

**A STUDY OF KAP OF CIRCUMCISED MEN TOWARDS SAFE SEX IN MANAKAYANE  
DISTRICT IN SWAZILAND**

by

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## **Declaration**

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## **Abstract**

World Health Organisation (WHO) and UNAIDS named male circumcision as a key intervention in halting the spread of HIV in Africa. Several countries in sub-Saharan Africa with low levels of male circumcision (MC) and high HIV prevalence are scaling up MC services, Swaziland being one of them. Despite the circumcisions done in Swaziland it seems there is no significant decrease in HIV prevalence which might be due to various reasons. One of the reasons noted was the behaviour of men after circumcision because of the belief of total of immunity. This has led to an increase in high risk behaviour, increased promiscuity, multiple partners, more unsafe sex and failure to use condoms, thereby defeating the own stated purpose.

### **Objectives:**

- 1) To identify the knowledge, attitude and practices (KAP) of circumcised men towards safe sex.
- 2) To establish the existing knowledge of the relationship between circumcision and HIV prevention.
- 3) To establish whether men in Swaziland take part in riskier sexual behaviour after or before being circumcised.
- 4) To make recommendations for the counseling programme.

**Methodology:** A cross-sectional analytical study whereby both qualitative and quantitative methods of data collection was used. Simple random sampling was used to select circumcised men from Mankayane hospital, Mankayane and Holy Rosary high schools and a total of 90(60 adults and 30 teenagers) filled in self-administered questionnaires and also took part in focus group discussions. Purposive sampling was used to choose the MC Counsellors and in-depth interviews were done to complement the information on knowledge, attitudes and practices of men towards safe sex before, during and after circumcision. An observation checklist was also used to check what they included in their counselling sessions.

**Results:** The responses solicited from the men who participated in this study show that there is basic knowledge with regards to safe sex and the value of MC in the prevention of HIV. The pattern in the data however shows that those that were the most recent to undergo medical circumcision had the most varied opinions on the extent to which MC protect one from HIV. There was mixed attitude towards safe sex after circumcision, some wanting to maximise their satisfaction without using protection. The data also points to

a pattern were the men have a high relationship turnover and this was more discernible among the teenagers who suggest that the relationships are not built on commitment but possible experimentation. While the study did not have control that tracked uncircumcised men for comparative purposes, the findings point to inconsistent use of condoms among men which heightens the risk of HIV transmission. The results point to a well-structured programme of counseling followed by MC counselors.

**Conclusion:** The study was able to satisfy the aim and objectives. The research process was designed to collect the necessary data and be analysed in a manner that answered the research question. The research target population and subsequent sample represented the geographical scope of the study. The research tools were designed to be easy for the respondents to use. The distribution and collection method was designed to give the respondents less hassle as possible. This had a positive impact on the response rate, which increased the validity of the data collected. Both the literature review and primary research findings affirm that MC without behaviour change is not the panacea for prevention of HIV.

## Opsomming

Die Wêreldgesondheidsorganisasie (WGO) en UNAIDS het manlike besnydenis as 'n belangrike intervensie uitgewys om die verspreiding van MIV in Afrika te stuit. Verskeie lande in Afrika suid van die Sahara met lae vlakke van manlike besnydenis (MB) en hoë vlakke van MIV is tans besig om MB-dienste uit te brei, en Swaziland is geen uitsondering nie. Ondanks die besnydenis wat in Swaziland gedoen word, blyk daar egter geen beduidende afname in MIV te wees nie. Dít kan aan verskillende redes toegeskryf word. Een daarvan is mans se gedrag ná besnyding vanweë hul oortuiging dat hul geheel en al immuun is. Dit het tot 'n toename in hoërisikogedrag, meer promiskuïteit, veelvuldige bedmaats, meer onveilige seks en 'n gebrek aan kondoomgebruik gelei, wat uiteraard die doel verydel.

Oogmerke:

- 1) Om besnyde mans se kennis, houdings en praktyke met betrekking tot veilige seks te bepaal.
- 2) Om bestaande kennis oor die verband tussen besnydenis en MIV-voorkoming te bepaal.
- 3) Om vas te stel of mans in Swaziland voor of ná besnyding geneig is tot meer riskante seksuele gedrag.
- 4) Om aanbevelings te doen vir die MB-beradingsprogram.

Metodologie: 'n Deursnee- analitiese studiebenadering met sowel kwalitatiewe as kwantitatiewe datainsamelingsmetodes is gevolg. Met behulp van eenvoudige ewekansige steekproefneming is mans van Mankayane-hospitaal en tienerseuns van Mankayane- en Holy Rosary-hoërskool gekies. Altesaam 90 respondente (60 volwassenes en 30 tieners) het vraelyste op hul eie ingevul en ook aan fokusgroepbesprekings deelgeneem. Doelbewuste steekproefneming is gebruik om 'n groep MB-beraders te kies, met wie daar diepteonderhoude gevoer is om die inligting oor mans se kennis, houdings en praktyke met betrekking tot veilige seks voor, gedurende en ná besnyding aan te vul. 'n Waarnemingskontrolelys is ook gebruik om af te merk wat die beraders by hul beradingsessies insluit.

Resultate: Die antwoorde van die mans wat aan hierdie studie deelgeneem het, toon basiese kennis met betrekking tot veilige seks en die waarde van MB in die voorkoming van MIV. Die patroon in die data toon egter dat diegene wat mees onlangs mediese besnydenis ondergaan het, die mees uiteenlopende menings het

oor die mate waarin MB jou teen MIV beskerm. Daar is 'n gemengde houding oor veilige seks ná besnyding: Party mans jaag eenvoudig so veel moontlik bevrediging na, sonder enige beskerming. Die data dui ook op 'n patroon van 'n hoë verhoudingsomset onder die respondente. Dít was veral waarneembaar onder die tieners, wat te kenne gee dat hul verhoudings nie op toewyding gegrond is nie, maar eerder moontlike eksperimentasie. Hoewel die studie geen kontrolegroep met onbesnyde mans vir vergelykende doeleindes gehad het nie, dui die bevindinge op inkonsekwente kondoomgebruik onder mans, wat op sy beurt die risiko van MIV-oordrag verhoog. Die resultate dui voorts daarop dat MB-beraders 'n goed gestruktureerde beradingsprogram volg.

Gevolgtrekking: Die studie het in sy doel en oogmerke geslaag. Die navorsingsproses was ontwerp om die nodige data in te samel en te ontleed ten einde die navorsingsvraag te beantwoord. Die navorsing steikenpopulasie en gevolglike steekproef was verteenwoordigend van die geografiese studiebestek. Die navorsingsinstrumente was ontwerp vir maklike gebruik deur respondente. Die verspreidings- en insamelingsmetode is gekies om so min moontlik moeite vir respondente te veroorsaak. Dít het 'n positiewe impak op die reaksiesyfer gehad, wat weer die geldigheid van die ingesamelde data verhoog het. Sowel die literatuuroorsig as die primêre navorsingsbevindinge bevestig dat MB sonder gedragsverandering allermins 'n 'wondermiddel' vir MIV-voorkoming is.

## **Acknowledgement**

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Special thanks goes to Dr Thozamile Qubuda my supervisor for his professional help and guidance throughout the research and everyone else who made this research a success.

## **Dedication**

I would like to dedicate this thesis to

My family, (Elizabeth Vambe, Bridget Mutaramutswa and Caltas Mutaramutswa).

My beloved husband (Nyakallang Moyo)

My lovely son (Nyakallang/Kupakwashe Moyo) for their support, patience and encouragement since the beginning of the research.



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## **CHAPTER 1: BACKGROUND OF THE STUDY**

### **1.1 Introduction**

Sub-Saharan Africa remains the epicenter of the global AIDS epidemic with an estimated 22.5 million people living with HIV at the end of 2007. HIV prevention remains a major challenge. With an estimated adult prevalence of 26.3 per cent, Swaziland has the world's most severe HIV/AIDS epidemic, posing a serious challenge to the country's economic development. The epidemic is fuelled by poverty, a lack of medical resources and a male –dominated and promiscuous culture in which polygamy is still common (UNAIDS, 2010).

Since Swaziland's first AIDS case was reported in 1986, the epidemic has spread relentlessly in all parts of the country. According to the Joint United Nations Program on HIV/AIDS's (UNAIDS's) Epidemic Update 2009, average Swazi life expectancy fell by half between 1990 and 2007, in great part due to the epidemic. Approximately 190,000 people in Swaziland are HIV positive, including 15,000 children under age 15.

Three randomised controlled trials in South Africa, Uganda and Kenya, between 2002 and 2006, demonstrated that male circumcision reduces the risk of HIV acquisition in men by about 60% through heterosexual sex (Gray, Kigozi, Serwadda & Makumbi, 2007). Male circumcision (MC) is now one of the newest HIV prevention strategies and is one of the most commonly performed operations globally. An estimated 665 million men, or 30% of all men, have undergone MC.

The prevalence of circumcised men varies greatly, from as low as 15% in parts of Southern Africa, to more than 70% in parts of Eastern Africa. It is estimated that the prevalence of MC in Swaziland's capital is approximately 14%, as infant MC is not routinely practiced (USAID, 2007).

World Health Organisation (WHO) and UNAIDS named male circumcision as a key intervention in halting the spread of HIV in Africa. Several countries in sub-Saharan Africa with low levels of MC and high HIV prevalence are scaling up MC services. This has led to massive nationwide campaigns to circumcise HIV-negative males in Swaziland. At the beginning of 2011 Swaziland launched an initiative to circumcise between 125,000 and 175,000 HIV negative males from 15 to 49 years of age in a 12-month period. The ambitious plan was based on mathematical modeling studies suggesting that male circumcision for HIV prevention could reduce annual HIV incidence in Swaziland by 75 per cent by 2025. Nevertheless, figures

released in 2011 show Swaziland has a long way to go; the number of circumcision performed in 2010 only reached a total of 18,896 ( USAID Regional HIV/AIDS Program, 2010 ).

Despite the circumcisions done in Swaziland it seems there is no significant decrease in HIV prevalence which might be due to various reasons. One of the reasons noted was the behaviour of men after circumcision. There is ever increasing evidence that men who have agreed to get circumcised it's because they have been told it will protect them from HIV infection and these men believe they are immune from HIV infection. This has led to an increase in high risk behavior, increased promiscuity, multiple partners, more unsafe sex and failure to use condoms, indicating that the much vaunted circumcision programs are producing an epidemic of unsafe and high risk sex thereby defeating the own stated purpose. This was supported by the Integrated Regional Information Networks (IRIN) (2008).

According to Integrated Regional Information Networks (IRIN) (2008), there is a growing belief among men in Swaziland that circumcision provides complete protection against HIV, a perception that worries non-governmental organizations (NGOs) battling the highest HIV prevalence rate in the world? In recent years circumcision has been lauded by Swazi public health officials as a procedure that reduces the rate of HIV transmission by about 50 per cent, but it is far from the silver bullet solution. A recent study by the UN Development Programme found only 20 per cent of Swazi men consistently used condoms, which probably indicated that circumcised men did not stop using condoms after circumcision, but had never used them in the first place. Education about circumcision should stress a clear and consistent message that the procedure should be part of the HIV prevention measures, until that happens, women will be infected with HIV this way, and male circumcision may do more harm than good if it is misused to deny women full protection.

## **1.2 Research problem and question**

Given the clinical evidence that MC is effective in reducing heterosexual HIV transmission among men, those who have undergone the procedure will consequently participate in riskier sexual behaviors. Unsafe sex in circumcised men increase the risk of HIV infection and defeat the whole purpose of it being one of the major interventions in prevention of HIV transmission. Little is known about the Knowledge, Attitude and Practices (KAP) of circumcised men towards safe sex.

## **Research question**

What is the KAP of circumcised men towards safe sex?

### **1.3 Aim and objectives**

#### **Aim**

To determine the KAP of circumcised men towards safe sex in order to contribute to reduction of HIV transmission.

#### **Objectives**

- 1) To identify the knowledge, attitude and practices (KAP) of circumcised men towards safe sex.
- 2) To establish the existing knowledge of the relationship between circumcision and HIV prevention.
- 3) To establish whether men in Swaziland take part in riskier sexual behavior after or before being circumcised.
- 4) To make recommendations for the counseling Programme.

### **1.4 Significance of study**

This study will highlight the gaps in the education and prevention of HIV messages pre and post circumcision. It will also help to stress clear and consistent messages concerning safe sex practices post circumcision and this will assist HIV prevention strategies. By doing so, it will strengthen the counseling Programme and communication strategy in order to contribute to reduction in HIV infection.

### **1.5 Outline of the chapters**

Chapter 1: This chapter includes the background to the study, the statement of the problem and the purpose and relevance of the study.

Chapter 2: In this chapter, a thorough review of the literature pertaining to the topic is presented. It is in this chapter that information from prior studies is mentioned to highlight the relevance of the research topic.

Chapter 3: The focus of this chapter is on methodological issues in terms of which the study adopted a qualitative and quantitative research approach. Additionally; a phenomenological orientation is incorporated

since the objectives were to explore the respondents' subjective meanings and experiences. The chapter also presented the procedures of data collection, ethical issues and discussion on quality and rigor in the study.

Chapter 4: This chapter gives a description of the sample and the qualitative and quantitative research findings of the study.

Chapter 5: In this chapter, the findings are summarized and discussed. Conclusions and recommendations of the study are presented. Comments are made regarding the limitations, the study implications and recommendations for future use.

## CHAPTER 2: LITERATURE REVIEW

### 2.1. Introduction

Male circumcision involves removing the foreskin, a loose fold of skin that covers the head of the penis. The procedure can be carried out at any stage; during infancy, childhood, adolescence or adulthood. There are plausible biological explanations for a protective effect. These include, removal of Langerhans cells from the underside of the foreskin, which are specific target cells for the virus, keratinization (hardening) of the skin surface, which promotes more rapid drying and reduces the likelihood of bacterial sexual infections (like chancroid), which in turn reduces the risk of acquisition of HIV (Szabo & Short, 2000). The soft mucosal surface of the inner foreskin is highly receptive to the virus; researchers at the University of Chicago found it difficult to infect specimens of outer foreskin tissue with HIV, whereas inner foreskin tissue absorbed HIV readily up to nine times more easily than cervical mucosal tissue (Patterson, 2002).

“The efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt. Promoting male circumcision should be recognised as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men” (WHO/UNAIDS, 2007).

Globally, the major determinant of male circumcision is religion: almost all Muslim and Jewish men are circumcised. There are various practices according to culture, with different ways of doing it (WHO/UNAIDS, 2007). The move towards medical male circumcision (MMC) as an HIV prevention measure is not without controversy. MMC is not merely a technical procedure; its roots are deeply embedded in the culture of a society. Traditionally, it is a practice with a host of social meanings. These may include what it is to be a man, a rite of passage into adulthood, religious connotations and most recently, public health reasons. However, MMC is a deeply political act with social, individual and physical consequences (Aggleton, 2007). A study in Guinea Bissau and Senegal, West Africa, showed that “male circumcision is of complex significance, with multiple and interconnected dimensions, religious, spiritual, social, biomedical, aesthetic and cultural. “The researchers noted concern about the dangers of male circumcision as a purely biomedical intervention. They suggest that it can reduce the complexity of the issue, and even divide sub-Saharan Africa into artificially separate zones. One that has carried out the biomedical (and western) intervention of MMC, and one that has not. “To avoid this division, it is crucial to give voice to local people and to understand how they conceptualize male circumcision within their own philosophical systems, social dynamics, gender relations, and symbolic meanings of learning and



transmitting knowledge.” There are other dangers to do with MMC and the potential misunderstandings that may arise through implementing it as an HIV prevention approach. Nuances in policy statements (such as the WHO/UNAIDS policy statement on MMC) may not be carried through in programming. The language is vague and insufficiently clear. Evidence suggests that, circumcision is partially protective only of the man who performs vaginal penetrative sex. This then will need to be stated clearly at every turn. The implications for women who are recipients of vaginal penetrative sex with circumcised men are unknown (Gruskin, 2007). The risks for anal sex and MMC are also unknown.

Men who are recently circumcised are advised to abstain from sex for six week following the operation to ensure that the wound is fully healed. Evidence from the randomized controlled trials showed that 11-14% of men did have sex before their wound healed, despite intensive counseling against it during this period. “Outside a clinical trial setting, where the emphasis on counseling will inevitably be far less, it is likely that the rates of sexual activity for men before their wounds heal completely would be far higher”(Gruskin, 2007). This would increase the likelihood of HIV transmission, rather than reduce it and put women at a greater risk.

If MMC is effective in preventing some transmission of HIV from women to men, then HIV negative women will in the longer term(perhaps as far away as ten years)have a lower probability of encountering an HIV positive sexual partner. But for women, there are serious potential gender related effects of male circumcision for HIV prevention. These could include conflation of MMC with Female Genital Mutilation (FGM), unsafe sex and violence (Hankins, 2007). There is a further risk that men and women who perceive a decreased risk of HIV transmission for circumcised men will be less willing to use condoms as a protection measure. Women may also face the challenge of negotiating safe sex with men who think they do not have to use condoms because they are circumcised. “Whether it (MC) can help to change gender norms and roles and promote gender equality and equity or whether it leads to increased HIV risk for women will depend on societal engagement, both within and outside male circumcision services, and in comprehensive HIV prevention programming” (Hankins, 2007).

Also problematic is that “male circumcision for HIV prevention is partially protective for HIV negative men but not for their partner(s), whether male or female, unless they also use condoms. It is the only HIV prevention intervention that does not protect both sexual partners, to some extent” (Berer, 2007). Partners of circumcised men have an equal right to protection, and the need to protect partners is not being taken enough into account, when policy on MMC is being set. The partners of men seeking circumcision should

be involved in several ways. Men and women need to have access to information, couple counseling and testing, safe sex promotion, and there should be extra support for women to negotiate safe sex. Women's health and advocacy organizations should be involved in policy making around MMC (Berer, 2007).

Evidence shows that MMC reduces the likelihood of heterosexual transmission of HIV from women to men. It is not known whether male circumcision reduces the sexual transmission of HIV from men to women.

Innovative health communication is required to address the above challenges. They could have serious implications for HIV transmission within a population. That is why despite circumcision campaigns being done, there is no significant decrease in HIV transmission.

As MMC is not 100% effective at reducing the risk of HIV, there has been discussion that unsafe sex among newly circumcised men could potentially mitigate some of the procedure's protective benefits. The three MC clinical trials done in Kenya (Kismu), Uganda (Rakai) and South Africa (Orange farm) investigated many of the same sexual behaviors which explored more on safe sex, including condom use, number of partners, non-marital partners, alcohol use and sex. The trial data showed no consistent evidence of any substantial risk compensation. Among these sexual behaviors evaluated in the Rakai, Uganda trial, significant differences were only shown in inconsistent condom use and alcohol use. Inconsistent condom use was higher in the circumcised group. In the trial in Kisumu, Kenya, sexual behaviors among the two groups were similar, with the exception of significantly more circumcised men reported having two or more sexual partners in the previous six months and more unprotected sexual intercourse at two years (Bailey, Moses & Parker, 2007). Risk behaviors declined for both circumcised and uncircumcised men, and this can likely be attributed to the counseling that participants received during the trial (Mattson, Christine, Campbell, Bailey, Kawango, Ndinya-Achola & Moses, 2008). This could possibly suggest that men who have undergone MMC have more sexual contacts at enrolment, or prior to the debut of the trial, than men who had not undergone the procedure. This could also suggest that MMC is unrelated to the number of sexual contacts, and that the two arms of the trial were simply different. The comparison between control and intervention groups following MMC does not adequately address the question of whether MMC is responsible for the increase in partners, or if the men in each group are practicing the same degree of risk-taking behavior as they were prior to the trial.

Risky behavior is difficult to identify in clinical trial settings, especially in trials powered to detect efficacy that were stopped early, which prevented long-term follow-up. Further analysis using a "risk scale" to

characterize “sexual risk propensity” among the same men from the trial in Kisumu found no evidence that circumcised men engaged in increased sexual risk behavior following circumcision (Mattson, Christine, Campbell, Bailey, Kawagoe, Ndinya-Achola & Moses, 2008). In fact they found that both circumcised and uncircumcised men reduced their sexual risk behavior over a year which is consistent with other experimental studies of behavioral disinhibition and male circumcision. There have been very few studies that evaluated behavioral disinhibition using qualitative methods, such as in-depth interviews. There is a strong need to better determine perceptions of risk and sexual behavior change following MMC. Qualitative studies, as opposed to experimental study designs, may explore this topic in more depth and allow for descriptive understanding of the components involved in sexual behavior and male circumcision. This area of research is critical; given the continued concern that behavioral disinhibition could mitigate the protective benefits of MMC.

A qualitative study was done by Grund and Hennick (2011) in urban Swaziland about adult male circumcision and it involved their sexual behavior change and risk compensation. Qualitative in-depth interviews were done to understand men's sexual behavior after circumcision and to determine whether and how men participated in riskier sexual behaviors following male circumcision. Men in urban Swaziland, circumcised in the previous 12 months, were recruited and asked about their perceptions of sexual risk and sexual behavior post-circumcision. Results showed that following circumcision, men experience changes in both their sexual attitudes and behavior, which can be considered both protective and risky for HIV transmission. Most of them described protective changes (e.g., more responsible attitudes towards safe sex, reducing sexual temptation and partners, easier condom use). A minority, however, experienced increased sexual risk-taking, typically during a brief period of sexual experimentation shortly after circumcision. HIV counseling and counseling throughout the circumcision process is shown to be critical in influencing protective behaviors. Findings in this study confirm the existence of risk compensation following circumcision; however, this study adds important contextual insight about precisely when and why such risk-taking occurs. Nevertheless this study suggests that male circumcision scale-up as an HIV prevention strategy is likely to foster protective behavior change among men. The integration of HIV counseling with circumcision provision remains critical for effectively mitigating HIV risk behavior as male circumcision gains momentum as a viable HIV prevention tool.

## **2.2. Soaring incidence of AIDS among circumcised populations shows that foreskin is not the problem and circumcision is not the answer.**

Reports from the United States and several African countries show that, despite the WHO push for circumcision as the key strategy against AIDS in underdeveloped countries, HIV infection rates are increasing rapidly among circumcised populations. The most recent evidence to undermine the hypothesis that circumcision is the most effective preventive intervention against AIDS is a report in the *New England Journal of Medicine (NEJM)*, which reveals an HIV epidemic in the (largely circumcised) USA that rivals the problem in (largely circumcised) regions of Africa.

The NEJM reports that more than 1 in 30 adults in Washington, D.C., are HIV-positive — prevalence higher than that found in Ethiopia, Nigeria, or Rwanda. Among men who have sex with men, the study reveals that in some parts of the USA as many as 30 per cent of active men are infected. With the overwhelming majority of adult males in the USA circumcised in infancy, these figures cast serious doubt the case that circumcision is a useful strategy against AIDS.

The authors of the NEJM report suggest that ideology is hampering America's approach to HIV prevention and point out that "Preventive interventions must be rooted in science, not driven by ideological concerns." They mention homophobia as one of these ideologies, but we would suggest that postthepobia (irrational hatred of the foreskin) should also be listed among the ideological obsessions that hamper the fight against AIDS.

Most recently, a study of 4,889 men published in the journal AIDS has shown that circumcised gay men are not less likely to become infected with HIV. Headlined in the press as "Circumcision may not cut HIV spread among gay men", the study in fact showed that HIV infection was higher among circumcised men than among the uncut After controlling for sexual behaviors and demographic factors the report concluded there was no difference between the two groups( B-Sadir, Meyer & Hodder, 2010).

In Swaziland, even though male circumcision is considered to have protective effects for HIV infection, circumcised men have a slightly higher HIV infection than those who are not. It is contained in the Swaziland Demographic and Health Survey (SDHS) of 2007 which still prevails. This report summarizes findings of the 2006 survey carried out by the Swaziland Central Statistical Office (SCO). The report places the infection rate for circumcised males at 22 per cent while for those uncircumcised stands at 20 per cent.

The report states that the protective aspect of male circumcision is based in part because of the physiological differences that increase the susceptibility to HIV infection among uncircumcised men.

However, the relationship between HIV prevalence and circumcision is not in the expected direction. Additional analysis is needed to determine if this lack of a relationship between male circumcision and HIV infection is a result of confounding factors or represents the true situation. In 2007 government introduced a policy on male circumcision, which has a goal of halting the spread of HIV infection to achieve an HIV-free generation. Cited in the report is that to meet this objective, male circumcision services, as part of the national comprehensive HIV prevention package, would have to be available to men of all ages. To maximize the health benefit for HIV prevention, the primary targets of the services are men who are HIV-negative, in the age bracket of 15-24 and also new born babies (Times of Swaziland, 2009).

In Kenya, Nairobi, as thousands of young men in Nyanza Province troop to health centers to be circumcised in hopes of fending off HIV, new studies show it might be too early to claim victory. Although circumcision has been touted as one of the ways to prevent HIV infection, recent findings show an increase in HIV infection in regions where most males are circumcised. According to findings of the Kenya Aids Indicator Survey (Kais) which has been released, North Eastern and Coast provinces, where 97 per cent of males are circumcised, registered an increase in HIV prevalence.

Within a span of five years, HIV prevalence in North Eastern and Coast provinces increased from 0 to 1.0 per cent and from 5.8 per cent to 8.3 per cent respectively. In the same period, HIV prevalence in Nyanza Province, where about 48 per cent of males are circumcised, stood at 15 per cent, the highest in the country.

These are sobering statistics for young men who have rushed to get circumcised in the belief that doing so would provide complete protection from HIV infection. The new findings of growing HIV prevalence among circumcised males indicates the practice cannot completely protect an individual from HIV infection unless it is combined with other practices including using condoms, being faithful to one partner, or abstaining from sex (All Africa News, 2009).

In Uganda, circumcised Muslim men have to be reminded that circumcision does not give them immunity to HIV infection. As East Africa News and Entertainment reports:

The Muslim Youth League has launched a campaign to fight against the spread of HIV among Muslims in the country. The Chairperson of the Youth League, Abdalla Karim Musitwa says the campaign will mainly

target preventing HIV infection amongst the Muslim youths. Musitwa says recent researches showing circumcision helps to protect men from HIV infection has confused some Muslims to go on rampage having multiple sexual relationships without any protection hoping that they are safe because of being circumcised.

He says the campaign will among others convince Muslims that circumcision is not a guaranteed protection against HIV infection. Musitwa says the Muslim Youth League will be promoting abstinence and being faithful as the major means of protection against HIV infection. He says without a HIV cure in place, prevention of infections remains the key intervention against the spread of HIV/AIDS (Uganda health news, 2009).

### **2.3. Safe sex practices**

Practicing safer sex means protecting oneself and partner from sexually transmitted infections such as HIV infection by taking the necessary precautions during sex and foreplay (Oxford English Dictionary, 2009). Safe sex practices became more prominent in the late 1980s as a result of the AIDS epidemic. Promoting safe sex is now one of the aims of sex education and is regarded as a harm reduction strategy aimed at reducing risks (WHO, 2007). Safe sex is effective on avoiding STDs if only both parties involved in sexual intercourse agreed on doing so and stick to it. In 1997, specialists in this matter promoted the use of condoms as the most accessible safe sex method (besides abstinence) and they called for TV commercials featuring condoms. During the same year, the Catholic Church in the United States issued their own "safer sex" guidelines on which condoms were listed, though two years later the Vatican urged chastity and heterosexual marriage, attacking the American Catholic bishops' guidelines. A study carried out in 2006 by Californian specialists showed that the most common definitions of safe sex are condom use (68% of the interviewed subjects), abstinence (31.1% of the interviewed subjects), monogamy (28.4% of the interviewed subjects) and safe partner (18.7% of the interviewed subjects). "Safer sex" is thought to be a more aggressive term which may make it more obvious to individuals that any type of sexual activity carries a certain degree of risk. The term "safe love" has also been used, notably by the French Sidaction in the promotion of men's underpants incorporating a condom pocket and including the red ribbon symbol in the design, which were sold to support the charity.

### **2.4. Condom use**

Condoms have been widely available in Swaziland since the 1990s. The government and other agencies made over one million male condoms available in 2000 and by 2004 this number had grown to over 7

million. Female condoms have also been distributed, but much less widely- around 312,000 were handed out in 2000 (Plus News, 2008). In spite of their good supply in Swaziland, the use of condoms remains controversial and unpopular. In the 2006/7 Swaziland Demographic and Health Survey around half of sexually active respondents aged 15-49 admitted to engaging in non-regular sex without using condoms. "Men in Swaziland do not use condoms. They are distributed all over, but they are not used." this was a comment made by an AIDS activist and health motivator. Although the government has encouraged condom use, some influential community leaders have undermined the government's message, and some people once stated that "condoms don't stop AIDS" and only "faithfulness and abstinence stop AIDS" Religious and traditional leaders have also described condoms as "unSwazi".

## **2.5. Counseling programme**

According to USAID Health Policy initiative on male circumcision presented to PEPFAR in 2007, men should practice safe sex before or after circumcision it is the duty of the counselors to make sure during the counseling process all men are educated on safe sex and the following points followed.

- Male circumcision reduces the risk of HIV infection for men but only provides partial protection. It is not a substitute for other proven HIV prevention methods.
- Men should not resume sexual intercourse for at least six weeks after circumcision to ensure the healing process is complete. Ideally sex should only recommence after a medical assessment confirms the healing process is complete.
- All males, whether circumcised or not, should seek to reduce the risk of HIV transmission through using condoms correctly and consistently and limiting their number of sexual partners.
- Whether circumcision takes place in a clinical or a traditional setting it is important to ensure safety.
- Information on HIV risk reduction and other benefits for male sexual and reproductive health need to be widely available to ensure individuals make informed choices about male circumcision.



## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1. Introduction**

Deciding on appropriate methods to study sexual behavior requires a look at methods used and their documented strengths and limitations and a critical look at ethics acceptability.

Like in other areas of behavioral research quantitative and qualitative methods have proven their value. Nowadays there is little doubt that both qualitative and quantitative approaches are needed (WHO/GPA, 1993). The aim of qualitative research in sexual behavior is to get insights in the personal and social context of sexual activity. The quantitative research provides data on how many people show a defined knowledge, attitude and practices but does not answer the question why they do what they do.

### **3.2. Study design and sample size**

A cross-sectional analytical study was used which involved both qualitative and quantitative methods of data collection. This took place soon after ethical clearance. For qualitative method, in-depth interviews and focus group discussions were used to allow people to voice their opinions, knowledge, practises and experiences the way they feel so as to get a comprehensive meaningful picture of a setting in its complex dynamic reality not just isolated information. This allowed the researcher to discover ideas, concerns, attitudes, values, and approaches of people in their own terms. For quantitative method a survey was done on circumcised men using a self-administered questionnaire. Due to limited resources and time, the study was conducted in Mankayane district at Mankayane hospital, Mankayane High School and Holy Rosary High School.

### **3.3. Sampling strategies**

Simple random sampling was used to select circumcised men from Mankayane hospital and Mankayane high schools. A total of 120 (80 adults and 40 teenagers) circumcised men were given questionnaires to fill in and a total of 90 (60 adults and 30 teenagers) returned filled in questionnaires. To get as much information as possible, focus group discussions were done which consisted of an average of eight circumcised men in each group. Purposive sampling was used to choose the MC Counsellors to complement the information on knowledge, attitudes and practices of men towards safe sex before circumcision, and also get some information on their counselling process. Male circumcision counsellors took part in-depth



interviews and they were only three of them. This was done face-to-face and it consisted of open ended questions.

It is a popular and basic equal probability selection method (Christensen, Johnson & Turner, 2011), which means everyone has the same chance of being chosen.

At hospital: Patients (males) at OPD, ART or MC clinics were picked at random whilst they were in a queue waiting to be attended or after they were attended whichever way suited them. After permission was granted to take part in the research, the researcher went ahead to ask further questions just to be sure they fit in the inclusion criteria. After that consent forms were signed in front of the researcher or research assistants and left behind and questionnaires were given and asked to return on completion.

At Schools: Permission to carry out the research was requested and granted from the headmasters of both schools, who went on to organise some free time when the researcher met with the students. Male students were randomly selected and checked if they fit in the inclusion criteria. Permission was asked and granted from both students and parents/guardians before going ahead with the research. Consent and assent forms were given to students for their parents /guardians and them to sign before answering the questions.

It's a non-random sampling technique. A researcher specifies the characteristics of the population of interest and then locates individuals who have those characteristics. The researcher used this sampling method to interview all the MC Counsellors at Mankayane MC Clinic after asking for their permission and signing of consent forms. It was a combination of both observation and in-depth interviews.

### **3.4. Study population**

According to Population Services International (PSI) in Swaziland, there are about 1 893 men who were circumcised in Mankayane from 2010 to 2012 during circumcision campaigns. There is no documentation for those who were circumcised before 2010; it seems documentation started because of the campaigns although circumcision was being practised. The target group was circumcised men from 13 years and above and they were in two groups, teenagers and those aged twenty years and above. They should have been circumcised from 2000 to 2012 and must be staying in Mankayane district in Swaziland. These men were found at the hospital OPD, ART clinic, MC clinic, Mankayane high School and Holy Rosary high school. The sample size was 90 and was randomly selected.

### **Inclusion criteria**

#### Patients

- adults (20 years and above).
- teenagers (13-19 years).
- circumcised from 2000-2012
- from Mankayane district.
- MC Counselor.

### **Exclusion criteria**

#### Patients

- circumcised before 2000.
- <13 years
- health worker who is not an MC Counselor.
- not circumcised
- not from Mankayane district.

### **3.5. Data collection methods.**

#### **Questionnaire**

Selected participants were given a completely anonymous self-administered questionnaire that contained both open and close ended questions that asked the knowledge, attitude and practices on safe sex after circumcision. A test run of these questionnaires were first administered and then standardized and validated to ensure reliability of responses. The questionnaires were administered personally to those with little or no formal education. For those guided by the interviewers, questions were posed in vernacular language. A total of 120 copies of the structured questionnaires were distributed among the target groups during the period of study. The demographics of the respondents such as sex, age, marital status, occupation and locality, were requested. The questionnaires were collected and all necessary precautions were taken to

ensure that the questionnaires were not accessible by any other person. From those questionnaires which came back an in-depth interview and focus group discussions with the target groups and the counselors who offer male circumcision in MC clinics were done.

### **In depth interviews and interview guide.**

In-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation. The primary advantage of in-depth interviews is that they provide much more detailed information than what is available through other data collection methods, such as surveys. They also may provide a more relaxed atmosphere in which to collect information, people may feel more comfortable having a conversation with you about their program as opposed to filling out a survey. However, there are a few limitations and pitfalls. The researcher developed an interview guide that listed the questions and issues to be explored during the interview and it also included an informed consent form. After setting up the interview, the purpose of the interview and the reason why the male circumcision counselors were chosen was explained. The expected duration of the interview, how the information will be kept confidential, and the use of a note taker was also explained. After consenting, the interview was then conducted. The researcher summarized the key data immediately following the interview and verified the information given in the interview whilst the people were still around. There were a total of eight questions for the counselors to guide the interview, and probes were included where helpful. Translation to local language was not necessary since they all understood English very well. Open-ended questions were asked rather than closed-ended and factual question were asked before opinion questions.

### **Observation**

The researcher observed MC Counselors during their counseling sessions. This was necessary to collect information on the nature of services provided to the clients, what they included in their circumcision package and how they verified whether clients understood or not. Checklists were used to collect this information. Three sessions were observed at random.

### **Focus group discussions.**

A focus group is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs, and attitudes towards a product, service, concept, advertisement, idea, or packaging

(Henderson & Naomi, 2009). Questions were asked in an interactive group setting where participants were free to talk with other group members. A group of an average of eight people was led through an open discussion by a skilled moderator whom the researcher coached and was not directly involved with the research. The group was large enough to generate rich discussion. The focus group moderator nurtured disclosure in an open and spontaneous format. The moderator's goal was to generate a maximum number of different ideas and opinions from as many different people in the time allocated. The amount of time set aside for a focus group was 30 to 45 minutes to ensure productivity and not impose on participant time. The focus groups were structured around a set of carefully predetermined questions no more than six and the discussion were free-flowing. Participant comments stimulated and influenced the thinking and sharing of others. Some people were even finding themselves changing their thoughts and opinions during the group discussions. A homogeneous group of strangers comprised the focus group since homogeneity leveled the playing field and reduced inhibitions. It took more than one focus group on any one topic to produce valid results; the researcher had ten focus group discussions, five for adults and five for teenagers. The researcher knew she had conducted enough groups (with the same set of questions) when she was not hearing anything new anymore, i.e. she had reached a point of saturation. A tape recorder was used so as to gather enough information as possible.

### **3.6. Data analysis**

After collecting data, it was analysed for themes, patterns and meanings. Throughout the process it was checked for its validity. Data coding, checking and cleaning were done before entry into the computer statistical Programme (SPSS and Excel) by a statistician. Each questionnaire/data collected from each study sample was coded. Data collected from interviews and focus group discussions was categorized and summarized into matrices, figures and tables based on the kind of the tool used.

### **3.7. Ethical considerations**

Study of sexual behavior implies eliciting information about the most private intimate sphere of human life and the interest of the researcher easily might violate the individual right of respect and discretion. The more overt the research the more likely is it to get socially desirable accounts. The more covert the research more likely it is to detect the truth. Thus there is a serious interest in research designs that allow measurement independently from reaction of the individual under study (Humphrey, 1970 as cited by Zeller, 1989). The growing need for research in the field of sexuality has created awareness of the necessity to define ethical

principles applicable in sexual behavior research. Principles also governing research with human subjects in other fields are equally applicable in sex-research:

Ethical clearance was sought from Swaziland Ethical Committee in the Ministry of Health and the University of Stellenbosch Ethics Committee. Permission was also requested from the hospital Superintendent and Principals from respected high schools. The researcher ensured that all participants gave informed consent which was in writing. A brief description of the purpose and procedure of the research, including the expected duration was given. Since the researcher was dealing with those below legal age that is below 18 years, consent from parents and guardians was requested and granted. The researcher did not pressure participants to answer questions if they were not comfortable. A statement of any risks, discomforts, or inconveniences associated with participation was given. The counselor was available for those participants who needed the services. The contact details were available in the consent forms. Procedures of confidentiality were made explicit to the interviewees from the beginning. Confidentiality was observed throughout the research from data collection, data analysis and storage. Unauthorized persons did not have access to the data collected. Each subject was assigned a study identification number, and these subject identifiers were not released outside the research group. Codes were used and no identification was made for the responders. Data was only accessed by the research group. Respondents were informed that their data will be used anonymously and that the aim of the study was to understand better the KAP of circumcised men towards safe sex and how we can strengthen the counseling programme. A statement that participation is completely voluntary and can be terminated at any time without penalty was included. Participants benefited knowledge and there were no incentives of some sort as this could be mistaken for coercion especially for poor people incentives are similar to coercion because they have no real choice to refuse. There was a critical analysis concerning the level of understanding and experience of children or adolescents addressed thus there was use of child assent forms.” One point of view is that investigators have a moral obligation to give those involved in the research a chance to find out what the results of the research are in an accessible way” ( de Koning, 1996). To organize a feedback as part of the research process is a way to respect the participants’ right to obtain information on the outcome of the study. Findings were reported verbally to participants and a copy of the final research report was made available to those who requested it, which is after submission to the university on 21 January 2013. They were told to contact the principal investigator and the contact details were in the consent forms. Results were made available to the University of Stellenbosch, the study leader as well as the ministry of health of Swaziland.

## CHAPTER 4: RESEARCH FINDINGS

### 4.1 Introduction

This chapter focuses on the presentation of data collected from circumcised men and MC Counsellors. The data is from self-administered questionnaires, focus group discussions, in-depth interviews and observation checklist. Frequency counts were conducted on the data gathered through the questionnaire. The responses for each individual question were added together to find the highest frequency of occurrence (i.e. the number of times that a particular response occurs). These responses to the questions, which are quantified, are then presented in percentage form.

### 4.2 Response rate

The table below summarises the number of questionnaires distributed and the responses received. A total of 30 respondents were targeted from the circumcised teenagers and 60 respondents from the adults aged 20 years and above. In-depth interviews were conducted with 3 MC Counsellors. Focus group discussions were conducted with 10 groups, 5 from teenagers and 5 from adults. Each group comprised an average of 8 participants drawn from different backgrounds but same age groups.

**Table 1: Analysis of the distribution and response rate for research instruments**

<b>Respondents</b>	<b>Distribution</b>	<b>Responses</b>	<b>Response Rate</b>
Teenagers	30	27	90%
Adults	60	54	90%
MC Counsellors	3	3	100%
<b>Total</b>	<b>93</b>	<b>84</b>	90%

*Source: Research Data (2012)*

Out of the target sample of 93 respondents, 84 responded resulting in a response rate of 90% of the total distributed data collection instruments.

### 4.3 Demographic patterns

The demographic distribution of the data shows that the majority of the respondents were Swazis. As shown in Table 1 below, 93.8% of respondents were Swazis, while 3.7% were South Africans with the remaining 2.5% constituted by Mozambicans

**Table 1: Nationality of Respondents at birth**

Nationality	Frequency	Per cent	Cumulative Per cent
Swazi	76	93.8	93.8
Mozambican	2	2.5	96.3
South African	3	3.7	100.0
Total	81	100.0	

The data reveals that the majority of the respondents have a minimum of secondary education. Table 2 below shows that a cumulative 96.3% of the respondents have a minimum of secondary education. The remaining 3.7% is constituted by 1.2% who have never been to school and 2.5% who attained up to primary school.

**Table 2: Highest level of education**

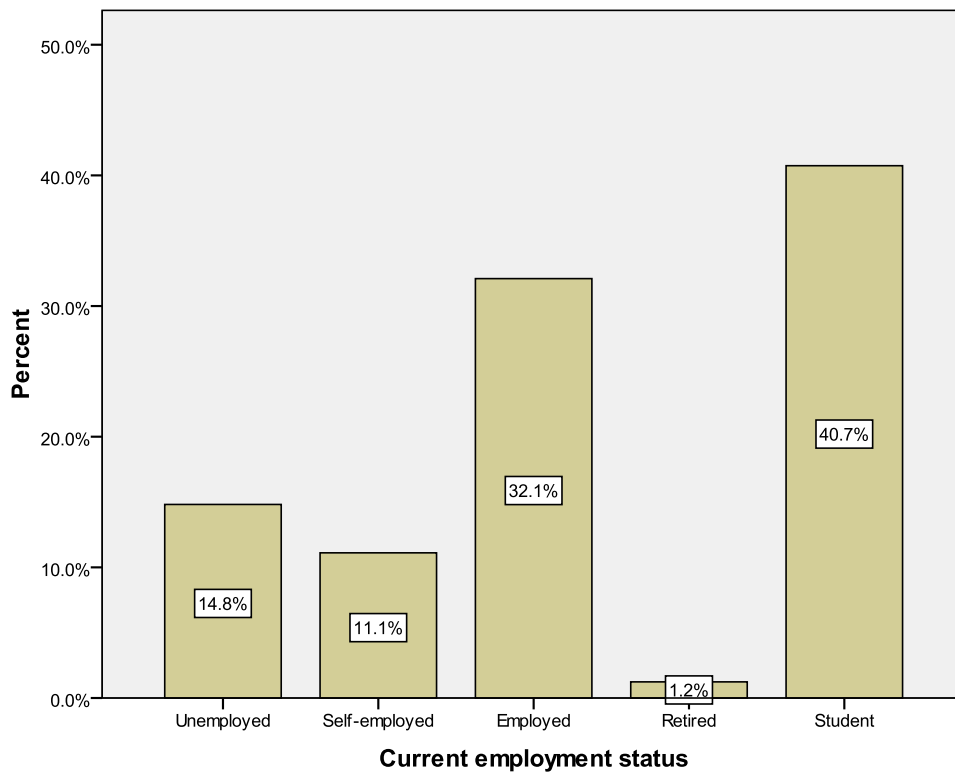
<b>Level of Education</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative Per cent</b>
Never been to school	1	1.2	1.2
Primary School	2	2.5	3.7
Secondary School	25	30.9	34.6
High School	26	32.1	66.7
University/College	27	33.3	100.0
Total	81	100.0	

The employment distribution patterns show that the majority of the respondents are students (40.7%), followed by the employed (32.1%). The unemployed constitute 14.8% of the respondents and the self-employed comprise 11.1% with the remaining 1.2% having retired.



Figure 1 below graphically paints the current employment status of the respondents

**Figure 1: Current employment status**



The data shows that the majority of the respondents are single and never married (59.3%), while the married constitute 17.3%. A significant proportion has a steady girlfriend but not living together (13.6%). The other categories were; divorced (3.7%), steady girlfriend living together (3.7%), widowed (1.2%) and the remaining 1.2% did not respond to the question on marital status. Table 3 below shows the distribution according to marital status

**Table 3: Marital status**

<b>Marital status</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative per cent</b>
Single/Never married	48	59.3	59.3
Married	14	17.3	76.5
Divorced/Separated	3	3.7	80.2
Widowed	1	1.2	81.5
Steady girlfriend not living together	11	13.6	95.1
Steady girlfriend living together	3	3.7	98.8
No response	1	1.2	100.0
Total	81	100.0	

The majority of respondents do not have any children (59.3%), while 13.6% have only one child. The respondents with two children comprise 9.9%, those with three children (9.9%), those with four children (3.7%), those with five children and above (2.5%), while an interesting 1.2% do not know the number of children they have. Table 4 below tabulates the respondents' number of children.

**Table 4: Number of children**

Number of children	Frequency	Per cent	Cumulative per cent
Zero	48	59.3	59.3
One	11	13.6	72.8
Two	8	9.9	82.7
Three	8	9.9	92.6
Four	3	3.7	96.3
Five and above	2	2.5	98.8
Don't know	1	1.2	100.0
Total	81	100.0	

The majority of respondents have either no wife or girlfriend, a cumulative 85.2%. The other 7.4% have two wives or girlfriends, 4.9% have three, 1.2% have four and a further 1.2% have 5 or more wives and, or girlfriends.

Table 5 below shows the distribution terms of number of wives and, or girlfriends.

**Table 5: Number of wives/wife/girlfriend(s)**

Number	Frequency	Per cent	Cumulative per cent
Zero	36	44.4	44.4
One	33	40.7	85.2
Two	6	7.4	92.6
Three	4	4.9	97.5
Four	1	1.2	98.8
Five and above	1	1.2	100.0
Total	81	100.0	

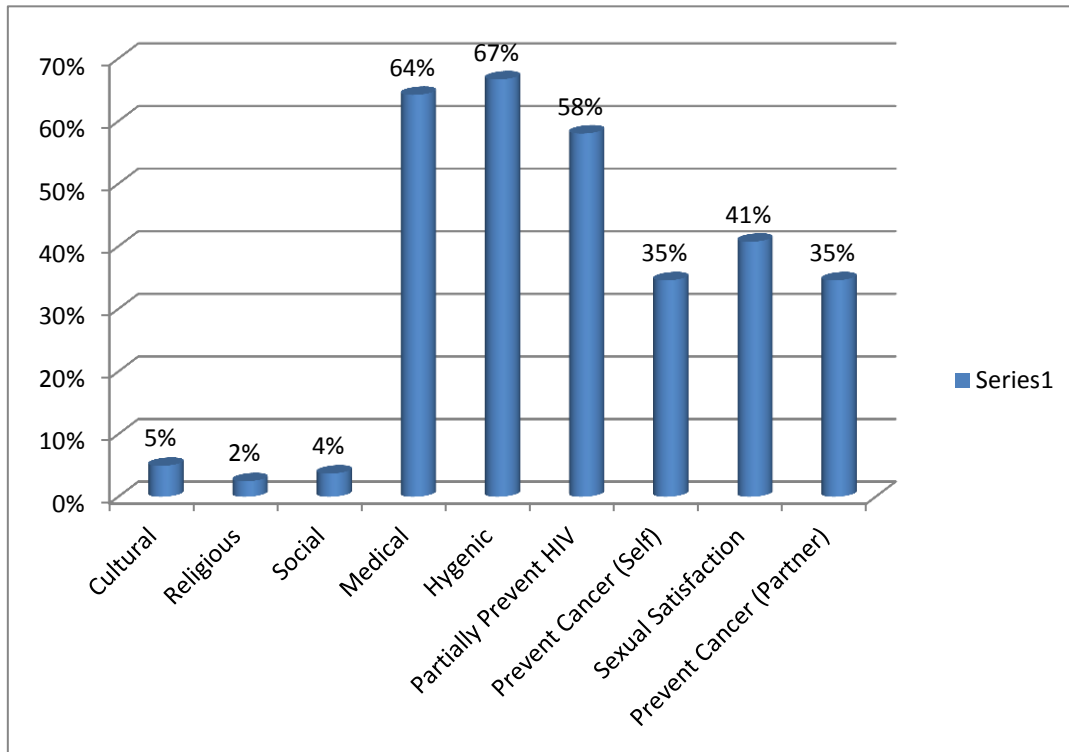
#### 4.4 Knowledge, Attitude and Practices (KAP)

The majority of respondents consider themselves to be heterosexual or straight (84%), with the others considering themselves to be bisexual (6.2%). Those considering themselves to be gay or homosexual comprised 2.5% and those who considered themselves to be transgender constituted 1.2% of the respondents. The remaining 6.2% comprised those who did not respond to the question and those who did not know their sexual orientation with proportional representations of 3.7% and 2.5% respectively. Table 6 below show the sexual orientation patterns.

**Table 6: What respondent considered their sexual orientation to be?**

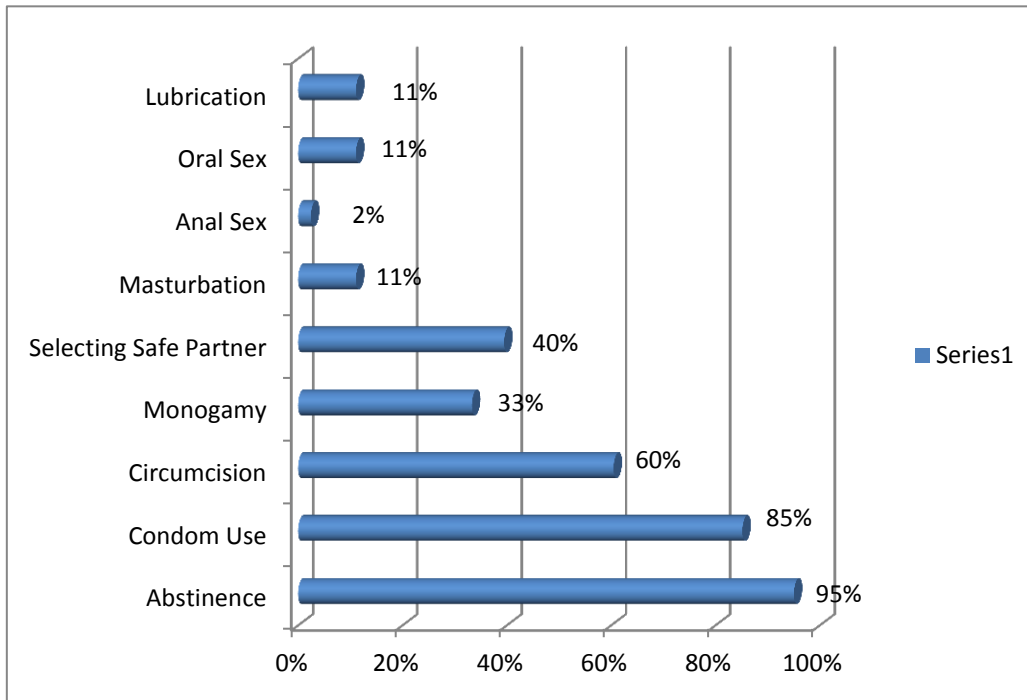
<b>Sexual orientation</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative per cent</b>
Gay or Homosexual	2	2.5	2.5
Bisexual	5	6.2	8.6
Heterosexual or Straight	68	84.0	92.6
Transgender	1	1.2	93.8
No response	3	3.7	97.5
Don't know	2	2.5	100.0
Total	81	100.0	

The personal reasons for circumcision given by the respondents vary from person to person. In response to a question where each respondent could tick as many reasons as applicable, the majority cited hygiene as their reason for undergoing circumcision (67%); others cited medical reasons (64%), while others got circumcised to prevent cancer on themselves (35%) and on their partners (35%). A significant proportion was motivated by the need for sexual satisfaction (41%). Very few respondents cited cultural, social and religious reasons (5%, 4% and 2% respectively). Figure 2 below graphically presents the respondents' reasons for undergoing circumcision.

**Figure 2: Reasons for circumcision**

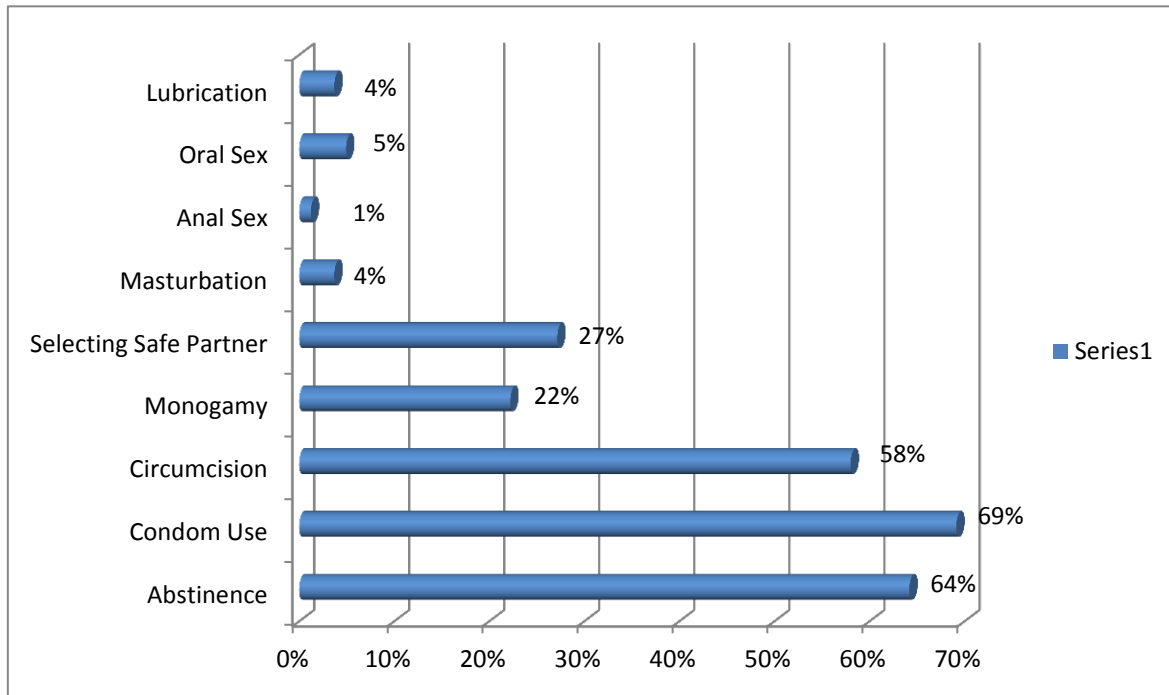
The majority of the respondents' demonstrated knowledge of the two main safe sex practices, namely abstinence (95%) and condom use (85%). The other practices are not very well known, with circumcision cited by 60% of the respondents; selecting a safe partner (40%); monogamy (33%); masturbation (11%); lubrication (11%); oral sex (11%) and anal sex (2%). Figure 3 below paints the pattern of safe practices known by the respondents.

**Figure 3: Safe sex practices known by respondents**



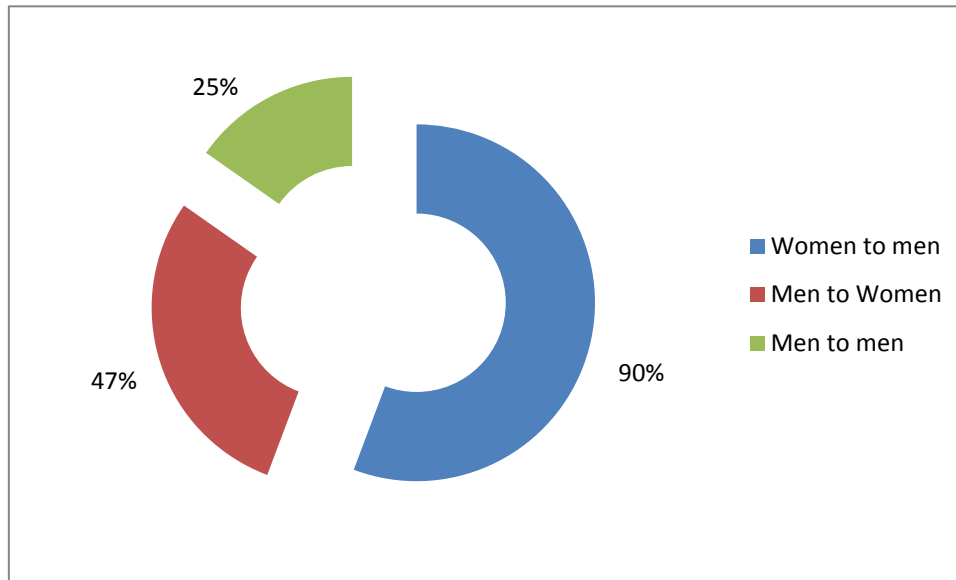
A juxtaposition of safe sex practices known by respondents against the ones used shows significant difference. This difference points to a paradox where knowledge does not necessarily translate to action. As shown in figure 4 below, the proportion of respondents that use abstinences as a safe sex practices is 64%, while those that use condoms are 69%. Those that cited circumcision were 58%; selecting safe partner (27%); monogamy (22%); oral sex (5%); lubrication (4%); masturbation (4%) and anal sex (1%). The preceding figures show a significant decrease in proportions of practices employed relative to the practices known by the respondents.

**Figure 4: Safe sex practices employed by respondents**



The majority of respondents were able to correctly point out that circumcision prevented transmission of HIV from women to men. The diagram below shows the distribution of views with regard to circumcision as a preventive measure against transmission of HIV across gender.



**Figure 5: Circumcision helps prevent transmission of HIV from which group to the other?**

The majority of the respondents were circumcised between 2009 and 2012. However a cross tabulation of when circumcision was done against knowledge of the extent to which circumcision protects from HIV infection reveals a peculiar pattern. The respondents who were the most recently circumcised have the most diverse views on the extent to which circumcision prevents HIV infection. The group circumcised between 2009 and 2012 is the only group where some expressed that circumcision protects no more than 50% (8.1%) and on the other extreme; others see circumcision protecting 100% (1.6%). This pattern is least expected in view of recent studies which place the extent of protection at 60%. The group circumcised between 2000 and 2004 could be excused for not having adequate knowledge as exemplified by 71.4% in that group who did not know the extent to which circumcision protect from HIV infection. The group circumcised between 2005 and 2008 was not too far from the correct extent to which circumcision protect from HIV infection. Table 7 below shows the cross tabulation of period of circumcision against knowledge of the extent to which circumcision protects from HIV infection.

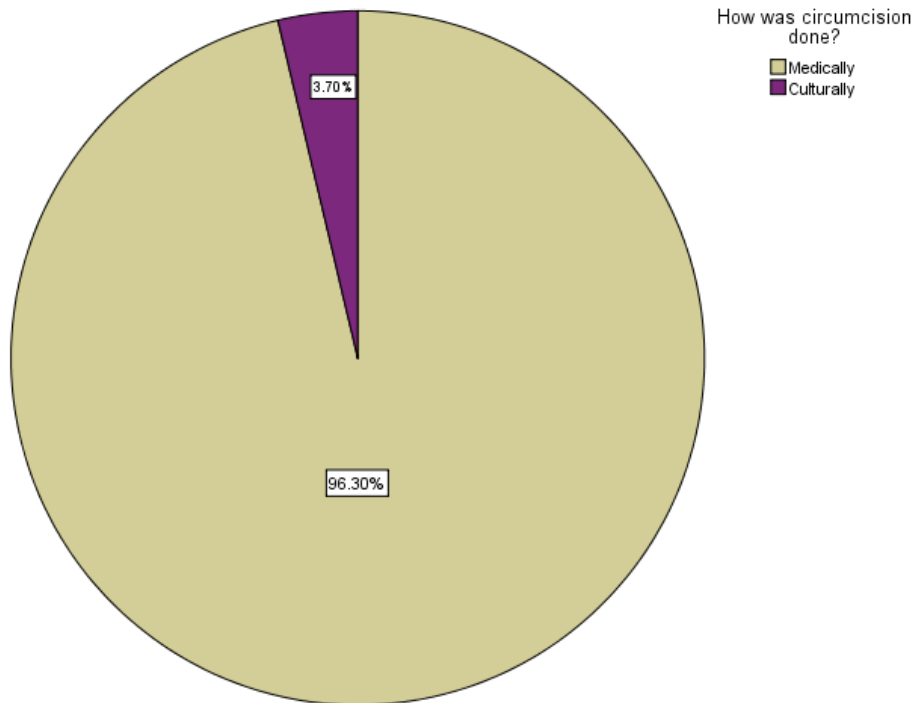
**Table 7: Cross tabulation - when circumcision was done \* what extent does circumcision protect from HIV infection**

When was Circumcision done? \* If yes to what extent does it protect you from being infected Crosstabulation

			If yes to what extent does it protect you from being infected							Total
			<50%	50-59%	60-69%	70-79%	100%	No response	Don't know	
When was Circumcision done?	2000 - 2004	Count	0	0	1	1	0	0	5	7
		% within When was Circumcision done?	.0%	.0%	14.3%	14.3%	.0%	.0%	71.4%	100.0%
	2005 - 2008	Count	0	4	4	1	0	0	2	11
		% within When was Circumcision done?	.0%	36.4%	36.4%	9.1%	.0%	.0%	18.2%	100.0%
	2009 - 2012	Count	5	18	31	3	1	1	3	62
		% within When was Circumcision done?	8.1%	29.0%	50.0%	4.8%	1.6%	1.6%	4.8%	100.0%
	Don't know	Count	0	0	0	0	0	1	0	1
		% within When was Circumcision done?	.0%	.0%	.0%	.0%	.0%	100.0%	.0%	100.0%
Total	Count	5	22	36	5	1	2	10	81	
	% within When was Circumcision done?	6.2%	27.2%	44.4%	6.2%	1.2%	2.5%	12.3%	100.0%	

The varying view expressed in table 7 above is least expected in view of the fact that the majority of the respondents were circumcised medically (96.3%) with the remaining few having been circumcised culturally (3.7%). It would therefore be expected that those that were circumcised medically got the opportunity to be educated on the extent to which circumcision protected from HIV infection. Figure 6 below shows the circumcision method employed.

**Figure 6: Method of circumcision employed**



The notion that those respondents that received medical circumcision were expected to have clear knowledge of the extent to which circumcision protects from HIV infection was reinforced by findings from in-depth interviews with MC Counsellors. Invariably all the three MC counsellors interviewed gave similar details on pre-circumcision counselling information. The information given by MC Counsellor is presented in table 8 below.

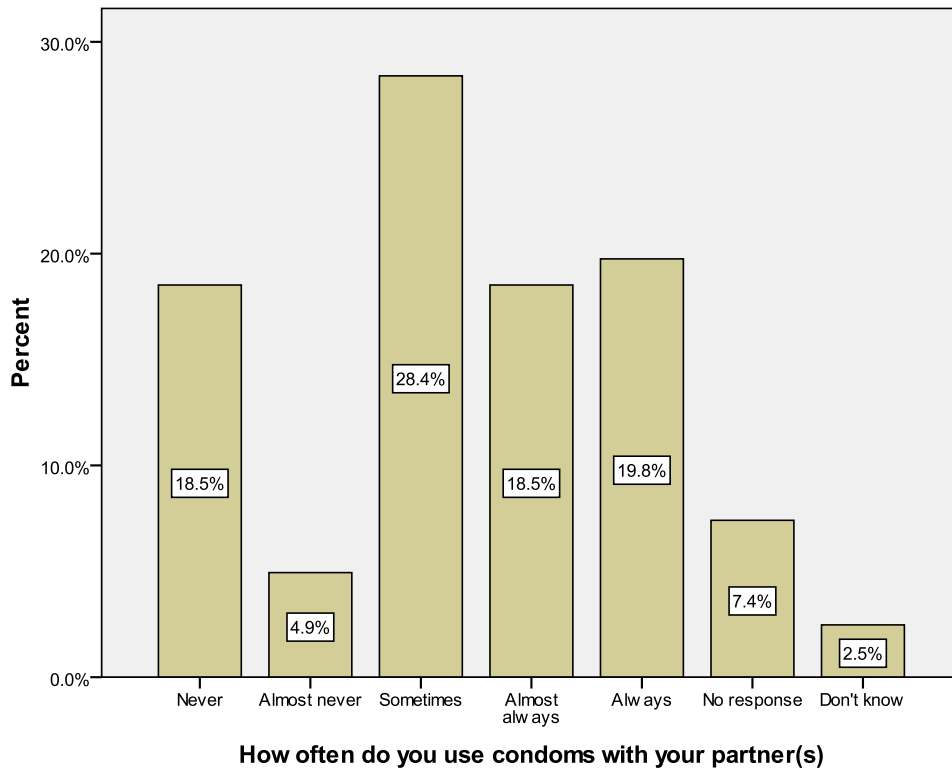
**Table 8: Summary of what MC counsellors include in their counselling sessions before circumcision**

MC Counsellor	Response to the question: What do you include in your counselling sessions before circumcision?
MC Counsellor 1	<ol style="list-style-type: none"> <li>1) Definition of male circumcision</li> <li>2) Benefits of male circumcision which include hygiene, reduced chances of contracting HIV by 60%, reducing chances of cancer STIs etc.</li> <li>3) Possible risks associated with circumcision which include pain, infection, allergic reaction, bleeding.</li> <li>4) HIV information</li> <li>5) Condom demonstration</li> <li>6) Steps or procedure before surgery</li> <li>7) After care including review dates, emergency number and the 6 weeks abstinence</li> </ol>
MC Counsellor 2	<ol style="list-style-type: none"> <li>1) Condom usage and demonstration</li> <li>2) HIV prevention               <ol style="list-style-type: none"> <li>1. Condom usage</li> <li>2. Usage of gloves when assessing someone who is injured</li> <li>3. No sharing of needles and razor blades</li> <li>4. Abstinence.</li> </ol> </li> <li>3) Pretest counseling</li> <li>4) HIV counseling</li> </ol>

	<ul style="list-style-type: none"> <li>5) Posttest counseling</li> <li>6) Benefits and risks of circumcision</li> <li>7) How it is done</li> <li>8) Post-operative care and follow up.</li> </ul>
MC Counsellor 3	<ul style="list-style-type: none"> <li>8) Definition of male circumcision</li> <li>9) How male circumcision reduces chances of acquiring HIV, modes of HIV transmission</li> <li>10) Importance of consistent use of condoms after circumcision.</li> <li>11) HIV counseling and testing(optimal)</li> <li>12) We also discuss STI and mode of transmission</li> <li>13) Post circumcision care and management of pain, hygiene</li> <li>14) Give review dates</li> <li>15) Discuss benefits of circumcision and associated risks</li> </ul>

The data reveals that very few respondents consistently use condoms with their partner(s). Only 19.8% always use condoms, 28.4% sometimes use condoms and 18.5 almost always use condoms. Figure 7 below gives the graphical impression of the respondents' views on condom use.

**Figure 7: Frequency of condom use with your partner(s)**



**4.5 Sexual behavior before and after circumcision**

The results show that 76.5% of respondents were never treated for STI before circumcision, while 22.2% had been treated for STI before circumcision. Of the 22.2% treated for STI before circumcision, 9.9% had been treated only once with 11.1% having been treated twice. Table 9 and 10 below show the pattern on whether or not respondent was ever treated for STI and frequency of treatment respectively

**Table 9: Has Respondent ever been treated for an STI before circumcision?**

<b>Response</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative per cent</b>
No	62	76.5	76.5
Yes	18	22.2	98.8
Don't know	1	1.2	100.0
Total	81	100.0	

**Table 10: Number of times respondent as treated for STI before circumcision**

<b>Response</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative per cent</b>
Never	54	66.7	66.7
Once	8	9.9	76.5
More than once	9	11.1	87.7
No response	9	11.1	98.8
Don't know	1	1.2	100.0
Total	81	100.0	

The responses to the question on whether or not the respondent was ever treated for STI after circumcision suggest that there is a drop in incidence of those that were treated compared to the pre-circumcision pattern. However the responses on frequency of treatment after circumcision do not tally as those that admitted to

having been treated once or more than once are a cumulative 9.9% compared to 8.6% who admitted to having been treated after circumcision. Table 11 and 12 below show the responses to the respective questions

**Table 11: Has respondent ever been treated for an STI after circumcision?**

<b>Response</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative per cent</b>
No	74	91.4	91.4
Yes	7	8.6	100.0
Total	81	100.0	

**Table 12: Number of times Respondent as treated for STI after circumcision**

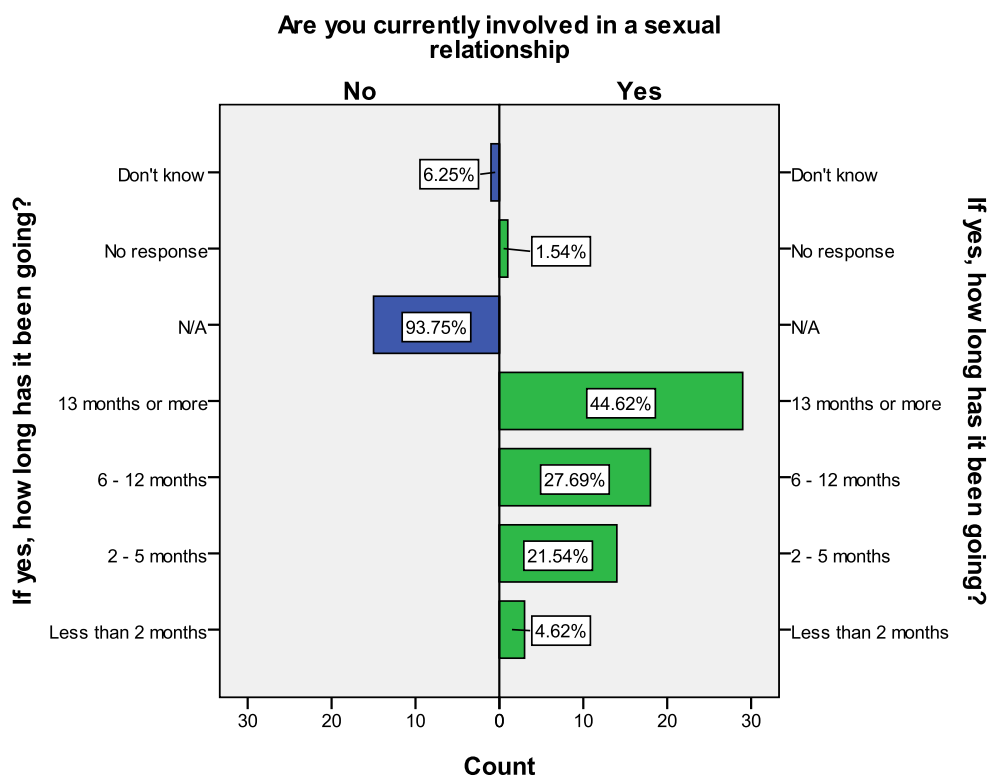
<b>Response</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative per cent</b>
Never	62	76.5	76.5
Once	6	7.4	84.0
More than once	2	2.5	86.4
No response	10	12.3	98.8
Don't know	1	1.2	100.0
Total	81	100.0	



The inconsistency reflected in tables 11 and 12 above marginally point to a possible untruthfulness in respondents' views on STI treatment after circumcision.

The majority of the respondents had existing sexual relationships (80.2%) while the remainder did not have any sexual relationships (19.8%). Figure 8 below shows the distribution in terms of current relationship status as well as duration of relationship.

**Figure 8: Current sexual relationship – duration of relationship**



The results show that among those that had currently relationship, a significant proportion of those relationships had been going for less than 12 months as represented by a cumulative 53.85% of the respondents that had current relationships ranging from less than 2 months old to 12 months.

A closer look at the data shows that the majority of those that had current relationships also had previous relationships before the current. Table 13 below shows the cross tabulation of current and previous relationships.

**Table 13: Cross tabulation of current and previous relationships**

**Are you currently involved in a sexual relationship \* Were you in a sexual relationship with another woman before the current relationship cross tabulation**

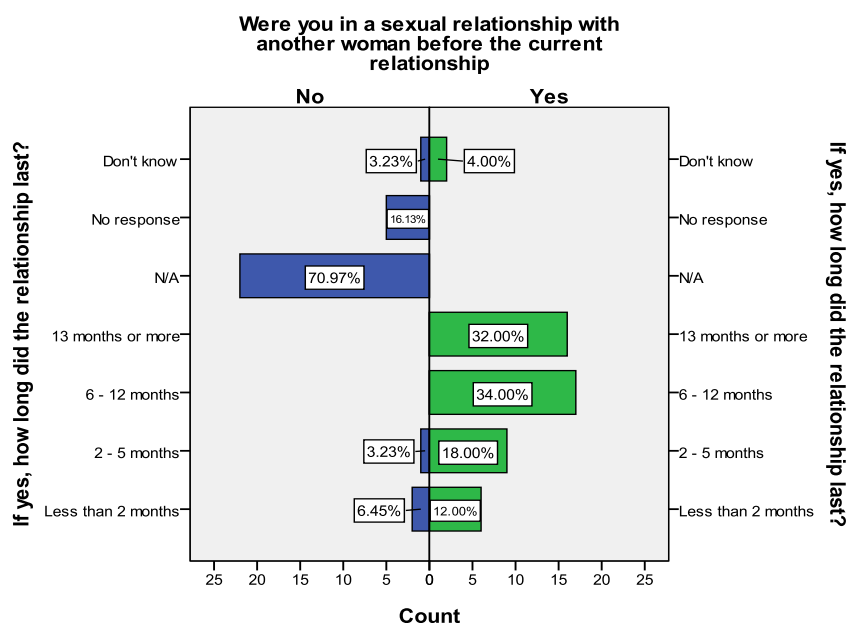
		Were you in a sexual relationship with another woman before the current relationship			Total
		No	Yes	No response	
Are you currently involved in a sexual relationship	No	Count 14	0	2	16
	% of Total	17.3%	.0%	2.5%	19.8%
	Yes	Count 15	50	0	65
	% of Total	18.5%	61.7%	.0%	80.2%
Total	Count	29	50	2	81
	% of Total	35.8%	61.7%	2.5%	100.0%

As shown in table 13 above, 50% of respondents who had current relationships, previously had other relationships, while 18.5% who had current relationships did not have any previous relationships. A further

17.3% did not have current relationships and had not had any previous relationship. It is instructive to note that there was none among the respondents who previously had any relationship and did not have a current relationship.

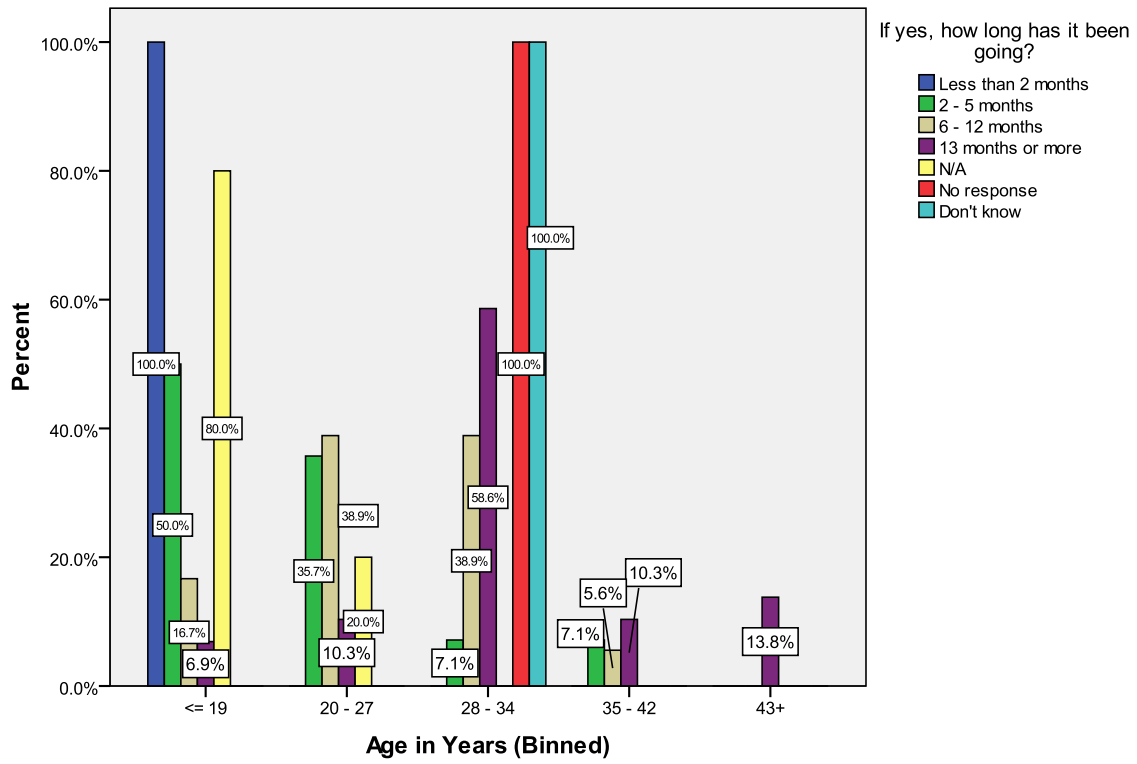
The results further show that the tenure of previous relationships was relatively short with a cumulative 64% of those that had previous relationships indicating that their relationships lasted between less than 2 months and 12 months. This pattern suggests a high relationship turnover. Figure 9 below show the distribution previous relationships and the tenure of those relationships.

**Figure 9: Previous relationships and the tenure of those relationships.**

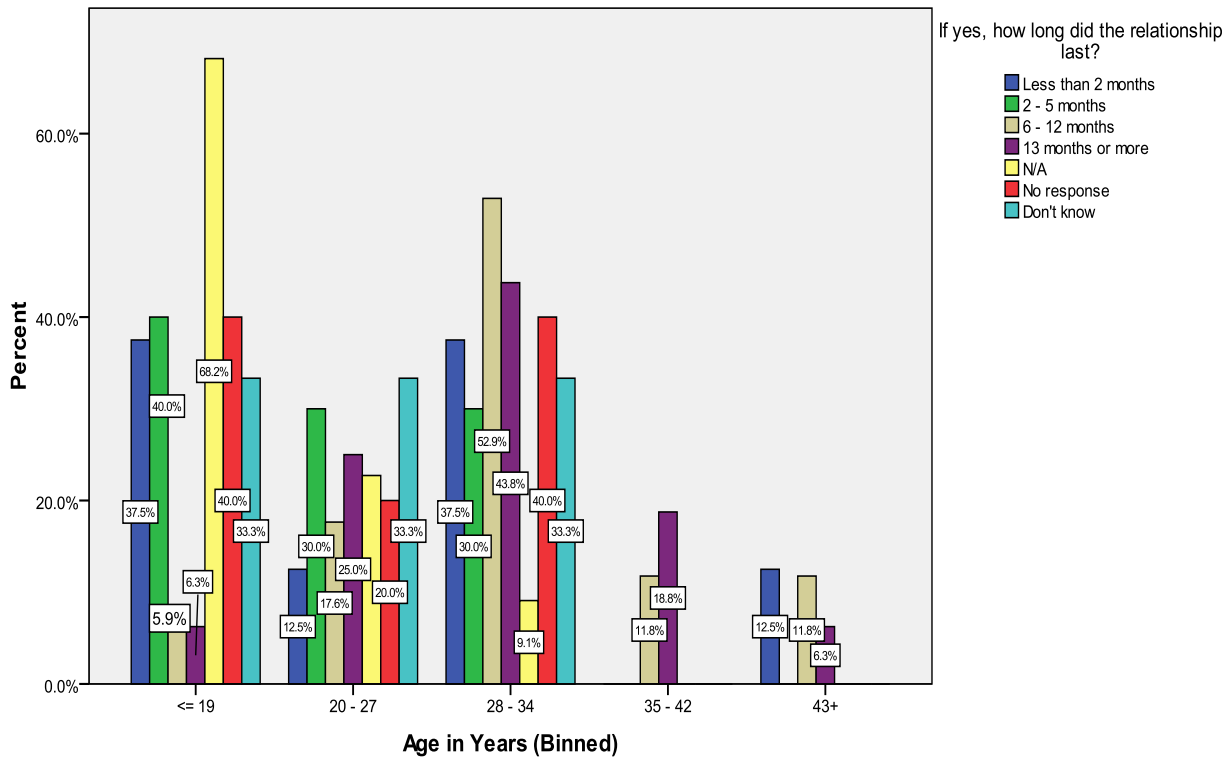


A closer look at the data also shows that the generality of relationships that did not last for long periods of time were among the teenagers and youthful adults as shown in figures 10 and 11 below

**Figure 10: Distribution of tenure of current relationships by age of respondent**



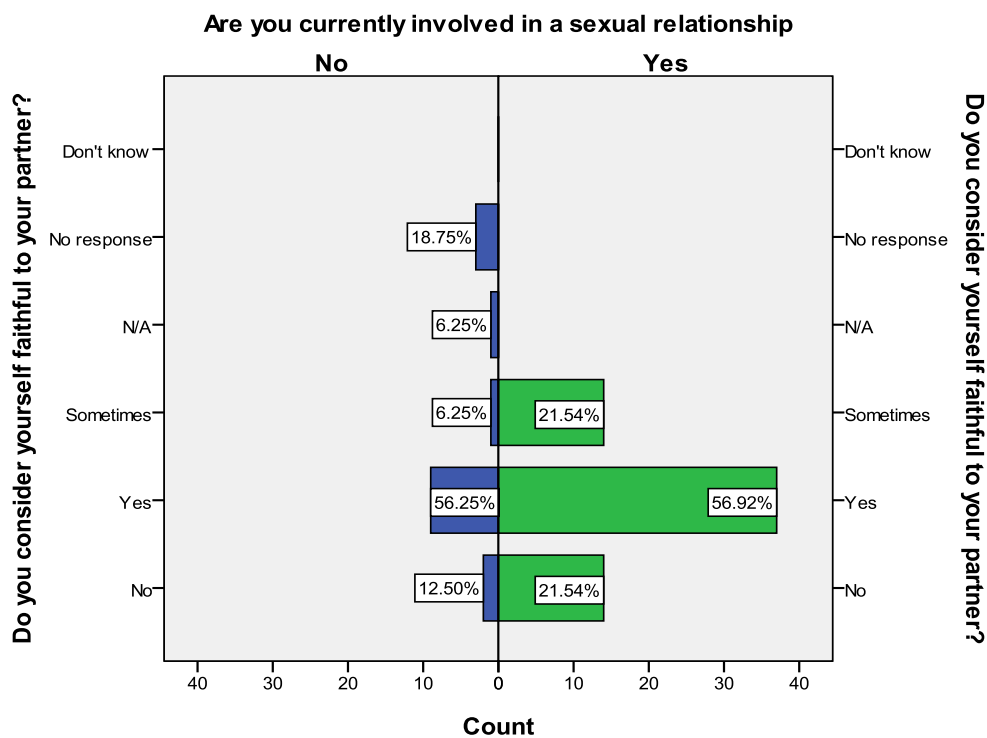
**Figure 11: Distribution of tenure of previous relationships by age of respondent**



The figures 10 and 11 above show that the majority of relationships of 5 months or less were found among the teenagers.

The data shows that although the majority of those in current relationships consider themselves faithful to their partners (56.92%), a significant proportion do not consider themselves faithful to their partners, with those out rightly not faithful comprising 21.54% and those who considered themselves to be faithful sometimes constituting 21.54%. The results further show that even those who did not have current relationships were in a position to form an opinion on whether they considered themselves faithful or not. Among those who did not have current relationships, 56.25% considered themselves to be faithful, while 12.5% considered themselves to be unfaithful and a further 6.25% viewed themselves as intermittent. Among the respondents who did not have current relationships, 18.75% did not respond to the question with the remaining 6.25% indicating that the question was not applicable to them. Figure 12 below paints the graphic impression of the respondents' views.

**Figure 12: Current relationship status against views on whether respondent considered himself faithful to his partner**



The results reveal a pattern where the majority of respondents have not had more sexual partners after circumcision relative to the pre-circumcision period (69.1%). However a significant proportion (22.2%) indicated that they had more sexual partners after circumcision than before. Table 14 below tabulates the findings.

**Table 14: Has respondent had more sexual partners after circumcision than before circumcision**

Response	Frequency	Per cent	Cumulative Per cent
No	56	69.1	69.1
Yes	18	22.2	91.4

N/A	2	2.5	93.8
No response	4	4.9	98.8
Don't know	1	1.2	100.0
Total	81	100.0	

The proportion of respondents with more than one wife and, or girlfriends constitutes a cumulative 14.8% of the respondents. This proportion is significantly smaller compared to those that did not have any partner (44.4%) and those who had 1 partner (40.7%). However the group that more than one partner displays a pattern of inconsistent condom use after circumcision. As shown in the cross tabulation in table 15 below, the respondents with two partners all indicated that they sometimes used condoms after circumcision. Another respondent among those with 3 partners indicated that he never used a condom after circumcision.

Number of wives/wife/girlfriend(s) \* After circumcision, have you been using condoms? Crosstabulation

			After circumcision, have you been using condoms?					Total	
			Never	Always	Sometimes	N/A	No response		Don't know
Number of wives/wife/girlfriend(s)	Zero	Count	10	8	12	2	3	1	36
		% within Number of wives/wife/girlfriend(s)	27.8%	22.2%	33.3%	5.6%	8.3%	2.8%	100.0%
	One	Count	7	11	15	0	0	0	33
		% within Number of wives/wife/girlfriend(s)	21.2%	33.3%	45.5%	.0%	.0%	.0%	100.0%
	Two	Count	0	0	6	0	0	0	6
		% within Number of wives/wife/girlfriend(s)	.0%	.0%	100.0%	.0%	.0%	.0%	100.0%
	Three	Count	1	2	1	0	0	0	4
		% within Number of wives/wife/girlfriend(s)	25.0%	50.0%	25.0%	.0%	.0%	.0%	100.0%
	Four	Count	0	0	1	0	0	0	1
		% within Number of wives/wife/girlfriend(s)	.0%	.0%	100.0%	.0%	.0%	.0%	100.0%
	Five and above	Count	0	1	0	0	0	0	1
		% within Number of wives/wife/girlfriend(s)	.0%	100.0%	.0%	.0%	.0%	.0%	100.0%
Total		Count	18	22	35	2	3	1	81
		% within Number of wives/wife/girlfriend(s)	22.2%	27.2%	43.2%	2.5%	3.7%	1.2%	100.0%

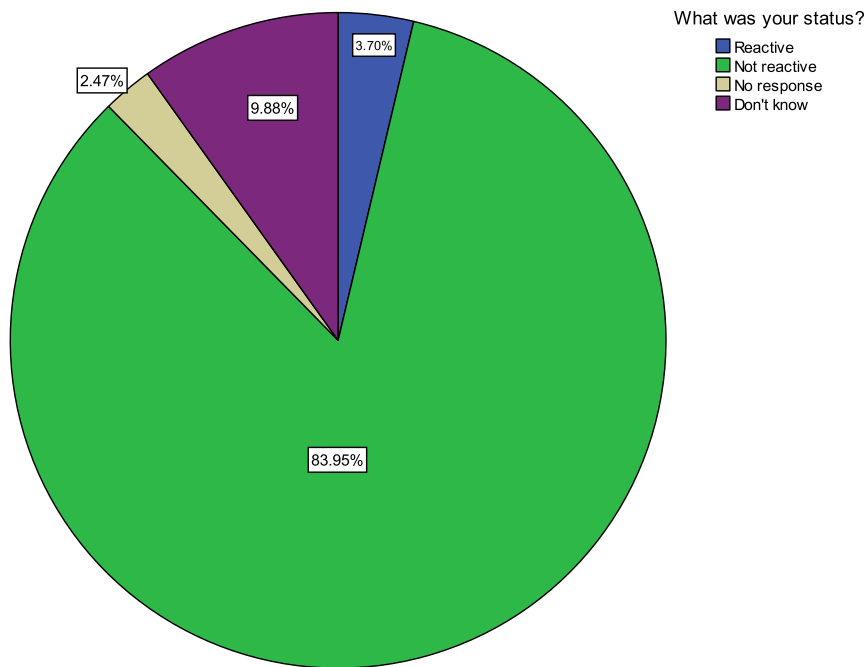
The majority of the respondents tested for HIV before circumcision (86.4%) while others did not test (12.3%). Table 16 below shows the pattern of testing for HIV before circumcision.

**Table 16: Was respondent tested for HIV before circumcision**

Response	Frequency	Per cent	Cumulative Per cent
No	10	12.3	12.3
Yes	70	86.4	98.8
Don't know	1	1.2	100.0
Total	81	100.0	

The majority of respondents that tested for HIV before circumcision were negative (84%), while 3.7% were positive. Figure 13 below show the HIV status of the respondents before circumcision.

**Figure 13: HIV status before circumcision**





A cumulative 63% of the respondents did not get tested for HIV at regular intervals. Those who got tested every three months comprised 14.8%, while those tested every 6 months constituted 8.6% and those tested annually had a proportional representation of 7.4%. The remaining 6.2% did not respond to the question on frequency of HIV testing. Table 17 below summarises the findings on frequency of HIV testing.

**Table 17: Frequency of HIV testing**

Response	Frequency	Per cent	Cumulative Per cent
Never	15	18.5	18.5
When it's necessary	36	44.4	63.0
Every three months	12	14.8	77.8
Every six months	7	8.6	86.4
Yearly	6	7.4	93.8
No response	5	6.2	100.0
Total	81	100.0	

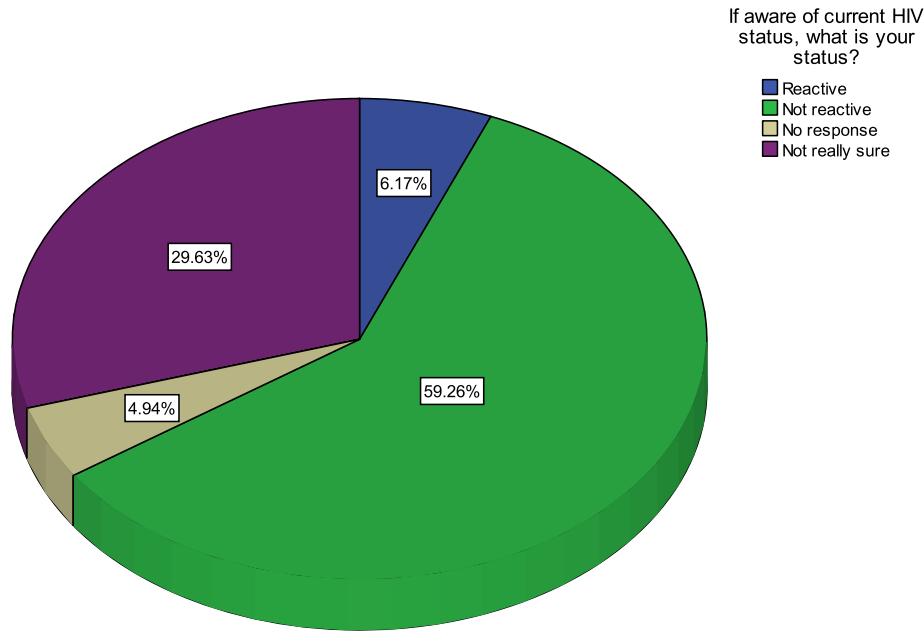
Relative to the period before circumcision, a significantly lower proportion of respondents were aware of their current HIV status. Whereas 86.4% of respondents knew their HIV status before circumcision, only 67.9% knew their current status post-circumcision. Table 18 below summarises the findings awareness of current HIV status.

**Table 18: Whether respondent was aware of his current HIV status**

<b>Response</b>	<b>Frequency</b>	<b>Per cent</b>	<b>Cumulative Per cent</b>
No	14	17.3	17.3
Yes	55	67.9	85.2
Not really sure	12	14.8	100.0
Total	81	100.0	

The results show a marginal increase on proportion of respondents that were positive in the post circumcision period compared to the pre-circumcision period. Similarly the number of respondents who were negative was significantly lower in the current period than in the pre-circumcision period. However a significant proportion of respondents were not really sure of their current status (29.6%). Figure 14 below paints the graphical picture of the findings.

**Figure 14: Current HIV status**



**Focus Group discussions**

**Teenagers**

Five groups of teenagers averaging 8 members were gathered at Mankayane and Holy Rosary high schools. The table below presents the transcribed responses and view of participants in the focus group discussions.

Teenage Groups	
<b>Question 1:</b> What do you understand about circumcision?	<p><b>Responses:</b></p> <ol style="list-style-type: none"> <li>1) According to my understanding it is the removal of the foreskin on the front of the penis, the long skin on the tip of the penis.</li> <li>2) I also understand it the same way but in addition it is the removal of the foreskin of the penis so that one can stay clean and have less chances of developing health problems like</li> </ol>

	<p>cancer and other problems.</p> <p>3) It is the removal of the foreskin of the penis so that one reduces the chances of contracting HIV.</p> <p>4) Also circumcision helps one to reduce the chances of contracting sexually transmitted infections.</p>
<p><b>Question 2:</b> Does circumcision help to prevent one from getting HIV?</p>	<p><b>Responses:</b></p> <p>1) I believe circumcision does help to prevent one from contracting HIV because if we can remember very well, when there is the foreskin of the penis, it easily get warm underneath the foreskin which creates a good medium for the growth of infections and that in turn increases the chances of contracting HIV during sexual intercourse. On the other hand, when one is circumcised, the area where the foreskin was stays dry, clean and hard which makes it hard for germs to grow. Even when you have not taken a bath it does not smell bad because the area is dry and germs cannot enter that dry place, they need a warm and moist place to grow.</p> <p>2) I heard that circumcision reduces the chances of contracting HIV by 60%, which means one has to use a condom on top of being circumcised so that he can be safe.</p> <p>3) According to my knowledge circumcision does not prevent one from getting HIV but only reduces the chances of one contracting HIV.</p>
<p><b>Question 3.</b> What do you think about</p>	<p><b>Responses:</b></p>

<p>condom use after circumcision?</p>	<ol style="list-style-type: none"> <li>1) It is a very good thing to do also. Ok actually it is good for family planning, according to me, but if you want to really enjoy sexual intercourse with your partner, you have to put it aside. In all truth, the answers to this question are numerous. I can say it helps you if you are the kind of guy who likes to go clubbing and have fun. There you meet a girl you didn't know before and you have to use a condom since you don't know the person you will be having sex with, you just met her at the club. That will ensure your safety from contracting HIV other than relying only on the fact that you are circumcised. In that way you will find yourself in trouble if you tell yourself that you are circumcised and you cannot get HIV because circumcision is not a full protective measure. The circumcision and condom use should go together in order to ensure full protection from HIV.</li> <li>2) Using a condom really helps after circumcision mostly because circumcision only reduces the chances of one contracting HIV and when you use the condom now you have increased your protection to about 99%.</li> <li>3) I also agree that it is good and advisable to use a condom after circumcision for the same reasons which my colleagues have already raised.</li> <li>4) I also think using a condom after circumcision helps to further reduce the chances of contracting HIV.</li> </ol>
<p><b>Question 4:</b> Do you think circumcision is allowing men to practise unsafe</p>	<p><b>Responses:</b></p> <ol style="list-style-type: none"> <li>1) Yes some people have the mentality that because now they are circumcised they can go and have sex anyhow, however a person needs to use his mind and think wisely. He needs to get</li> </ol>

<p>sex?</p>	<p>rid of this mentality although we vary as individuals in our way of thinking, some really cannot make good choices for themselves.</p> <p>2) I also think for some men yes it gives them the courage to practise unsafe sex with the knowledge that since they are circumcised they cannot contract HIV, which is not true. Circumcision only reduces the chances and do not provide 100% protection from HIV.</p>
<p><b>Question 5:</b> Are we sending the right message out there about circumcision? Give your reasons.</p>	<p><b>Responses:</b></p> <p>1) I can safely say they are sending the right and relevant message considering the increased numbers of people who are going for circumcision. It is rare to have the majority or a large number of people doing what are wrong and by the numbers that have responded positively to circumcision, I can say the right message is being sent. Even the strategies that they use to motivate the public are working quite well when you consider the response. According to me, I think the wrong message is being sent out because when I went for circumcision and HIV testing we were told our results were negative and most of us came out smiling because of that. No one was told he was HIV positive. However when it was reported on the radio, it was said that 80% of those who were circumcised were HIV positive but that was never communicated directly to us who were tested and circumcised. That even prompted me to go back for a retest later on when I was sick with asthma.</p> <p>2) I think and believe the right message is being sent out because after the talks and education one is able to have the courage to go for the circumcision and the HIV test.</p>

<p><b>Question 6:</b> What were you taught during counselling before circumcision? Tell me anything that you can remember.</p>	<p>3) I was taught that after circumcision I should not go sleeping around and engaging in unprotected sex just because I am circumcised.</p> <p>4) I was told that if I were to engage in sexual intercourse, I should always use a condom and must not rely only on the fact that I am circumcised. I should know that circumcision only reduces the chances of contracting HIV and does not completely eliminate them. They emphasised on good behaviour and responsible actions.</p> <p>5) I was strongly advised to practise safe sex after circumcision at all times. I was told not to trust people's appearance because one may look fresh and beautiful only to find that he/she is HIV positive. It is very important to use protection because the blood may not be as fresh as the looks.</p> <p>6) I was told that after circumcision the penis stays clean and free from most infection causing organisms. I was also told that I have reduced chances of infecting my sexual partner diseases like cancer</p> <p>7) I was told to continue behaving myself well.</p> <p>8) I was taught that I get 60% protection from circumcision and the other 40% protection comes from me.</p>
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## Adult groups

Focus group discussions for adults were all held at Mankayane Government hospital. Five groups averaging 8 participants were gathered below is transcription of their responses to various questions

<b>Adult groups</b>	
<b>Question 1:</b> What do you understand about circumcision?	<b>Responses:</b> <ol style="list-style-type: none"> <li>1) It is the surgical removal of the foreskin of the male penis by a doctor for hygienic purposes.</li> <li>2) It is the tradition of the Xhosa people through which their young boys are initiated in to adulthood or manhood. They spend a long time in the mountains where a number of rituals are performed of which circumcision is the major one.</li> <li>3) It is a strategy that has been discovered to help in reduction of the chances of transmission of HIV from women to men.</li> <li>4) It is the removal of the foreskin from the male penis to prevent contracting STIs.</li> <li>5) It helps in lowering the risk of women developing cervical cancer if their sexual partners are circumcised.</li> <li>5) It helps in improving sexual pleasure by enabling the male partner to last longer during intercourse.</li> </ol>
<b>Question 2:</b> Does circumcision help to prevent one from getting HIV?	<b>Responses:</b> <ol style="list-style-type: none"> <li>1) It does protect me to a certain extent as it offers only 60% protection. This means I still have to use other measures of prevention like the use of a condom and faithfulness to one sexual partner who is also faithful to me.</li> </ol>



	<ol style="list-style-type: none"> <li>2) It does not protect me as there are still chances of contracting the virus even after circumcision. We are always encouraged to use condoms even when we are circumcised.</li> <li>3) Circumcision offers partial protection as there are still chances of getting bruised during sex which allows easy entry of the virus in to the body.</li> <li>4) I think it does protect me because if we say it reduces the chances of contracting the virus by 60%, that means its more than half protection which leaves less chances of me contracting the virus..</li> <li>5) I believe it doesn't but makes it easy for me to clean my penis and help it to stay clean and free from germs.</li> <li>4) I think it does protect me and that is why I got circumcised. But I was encouraged to use a condom every time I have sex to make sure I am fully protected from HIV</li> </ol>
<p><b>Question 3.</b> What do you think about condom use after circumcision?</p>	<p><b>Responses:</b></p> <ol style="list-style-type: none"> <li>1) It is a wise thing to do as it will increase the protection from the 60% of circumcision to about a hundred percent.</li> <li>2) It is the right thing to do especially because we are always encouraged to do so even after we are circumcised. What we are being told by counselors and health educators is very important as they are trained and they know better.</li> <li>3) I think it is wise to use it especially if you have multiple sex partners or you sometimes have sex with people you don't know very well like in clubs, parties and bars.</li> </ol>

	<p>4) It is still recommended that one use a condom after circumcision as we all know that a condom is not only for the prevention of HIV but also family planning and the prevention of other STIs.</p> <p>5) I think you can use a condom after circumcision when you are having sex with someone who is not your wife or steady girlfriend. But when you are having sex with your wife or steady girlfriend you can leave it as you know and trust her. But the others you don't know and you have to be careful with them.</p> <p>6) We are encouraged to use a condom and I support that too. In order to be safe it is wise to use both methods together as they don't contradict each other and they can be used at the same time without any problem.</p>
<p><b>Question 4:</b> Do you think circumcision is allowing men to practise unsafe sex?</p>	<p><b>Responses:</b></p> <p>1) Personally I don't think it does encourage men to practice unsafe sex because we are taught very well that it only offers 60% protection and the 40% is still there and if one engages in unprotected sex, he puts his life in danger of contracting the virus. 40% is still a huge gap.</p> <p>2) I don't think it does encourage men to practice unsafe sex because there are still other needs for the condom like family planning and also to prevent other STIs. So even if you are circumcised there are other things that require you to use the condom.</p> <p>3) I don't think it does because we are taught very well and encouraged to use a condom every time we engage in sex even after circumcision. Therefore I think it would be unfair because</p>

	<p>the providers of circumcision always emphasize safe sex.</p> <p>I agree with my fellow respondents but we cannot run away from the fact that there are people who abuse the service and think just because they are now protected they can have sex without a condom and even worse have sex with more than one partner. In a way I think it do give others the ground to be promiscuous and careless.</p>
<p><b>Question 5:</b> Are we sending the right message out there about circumcision? Give your reasons.</p>	<p><b>Responses:</b></p> <ol style="list-style-type: none"> <li>1) I think the message is loud and clear. I would suggest emphasis is made on responsible behavior after circumcision so that the benefits are fully enjoyed.</li> <li>2) I think the message is right although circumcision has been made to appear all good whereas there is nothing that is all good. I think even the negatives should be clearly outlined to avoid frustrations after the procedure has been done.</li> <li>3) The message is obviously good and I would suggest that great emphasis is put on the younger generation who stand a better chance of reaping the benefits of the procedure. That is the newborns and the still sexually latent or inactive.</li> <li>4) I personally believe the message that is being communicated about circumcision somehow is not the right message because some of the people like Christians don't usually welcome you well if you are preaching the gospel of circumcision and HIV only without including the other benefits of circumcision. Most people don't go for circumcision because of the HIV attached to it whereas there are other benefits like cleanliness, protecting ones partner from cervical cancer. These benefits are not loudly echoed like the HIV element and this hinders other people from adopting and using the service. I think in that way we are not</li> </ol>

	<p>sending the right message and at the end we have people who are reluctant to circumcise.</p> <p>5) The message is not 100% right. It is lacking somehow. I understand and acknowledge the fact that the major emphasis is on HIV because it is a big problem in the country that is really affecting us; there are also other things that you do not say concerning some effects or side effects of circumcision on us the recipients. You always give us the benefits or the good about circumcision yet there are disadvantages of circumcision for example ones sexual life might be compromised somehow although this may depend on the individual. We are taught that the foreskin is sensitive and when the foreskin is removed you may find that this has a negative bearing on the person's libido making him less sexually active. I strongly believe it affects some of us in our sexual life and with my little experience I has felt that negative impact. For some it may not affect and for some it does affect and making them not to perform well sexually.</p> <p>6) I would suggest that circumcision be marketed as a hygiene benefiter not as an HIV prevention strategy so that it can cover and include almost everyone from all walks of life. It must not be made a religious thing or pinned to HIV as the major reason. Hygiene could be the better variable</p>
<p><b>Question 6:</b> What were you taught during counselling before circumcision? Tell me anything that</p>	<p>1) I was told about how the procedure will be done.</p> <p>2) I was told of the benefits and disadvantages of circumcision</p> <p>3) I was told of how to take care of my penis after the procedure,</p> <p>4) I was told to always use a condom when having sex.</p> <p>5) I was told to wait for six weeks after the procedure then I can</p>

<p>you can remember.</p>	<p>resume sex after that.</p> <p>6) I was told that I have some protection from HIV and that my partner has reduced chances of contracting or developing cervical cancer.</p> <p>7) I was taught that my penis will stay clean,</p> <p>8) I was taught that chances of me contracting HIV from a woman will be lessened by 60%; they also mentioned that it may offer some protection from man to man transmission for those who are homosexual or bisexual. However they did not go deep in explaining that.</p> <p>9) I was also taught that I will enjoy better performance during sexual activity which actually made me run over my heels to do the procedure thinking that I will come back and perform exceptionally well in bed in order for the Swazi nation to grow and live on the years. However that is yet to be proven true or otherwise.</p>
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#### 4.6 Observation of counselling sessions

Three visits were made to observe counselling sessions. The observed counselling sessions were conducted in a professional manner. The observation checklists that were used in all three visits were ticked on every item to indicate the efficacy of the counselling sessions.

#### 4.7 Conclusion

From the above graphical as well as tabular presentations and subsequent analysis, very significant findings or revelations have surfaced. Consequently, the researcher presents the interpretation, discussion and analysis of the findings and linking to literature review in the next chapter.

## **CHAPTER FIVE: DISCUSSION OF FINDINGS**

### **5.1 Introduction**

Having displayed the findings of the collected data from self-administered questionnaires, focus group discussions, in-depth interviews and observation checklist, the researcher proffers insight into the meaning of the patterns displayed in the preceding chapter. In this chapter therefore, the researcher exhibits the interpretation, discussion and further analysis of the findings in light of the research question and objectives of the study. The findings are justified, supported, or contradicted by linking the primary findings to the secondary findings as presented in the literature review.

### **5.2. Knowledge, Attitude and Practices (KAP) of circumcised men towards safe sex**

The subsequent analysis disaggregates the KAP in order to analyse each aspect individually.

#### **Knowledge of circumcised men towards safe sex**

The responses solicited from the men who participated in this study show that there is basic knowledge with regards to safe sex and the value of MC in the prevention HIV. The pattern in the data however shows that those that were the most recent to undergo medical circumcision had the most varied opinions on the extent to which MC protect one from HIV. Some among the group that was circumcised between 2009 and 2012 pinioned that circumcision gave as much as 100% protection from HIV contrary to studies which place the protection rate at 60%.

Overwhelming evidence pointed to the fact that the men have adequate knowledge as to what MC is all about. Responses from teenagers and adults in focus group discussion invariably gave satisfactory answers to the questions regarding what MC was. Only a marginal few viewed MC as a foreign concept, with the majority articulating reasons and benefits of circumcision.

The data further revealed that majority of men had attained a minimum of secondary education (96%) which gives them adequate exposure to literature on HIV as well as ability to read. The literacy levels among the men make it probable that they have encountered literature on HIV beyond their experience with the MC Counsellors. This is a reasonable assumption to make in light of the nationwide campaigns by the Ministries

of Health and Education as well as the National Emergency Response Council on HIV and AIDS (NERCHA).

The majority of the respondents' demonstrated knowledge of the two main safe sex practices, namely abstinence (95%) and condom use (85%). The other practices are not very well known, with circumcision cited by 60% of the respondents. This knowledge deficiency contrasts negatively with the global acceptance of MC as one of the key practice that reduces HIV. According to the World Health Organisation (WHO), "The efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt. Promoting male circumcision should be recognised as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men" (WHO/UNAIDS, 2007).

The majority of respondents demonstrated knowledge of the fact that MC male circumcision for HIV prevention is partially protective for HIV negative men but not for their partner(s), whether male or female. However some thought that MC can also protect HIV negative women from HIV positive men who are circumcised. Such a notion is contrary to the assertion by Berer (2007) that MC is the only HIV prevention intervention that does not protect both sexual partners, to some extent.

### **Attitude of circumcised men towards safe sex**

The majority of men revealed that they considered themselves to be heterosexual or straight. The reasons cited by most men for choosing circumcision are related to hygiene, medical as well as partial prevention of HIV. This is in stark contrast to the global trends where, the major determinant of male circumcision is religion: almost all Muslim and Jewish men are circumcised. In Swaziland, very few men consider culture or religion as the motivation for circumcision as the data revealed.

As studies elsewhere have proved, (MMC) as an HIV prevention measure is not without controversy. Studies have shown that MMC is not merely a technical procedure; its roots are deeply embedded in the culture of a society. Traditionally, it is a practice with a host of social meanings (Aggleton, 2007). The controversy with MC was brought up in one of the focus group discussion with other participants alleging that the practice was foreign to Swaziland and only known to have been practiced among the Xhosas. Among the reasons cited for circumcision, a significant proportion (40%) underwent the procedure for sexual satisfaction. Such a reason could give the men the desire to experiment without use of protection in

order to maximise their satisfaction. Some men didn't see the reason why they went for circumcision yet they were expected to use condoms. They really wish it was 100% protective.

### **Practices of circumcised men towards safe sex**

The data points to a pattern where the men have a high relationship turnover with some relationships not lasting longer than 2 months. This pattern is more discernible among the teenagers who suggest that the relationships are not built on commitment but possible experimentation. While the study did not have control that tracked uncircumcised men for comparative purposes, the findings point to inconsistent use of condoms among men which heightens the risk of HIV transmission.

The above notion is supported by literature which revealed that there were three MC clinical trials done in Kenya(Kismu),Uganda(Rakai) and South Africa(Orange farm) investigated many of the same sexual behaviours which explored more on safe sex, including condom use, number of partners, non-marital partners, alcohol use and sex. The trial data showed no consistent evidence of any substantial risk compensation. Among these sexual behaviours evaluated in the Rakai, Uganda trial, significant differences were only shown in inconsistent condom use and alcohol use. Inconsistent condom use was higher in the circumcised group.

The pre-circumcision and post-circumcision HIV status of respondents seems to suggest that a few got HIV after they had been circumcised. Literature points to an increasing pattern where circumcised men are found to have higher incidence of HIV than uncircumcised men. Reports from the United States and several African countries show that, despite the WHO push for circumcision as the key strategy against AIDS in underdeveloped countries, HIV infection rates are increasing rapidly among circumcised populations. The most recent evidence to undermine the hypothesis that circumcision is the most effective preventive intervention against AIDS is a report in the *New England Journal of Medicine(NEJM)*, which reveals an HIV epidemic in the (largely circumcised) USA that rivals the problem in (largely circumcised) regions of Africa.

The pattern where the majority of the respondents knew their HIV status before circumcision than the proportion that new their post-circumcision HIV status could be interpreted in two ways. It could be that the respondents have not been engaging in risky behaviour that exposed them to the virus and hence did not see the need to test or it could mean that the men have been engaging in risky sexual behaviour causing them hesitation to test for HIV.



The finding shows that much as the men knew that condom use was a key to HIV prevention practise, few showed willingness to use the method. Literature revealed that there is a further risk that men and women who perceive a decreased risk of HIV transmission for circumcised men will be less willing to use condoms as a protection measure. Women may also face the challenge of negotiating safe sex with men who think they do not have to use condoms because they are circumcised, (Hankins, 2007).

The unwillingness by men to use condoms contrasts negatively with the drive by the authorities to ensure accessibility of condoms throughout the country. Reviewed literature showed a similar picture to the one painted by the findings of this study where condoms have been widely available in Swaziland since the 1990s. The government and other agencies made over one million male condoms available in 2000 and by 2004 this number had grown to over 7 million. Female condoms have also been distributed, but much less widely- around 312,000 were handed out in 2000(Plus News, 2008).In spite of their good supply in Swaziland, the use of condoms remains controversial and unpopular. In the 2006/7 Swaziland Demographic and Health Survey around half of sexually active respondents aged 15-49 admitted to engaging in non-regular sex without using condoms. "Men in Swaziland do not use condoms. They are distributed all over, but they are not used." this was a comment made by an AIDS activist and health motivator. Although the government has encouraged condom use, some influential community leaders have undermined the government's message, and some people once stated that "condoms don't stop AIDS" and only "faithfulness and abstinence stop AIDS" Religious and traditional leaders have also described condoms as "unSwazi".

### **5.3 Efficacy of counseling programme**

The results point to a well-structured programme of counseling followed by MC counselors. The focus group discussions reflect on the counselors as most participants could recount details and facts obtained during counseling sessions. According to USAID Health Policy initiative on male circumcision presented to PEPFAR in 2007, men should practice safe sex before and after circumcision. It is the duty of the counselors to make sure during the counseling process all men are educated on safe sex and the following points followed.

- 1) Male circumcision reduces the risk of HIV infection for men but only provides partial protection. It is not a substitute for other proven HIV prevention methods.

- 2) Men should not resume sexual intercourse for at least six weeks after circumcision to ensure the healing process is complete. Ideally sex should only recommence after a medical assessment confirms the healing process is complete.
- 3) All males, whether circumcised or not, should seek to reduce the risk of HIV transmission through using condoms correctly and consistently and limiting their number of sexual partners.
- 4) Whether circumcision takes place in a clinical or a traditional setting it is important to ensure safety.
- 5) Information on HIV risk reduction and other benefits for male sexual and reproductive health need to be widely available to ensure individuals make informed choices about male circumcision.

All the above factors have been taken into consideration and religiously followed during counseling sessions. The findings however reveal that the packaging of the MC message should not concentrate on reduction of HIV only but also talk about hygiene so as to appeal to a wider audience like those in religious groupings that may stigmatize men who circumcise and label them immoral.

#### **5.4 Conclusions**

The aim of the study was to determine the KAP of circumcised men towards safe sex in order to contribute to reduction of HIV transmission. The objectives were to identify the knowledge, attitude and practices (KAP) of circumcised men towards safe sex; establish the existing knowledge of the relationship between circumcision and HIV prevention; establish whether men in Swaziland take part in riskier sexual behaviour after or before being circumcised; and make recommendations for the counselling programme. The study was able to satisfy the aim and objectives. The research process was designed to collect the necessary data and be analysed in a manner that answered the research question. The research target population and subsequent sample represented the geographical scope of the study. The research tools were designed to be easy for the respondents to use. The distribution and collection method was designed to give the respondents less hassle as possible. This had a positive impact on the response rate, which increased the validity of the data collected. Both the literature review and primary research findings affirm that MC without behaviour change is not the panacea for prevention of HIV.

## 5.5 Recommendations

Discussions with circumcised men and MC Counselors revealed that circumcision is gaining strength as a preventive measure towards HIV transmission but currently it is not the only reason why men undergo circumcision, some of the reasons cited out medical, cultural, hygienic, religious and social. Innovative communication about the complex issue of MC and HIV prevention is critical to prevent myths from circulating and to ensure people adhere to the correct advice. Specifically, communication needs to be clear, consistent and effective on the following points:

- 1) Male circumcision is only partially protective and people should never replace known methods of HIV prevention.
- 2) If men resume sexual relations before complete wound healing has taken place ,they may increase their risk of acquiring HIV.
- 3) The risk of HIV transmission to female partners of recently circumcised HIV positive a man is also increased.
- 4) Men who undergo circumcision should abstain from sexual activity for at least six weeks after the operation. Ideally medical inspection should establish whether the wound is healed completely.
- 5) Women are not protected against HIV if they have unprotected sexual relations with circumcised men.
- 6) MC does not replace other prevention measures such as delay in the onset of sexual relations ,avoidance of penetration ,reduction in the number of sexual partners ,and consistent use of male or female condoms
- 7) People still need to go for HIV testing and counseling, and treat STIs.
- 8) Women and young girls need extra support to negotiate safe sex in an environment where men think they are protected, either fully or partially, against HIV.
- 9) Men who are at risk of HIV infection are connected into sexual networks of multiple partnerships .This should influence the counseling before and after circumcision

- 10) Both men and women should have access to accurate information about the procedure itself: where to access an official MC Service, the levels of pain involved, and the healing process, in particular when to resume sexual activity.
- 11) There should be counseling of both men and their sexual partners to prevent them developing a false sense of security.
- 12) More research is needed to understand community's perceptions of MC.
- 13) Prevailing myths and misconceptions about MC should be addressed in communication strategies and activities.
- 14) More research is needed to explore how participatory approaches could best address MC, particularly with people who have less power and access to information. More research is needed to assess the type and efficacy of harm reduction' approaches that find acceptance in the local and cultural context.

## **5.6 Future research**

Future research is necessary as the dynamics and composition of the population continue to evolve. The findings of this study can inform studies in other parts of the country to ensure countrywide interventions informed by evidence. Results of this study can further be used as reference for similar studies elsewhere in the world.

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## APPENDIX A

Dear Respondent/Participant

### **Re: Knowledge, attitudes and practices of circumcised men towards safe sex in Mankayane district.**

In partial fulfillments of the requirements of the Master Philosophy Degree in HIV/AIDS Management from the Africa Center of HIV/AIDS Management at Stellenbosch University. I am carrying out a study with the above title. The information you will supply is for academic purposes and will be treated with confidence. The purpose of this study is to highlight the gaps in the education and prevention of HIV messages pre and post circumcision. It will also help to stress clear and consistent messages concerning safe sex practices post circumcision which will assist HIV prevention strategies. Through the questionnaire I intend to ask the following research question- What is the knowledge, attitudes and practises of circumcised men towards safe sex? The aim of the study is to determine the knowledge, attitudes and practises of circumcised men towards safe sex with the hope of strengthening the counselling programme pre and post circumcision and communication strategy in an effort to reduce the transmission of HIV.

#### **The study objectives are as follows-**

1. To identify the knowledge, attitude and practices (KAP) of circumcised men towards safe sex.
2. To establish the existing knowledge of the relationship between circumcision and HIV prevention.
3. To establish whether men in Swaziland take part in riskier sexual behaviour before or after being circumcised.
4. To make recommendations for the counselling programme.

Please feel free to contact me should you have any questions or you need clarification. Thank you.

Yours sincerely

Dr. Debrah Vambe



**APPENDIX B****QUESTIONNAIRE****A STUDY ON KNOWLEDGE, ATTITUDE AND PRACTICES (KAP) OF CIRCUMCISED MEN TOWARDS SAFE SEX IN MANKAYANE DISTRICT.****CODE:****Demographic and Socio Economic Information**

<b>No.</b>	<b>Question</b>	<b>Coding</b>	<b>Response</b>
<b>1.00</b>	How old are you?	Age in Years 99= Don't Know	_ _
<b>1.02</b>	What was your nationality at birth?	01= Swazi 02= Mozambique 03= South African 04=Other → _____ 88= No response 99= Don't know	_ _
<b>1.03</b>	What is the highest level of your education?	01= Never been to school 02= Primary School 03= Secondary school	_ _

		<p>04= High School</p> <p>05= University/College</p> <p>88= No response</p> <p>99= Don't know</p>	
<b>1.04</b>	What is your current employment status?	<p>01= Unemployed</p> <p>02=Self-Employed</p> <p>03= Employed</p> <p>04=Retired</p> <p>05=Student</p> <p>88= No response</p> <p>99= Don't know</p>	
<b>1.05</b>	What is your marital status?	<p>01=Single/Never married</p> <p>02=Married</p> <p>03=Divorced/separated</p> <p>04=Widowed</p> <p>05=Steady girlfriend not living together</p> <p>06=Steady girlfriend living together</p> <p>88= No Response</p> <p>99= Don't know</p>	
<b>1.06</b>	How many children do you have?	<p>01=Zero</p> <p>02=One</p>	

		<p>03=Two</p> <p>04=Three</p> <p>05=Four</p> <p>06=Five and above</p> <p>88= No response</p> <p>99= Don't know</p>	
<b>1.07</b>	<p>How many wives/wife/girlfriend(s) do you have?</p>	<p>01= Zero</p> <p>02= One</p> <p>03=Two</p> <p>04=Three</p> <p>05=Four</p> <p>06=Five and above</p> <p>88= No response</p> <p>99= Don't know</p>	<p>   </p>
<b>1.08</b>	<p>What do you consider your sexual orientation to be?</p>	<p>01= Gay or homosexual</p> <p>02= Bisexual</p> <p>03= Heterosexual or straight</p> <p>04= Transgender</p> <p>05= Other: (specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>

**Circumcision**

No.	Question	Coding	Response
2.00	When were you circumcised?	01= 2000-2004 02= 2005-2008 03= 2009-2012 88= No Response 99= Don't know	_ _
2.01	How were you circumcised?	01= Medically 02= Culturally 03= Other..... 88= No Response 99= Don't know	_ _
2.02	What was your reason for circumcision?  A. Cultural  B. Religious  C.Social  D.Medical(phimosis/paraphimosis, balanitis, UTI, etc)  E.Hygienic	01=A only 02=A&B only 03=C&E only 04=All those listed 05=D&E only 06=F only	_ _

	<p>F.Partially prevent HIV infection</p> <p>G.Reduce incidence of penile cancer</p> <p>H.To increase sexual satisfaction</p> <p>I. To reduce incidence of cervical CA in my partner.</p> <p>J.Other.....</p>	<p>07=H only</p> <p>08=D,E,F,G,H&amp;I</p> <p>88=No Response</p> <p>99=Don't Know</p>	
<b>2.03</b>	<p>Which safe sex practices do you know?</p> <p>A.Abstinence</p> <p>B.Condom use</p> <p>C.Circumscision</p> <p>D.Monogamy</p> <p>E.Partner selection/safe partner</p> <p>F.Masturbation</p> <p>G.Anal sex</p> <p>H.Oral sex</p> <p>I. Lubrication</p> <p>J.Other.....</p>	<p>01= A only</p> <p>02= A&amp;B only</p> <p>03=A,B,C only</p> <p>04=A,B,C,D,E only</p> <p>05=A,B,C,E only</p> <p>06=A,B,C,D,E,H only</p> <p>07=A,B,C,D,E,F,H,I</p> <p>08=F,G,H,I only</p> <p>09=All those listed</p> <p>88=No Response</p> <p>99= Don't know</p>	<p> _ _ </p>
<b>2.04</b>	<p>Referring to 2.03, which ones do you practice?</p>	<p>01=A only</p> <p>02=A,B ,C only</p> <p>03=B,C only</p> <p>04=B,C,D,E only</p> <p>05=B,C,E only</p>	<p> _ _ </p>

		<p>06=B,C,D,E,H only</p> <p>07=B,C,D,E,F,H,I only</p> <p>08=F,G,H,I only</p> <p>09=All those listed</p> <p>88= No Response</p> <p>99= Don't know</p>	
<b>2.05</b>	How often do you use condoms with your partner?	<p>00= Never</p> <p>01= Almost never</p> <p>02= Sometimes</p> <p>03= Almost always</p> <p>04= Always</p> <p>88= No Response</p> <p>99= Don't know</p>	
<b>2.06</b>	Does circumcision protect you from being infected with HIV?	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	
<b>2.07</b>	If yes, to what extent does it protect you from being infected?	<p>01= &lt;50%</p> <p>02=50-59%</p> <p>03=60-69%</p>	

		04=70-79% 05=100% 77=Not Applicable 88= No Response 99= Don't know	
<b>2.08</b>	Does circumcision prevent transmission of HIV from A.Women to men? B.Men to women? C.Men to men?	01=A only 02=A&B only 03=A&C only 04=All those listed 88= No Response 99= Don't know	_ _
<b>2.09</b>	Have you ever been treated of an STI before circumcision?	00= No 01= Yes 88= No Response 99= Don't know	_ _
<b>2.10</b>	Referring to 2.09, how many times were you treated?	00= Never 01= Once 02=More than once 88= No Response 99= Don't know	_ _

<b>2.11</b>	Have you ever been treated of an STI after circumcision?	00=No 01=Yes 88=No Response 99=Don't know	_ _
<b>2.12</b>	Referring to 2.11, how many times were you treated?	00=Never 01=Once 02=More than once 88=No Response 99=Don't know	_ _
<b>No.</b>	<b>Question</b>	<b>Coding</b>	<b>Response</b>
	<b>Sexual Partners</b>		
<b>3.00</b>	Are you currently involved in a sexual relationship?	00= No 01= Yes 88= No Response 99= Don't Know	_ _
<b>3.01</b>	If yes, how long has it been going?	00= Less than 2 months 01= 2-5 months	_ _



		<p>02= 6-12 months</p> <p>03= 13 months or more</p> <p>77=Not Applicable</p> <p>88= No response</p> <p>99= Don't know</p>	
<b>3.02</b>	Were you in a sexual relationship with another woman before the current relationship?	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't Know</p>	<p>   </p>
<b>3.03</b>	If yes, how long did it last?	<p>00= Less than 2 months</p> <p>01= 2-5 months</p> <p>02= 6 -12 months</p> <p>03= 13 months or more</p> <p>77=Not Applicable</p> <p>88= No response</p>	<p>   </p>

		99= Don't know	
<b>3.04</b>	Do you consider yourself faithful to one partner?	00=No 01=Yes 02=Sometimes 88=No Response 99=Don't know.	_ _
<b>3.05</b>	Have you had more sexual partners after circumcision than before circumcision?	00=No 01=Yes 88=No Response 99=Don't know	_ _
<b>3.06</b>	After circumscision, have you been using condoms?	00=Never 01=Always 02=Sometimes 88=No Response 99=Don't know	_ _
	<b>HIV Testing and counselling (HTC).</b>		
<b>No.</b>	<b>Question</b>	<b>Coding</b>	<b>Response</b>
<b>4.01</b>	Were you tested for HIV before circumcision?	00=No 01=Yes	_ _

		88=No Response 99=Don't Know	
<b>4.02</b>	What was your status?	00=Reactive 01=Not Reactive 88=No Response 99=Don't know	
<b>4.03</b>	How often do you go for HIV Testing?	00=Never 01=When it's necessary. 02=Every three months 03=Every six months 04=Yearly 88=No Response 99=Don't know	
<b>4.04</b>	Are you aware of your current HIV status?	00=No 01=Yes 88=No Response 99=Not really sure	

<p><b>4.05</b></p>	<p>If yes to 4.04, what is your status?</p>	<p>00=Reactive                  01=Not Reactive                  77=Not Applicable                  88=No Response                  99=Not really sure</p>	<p>   </p>

## APPENDIX C

### INTERVIEW SCHEDULE

I want to thank you for taking the time to meet with me today. My name is \_\_\_\_\_ and I would like to talk to you about circumcision and safe sex practises. Specifically, this study will highlight the gaps in the education and prevention of HIV messages pre and post circumcision. It will also help to stress clear and consistent messages concerning safe sex practices post circumcision which will assist HIV prevention strategies. Overall we will be in a position to strengthen the counseling Programme and communication strategy in order to contribute to reduction in HIV infection. The interview should take 30-45 minutes of your time. I will be taping the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we're on tape, please be sure to speak up so that we don't miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

\_\_\_\_\_

Interviewee

Witness

Date

\_\_\_\_\_

Legal guardian (if interviewee is under 18)

## **APPENDIX D**

### **INTERVIEW QUESTIONS FOR CIRCUMCISED MEN**

- 1) What do you understand about circumcision?
- 2) Does circumcision protect you from being infected with HIV? Give your reason.
- 3) What do you think about using a condom after circumcision?
- 4) Do you think circumcision is allowing men to practice unsafe sex? Explain
- 5) Are we sending the right message out there about circumcision? What would you suggest?
- 6) What were you taught during counseling before circumcision? Tell me anything that you can remember.

## **APPENDIX E**

### **INTERVIEW QUESTIONS FOR MC COUNSELLORS**

- 1) What do you include in your counseling sessions before circumcision?
- 2) What is the level of knowledge of your clients about HIV?
- 3) What is the attitude and practices of your clients towards safe sex?
- 4) Are they willing to use condoms after circumcision?
- 5) Do they follow the protocol of having sexual intercourse after six weeks post circumcision?
- 6) If client is HIV positive, do you go ahead and do circumcision? Explain.
- 7) Any recommendations for your counseling Programme?
- 8) Anything you need to add?

## **APPENDIX F**

### **OBSERVATION CHECKLIST FOR THE COUNSELLING SESSIONS**

**Checking whether the following points are included in the counseling sessions.**

**(Tick if included).**

- 6) HIV test should be done before circumcision and those clients that are positive are referred for further management.
- 7) Male circumcision reduces the risk of HIV infection for men but only provides partial protection. It is not a substitute for other proven HIV prevention methods.
- 8) Men should not resume sexual intercourse for at least six weeks after circumcision to ensure the healing process is complete. Ideally sex should only recommence after a medical assessment confirms the healing process is complete.
- 9) All males, whether circumcised or not, should seek to reduce the risk of HIV transmission through using condoms correctly and consistently and limiting their number of sexual partners.
- 10) Whether circumcision takes place in a clinical or a traditional setting it is important to ensure safety.
- 11) Information on HIV risk reduction and other benefits for male sexual and reproductive health need to be widely available to ensure individuals make informed choices about male circumcision.



## APPENDIX G



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### RESEARCH ETHICS COMMITTEE: HUMAN RESEARCH (HUMANIORA) ETHICS COMMITTEE APPLICATION FORM

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Application to the University of Stellenbosch RESEARCH ETHICS COMMITTEE: HUMAN RESEARCH (HUMANIORA)

For clearance of new/revised research projects

**This application must be typed or written in capitals**

**Name: Prof/Dr/Mr/Ms: Dr Debrah Vambe**

**Position/Professional Status: Student-MPHIL HIV/AIDS Management**

**Affiliation: Research Programme/Institution / Department: Africa Centre for HIV/AIDS-Stellenbosch University.**

**Please indicate (✓) if you are a registered student at SU?**

YES	<input checked="" type="checkbox"/>
NO	<input type="checkbox"/>

**If yes, for which degree/programme are you registered.**

**MPHIL HIV/AIDS Management.**\_\_\_\_\_

**Please specify the relevant Department at SU\_Africa Centre for HIV/AIDS.**\_\_\_\_\_

**Who is your supervisor? \_Dr Thozamile Qubuda.**\_\_\_\_\_

**Your telephone and extension no. Code:+268 no.76591795 Email:dvambe@gmail.com**

**Title of research project: (*Do not use abbreviations*)**

**A study on knowledge, attitude and practices of circumcised men towards safe sex.**

**Where will the research be carried out?**

**Mankayane district in Swaziland. This will be at the Mankayane hospital and the high schools.**

All the following sections must be completed (Please tick all relevant boxes where applicable)

**1. FUNDING OF THE RESEARCH: How will the research be funded?**

**The study will be financed through the researcher's own funds.**

**2. PURPOSE OF THE RESEARCH:**

**This study will highlight will highlight the gaps in the education and prevention of HIV messages pre and post circumcision. It will also help to stress clear and consistent messages concerning safe sex practices post circumcision which will assist HIV prevention strategies. Overall we will be in a position to strengthen the counseling programme and communication strategy in order to contribute to reduction in HIV infection.**

**3. AIMS AND OBJECTIVES OF THE RESEARCH: (*Please list objectives*)**

**To identify the knowledge, attitude and practices (KAP) of circumcised men towards safe sex.**

**To establish the existing knowledge of the relationship between circumcision and HIV prevention.**

**To establish whether men in Swaziland take part in riskier sexual behavior after or before being circumcised.**

**To make recommendations for the counseling programme.**

#### 4. SUMMARY OF THE RESEARCH

The research will be conducted at Mankayane hospital and Mankayane high schools. The research plan is summarized below. Data collection, data analysis and the write up of the report will take approximately 4-5 months from date of ethical clearance.

ACTIVITY	JUL	AUG	SEP	OCT	NOV	DEC	JAN
Submit application to ethics committee	x	x					
Data collection			x	x	x		
Data analysis				x	x		
Write-up					x	X	

#### 5.1 How should the research be characterized (*Please tick ALL appropriate boxes*)

<input checked="" type="checkbox"/> 5.1.1 Personal and social information collected directly from participants/subjects
5.1.2 Participants/subjects to undergo physical examination
5.1.3 Participants/subjects to undergo psychometric testing
5.1.4 Identifiable information to be collected about people from available records
5.1.5 Anonymous information to be collected from available records
5.1.6 Literature, documents or archival material to be collected on individuals/groups

**5.2 Participant/Subject Information Sheet attached? (For written and verbal consent)**

YES	✓
NO	

**5.3 Informed Consent form attached? (for written consent)**

YES	✓
NO	

**5.3.1 If informed consent is not necessary, please state why:**

---

Not applicable

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NB: If a questionnaire, interview schedule or observation schedule/framework for ethnographic study will be used in the research, it must be attached. The application cannot be considered if these documents are not included.

**5.4 Will you be using any of the above mentioned measurement instruments in the research?**

YES	✓
NO	

**6 PARTICIPANTS/SUBJECTS IN THE STUDY**

**6.1 If humans are being studied, state where they are selected:**

**The participants will be selected at OPD, VCT, MC clinics and high schools in Mankayane district.**

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**6.2 Please mark (✓) the appropriate boxes:**

<b>Participants/subjects will:</b>	<b>YES</b>	<b>NO</b>
<b>be asked to volunteer-interviews</b>	✓	
<b>be selected-questionnaire</b>	✓	

**6.2.1 State how the participants/subjects will be selected, and/or who will be asked to volunteer:**

Random sampling is going to be used to select 60 circumcised men and give questionnaires. The participants are going to be asked to volunteer for indepth interviews. Purposive sampling is going to be used

**6.2.2. Please mark (✓) the appropriate boxes:**

<b>Participants/subjects are:</b>	<b>YES</b>	<b>NO</b>
<b>Will SU student, alumni of staff data be used in this research</b>		✓
<b>Will interviews be conducted with SU student, alumni of staff</b>		✓
<b>Will questionnaires be used and distributed on SU campuses</b>		✓

Will electronic questionnaires be placed on the SU website?		✓
---	--	---

**6.3 Are the participants/subjects subordinate to the person doing the recruiting?**

YES	
NO	✓

**6.3.1 If yes, justify the selection of subordinate participants / subjects:**

\_\_\_\_\_

Not\_applicable\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**6.4 Will control participants/subjects be used?**

YES	
NO	✓

**6.4.1 If yes, explain how they will be selected:**

\_\_\_\_\_

\_\_\_\_\_

Not\_applicable\_\_\_\_\_

\_\_\_\_\_

**6.5 What records, if any, will be used, and how will they be accessed? Have you obtained formal permission to use these records?**

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**6.6 What is the age range of the participants/subjects in the study? 13 years and above.**

**6.6.1 Will consent from guardians/parents be obtained for participants/subjects 17 years and younger?**

YES	✓
NO	

*If YES, please attach the appropriate forms.*

**6.6.2 If NO, please state why:**

Not applicable.

YES	
NO	✓

**6.7.1 If yes, explain in what way:**

---

Not applicable.

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**6.8 Will the research benefit the participants/subjects in any direct way?**

YES	✓
NO	

**6.8.1 If yes, please explain in what way:**

The participants will gain knowledge on the relationship between HIV and circumcision. They will be in a position to understand the right messages about circumcision and therefore practise safe sex accordingly.

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**7. PROCEDURES**

**7.1 Mark research procedure(s) that will be used:**

Literature	
Documentary	
Personal records	
Interviews	✓
Survey	✓
Participant observation	✓
Other (please specify)	
_____	
_____	



**7.2 How will the data be stored to keep it safe and prevent unauthorized access? What happens to the data on completion of the research?**

**Data will be stored electronically with a password which will only be accessed by the researcher. Data will be destroyed after three years.**\_\_\_\_\_

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7.3 If an interview form/schedule; questionnaire or observation schedule/framework will be used, is it attached?

<b>YES</b>	✓
<b>NO</b>	

**7.4 Risks of the procedure(s): Participants/subjects will/may suffer:**

<b>No risk</b>	
<b>Discomfort</b>	✓
<b>Pain</b>	
<b>Possible complications</b>	
<b>Persecution</b>	
<b>Stigmatization</b>	
<b>Negative labeling</b>	
<b>Other (please specify)</b>	
_____	
_____	

7.4.1 If you have checked any of the above except “no risk”, please provide details:

\_\_\_\_\_ There will be discomfort since we will be dealing with sexual behaviour. Counselling services will be offered to those in need of them. \_\_\_\_\_

## 8. RESEARCH PERIOD

(a) When will the research commence:

\_\_\_As soon as the SU Ethics committee grants permission.\_\_\_\_\_

(b) Over what approximate time period will the research be conducted:

\_\_\_Over a 2 month period depending on the date of ethical clearance.\_\_\_\_\_

—

## 9. GENERAL

9.1 Has permission of relevant authority/ies been obtained?

YES	<input checked="" type="checkbox"/>
NO	<input type="checkbox"/>

9.1.1 If yes, state name/s of authority/ies:

Swaziland ethics committee.

Mankayane hospital superintendent

High school principals. \_\_\_\_\_

**9.2 Confidentiality:** How will confidentiality be maintained to ensure that participants/subjects/patients/controls are not identifiable to persons not involved in the research?

No identifying information will be requested on the questionnaire. Anonymity will be maintained throughout data collection, data analysis and storage. Report on findings will be made in such a way that it won't enable any participant to be identified or stigmatised. Data will be stored electronically with a password which can only be accessed by the researcher. \_\_\_\_\_

**9.3 Results:** To whom will results be made available, and how will the findings be reported to the research participants?

Findings will be reported verbally to participants and a copy of the final research will be made available to those who request it. Results will be made available to the University, the study leader as well as the ministry of health. \_\_\_\_\_

**9.4 There will be financial costs to:**

participant/subject	
institution	
Other (please specify)	
_____	
_____	

**9.4.1 Explain any box marked YES:**

Not\_applicable\_\_\_\_\_

\_\_\_\_\_

**9.5 Research proposal/protocol attached:**

YES	<input checked="" type="checkbox"/>
NO	<input type="checkbox"/>

**9.6 Any other information which may be of value to the Committee should be provided here:**

Translated\_copies\_of\_questionnaire,interview\_guide,interview\_questions,informed\_consent,as  
sent\_form.\_\_\_\_\_A\_certificate\_to\_show\_that\_the\_tran  
slation\_is\_correct.\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Date:**

**Applicant's signature**

25 June 2012\_\_\_\_\_

\_\_\_\_\_

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**Who will supervise the project?**

Name: **Dr\_Thozamile\_Qubuda** Programme/Institution/Department: **Africa**  
Centre\_for\_HIV/AIDS\_\_\_\_\_



Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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**Director/Head/Research Coordinator of Department/Institute in which study is conducted:**

**I declare that this research proposal has been approved by the relevant Department or Faculty and that it complies with acceptable scientific research standards.**

Name: \_\_\_\_\_

## APPENDIX H



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### STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

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#### **A STUDY ON KNOWLEDGE, ATTITUDES AND PRACTISES OF CIRCUMCISED MEN TOWARDS SAFE SEX IN MANKAYANE DISTRICT.**

You are asked to participate in a research study conducted by Dr. Debrah Vambe (Student for MPHIL HIV/AIDS Management) and Dr. Thozamile Qubuda (Supervisor), from the Africa Centre for HIV/AIDS Management at Stellenbosch University. The research is primarily academic and the results will be contributed to the research paper. You were selected as a possible participant in this study because you are circumcised and you fall within the preferred age group.

##### **1. PURPOSE OF THE STUDY**

This study will highlight the gaps in the education and prevention of HIV messages pre & post circumcision. It will also help to stress clear & consistent messages concerning safe sex practices post circumcision which will assist HIV prevention strategies. Overallly we will be in a position to strengthen the counseling programme & communication strategy in order to contribute to reduction in HIV infection.

##### **2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

- Fill in a completely anonymous self-administered questionnaire which contains both open and close ended questions.
- The questionnaires will be administered personally to those with little or no formal education.
- When you submit the questionnaire, an in-depth interview will be conducted.
- The researcher will ask 6 open-ended questions
- It will take less than 30 minutes of your time.
- The interview will take place at Mankayane hospital in one of the free consultation rooms.

### **3. POTENTIAL RISKS AND DISCOMFORTS**

There will be some discomfort since we will be dealing with sexual behavior. The participants won't be pressured to answer questions if they aren't comfortable.

Counseling services will be provided to those in need of them.

Available counselor

Mr Nkambule

Psychiatric nurse specialist

Mental health focal person

Mankayane OPD, Consulting room B24

[Tel:+26825388311/Ext 2227](tel:+26825388311/Ext 2227)

Cell: +26876249796

### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The participants will benefit knowledge about the relationship of circumcision and HIV infection and also about safe sex practices. If the participants are knowledgeable then the society will also benefit.

### **5. PAYMENT FOR PARTICIPATION**

There won't be any payment to participants.

## **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Confidentiality will be observed throughout the research from data collection, data analysis and storage. Unauthorized persons will not have access to the data collected. Each subject will be assigned a study identification number, and these subject identifiers will not be released outside the research group. Codes will be used and no identification will be made for the responders. Data will be stored electronically with a password which is only accessed by the researcher.

Findings will be reported verbally to participants and a copy of the final research report will be made available to those who request it. Results will be made available to the University of Stellenbosch, the study leader as well as the ministry of health.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

## **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact

1) Dr. Debrah Vambe

Address : Mankayane hospital area

Mankayane

Swaziland

Home tel: +26825398604

Work tel : +26825388311



Cell : +26876591795

Email : [dvambe@gmail.com](mailto:dvambe@gmail.com)

2) Dr. Thozamile Qubuda

Address: Africa Centre for HIV/AIDS Management

Industrial Psychology Building

Private Bag X1

Matieland

7602

Work <tel:+27218083999>

Fax : +27218083075

Email : [tqubuda@sun.ac.za](mailto:tqubuda@sun.ac.za)

## 9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021 808 4622] at the Division for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to (me/the subject/the participant) by.....in English/SiSwati and (I am/the subject is/the participant is) in command of this language or it was

satisfactorily translated to (me/him). (I/the participant/the subject] were given the opportunity to ask questions and these questions were answered to (my/his) satisfaction.

I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study. I have been given a copy of this form.

\_\_\_\_\_

**Name of Subject/Participant**

\_\_\_\_\_

**Name of Legal Representative (if applicable)**

\_\_\_\_\_

**Signature of Subject/Participant or Legal Representative**

**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of the subject/participant*] and/or his representative \_\_\_\_\_ [*name of the representative*]. [*He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted  
ii \_\_\_\_\_ *used/this conversation was translated into* \_\_\_\_\_ by \_\_\_\_\_].

Signature of Investigator

## APPENDIX I



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### STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

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#### **A STUDY ON KNOWLEDGE, ATTITUDES AND PRACTISES OF CIRCUMCISED MEN TOWARDS SAFE SEX IN MANKAYANE DISTRICT.**

You are asked to participate in a research study conducted by Dr. Debrah Vambe (Student for MPHIL HIV/AIDS Management) and Dr. Thozamile Qubuda (Supervisor), from the Africa Centre for HIV/AIDS Management at Stellenbosch University. The research is primarily academic and the results will be contributed to the research paper. You were selected as a possible participant in this study because you work at Mankayane male circumcision clinic and you are a counselor.

#### **5. PURPOSE OF THE STUDY**

This study will highlight the gaps in the education and prevention of HIV messages pre & post circumcision. It will also help to stress clear & consistent messages concerning safe sex practices post circumcision which will assist HIV prevention strategies. Overallly we will be in a position to strengthen the counseling programme & communication strategy in order to contribute to reduction in HIV infection.

#### **6. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

- You are going to participate in an in-depth interview.
- The researcher will ask 8 open-ended questions.
- It will only take 30 minutes of your time.

- The interview will take place at Mankayane hospital in one of the free private rooms at male circumcision clinic.

## **7. POTENTIAL RISKS AND DISCOMFORTS**

There will be some discomfort since we will be dealing with sexual behavior of their clients. The participants won't be pressured to answer questions if they aren't comfortable.

Counseling services will be provided to those in need of them.

Available counselor

Mr. Nkambule

Psychiatric nurse specialist

Mental health focal person

Mankayane OPD, consulting room B24

[Tel:+26825388311/Ext 2227](tel:+26825388311/Ext 2227)

Cell: +26876249796

## **8. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The participants will be able to see any gaps in their counseling services about circumcision. Then, they will be in a position to effectively counsel their clients on the relationship between HIV infection and circumcision and also emphasize on safe sex practices. If the participants are knowledgeable then the society will also benefit.

## **9. PAYMENT FOR PARTICIPATION**

There won't be any payment to participants.

## **10. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be observed throughout the research from data collection, data analysis and storage. Unauthorized

persons will not have access to the data collected. Each subject will be assigned a study identification number, and these subject identifiers will not be released outside the research group. Codes will be used and no identification will be made for the responders. Data will be stored electronically with a password which is only accessed by the researcher.

Findings will be reported verbally to participants and a copy of the final research report will be made available to those who request it. Results will be made available to the University of Stellenbosch, the study leader as well as the ministry of health.

### **11. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

### **12. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact

1) Dr. Debrah Vambe

Address : Mankayane hospital area

Mankayane

Swaziland

Home tel: +26825398604

Work tel : +26825388311

Cell : +26876591795

Email : [dvambe@gmail.com](mailto:dvambe@gmail.com)

2) Dr. Thozamile Qubuda

Address: Africa Centre for HIV/AIDS Management

Industrial Psychology Building

Private Bag X1

Matieland

7602

Work <tel:+27218083999>

Fax : +27218083075

Email : [tqubuda@sun.ac.za](mailto:tqubuda@sun.ac.za)

### 13. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021 808 4622] at the Division for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to me by.....in English/SiSwati and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

---

**Name of Subject/Participant**

\_\_\_\_\_

**Name of Legal Representative (if applicable)**

\_\_\_\_\_

**Signature of Subject/Participant or Legal Representative**

**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of the subject/participant*] and/or his/her representative \_\_\_\_\_ [*name of the representative*]. [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*English/SiSwati*] and [*no translator was used/this conversation was translated into \_\_\_\_\_*] by \_\_\_\_\_].

\_\_\_\_\_

Signature of Investigator

## APPENDIX J



### PARTICIPANT INFORMATION LEAFLET AND ASSENT FORM



**TITLE OF THE RESEARCH PROJECT:** A STUDY OF THE KNOWLEDGE, ATTITUDES AND PRACTISES OF CIRCUMCISED MEN TOWARDS SAFE SEX IN MANKAYANE DISTRICT.

**RESEARCHERS NAME(S):** Dr Debrah Vambe and Dr Thozamile Qubuda

**ADDRESS:** Mankayane Hospital area

**CONTACT NUMBER:** Cell: +26876591795

**What is RESEARCH?**



**Research is something we do to find new knowledge about the way things (and people) work. We use research projects or studies to help us find out more about disease or illness. Research also helps us to find better ways of helping, or treating children who are sick.**

**What is this research project all about?**

To determine what you know about circumcision and HIV infection and why you were circumcised. To investigate whether the MC Counsellors were able to give you enough information during the counselling sessions. The researcher would also like to verify what you think about using protection during sexual intercourse after circumcision and also find out if you have been using protection.

**Why have I been invited to take part in this research project?**

You have been invited because you are circumcised, you stay in Mankayane and you are 13 years and above.

**Who is doing the research?**

The research is being done by, Dr Debrah Vambe, an MPhil student for HIV/AIDS Management at Stellenbosch University. She is currently working at Mankayane hospital. The research is primarily academic which means whatever you tell me will contribute to my studies as part of my curriculum.

**What will happen to me in this study?**

You are required to answer some questions and fill in the answers on your own. If you don't understand feel free to ask and the researcher will be in a position to help.

After filling in all the answers you must submit it to the researcher.

The researcher will then ask you a few questions, 6 at most where you are free to answer truthfully and give your own opinions.

This will take less than 30 minutes of your time.

The interview will take place at your school in a private room.

**Can anything bad happen to me?**

There won't be any physical pain or risks. There might be mild discomfort since we will be talking about sexual behaviour. You won't be pressured to answer anything if you are not comfortable. Feel free to report to your parents or guardians if there is any discomfort. We can offer counselling services if you need them

Available counsellor.

Mr Nkambule

Psychiatric nurse specialist

Mental health focal person

Mankayane OPD, consulting room B24

[Tel:+26825388311/Ext 2227](tel:+26825388311/Ext 2227)

Cell: +26876249796

### **Can anything good happen to me?**

Yes, you will gain so much knowledge about the relationship between circumcision and HIV infection and also how to protect yourself during sexual intercourse when you are circumcised.

### **Will anyone know I am in the study?**

No one will know that you are in the study because we don't use names. We just use numbers to identify the forms; Information about the participants will be kept in the computer with a password which is known by the researcher. The information will be available to the University where am learning and also to the Ministry of Health.



### **Who can I talk to about the study?**

Dr Debrah Vambe

Address: Mankayane Hospital area

Mankayane

Swaziland

Work <tel:+26825398604>

Home <tel:+26825388311>

Cell : +26876591795

Email : [dvambe@gmail.com](mailto:dvambe@gmail.com)

Dr Thozamile Qubuda

Address: Africa Centre for HIV/AIDS

Industrial Psychology building

Private Bag X1

Matieland

Stellenbosch

Tel : +27218083999

Fax : +27218083075

Email : [tqubuda@sun.ac.za](mailto:tqubuda@sun.ac.za)

### **What if I do not want to do this?**

You are allowed to withdraw from the study at any given time if you feel you don't want to take part anymore, even if your parents have agreed that you participate and you won't get into trouble.

Do you understand this research study and are you willing to take part in it?

YES NO

Has the researcher answered all your questions?

 YES NO

Do you understand that you can pull out of the study at any time?

 YES NO

---

Signature of Child

---

Date

## APPENDIX K



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvenoot • your knowledge partner

### **Approved with Stipulations**

#### **New Application**

06-Aug-2012

Vambe, Debrah D

Stellenbosch, WC

Dear Dr Debrah Vambe,

The **New Application** received on **16-Jul-2012**, was reviewed by Research Ethics Committee: Human Research (Humanities) via Committee Review

Procedures on **26-Jul-2012**.

Please note the following information about your approved research protocol:

#### **Present Committee Members:**

Theron, Carl CC

Somhlaba, Ncebazakhe NZ

Viviers, Suzette S

Van Zyl, Gerhard G

Fouche, Magdalena MG

Van Wyk, Berte B

Hansen, Leonard LD

Horn, Lynette LM

De Villiers-Botha, Tanya T

Newmark, Rona R

Prozesky, Heidi HE

Beukes, Winston WA

The Stipulations of your ethics approval are as follows:

Assent Form: Assent form is to be drafted age-appropriate and translated accordingly.

Consent Form: In the consent form the PI states 6 questions will be asked, in participant information sheet she indicates 8 questions. Please correct the inconsistency.

Questionnaire: The layout of the questionnaire is not participant friendly and may impact negatively on reading and understanding and hence response. Please pay attention to formatting and present the questionnaire in more participant-friendly format.

REC Application Form: 1. Permission letters from all institutions listed are absent. Action required: Permission letters are to be obtained and offered to REC office before research can commence. 2. The school(s) at which sampling will be performed is (are) not identified. Action required:

The school(s) at which sampling will be performed is (are) to be recorded and REC office to be notified before research can commence.

Research proposal: 1. PI states that results will be made available to participants and other beneficiaries of the study. Action required: PI to explain how, where and when these results will be made available to participants and associated communities (school, hospital, clinic, etc). 2.

Participants will be selected randomly and purposively. Action required: PI to explain exactly how this will be done to mitigate exposure and harm, both in hospital and school. Protection is "promised", yet not explained in detail. 3. Sampling is indicated as 60 (40 men, 20 "boy-men"), and elsewhere indicated as "equally representative". Action required: PI to indicate sample accurately and consistently. 4. Counselling is promised in case trauma is experienced. Action required: The full detail of this mitigation strategy should be provided, inclusive of professional status, title and identity, venue of service provision, contact detail.

Standard provisions

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.

2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.

3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.

4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.

You may commence with your research with strict adherence to the abovementioned provisions and stipulations.

**Protocol #: HS811/2012**

**Title: A study on knowledge, attitude and practices of circumcised men towards safe sex.**

Protocol Approval Period: **26-Jul-2012 -25-Jul-2013**

Please remember to use your **protocol number (HS811/2012)** on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

**After Ethical Review:**

Please note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required.

The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) number REC-050411-032.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

**Provincial and City of Cape Town Approval**

Please note that for research at primary or secondary healthcare facility permission must be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za) Tel: +27 21 483 9907) and Dr Helene Visser at City Health ([Helene.Visser@capetown.gov.za](mailto:Helene.Visser@capetown.gov.za) Tel: +27 21 400 3981).

Research that will be conducted at any tertiary academic institution requires approval from the relevant parties. For approvals from the Western Cape Education Department, contact Dr AT Wyngaard ([awyngaar@pgwc.gov.za](mailto:awyngaar@pgwc.gov.za), Tel: 0214769272, Fax: 0865902282, <http://wced.wcape.gov.za>).

Institutional permission from academic institutions for students, staff & alumni. This institutional permission should be obtained before submitting an application for ethics clearance to the REC.

Please note that informed consent from participants can only be obtained after ethics approval has been granted. It is your responsibility as researcher to keep signed informed consent forms for inspection for the duration of the research.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at.

Sincerely,

Winston Beukes

REC Coordinator

Research Ethics Committee: Human Research (Humanities)

**Included Documents:**

Translation Statement DESC Appl

Questionnaire Translated

Interview Schedule

Consent Form

Info Sheet

Observation Checklist

Research Proposal

Admin Review

REC App

Questionnaire

Assent Form

**Investigator Responsibilities**

**Protection of Human Research Participants**

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.



2. Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research protocol and all amendments; all

informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8. Reports to Sponsor. When you submit the required reports to your sponsor, you **must** provide a copy of that report to the REC. You may submit the report at the time of continuing REC review.

9. Provision of Counseling or emergency support. When a dedicated counselor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

10. Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

11. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

## APPENDIX L

Telegrams:  
Telex:  
Telephone: (+268 404 2431)  
Fax: (+268 404 2092)



MINISTRY OF HEALTH  
P.O. BOX 5  
MBABANE  
SWAZILAND

### THE KINGDOM OF SWAZILAND

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**FROM:** The Chairman  
Scientific and Ethics Committee  
Ministry of Health  
P. O. Box 5  
Mbabane

**TO:** Debrah Vambe  
Principal Investigator

**DATE:** 04<sup>th</sup> October 2012

**REF:** MH/599C

**RE: A Study On Kap Of Circumcised Men Towards Safe Sex In  
Mankavane District In Swaziland**

The committee thanks you for your submission to the Scientific and Ethics Committee

*A letter of permission needs to be submitted to the secretariat of the SEC, from the hospital and from the school, before data collection.*

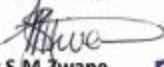
*Please note that you need to re-format your protocol on pages 5 – 9 and also include a dissemination plan.*

In view of the importance of the study and the fact that the study is in accordance with ethical and scientific standards, the committee therefore grants you authority to conduct the study. You are requested to adhere to the specific topic and inform the committee through the chairperson of any changes that might occur in the duration of the study which are not in this present arrangement.

The committee requests that you ensure that you submit the findings of this study to the Secretariat of the SEC committee.

The committee wishes you the best and is eagerly awaiting findings of the study to inform proper planning and programming to use for analysis

Yours Sincerely,

  
**Dr S.M. Zwane**  
DIRECTOR OF HEALTH SERVICES  
(THE CHAIRMAN)  
cc: SEC members



APPENDIX M

SWAZILAND



GOVERNMENT

Mankayane Government Hospital

Box 6

MANKAYANE.

19/10/2012

TO: Dr Debrah Vambe

Mankayane Government Hospital

Box 6

MANKAYANE.

Dear Doctor,

**RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH PROJECT AT  
MANKAYANE HOSPITAL.**

Reference is made to the above request. Management is glad to grant you permission to conduct your research in our hospital.

We would be pleased to have a copy of your study in order to improve quality of our care.

Yours Sincerely,

A handwritten signature in blue ink, appearing to read 'C. AISU'.

**DR C. AISU**

ACTG SENIOR MEDICAL OFFICER



APPENDIX N



APPENDIX: O



## HOLY ROSARY HIGH SCHOOL

P O BOX 329  
MANKAYANE  
TEL 253 88 002

24 October 2012

Dr. Debrah Vambe  
Mankayane  
P O Box 6  
Mankayane

Dear Madam

**RE: PERMISSION TO CONDUCT RESEARCH PROJECT AT THE ABOVE SCHOOL**

I hereby respond on behalf of the above school to say we have no problem and we grant you permission to do your research at the same time wish you a success.

Presently we shall offer to you the form ones, twos and fours while we exclude the external classes because of examinations but when they finish the exam while you are still around you can have them. We shall talk to them and make an arrangement for you.

Many thanks

