision is for younger boys.
- Correct misconceptions that circumcision is not part of the Zulu culture. In actual fact, it should be stated that it was part and parcel of Zulus until they relinquished it in the 19th century during the times of King Shaka Zulu who believed circumcision robbed him of warriors at a time (RHRU 2010:11). This information should be given to Zulu-speaking communities so as to clear the misconception that circumcision is not for Zulus.

5.4.2 Guideline to improve health service accessibility

The purpose of this guideline is to address the issue of shortage of health service centres. This is common, more especially in the rural arears where health centres are limited. According to Sabone et al (2013:3), one way of taking service to the people could be through a moving circumcision clinic whereby an appropriately designed and fully equipped and staffed vehicle moves around camping at strategically located community sites to deliver services, goes back for refilling, and then heads to another locality.

To formulate this guideline the researcher summarised the findings related to health service accessibility. See box 5.2 for summary of the findings that were used by the researcher to deduce the guidelines in this section.

BOX 5.2 Summary of conclusion statements for the health service inaccessibility

- MMC is performed at uNtunjambili Hospital only and peripheral clinics have to book patients for MMC and send them to the hospital for the procedure.
- NGO staff provide Forceps Guided method only and are discouraging boys and men from performing Tara Klamp method while DOH staff are trained in Tara Klamp method but they hardly motivate boys and men on the method.

GUIDELINE 2: Improve health service accessibility

OUTCOME: To make the programme more accessible to the communities as it has been researched that expanding the coverage of VMMC to 80% of 15 to 49 year old men within 5 years could avoid around 3.5 million people becoming newly infected with HIV in Eastern and Southern Africa, representing cost saving of about US $ 16.6 billion between 2011 and 2025 (WHO/UNAIDS/UNICEF 2011:19).

RATIONALE: To ensure that MMC services are accessible to all boys and men requiring it.

Recommended activities and procedures for the implementation of the guideline

- MMC must be performed on boys and men where they live, e.g. by organising mobile MMC camps to reach out to many boys and men at a time. Therefore, there will be no need to transport them to hospital, which is always a challenge at Untunjambili Hospital. Sabone et al (2013:3) suggest that taking services to the people may probably be one of the best ways as in Botswana, in areas where there is no reliable public transport, local facilities could screen interested people, provide them with counselling and HIV testing, and submit a list of eligible candidates for booking at the treatment centres. The MMC team can visit these clinics and perform MMC right there to avoid expenses related to transport issues.
- Train more HCPs on MMC including Enrolled Nurses (ENs) as this cadre is even used by the NGO partners in performing MMC under the supervision of a qualified medical practitioner.
- Use both MMC methods, i.e. Forceps guided method and Tara Klamp method equally as per KZN DOH guidelines and take advantage that Tara Klamp method can circumcise many boys within a short space of time, thereby increasing the accessibility of MMC programme to many boys and men at a time.

5.4.3 Guideline to advance dynamic partnership among government agencies and other key stakeholder groups

The purpose of these guidelines is to advance cooperation between the DOH and other stakeholders. The Department of Health must be self-reliant and drive the programme and not be solely relying on supporting partners for sustainability of the programme. Although Kenya National AIDS and STI Control Programme (2011:23) reiterated that VMMC programmes may need to rely on implementation partners to deliver services during early catch-up place, it is important that the capacity of DOH staff is built in the process.

To formulate this guideline the researcher summarised the findings related to the partnership that exists between DOH and other key stakeholders. See box 5.3 for a summary of findings that were used by the researcher to deduce the guidelines in this section.

BOX 5.3 Summary of conclusion statements on partnership that exists between DOH and other stakeholders

- The NGO assisting the DOH seemingly has taken over everything about MMC programme including the fact that KZN DOH wanted to give and option between Forceps Guided Method and Tara Klamp method. The latest trend is that all boys and men are no longer given an option excepts Forceps Guided method only because other methods like Tara Klamp method is not agreeable to the NGO partner,
- The DOH staff have issues when they are to perform Forceps Guided Method while the NGO staff as junior as Enrolled nurses can perform this method without inviting unions to defend them while the DOH staff are quick to turn to unions to defend them against the abuse because the task is supposedly beyond their scope of practice.

GUIDELINE 3: Advance dynamic partnership among government agencies and other key stakeholder groups

OUTCOME: To have a capacitated KZN DOH staff who can run the MMC programme on their own and sell both MMC methods equally.

RATIONALE: For the MMC programme to be sustainable, staff working at health facilities employed by KZN Department of Health must be committed to the programme and be empowered to provide the MMC service. Kenya National AIDS and STI Control Programme (2011:23) further echoed that partnerships may be necessary between the public service and NGOs to help build capacity for public sector or providers to integrate VMMC services into public health system.

Recommended activities and procedures for the implementation of the guideline

(1) Strengthen partnership with MMC partners

- Promote the use of Forceps Guided method equally as other methods such as Tara Klamp method to give boys and men a choice.
- The KZN DOH staff must take a leading role in MMC programme so that they do not wait for supporting partners to dictate everything.
- Take advantage of NGO skilled staff and work on transferring skills to DOH staff since the supporting NGO cannot remain with the Department of Health forever and if DOH staff do not learn skills from them, the MMC programme will collapse as soon as the NGO partners withdraw their services.
- Add the provision of MMC services as part and parcel of the job description of HCPs involved in the MMC programme so as to eliminate the tendency of task shifting among staff.

(2) Solicit support from community leaders, particularly traditional and or religious leaders in MMC camps

- Community leaders, particularly traditional leaders, must be used to deliver motivational speeches during MMC campaigns and camps. Provide an information sharing session with traditional leaders before and after men have been circumcised.
- Religious leaders, more especially those whose Churches are not opposed to circumcision, must also be given a platform to talk about these since the community of Untunjambili area is known to be highly religious and can easily conform to what is said by religious leaders.
- The MMC recruiters or coordinators must try to organise MMC camps such that men of similar age groups are recruited, since this point was raised as important by some men who were interviewed, i.e. older men felt uncomfortable if they are to be circumcised together with much younger boys.

5.4.4 Guideline to address the fear of pain of MMC procedure

The main purpose of this guideline is to allay anxiety related to pain associated with circumcision. The majority of studies conducted previously, including this one, also identified pain as a major factor prohibiting men and boys from undergoing circumcision. Fear of pain during and after MMC surgical procedure is reported to be the major barrier for acceptability of circumcision (Goshme 2012:27; Scott et al 2005:304−313).

To formulate this guideline the researcher summarised the findings related to the fear of pains associated with MMC. See box 5.4 for summary of findings that were used by researcher to deduce the guidelines in this section.

BOX 5.4 Summary of conclusion statements for the fear of pains associated with MMC

Fear of pains associated with MMC was mentioned as a hindrance to MMC uptake. Sabone et al (2013:5) echoed that men undergoing circumcision need an effective postoperative pain relief because pain has been reported as a deterrent to seeking circumcision.

GUIDELINE 4: To manage and relieve post-operative MMC pains effectively

OUTCOME: To reduce anxiety from boys and men that pain will be minimal post-operatively.

RATIONALE: To reassure boys and men that there will be less post-operative pains following MMC procedure.

Recommended activities and procedures for the implementation of the guideline

- A detailed explanation of the procedural steps should be provided to eligible men before the surgery to avoid misconceptions about what to expect. Previously circumcised boys and men can be used to testify on this.

- It is also important that circumcised men are thoroughly counselled to reduce their chances of exaggerating the pain and intimidating others about pains experienced during the procedure. Part of counselling should include instructions on how to take medications post-operatively and cleaning of the incision site wound.
- Men undergoing circumcision need an effective postoperative pain relief, e.g. the use of Ibuprofen and or Paracetamol tablets will serve this purpose.

5.4.5 Guideline to strengthen the "Hlola manje − know your status" campaign

The main purpose of this guideline is to strengthen HIV testing for the community to prepare men for the next step, i.e. undergoing MMC procedure.

To formulate this guideline the researcher summarised the findings related to the fear of an HIV test. See box 5.5 for a summary of findings that were used by the researcher to deduce the guidelines in this section.

BOX 5.5 Summary of conclusion statements for the fear of an HIV test

Fear of and HIV test was stated as a hindrance to the MMC uptake and the DOH staff is not aggressive enough to sell HIV test to the patients.

GUIDELINE 5: To strengthen the "Hlola manje know your status" campaign

OUTCOME: To ensure that as many people as possible know their HIV status and method of doing the testing is improved and shortened.

RATIONALE: To fast track the testing for HIV to consequently prepare men for MMC. As the fear of an HIV test was revealed as one factor that will deter men from considering MMC at Untunjambili area, PICT must be introduced as it can dramatically increase the number of clients getting tested for HIV so as to prepare them for the next

step, i.e. MMC (FHI 360 2011:4; Kenya National AIDS and STI Control Programme 2011:24).

PICT is the Departmental strategy whereby all health workers that come into contact with clients or patients are equipped to provide a basic HIV counselling within the shortest time possible. The PICT campaign was introduced by the Department of Health as an initiative to encourage all people to know their HIV status so that those found to be HIV negative will be told how to keep themselves negative and those found to be HIV positive will be fast tracked for ARV treatment so that they live healthier and longer.

Recommended activities and procedures for the implementation of the guideline

- Train more nurses in PICT procedure, which is a Department of Health strategy to test as many people as possible for HIV as an aggressive approach to HIV testing than Voluntary Counselling and Testing (VCT). The crux of PICT seeks to test everybody regardless of illnesses they are presented with.
- Plan more of the "Hlola manje – Know your status campaigns" so that the men from Untunjambili area can be easily motivated to go for MMC already knowing their HIV status.
- Encourage HIV positive men to consider MMC if their health status still allows and provide them with information that being HIV positive does not mean you cannot undergo MMC if the CD4 count still permits.

5.4.6 Guideline to support supplementation of MMC camps with routine day to day MMC services

The purpose of these guidelines is to support supplementation of MMC camps with routine day to day MMC services. Despite the fact that MMC camps tend to produce more statistics at a time, it is not a good idea to depend exclusively on them to produce desired numbers.

To formulate this guideline the researcher summarised the findings related to the supplementation of MMC camps with routine day to day MMC services. See box 5.6 for a summary of findings that were used by the researcher to deduce the guidelines in this section.

BOX 5.6 Summary of conclusion statements for supplementation of MMC camps with routine day to day MMC services

Untunjambili Hospital MMC services only rely on MMC camp statistics and the routine day to day MMC services are lacking.

GUIDELINE 6: **To improve MMC statistics by supplementation of MMC camps with routine day to day MMC services**

OUTCOME: To increase MMC statistics so as to meet the set target.

RATIONALE: Depending solely on statistics from MMC camps will not be enough to meet set MMC targets.

Recommended activities and procedures for the implementation of the guideline

- Strengthen the MMC team since there is 1 Clinical Associate and 1 Enrolled Nurse allocated for routine day to day MMC services. Increasing the number of staff doing MMC will help increase MMC statistics. Appoint a dedicated MMC team as the officers complained that they still need to work in their respective units and do MMC on a part-time basis.
- Increase the number of days dedicated for routine day to day MMC services from one day a week to even accommodate walk-ins i.e. those patients that are unbooked on daily basis.
- Incorporate MMC into other priority programmes so that staff do not look at it as another programme, e.g. MMC is an HIV prevention strategy, therefore, it can be incorporated into HIV, AIDS, Sexually Transmitted Infections and Tuberculosis (HAST) programme.

5.4.7 Guideline to support HCPs to host user-friendly MMC camps that accommodate both working men and school boys

The purpose of these guidelines is to support HCPs to host user-friendly MMC camps that accommodate both working men and school boys. The study findings showed that the timing of an MMC camp plays a pivotal role in it, i.e. if MMC camps are not synchronised with school holidays, they tend to be a flop.

To formulate this guideline the researcher summarised the findings related to the support of HCPs to host user-friendly MMC camps that accommodate both working men and school boys. See box 5.7 for a summary of findings that were used by the researcher to deduce the guidelines in this section.

BOX 5.7 Summary of conclusion statements for support of HCPs to host user-friendly MMC camps that accommodate both working men and school boys

- Poor timing of MMC camp can lead to poor MMC statistics.
- Poor coordination between traditional MMC coordinator employed by DOH and NGO.

GUIDELINE 7: To support HCPs and TMMCs to host user-friendly MMC camps.

OUTCOME: To coordinate the MMC programme such that the intended target group is met and MMC coordinators work hand in hand on the ground for the success of the MMC camps.

RATIONALE: To host MMC camps that are effective in that they produce required targeted statistics.

Recommended activities and procedures for the implementation of the guideline

- Give some time off and provide sick notes to men, more especially working men, so as to cover for their time lost at work and this can also be synchronised with their leaves or time-off as this will also ensure that their recuperation is uninterrupted.
- For school boys, MMC camps should be scheduled such that they coincide with school holidays or after the school boys have finished writing their examinations in order to allow for wound healing before they return to school and also to prevent disruptions in schools.
- MMC camp must last between 2 to 3 days as it has been observed that there has been shortcuts in that boys are done MMC and discharged same time. It does not become a camp if there is no information sharing and the focus is only on "cutting the foreskin", as Dr Ndaba, KZN DOH MMC Manager clarified in iLembe District MMC meeting.
- Encourage TMMCs for DOH and NGO to work hand in hand with each other for the success of any planned MMC camp. There has been conflicts between the two TMMCs fighting over MMC statistics as they both have monthly targets to meet. There must be clear demarcation of areas as to who works where so that there are no further conflicts or, alternatively, they can work together to recruit and assist one another to meet the targets.

5.5 EVALUATION OF THE GUIDELINES

The guidelines formulated for supporting HCPs to promote MMC uptake at Untunjambili area under iLembe District in KwaZulu-Natal were given to experts in the field of MMC for evaluation of clarity, simplicity and adequacy for implementation. The officials at both Hospital and District levels were consulted during MMC meeting in the hospital for inputs to these guidelines so that it does not become a unilateral decision by the researcher as to what should happen to promote the uptake of MMC in this area. In this regard, the guidelines were appraised for clarity, simplicity and operational adequacy.

5.6 CONCLUSION

This chapter discussed guidelines for supporting HCPs to promote MMC at Untunjambili area under iLembe District in KwaZulu-Natal. The guidelines have not been tested for effectiveness since testing for the effectiveness is outside the scope of this study. They are based on the findings of the study and it is hoped that these would be implemented by HCPs working in the MMC programme in the KZN Department of Health.

Chapter 6 concludes the study by discussing its limitations and makes recommendations for supporting HCPs to promote MMC at Untunjambili area under iLembe district in KwaZulu-Natal.

CHAPTER 6

DISCUSSION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

In chapter 5 the researcher developed guidelines for support of HCPs in the promotion of the uptake of MMC by men at Untunjambili area under iLembe District in KZN. In this chapter the researcher draws conclusions from the findings of the study, discusses application of theory in the study findings, discusses its limitations, and makes recommendations.

6.2 DISCUSSION AND APPLICATION OF HEALTH BELIEF MODEL AND THEORY OF REASONED ACTION/THEORY OF PLANNED BEHAVIOUR IN THE STUDY FINDINGS

In this study the Health Belief Model (HBM) and the Theory of Reasoned Action/ Theory of Planned Behaviour (TpB) were used to develop the conceptual framework and interpret and discuss the findings. These theories take into consideration individual-level factors and socio-cultural factors in predicting and explaining health behaviours (Decosas 2002:15). It is vital for the researcher to consider both the individual and the environmental factors that may influence poor MMC uptake by boys and men. Swanepoel (2005:6) argues that problematic health-related behaviours are a function of a complex range of contextual and personal determinants. He further argues that attempts to change such behaviours should address both the contextual/ecological and the personal determinants of the behaviour. These models are briefly discussed below:

6.2.1 The Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours by focusing on the role of perceptions in determining the attitudes and beliefs of the individuals. According to Munro, Lewin, Swart and Volmink (2007:6), a person's health-related behaviour depends on their susceptibility to that illness, the benefits of taking preventive action and the barriers to taking action. This model assisted the researcher in establishing the social barriers and benefits that either encouraged or acted as a deterrent for boys and men to consider MMC at uNtunjambili area.

Ross and Deverell (2004:214) maintain that the HBM has helped researchers in guiding the search for "why" these behaviours occur and identifying points for change. This model does not incorporate the influence of social and cultural norms on people's decisions on their health behaviours and there is also no evidence that belief formation always precedes behavioural change (AIDSCAP 2004:2). The researcher assumes that boys and men with a low perception on MMC are less likely to perform MMC, as they might be under the impression that they will not be infected even if not circumcised. HBM is based on the understanding that a person will take a health-related action if that person: feels that a negative health condition can be avoided (e.g. STIs, HIV/AIDS etc. in this case), has a positive expectation that by taking a recommended action (performing MMC), he or she will avoid a negative health condition and, lastly, believes that he or she can successfully take a recommended health action (MMC).

The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived susceptibility (one's opinion of chances of getting a condition), perceived severity (one's opinion of how serious a condition and its consequences are, perceived benefits (one's belief in the efficacy of the advised action to reduce risk or seriousness), and perceived barriers (one's opinions on cultural beliefs on circumcision). These components were proposed as accounting for people's "readiness to act". An added concept, cues to action, would activate that readiness and stimulate the behaviour. This model simply describes a combination of a personal risk analysis, followed by an evaluation of the proposed solution and its use. Below is figure 6.1 illustrating the Health Belief model:

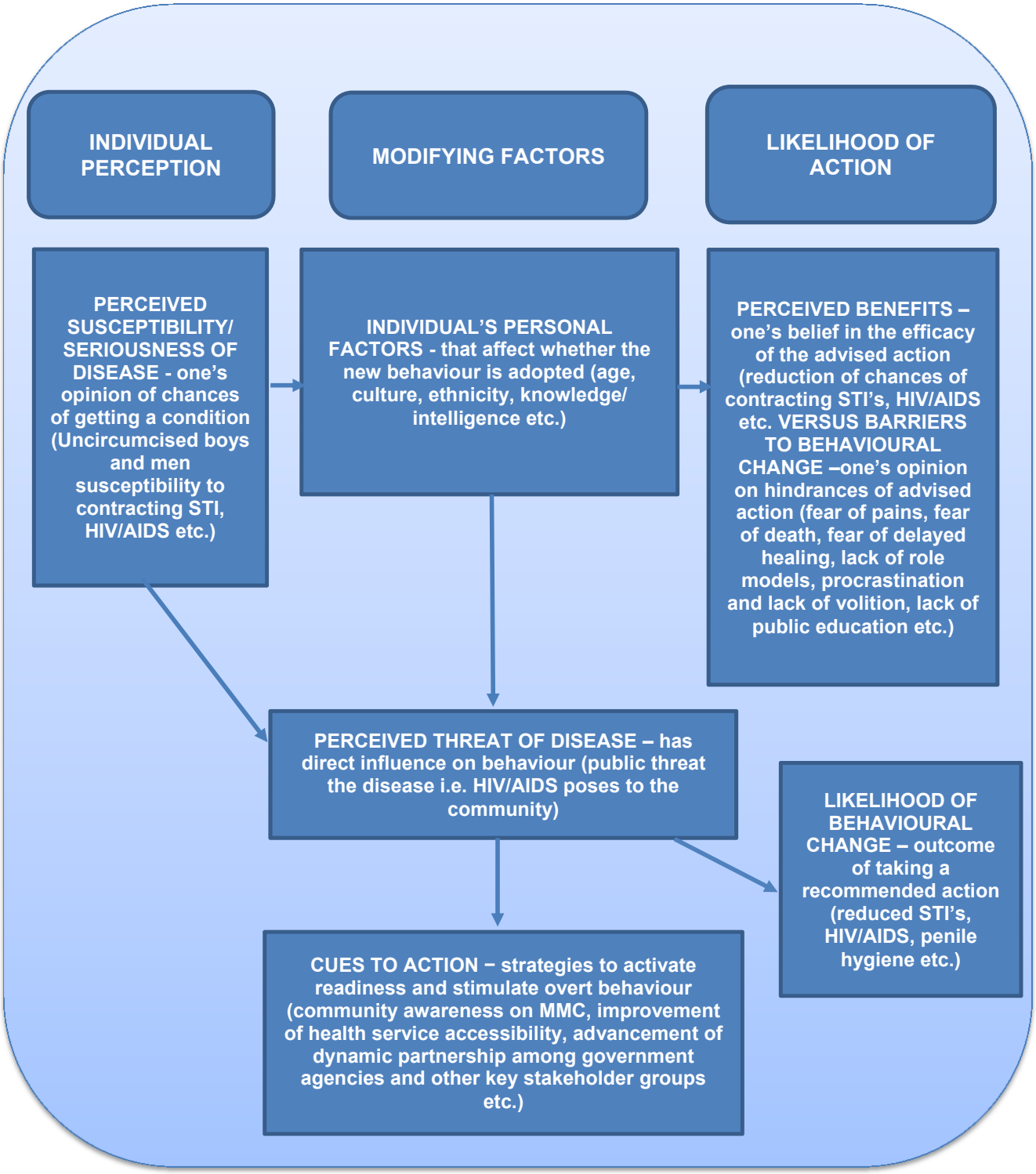

Figure 6.1 The Health Belief Model

(Adapted from Glanz, Rimer & Lewis 2002:52)

6.2.2 The Theory of Reasoned Action/Planned Behaviour

The Theory of Reasoned Action (TRA) or Theory of Planned Behaviour (TpB) is conceptually similar to the HBM, but adds the constructs of behavioural intention as a determinant of health behaviour (UNAIDS 1999:7). The TRA was developed by Ajzen and Fishbein in 1980 to estimate the discrepancy between attitude and behaviour while the TpB is a theory which predicts deliberate behaviour, because behaviour can be deliberative and planned. The TRA focuses on the individual's intention to perform a specific behaviour. The TRA focuses on the individual's intention to perform a specific behaviour. Behavioural intention is an indication of an individual's readiness to perform a given behaviour. The intention to enact a particular behaviour is shaped by the person's beliefs, attitude and subjective norm (Van Dyk 2008:122−123). The researcher briefly explained attitudes to behaviour and subjective norms as major tenets of this theory as follows:

6.2.2.1 Attitude towards behaviour

Attitude toward behaviour refers to the person's attitude towards enacting a particular behaviour. People are more likely to perform a particular behaviour if they have a positive attitude towards the specific behaviour and the belief that the enacted behaviour has more advantages than disadvantages (Van Dyk 2008:124). Uncircumcised boys and men in the area of uNtunjambili must feel that advantages of circumcision outweigh disadvantages thereof. Both boys and men must believe that performing circumcision will bring about more advantages than disadvantages. If there are more disadvantages than advantages, behaviour change will hardly take place. The researcher believes that boys and men in this area who have negative attitude towards MMC, are less likely to perform it. It was also important for the researcher to understand boys' and men's' attitudes and beliefs about MMC so as to assess their intention to perform MMC. Ross et al (2004:203) recommend that researchers determine and influence intentions so that behaviour becomes easy to predict and manipulate. Apart from attitude towards behaviour, the researcher believes the subjective norm also plays an important part in this theory.

6.2.2.2 The subjective norm

This also determines the behavioural intention which refers to the person's perception of their significant other's beliefs and perceptions on the specific behaviour (Mdunge 2011:33). AIDSCAP (2002:11) continues to define the subjective norm as a person's normative belief regarding other people's views of behaviour and the person's willingness to conform to those views. Influence of subjective norm could either be motivating or discouraging to boys or men under study. This means that the subjective norm of negative belief and attitude towards MMC may negatively influence individuals' willingness to use MMC services. The intention to go for MMC may depend on boys' and men's subjective norms since those who hold conservative behaviours against it are likely to uphold collective decisions made by this community of uNtunjambili (Van Dyk 2008:206).

This is equally correct in the case of this study that before boys or men consider a certain behaviour, i.e. performing MMC, they must first have a strong willpower that will be informed by a set of their individual attitudes and norms that performing MMC is a right thing to do. According to TRA, the best predictor of behaviour is intention (Ajzen 2011:1119).

Ajzen (2011:1119) concludes that the more favourable the attitude and the subjective norm and the greater the perceived control, the stronger should the person's intention to perform the behaviour in question. As time passes, an increasing number of intervening events can change people's behavioural, normative or control beliefs, modify attitudes, subjective norms or perceptions of control, thus generating revised intentions (Ajzen 2011:1115). The latter suffices to say that even if initially people were against a certain health intervention, they may later change their minds and consider it and incorporate it into their belief system, attitudes and subjective norms. This is also equally important in the non-circumcising community of uNtunjambili area that with continued community awareness campaigns, they may adopt the MMC practice with the benefits it comes with. Below is figure 6.2 illustrating the Theory of planned behaviour.

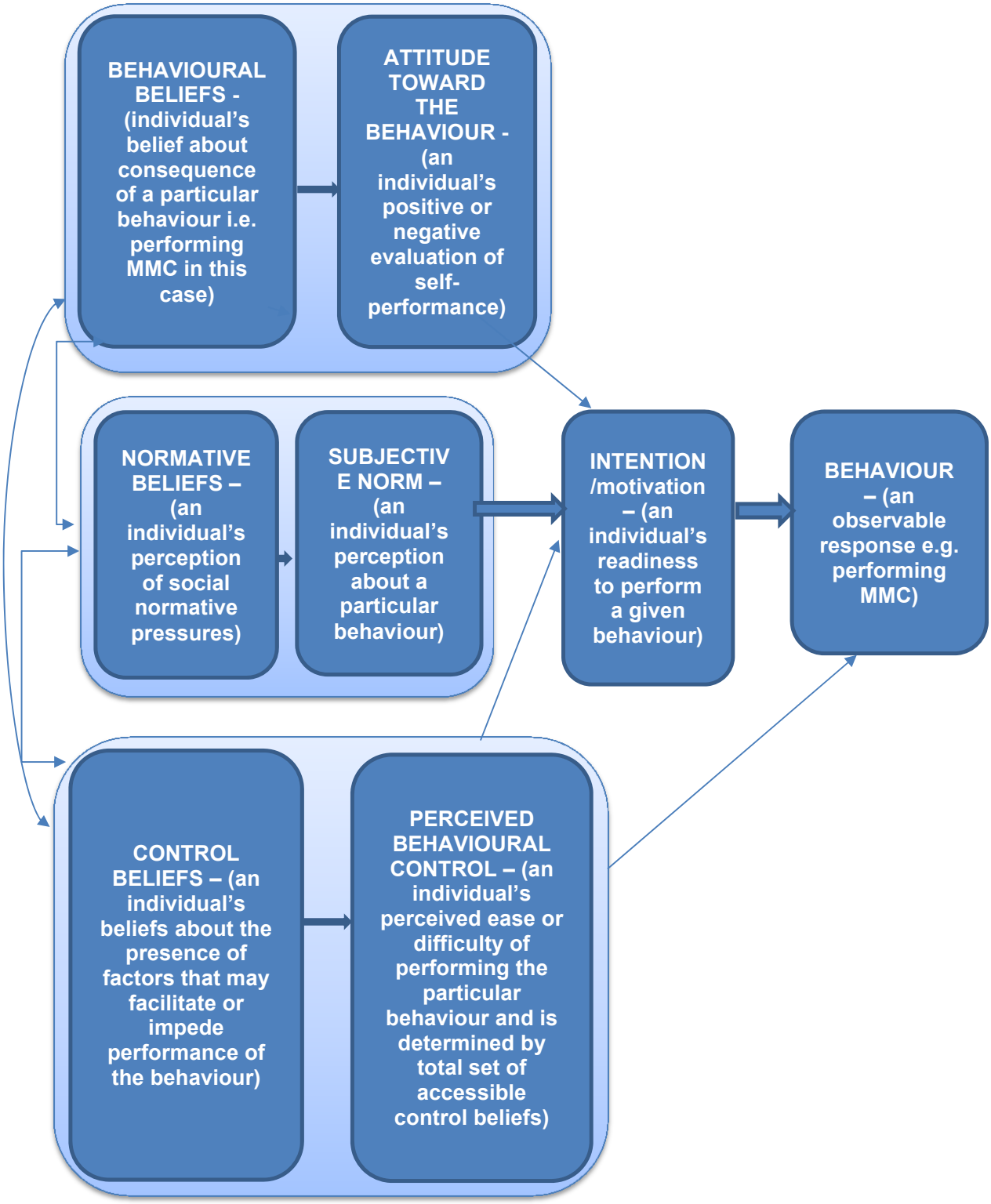

Figure 6.2 The theory of planned behaviour

(Adapted from Ajzen 1991:179−211)

6.3 LIMITATIONS OF THE STUDY

This study had its own limitations, e.g. uncircumcised men were not a representative sample of the entire population of men in the KZN Province. The convenience sampling method used, had a limitation of participants not turning up due to various factors and also caution was exercised in generalising the findings of the study to other contexts in KwaZulu-Natal since only a small size of study population in only one hospital was interviewed. Therefore, the findings are contextualised to the region where the study was conducted, i.e. uNtunjambili area. Not all men could freely participate in the interviews as only those visiting uNtunjambili Hospital OPD were targeted.

6.4 RECOMMENDATIONS

Most of the recommendations have been either hinted at or discussed in some detail earlier under the findings of the study in chapter 4. The researcher will now consolidate them into a list and only give their brief outline under the following sub-sections, namely: recommendations for practice of HCPs, recommendations for education of HCPs and recommendations regarding further research as follows:

6.4.1 Recommendations for practice of HCPs

The researcher came up with recommendations for practice of HCPs. This is what the researcher recommended for the practice of HCPs:

Partnership among government agencies and other key stakeholder groups must be strengthened. This suggests that MMC partners such as community leaders, particularly traditional and or religious leaders in the community, should always be brought on board to support the programme, more especially during the MMC camps, since they enjoy vast support of the community. So, whatever is affirmed by these community leaders will be supported by the community.

While partnership among government and other key stakeholders proved to be crucial, the fear of pain of MMC procedure must also be addressed**.** In an attempt to deal with the fear of pain during circumcision, boys, men and the community at large need

reassurance that the procedure will be less painful with the help of local anaesthesia and analgesia that is administered during and after the procedure.

On the one hand, addressing fear of pain will bring about reassurance that the MMC procedure will not be unbearably painful, strengthening the “Hlola manje − know your status” campaign will also encourage boys and men to know their HIV status well in advance. HCPs must plan to test as many people as possible for HIV as the DOH also advocates for this in order to prepare men for the next step, i.e. MMC as HIV testing was mentioned as a hindrance to MMC programme. The researcher believes that when people know their HIV status it becomes easier for them to accept MMC readily.

Apart from encouraging men to know their HIV status, taking MMC to where most men are can also improve the accessibility of the health service to the community and this was also cited during the interviews as a strategy that can promote MMC, since there is a huge transport problem when it comes to collecting men from the periphery to the Hospital. According to the researcher, it might be a better idea to transport a few MMC team members to the community than transporting ±100 men from various areas to the Hospital. It will not only need more transport, but also it will be time-consuming and will take more resources, like the services of drivers to transport patients and kitchen staff to cater for boys and men.

Besides improving the accessibility of the health service, the researcher suggests that HCPs plan separate MMC camps for boys and older men. As this was raised by most men that they feel uncomfortable when they are circumcised together with younger boys, while on the other hand, younger boys feel intimidated if circumcised together with older men. The TMMCs seem to target mostly younger boys, since they accept MMC more readily and in larger numbers than their older counterparts, but this should not be the only deciding factor for recruitment, but also the target group should be borne in mind, as outlined by MMC guidelines. It is understandable that some TMMCs are employed by the NGOs that insist on numbers for remuneration purposes and it is not surprising that their recruitment focuses more in schools where they will get young boys accepting MMC in numbers, but what about older men who are already sexually active and more at risk of contracting HIV? There must be a deliberate plan to host MMC camps for older men only at a time and another one for boys on a separate occasion.

6.4.2 Recommendations for education of HCPs

In addition to recommendations for practice of HCPs, the researcher also recommended the following for the education of HCPs:

An in-depth community awareness about MMC must be provided. During interviews, it transpired that as much as most men are not totally against MMC, this does not mean that they are ready for it, they still need to be motivated in order to correct misconceptions they may still be holding against MMC. Not only men need to be provided with in-depth information in this regard, but also the community at large, inter alia, parents and women in particular, who may either be partners to them or mothers or family heads. This factor also strongly resonated with the views of most men who were interviewed.

Apart from providing community awareness about MMC to the community, the researcher believes training MMC teams can also help to render MMC services effectively and efficiently and independently of an NGO. Men need to know that people rendering the service are professional people who are well trained to limit unnecessary complications. This was also echoed by most men in the interviews. The researcher suggests that MMC programme be driven by DOH staff and the role of the NGO must only be to support the programme. Ensure both Tara Klamp method and Forceps Guided method are performed equally, giving men of uNtunjambili a choice. Ensure there is a dedicated MMC team that has its job descriptions clearly articulating activities of the MMC programme.

Notwithstanding the fact that establishing MMC teams can render an effective and efficient MMC service, providing correct health messages all the time can also improve MMC statistics. Messages that are provided by HCPs must be congruent with MMC programme guidelines, e.g. when recruiting men for MMC, HCPs mentioned that they were looking for boys and this factor proved to be important since this can make older men to shy away since the message is targeting boys and not men in general. There must also be mass mobilisation of communities on MMC programme as this proved to be a gap and communities lack knowledge on the benefits of MMC programme.

6.4.3 Recommendations regarding further research

Apart from recommendations for education of HCPs, the researcher also deduced recommendations for further research with regard to the uptake of MMC in Untunjambili area. The recommendations for further research are detailed below.

Involving circumcised men in KwaZulu-Natal to find out about their experiences during MMC. It is recommended that an investigation be conducted on circumcised men to compare their responses with what was uncovered from uncircumcised men in this study.

Besides involving circumcised men in future research, quantifying findings to check whether men's views are generalizable within other men in KwaZulu-Natal may also be necessary, since with the findings in this study there can be no generalisation because only few men were interviewed and their views cannot represent those of a representative sample.

In addition to conducting a quantitative research to improve the representativeness of the sample, the researcher also recommends involving women in future research as partners to men or as family heads. The researcher believes that if females had been interviewed in this study, this could have provided a more holistic sense of perceptions of how people in general feel about MMC, more especially a feminine perspective to MMC.

With these findings, it is believed the ultimate goal of this research study was achieved.

6.5 CONCLUSION

The results described in this chapter are an outcome of the in-depth individual interviews from a convenience sample of uncircumcised boys and men visiting uNtunjambili Hospital OPD who were interviewed to explore Factors Influencing the Uptake of MMC at Untunjambili Area under ILembe District in KwaZulu-Natal. The use of unstructured interviews by the researcher helped him to delve deeper into meaning than other research techniques. The in-depth interviews provided critical insights into

the complex decision-making processes of the research participants, e.g. the researcher found that men in the area of uNtunjambili are not in favour of MMC, taking into consideration that the DOH has gone out of its way to spare resources such as transport to collect boys and men from their homes, and also providing catering for them. On the other hand, HCPs were found to be not doing enough in terms of selling the MMC programme to men and community at large. Even though boys and men verbalised their interest in the MMC programme during the in-depth individual interviews, it was remarkable that they are not going for it and this was similar with what was uncovered in a study conducted in Malawi (Pierotti & Thornton 2012:24). In addition, it was imperative to come up with guidelines that will guide HCPs to improve MMC uptake in this area. The following factors were uncovered as factors that would make boys and men to consider MMC, namely: protective function against HIV/ AIDS and other STIs, maintenance of personal hygiene, sexual pleasure, the person performing the procedure, taking MMC to the people and providing the community with awareness about MMC programme. On the other hand, the researcher unveiled factors that would make men to shy away from MMC, namely: fear of pain, fear of HIV test, fear of death, delayed wound healing, lack of communication about MMC, procrastination and lack of volition, culture issues, natural circumcision, age at circumcision and faithfulness to one's sexual partner.

During the reflection process, the researcher realised that the findings of this study affected the internal as well as the external environment of the research participants. This leads to further categorisation of the research findings into physical and psychosocial factors that influence the uptake of MMC. According to the researcher in this study, physical factors are those that influence the physical functioning of a man's body. Within the physical factors, the researcher identified the following factors to be responsible for promoting MMC, namely: the protective function of MMC against HIV/ AIDS and other STIs and maintenance of hygiene to the circumcised men, while physical factors identified to be hindering MMC uptake were fear of pain, fear of HIV test, fear of death, natural circumcision and age at circumcision. Within the psychosocial factors, i.e. those affecting both the psychological as well as the social functioning of men were factors promoting MMC, such as sexual pleasure, community awareness and taking MMC to the people, whilst those hindering MMC uptake were lack of communication about MMC, procrastination and lack of volition, cultural issues and faithfulness to one's sexual partner.

It is important to mention in this study that HIV/AIDS prevention as a benefit of MMC was not mentioned as a strong motivating factor for seeking MMC, and may not, on its own, promote its adoption (WHO/UNAIDS 2011:7; Goshme 2012:22; Hartzol et al 2014:2; Kebaabetswe et al 2003:216). This was found to be consistent with most studies conducted elsewhere in the continent and in the world and this was echoed by most interviewed boys and men in this study. While the focus is always put on HIV related benefits, it becomes clear that other non-HIV-related factors are also equally important to men and during awareness campaigns this should be incorporated in MMC messages. However, research participants confirmed that awareness on MMC seem to be lower in the community in general. Consequently, younger boys and men do not get enough support if they opt for MMC (Maibvise 2012:94).

The fact that circumcision will bring about hygiene of the penis was also unveiled as the factor that would motivate men to consider MMC. This was found to be congruent with other studies that uncovered that circumcision does improve penile hygiene (Bailey et al 2002:27−40; George et al 2014:181; Harzol et al 2014:4; Maibvise 2012:89; Ngalande et al 2006: 377−385). The sexual pleasure was also mentioned as one factor that would make men to consider MMC while other research participants strongly believed that it is beneficial to the circumcised men to get pleasure. Other participants were of the opinion that circumcision would help the female partner to enjoy sex to the fullest. The fact that MMC enhances sexual performance was in line with what was unveiled in other studies in the continent (George et al 2014:181; Goshme 2012:24; Hartzol et al 2014:4; Maibvise 2012:35). The person performing the MMC will provide confidence on men to consider MMC, more especially if a person performing the procedure is medically qualified, particularly those from non-circumcising communities would go for hospital circumcision (Goshme 2012:30; Friedman et al 2011:17; Scott et al 2005:304−313). This could be attributed to fear of complications that result from botched traditional circumcision or traditional “bush” circumcision (Mavundla et al 2009:395)

Taking MMC to the people was also uncovered as an important factor that will motivate men to consider undergoing circumcision and this was associated to health service accessibility that must be improved and prompt most boys and men to consider MMC (WHO 2009:12). Community awareness was also unveiled as an important factor that will make most men and communities to favour MMC and inaccessibility of accurate

information on the medical circumcision process from either first-hand sources or medical experts means that men would have a limited means to alleviate their fears. This is congruent with the fact that information awareness plays a vital role in convincing men to consider MMC (Kebaabetswe et al 2003:214−217). While most men are generally known to be sceptical to use health centres, this was also evident in the area of uNtunjambili and making awareness about new health interventions like MMC may need HCPs to go out of their way in order to bring about community awareness on MMC and not to focus only on those visiting the hospitals or clinics, but also to do community outreach to places frequently visited by men.

Procrastination and lack of volition were also common factors that some boys and men verbalised to be a hindrance to them, considering circumcision due to other reasons identified in this study that make them to keep on postponing getting circumcised. This is also consistent with Pierotti and Thornton (2012:24) who suggested that the barriers in the decision-making process that now prevent men with moderate levels of interest in circumcision from choosing to undergo the surgery may need to be reduced and this tells us that men in the area would need to be psychologically prepared before considering MMC or there must be a tangible reason for them to consider MMC. This is consistent with the findings that were uncovered in one study that it takes time for people to change their minds (Pierotti & Thorntown 2012:15). Yet, the most important barrier that will need to be overcome at uNtunjambili area is the culture issue, i.e. the belief that circumcision is not for the Zulus and the belief that by accepting MMC the participants would be selling their ‘Zuluness’. This finding is congruent with what was uncovered by earlier studies that some people expressed fear that introducing circumcision could cause loss of cultural identity (Obure et al 2009:671; PEPFAR & USAID 2014:2).

This study postulates that while some findings look similar to what has been unveiled in previous studies, the researcher uncovered what was found to be unique that would hinder men from considering MMC at uNtunjambili area, like fertility, faithfulness to the sexual partner, procrastination and lack of volition that have not been researched in depth and this tells the researcher that these factors may need to be explored further in future research.

LIST OF REFERENCES

AIDSCAP. 2002. Behaviour change – a summary of four major theories. Health Belief Model AIDS Risk Reduction Model Stages of change Theory of Reasoned Action. Available from: http://pdf.usaid.gov/pdf_docs/PNABZ712.pdf(accessed (accessed on 16 June 2014).

AIDSCAP. 2004. Behaviour change: a summary of four theories. Available from: vrfjvubwyzclvqjcbdgexyzl3msu4mn6xv5j/bccsummaryfourmajortheories.pdf (accessed on 16 June 2014).

AIDS Foundation South Africa (AFSA). 2011. Circumcision and Initiation Policy Forum Report *Traditional initiation and circumcision: Seeking good health for safety, prevention and health-seeking methods.* 8-9 March 2011. Dennis Hurley Hall Diakonia Centre

Ajzen, I. 1991. The theory of planned behaviour. *Organizational Behaviour and Human Decision Processes* 50:179−211.

Ajzen, I. 2011. The theory of planned behaviour: Reactions and reflections. *Psychology and Health* 26(9):1113-1127.
Available from: http://www.tandfonline.com/doi/pdf/10.1080/08870446.2011.613995
(accessed on 26 December 2014).

Avert. 2014. *Voluntary medical male circumcision (VMMC) for HIV prevention*. Available from: http://www.avert.org/male-circumcision.htm (accessed on 11 June 2014).

BBC News. 2009. *South Africa Zulus to revive circumcision to fight AIDS*:7 December.

Bailey, RC & Westercamp, N. 2007. Acceptability of male circumcision for prevention of HIV/ AIDS in Sub-Saharan Africa: A review. *AIDS Behaviour* 11(3):341-355.
Available from:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC184741/ (accessed on 13 June 2014).

Bailey, RC, Muga, R, Poulussen, R & Abicht, H. 2002. The acceptability of male circumcision to reduce HIV infections in Nyanza Province. Kenya. *AIDS Care* 14(1):27–40.

Bengo, JM, Chalulu, K, Chinkumba, Kazembe, L, Maleta, KM, Masiye, F & Mathanga, D. 2010. *Situation analysis of male circumcision in Malawi.* Lilongwe: College Medicine.

Bottoman, B, Mavundla, TR & Toth, F. 2009. Peri-rite Psychological Issues Faced by Newly Initiated Traditionally Circumcised South African Xhosa Men. *Journal of Men's Health* 6(1):28−35.

Botes, AC. 1995. The operationalization of the research model in nursing. Unpublished dissertation. Johannesburg: Rand Afrikaans University.

Botma, Y, Greeff, M, Mulaudzi, FM & Wright, SCD. 2010. *Research in health sciences.* Pinelands, Cape Town: Pearson Education.

Brink, H. 1999. *Fundamentals of research methodology for health care professionals*. 2nd edition. Kenwyn: Juta.

Brink, H, Van der Walt, C & Van Rensburg, G. 2012. *Fundamentals of research methodology for health care professionals.* 3rd edition. Cape Town: Juta.

Brooks, RA, Etzel, M, Klosinski, LE, Leibowitz, AA, Sawires, S, Szekeres, G, Weston, M & Coates, TJ. 2010. Male circumcision and HIV prevention: Looking to the future: *AIDS Behaviour* 14(5):1203−1206.

Burns, N & Grove, SK. 2009. *The practice of nursing research: conduct, critique and utilization.* 6th edition. St Louis, Missouri: Elsevier Saunders.

Chaps. 2014. Medical Male Circumcision in South Africa. Available from: http://www.chaps.org.za/mmc.htm (accessed on 11 June 2014).

Coll, JR. 2005. *Ritual male circumcision: A brief history. Physicians.* Scotland: Edinburgh 35:279-285.

Collins Concise Dictionary. 2004. 21st century edition Glasgow: HarperCollins.

Cresswell, J. W. 1994. *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Decosas, J. 2002. *The social ecology of AIDS in Africa*. Geneva: United Nations Research Institute for Social Development.

De Poy, E & Gilpin, LN. 1998. *Introduction to research: understanding and applying multiple strategies.* Philadelphia: Lippincott.

Dickoff, J, James, P & Wiedenbach, E.1968. Theory in practice discipline. Part 1 Practice oriented theory. *Nursing Research* 17(5):245−435.

Dushoff, J, Patocs, A & Shi, CF. 2011. Modelling the population- level effect of male circumcision as an HIV-preventive measure: A gender perspectives. *PLoS One* 6(12):e28608.

Family Health International (FHI) 360 2011. *FHI launches 13 VCT centers in Lagos*. Available from: http://www.fhi360.org/en/CountryProfiles/Nigeria/res_vctsites.htm (accessed 12 November 2010).

Friedman, I, Rose, A & Titus, JM. 2011. *Draft progress report on a review of MMC records in KwaZulu-Natal:* A Review of male medical circumcision records in KwaZulu-Natal.

Garenne, M. 2008 *Mass campaigns of male circumcision for HIV control in Africa*: Clinical efficacy, Population effectiveness, Political issues. Paris France.

George, G, Strauss, M, Chirawu, P, Rhodes, B, Froehlich, J, Montagne, C & Govender, K. 2014. Barriers AND facilitators to the uptake of Voluntary Medical Male Circumcision (VMMC) among adolescent boys in KwaZulu-Natal, South Africa. *African Journal of AIDS Research* 13(2):179−182.
Available from: http://www.dxdoi.org/10.2989//6085906.2014.943053 (accessed on 26 October 2014).

Glanz, K, Rimer, BK & Lewis, FM. 2002. *Health behaviour and health education. theory, research and practice.* San Fransisco: Wiley & Sons.

Goshme, YM. 2012. *Factors influencing the uptake of male circumcision as HIV Prevention Strategy among adolescent boys in Nanogang Community Junior Secondary School* (NCJSS). Gaborone, Botswana.

Grant, E, Brown, J, Michen, K, Grant, A, Manuthu, E & Njeru, J. 2004. "Seizing the day": right time, right place, and right message for adolescent male reproductive sexual health: lessons from the Meru of Eastern Province Kenya. *International Journal of Men's Health* 3(3):189−196.

Grove, SK, Burns, N & Gray, JR. 2013. *The Practice of nursing research. Appraisal, Synthesis, and Generation of Evidence*. 7th edition. St Louis Missouri: Elsevier Saunders.

Herman-Roloff, A, Otieno, N, Agot, K, Ndiya-Achola, G & Bailey, RC. 2011. Acceptability of medical male circumcision among uncircumcised men in Kenya one year after the launch of the national male circumcision programme. *PLoS One* 6:e19814.doi:10.1371/journal.pone.0019814. Epub 2011 May 16 Available from: http://www.ncbi.nlm.nih.gov/pubmed/ 21603622 (accessed on 19 July 2014).

Halperin, D, Fritz, K, McFarland, W & Woelk, G. 2005. Acceptability of adult male circumcision for Sexually Transmitted Disease and HIV prevention in Zimbabwe. *Sexually Transmitted Disease* 32(4):238-239.

Hartzol, K, Mavhu, W, Jasi, P, Chatora, K, Cowan, FM, Taruberekera, N, Mugurung, O, Ahanda, K & Njeuhmeli, E. 2014. Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: Results from a mixed method study. *PloS One* 9(5):e85051.doi:10.1371/journalpone0085051. Available from: www.plosone (accessed on 03 November 2014).

Jayeoba, O, Dryden-Petersen, S, Okui, L, Smearton, L, Magetse, J, Makori, L, Modikwa, V, Mogodi, M, Plank, R & Lockman, S.2012. Acceptability of male circumcision among adolescent boys and their parents, Botswana. *AIDS Behavior* 16(12)340-349. doi:10.1007/s10461-011-9929-7

Available from: http://www.ncbi.nlm.nib.gov/pmc/articles/PMC3951752/(accessed on 28 April 2014).

Kebaabetswe, P, Lockman, S, Mogwe, S, Mandevu, R, Thior, I, Essex, M & Shapiro, RL. 2003. Male circumcision: an acceptable strategy for HIV prevention in Botswana. *Sexually Transmitted Infections* 79(3):214−219.

Kennedy, K.2012. *Male circumcision as a means of HIV/ AIDS prevention in Lusaka urban: an ethical evaluation*. University of Zambia.

Kenya National AIDS and STI Control Programme, Kenya Ministry of Health 2011. *Progress report on Kenya's voluntary medical male circumcision programme 2008-10.* Available from: http://malecircumcision.org/country_updates/documents/vmmc_2010_report_final.pdf (accessed on 24 April 2014).

Kepe, T. 2009. Secretes that kills. Kepe, T. *Social Science and Medicine* 70(2010):729−735.

Krefting, L. 1991. Rigor in qualitative research: the assessment of trustworthiness. *American Journal of Occupational Therapy* 45(3):214−222.

KZN DOH Strategic Plan. 2010-14. Available from: http://www.kznhealth.gov.za/stratplan2010-14.pdf (accessed on 24 May 2014).

Lagarde, E, Dirk, T, Puren, A, Reathe, RT & Bertran, A. 2003. Acceptability of male circumcision as a tool for preventing HIV infection in a highly infected community in South Africa*. AIDS* 17(1):89−95.

Lincoln, YS & Guba, EG. 1985. *Naturalistic inquiry.* Newbury Park, CA: Sage.

Lukobo, MD & Bailey, RC. 2007 Acceptability of male circumcision for prevention of HIV infection in Zambia. *AIDS Care* 19(4) 471-477. Available from: http://www.ncbi.nlm.nih.gov/pubmed/17453585 (accessed on 16 June 2014).

Maibvise, C, 2012. The motives behind Swazi men's increasing interest in circumcision. Unpublished dissertation. Pretoria: UNISA.

Mail and Guardian online. 2009. *Zulu tradition to challenge push for HIV circumcision*. 22 September. Available from: http://www.mg.co.za/ (accessed 12 May 2014).

Mandova, E, Mutonhori, T & Mudzanire S. 2013. The cultural significance and relevance of the shangani rite of male circumcision in light of HIV and AIDS mitigation in Zimbabwe. *International Journal of Asian Social Science* 3(3):584−589.

Masumbuko, YM, Ipyana, HM, Alexander, R & Ainory, PG. 2013. The male circumcision: the oldest ancient procedure, its past, present and future roles. *Tanzania Journal of Health Research* 15(3):1-8.

Mattson, CL, Bailey, RC, Muga, R, Poulussen, R & Onyango, T. 2005. Acceptability of male circumcision and predictors of circumcision preference among men and women in Nyanza Province, Kenya. *AIDS Care* 17(2):182−194.

Mavundla, TR, Netswera, FG, Bottoman, B & Toth, F. 2009. Rationalization of indigenous male circumcision as a sacred religious custom: health beliefs of Xhosa men in South Africa. *Journal of Transcultural Nursing* 20(4):395−404.

Mavundla, TR, Netswera, FG, Toth, F, Bottoman, B & Tenge, S. 2010. How boys becomes dogs: stigmatization and marginalization of uninitiated Xhosa males in East London. South Africa*. Qualitative Health Research* 20(7):931-941.

May, RW. 2014. Ethical considerations surrounding voluntary medical male circumcision (VMMC) in South Africa as an intervention for HIV prevention: Stellenbosch University.

Mayaki, TF. 2012. Knowledge, attitudes and practices towards voluntary HIV counselling and testing among adolescents of a Senior High School in Nigeria. Unpublished dissertation. Pretoria: UNISA.

Mosothwane, MN. 1909. An ethnographic study of initiation schools among the Bakgatla bag a Kgafela at Mochudi. Pula. *Botswana Journal of African Studies* 15(1):144−65.

Munro, S, Lewin, S, Swart, T & Volmink, J. 2007. A review of health behaviour theories: How useful are these for developing interventions to promote long term medication and adherence for TB and HIV/AIDS? *BioMedical Central Public Health* 7:1−16.

Ncayiyana, DJ. 2011. "The illusive promise of circumcision to prevent female-to-male HIV infection- not the way to go for South Africa" (editorial) *South African Medical Journal* 101(11):775−776.

Ngalande, R, Levy, J, Kapondo, C & Bailey, RC. 2006. Acceptability of male circumcision for prevention of HIV infection in Malawi. *AIDS and Behavior* 10(4):377−385.

Nnko, S, Washija, R, Urassa, M & Boerma, JT. 2001. Dynamics of male circumcision practices in northwest Tanzania. *Sexually Transmitted Infections* 28(4):214−218.

Obure, AFXO, Nyambedha, EO; Oindo, BO, Kodero, HMN. 2009. Psychosocial factors influencing promotion of male circumcision of HIV prevention in a non-circumcising community in rural Western Kenya. *The quantitative Report* 14 (4):665−687.

Peltzer, K., & Kanta, X. 2009. Medical circumcision and manhood initiation rituals in the Eastern Cape, South Africa: a post intervention evaluation. *Culture, Health and Sexuality* 11(1):83–97.

Peltzer, K, Nqeketo, A, Petros, G & Kanta, X. 2008. Traditional circumcision during manhood initiation rituals in the East Cape, South Africa: a pre-post intervention evaluation. *BMC Public Health* 8:64.

PEPFAR & USAID. 2014 *Integrating gender in Voluntary Medical Male Circumcision programs.* Available from: https://www.usaidassist.org/assist/files/assist_integrity_gender_in_VMMC_techbrief_june2014.pdf (accessed on 28 July 2014).

Pierotti, RS & Thornton, R. 2012. *Contemplating circumcision for HIV prevention.* Population Studies Center Research Report 12-764. Available from: www.psc.isr.umich.edu (accessed on 02 November 2014).

Polit, DF & Beck, CT. 2004. *Nursing research: principles and methods*; 7th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, DF & Beck, CT. 2008. *Nursing research: generating and assessing evidence for nursing practice.* 8th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, DF & Beck, CT. 2012. *Nursing research: generating and assessing evidence for nursing practice.* 9th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, DF & Hungler, BP. 1995. *Nursing research: principles and methods*. 5th edition. Philadelphia: Lippincott.

Research Health and HIV Research Unit (RHRU) 2010. *Desktop Review of Male Circumcision Research and Services in South Africa.* University of Witwatersrand

Sabone, M, Magowe, M, Busang, L, Moalosi, J, Bingaman, B & Mwambona, J. 2013. *Impediments for the Uptake of the Botswana Government's Male Circumcision Initiative for HIV Prevention.* Hundawi Publishing Corporation. Scientific World Journal 2013 Article ID 387508. Available from: http://dx.doi.org/10.155/2013/387508 (accessed on 26 October 2014).

SA FM. 2014. *Health Talk Interview*, 28 May 2014, 19h00 to 20h00.

Scott, BE, Weiss, HA & Viljoen, JL. 2005. The acceptability of medical circumcision as an HIV intervention among a rural Zulu population, KwaZulu-Natal population. *AIDS Care* 17(3):304−313.

Simon, MK & Goes, J. 2013. Scope, limitations and delimitations. Available from: www.dissertationrecipes.com (accessed on 14 January 2014).

Silverman, EK. 2004. Anthropology and circumcision. *Annual Review of Anthropology* 33(1):419−445.

Swanepoel, P. 2005. Persuading South Africans at risk of HIV/AIDS to voluntarily present themselves for counselling, testing and referral (VCT): using theory and empirical evidence in formative research for VCT message design. Unpublished manuscript. Pretoria: University of South Africa.

Tang, JW. 2014. Barriers and Motivators to Voluntary Medical Male Circumcision Uptake among Groups of Men in Zimbabwe: Results from a Mixed Methods Study. *Plos One* 9(5):e85051. 10.1371/journal.pone.0085051. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4011705/ (accessed on 13 June 2014).

Tesch, R.1990. *Qualitative research: Analysis Types and software tools.* Philadelphia: Routledgefalmer

Thomsen, S.C. 2014. *Identifying and Addressing Barriers to Uptake of Voluntary Medical Male Circumcision in Nyanza, Kenya among Men 18-35: A Qualitative Study.* Plos One. 2014; 9(6):e98221. Published online Jun 5, 2014. Doi: 10.137/journal.pone0098221.Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/pmc4047024/ (accessed on 13 June 2014)

Tobian, AA, Serwadda, D, Quinn, TC, Kigozi, G, Gravitt, PE, Laeyendecker, O, Charvat, B, Ssempijja, V, Riedesel, M, Oliver, AE, Nowak, RG, Moulton, LH, Chen, MZ, Reynolds, SJ, Wawer, MJ & Gray, RH. 2009. Male circumcision for the prevention of HSV-2 and *HPV infections and syphilis. The New England Journal of Medicine* 360(13):1298−1309.

UNAIDS. 2000. *Report on the global HIV/ AIDS epidemic*, June 2000. Voluntary medical male circumcision for HIV prevention, July 2012.
Available from:
www.who.int/hiv/topics/malecircumcision/fact_sheet/index.html/ (accessed 05 May 2013.).

UNAIDS. 2008. *Male Circumcision and HIV prevention in Eastern and Southern Africa. Communication guide*. Available from: http://www.unaids.org/mc-hiv-prevention-eastern-southern-africa.pdf (accessed on 18 April 2014).

Uys, L & Middleton, L. 2004. *Mental health nursing a South African perspective.* 4th edition. Cape Town: Juta.

Van Dyk, A. 2008. *HIV/AIDS care and counselling: a multi-disciplinary approach.* 4th edition. Cape Town: Pearson Education.

Watson, DE, Broemeling, A, Reid, RJ & Black, C. 2004. *Centre for Health Services and Policy Research,* University of British Columbia, Vancouver, Canada.

Watson, DE, Broemeling, A & Wong, T 2009. A *result-based logic model for PHC. A conceptual foundation for population-based information systems.* Healthcare policy volume 5. Special issue November 2009.

Westercamp, M, Agot, KE, Ndiya-achola, J & Bailey, RC. 2012. Circumcision preference among women and uncircumcised men prior to scale-up of male circumcision for HIV prevention in Kisimu, Kenya. *AIDS Care* 24(2):157-66. doi:10.1080/09540121.2011.597944. Epub 2011 Aug 22.
Available from: http://www.ncbi.n/m.nih.gov/pubmed/21854351 (accessed on 15 January 2014).

WHO. 2011. *Global Health Sector Strategy on HIV/AIDS 2011-2015*. Available from: http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf (accessed on 11 August 2014).

WHO. 2012a. *HIV/AIDS programme: Framework for clinical evaluation of devices for male circumcision.* Available from: http://www.malecircumcision.org/programs/WHO_MC_framework_clinical_evaluation_device_2012.pdf (accessed on 30 January 2015).

WHO. 2012b. *Voluntary male circumcision for HIV prevention.* Available from: http://www.who.int/hiv/topics/malecircumcision/en/ (accessed on 19 May 2013).

WHO & UNAIDS. 2007. *Male circumcision: global trends and determinants of prevalence, safety and acceptability.* WHO Press. Geneva. Available from: http://www.malecircumcision.org/media/documents/MC_Global_Trends_Determinants.pdf (accessed 27 May 2014).

WHO/UNAIDS. 2010. *Progress in male circumcision scale-up: country implementation and research update 2010.* Available from: http://www.who.int/hiv/pub/malecircumcision/mc_country_progress_June2010.pdf (accessed on 26 August 2014).

WHO/UNAIDS 2011. *Joint strategic action framework to accelerate the scale-up of voluntary medical male circumcision for HIV prevention Eastern and Southern Africa 2012-2016.* Available from: http://who.int/hiv/pub/strategic_action2012_2016/en/ (accessed on 24 June 2014).

WHO/UNAIDS/UNICEF. 2011. *Global update and health sector progress towards universal access*. Progress Report. Available from: www.unaids.org/en/media/unaids/contentassets/unaidspublication/2011/20111130report_en.pdf (accessed on 04 May 2014).

Wilcken, A, Miiro-Nakayima, F, Hizaamu, RNB, Keil, T & Balaba-Byansi, D. 2010. Male circumcision for HIV prevention-a cross-sectional study on awareness among young people and adults in rural Uganda. *BMC Public Health* 10:209.

Wilson, HS & Kneisl, CN. 1988. *Psychiatric nursing*. 3rd edition. California: Addison-Wesley.

Yang, X, Abdullah, AS, Wei, B, Jiang, J, Deng, W, Qin, B, Yan, W, Wang, Q, Zhong, C, Wang, Q, Ruan, Y, Zou, Y, Xie, P, Wei, F, Xu, N & Liang, H. 2012. Factors influencing Chinese male's willingness to undergo circumcision: a cross-sectional study in Western china. *PLoS One* 7(1):e30198.

Annexure A

Ethical clearance certificate, Health Studies Higher Degrees Committee, Unisa

Annexure A: Ethical clearance certificate, Health Studies Higher Degrees Committee, Unisa

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/260/2013

Date:	27 November 2013	Student No:	4346-423-8
Project Title:	Factors influencing men's uptake of male medical circumcision at ILembe Health district in KwaZulu Natal.		
Researcher:	Promise Nhlanhla Sangweni		
Degree:	MA in Nursing Science	Code:	MPCHS94
Supervisor:	Prof TR Mavundla		
Qualification:	D Cur		
Joint Supervisor:	-		

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

pp
Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

pp
Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

UNIVERSITEIT VAN SUID-AFRIKA
PRETORIA
UNIVERSITY OF SOUTH AFRICA

Annexure B

Approval letter granting permission from KZN DOH

Annexure B: Approval letter granting permission from KZN DOH

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 331/13
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Mr PN Sangweni

Subject: Approval of a Research Proposal

1. The research proposal titled '**Factors influencing men's uptake of male medical circumcision at iLembe Health District in KwaZulu Natal**' was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at Community of Untunjambili area.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified community/facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 28/01/2014

Annexure C

Approval letter from iLembe District Office

Annexure C: Approval letter from iLembe District Office

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ILEMBE HEALTH DISTRICT/
Private Bag X 10620
Kwa Dukuza, 4450
OK Mall Building
First Floor
Tel: 032 4373536, Fax: 032 5511590/2
Email: melusi.ndaba@kznhealth.gov.za

Enquiries: C.M. Ndaba
Date: 10 December 2013
Reference:Research

Mr P.N.Sangweni
Deputy Manager Nursing
Untunjambili Hospital
Contact No. 0823280013

Dear Mr N Sangweni

RE: REQUEST TO CONDUCT RESEARCH

1. The above subject bears reference.
2. This office has received your request to conduct a research, in that this office fully supports the research. However your office is requested to contact the Department of Health ethics and research committee unit to grant permission and attach this letter.

   The details of the unit are as follows:

   Manager: Dr Elizabeth Lutge
   Tel: 033 395 2046
   Fax: 033 394 3782
   elizabeth.lutge@kznhealth.gov.za
3. Please note that prior commencement a letter from the ethics and research committee must be obtained in order for the students to be allowed to conduct a research.
4. However further information may be obtained from the department of health web site: www.kznhealth.gov.za

Regards

MR. C.M. NDABA
ACTING MANAGER
Ilembe health district

Annexure D

Approval letter from uNtunjambili Hospital CEO

Annexure D: Approval letter from uNtunjambili Hospital CEO

APPENDIX

HEALTH
KwaZulu-Natal

FACILTY NAME: Untunjambili Hospital
POSTAL ADDRESS: P/Bag X216 Kranskop, 3268
Tel no.: 033 44 1259
Fax no. : 033 444 1175
Email : lungile.phakathi@kznhealth.gov.za

Date: 09/12/13

Enquiries: Dr N.L.Phakathi

Principal Investigator: Mr P.N.Sangweni

Address: P.O.Box 1202, Eshowe, 3815

RE: PERMISSION TO CONDUCT RESEARCH AT FACILITY

I have pleasure in informing you that permission has been granted to you by the facility to conduct research on **"Factors influencing men's uptake of Male Medical Circumcision (MMC) at ILembe Health District in KwaZulu-Natal"**.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Facility.

Thanking you

Sincerely

Faculty Manager's Name: **Dr N.L.Phakathi**

Faculty Name: **Untunjambili Hospital**

DEPARTMENT OF HEALTH
UNTUNJAMBILI HOSPITAL
Untunjambili Area
Kranskop Main Road
3268
09/12/13

Annexure E

Letter requesting permission to conduct research from PN Sangweni

Annexure E: Letter requesting permission to conduct research from PN Sangweni

P.O.Box 1202

ESHOWE

3815

06 December 2013

The Chief Executive Officer

Untunjambili Hospital

KRANSKOP

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AMONG MALE PATIENTS VISITING UNTUNJAMBILI HOSPITAL UNDER ILEMBE HEALTH DISTRICT OFFICE

Kindly receive my request for permission to conduct research on the aforementioned topic.

I am **Promise Nhlanhla Sangweni** currently working at Untunjambili Hospital as Nursing Manager and I am the student with UNISA doing Master of Art in Nursing Science and my research proposal has been approved by UNISA Ethical Clearance Committee. Next year I intend to start with my research project and your permission is sought in that regard.

The title of my research is: **"Factors influencing men's uptake of Male Medical Circumcision (MMC) at iLembe Health District in KwaZulu –Natal."** The purpose of this study is to explore men's perceptions on MMC at iLembe Health District in KwaZulu-Natal as to why older men tend to shy away from performing MMC. The ultimate aim is to come up with guidelines that can assist policy makers and health care practitioners to promote the uptake of MMC by men in iLembe Health District.

These men will be selected using convenience sampling. In-depth face to face interviews will be used to collect data on men's perceptions on MMC. No name is required for these interviews.

Kindly, let me know if you require additional information to support this request.

Yours faithfully

Mr P.N.Sangweni

Annexure F

Consent form

Annexure F: Consent form

FACTORS INFLUENCING MEN'S UPTAKE OF MEDICAL MALE CIRCUMCISION AT UNTUNJAMBILI AREA UNDER ILEMBE DISTRICT IN KWAZULU- NATAL.

Dear Participant/ Respondent

My name is Nhlanhla Sangweni, a student of University of South Africa (UNISA), Pretoria South Africa. I am currently conducting a research to explore factors influencing men's uptake of Male Medical Circumcision. This research is in fulfilment of the award of Master of Nursing Science (MA NSC) at the above named university.

I do not want to collect information from you at Untunjambili Hospital without your informed about the project. I am interested in learning more about factors influencing men's uptake of Male Medical Circumcision. The information that will be gathered in this study will assist policy makers to understand barriers to MMC and implement *strategies* or guidelines that can improve uptake of MMC by men in the ILembe District in KwaZulu Natal thereby reducing the incidence of HIV infection in the long run.

Participation requires that each participant complete a questionnaire which will not bear your names and all information collected will be kept private by me. Please know that participation in this study is voluntary and no opinion will be formed against anyone who decline to participate. If you wish to participate, kindly circle below YES and sign. Circle NO if you do not want to participate.

Do you want your child to participate? YES ☐ NO ☐

Signature of participant/ respondent

Date: _____

Thank you.

Nhlanhla Sangweni

Annexure G

Interview transcript

Annexure G: Interview transcript

Interviewer: Ok Brother. I will ask you three questions as I had promised. My first question asks what does you view say about circumcision in hospital?

Interviewee P5: No. 1, my view says it is the right thing to do since it is done in a professional way that is safe and not the traditional way it used to be. It is also right because before you are circumcised you are taught as to how to conduct yourself as men that it is important not to be promiscuous. I would say in my opinion it is the right thing to do. I do not know if I can continue?

Interviewer: It is right because there is health education that is provided…?

Interviewee P5: Yes it is right since boys are taught before circumcision. **Interviewer:** They are taught about what?

Interviewee P5:Ok. No.1. They are taught as to how boys should behave after circumcision. They are not saying circumcision will protect you against HIV but they teach that this will only reduce chances of contracting HIV. They also teach that the foreskin that is excised is the area that carries dirt or germs and that you still need to abstain and be faithful to your partner. That's what they teach in hospital. And that those that have been circumcised must motivate others to undergo circumcision so that they are safe although that does not mean 100% safe but chances are lower. I do not know if I am repeating one and the same thing. It is because I am used to preaching.

Interviewer: I thank you. The second question asks why have not been circumcised up to now?

Interviewee P5: You see that one is a good question. No.1 when I was growing up, I was born in the 70's, it was not in the culture of the Zulu's to circumcise there was this thing of cutting the frenulum underneath the glans penis "ukuqhatha" and because we were not enlightened, I told myself that it is one and the same thing as to circumcise. And even when this MMC came I told myself that there is no need since I did "ukuqhatha". Another thing Mr Sangweni I do not know how you call this thing that is excised… the foreskin "Ijwabu". I think it is not all people who have long foreskin like myself I have a very short foreskin but also the issue of faithfulness since I am married and I saw no need since I am faithful to my wife and she is faithful to me and most boys do it because they are not faithful. That's what I can say.

Interviewer: Ok. I can hear that you say your foreskin is short, how short is it? Is it short such that the glans penis is absolutely exposed or half exposed?

Interviewee P5: I will say it is half exposed and I think something was going to be excised but I had that feeling that I am safer. Others are born with longer foreskin.

Interviewer: But, It is important to circumcise not only on STI's and HIV but also in conditions such as candidiasis and as you grow older other conditions like Diabetes Melllitus may develop later in life and if you are circumcised, this will help if you are circumcised. I hear your view. Is there anything you still want to say?

Interviewee P5: The third one. Oh yes. There is this research that I heard but I am not sure it is true that when you have done circumcision, you do not get sexual pleasure but it is the female partner although others say it is the vice versa that if you are circumcised you tend to get more pleasure in sex.

Interviewer: Ok. Thank you. The last question asks what do you think can be improved by decision makers or health workers to make the programme more appealing to men?

Interviewee P5: Ok. I will speak according to my age. Especially the health workers, I think they only target mostly younger ages and they do not show the importance of circumcising in all age groups like ourselves in the 40's to encourage us. They say they want boys and not males to go for circumcision. The emphasis should not be on ages since it looks like it is for a particular age group only. I think we can also be encouraged us who are not circumcised yet. Even you if you are among younger boys they will say this old brother or sometimes call us fathers. If they say all age groups, may be we can all be encouraged.

Interviewer: With what you have said, do you think that people of different age groups can deter others to come for circumcision?

Interviewee P5: Yes. It is what I say if you look at the age gap. As I was born in the 70's when I am among the young boys as young as 12 or 14 years that will cause an embarrassment. If they can say this time we are targeting these age groups. They must not mix ages. Even myself when I am among the people of my same age group, I will be more comfortable. It will not be same as I am among my "sons".

Interviewer: Is there anything besides what you have mentioned that you think can also be improved by health workers to improve the uptake of circumcision. As you have

mentioned that they seem to be targeting young ones and that if the programme is done according to different age groups that people will be more comfortable. Is there anything else that can be done?

Interviewee P5: I do not know the things like budget since there is always an outcry that there is no enough budget. If there can be things like mobile visits to various communities so that circumcision can be done near their homes so that people are not always collected to the hospital like the mobile clinics do. The information should also be cascaded to people like Community Care Givers (CCG's) "Onompilo" so that information can be circulated at a community level and at hospital level it must focus on detecting those who have not circumcised like picking up a raised sugar level. Even when you have visited the hospital OPD, you must be asked if you are circumcised. Like myself I was once sick and I visited the hospital but I have not heard anyone teaching people about the programme.

Interviewer: By so saying do you think other people do not have enough knowledge on MMC.

Interviewee P5: Yes. There is lack of information on MMC since I said older people think is for younger ones but if we were all given information that misconception could have been corrected. Since we are too many and others think they are circumcised when they are not circumcised at all like myself.

Interviewer: Thank you very much. My brother. Since I think most of the things you raised will help us to improve this MMC programme.

Interviewee P5: Yes. Thank you for having included me in your research and I believe there is something you gained from my participation.

Interviewer: Thank you very much for your participation.