

# **The power of context in health partnerships**

Exploring synergy and antagonism between external and internal ideologies in implementing Safe Male Circumcision (SMC) for HIV prevention in Botswana

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## **Dedication**

This PhD thesis is dedicated to my sons Thomo Steward Thamuku and Tumo Stanley Thamuku, who have been the key motivation why I took this PhD. I hope it sets an example of determination and perseverance for you.

**Scientific environment**

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## **Abstract**

### **Background**

The aim of this thesis is to explore partnership functioning and the power of context in a North-South partnership in Botswana whose mission is to promote sexual health via Safe Male Circumcision (SMC) for HIV prevention. Specifically the study explores the power of cultural relevance as well as elements that bring synergy and antagonism in a partnership. The Botswana SMC partnership comprised Ministry of Health (MH) and two international organisations, US Centers for Disease Control (CDC) and African Comprehensive HIV/AIDS Partnership (ACHAP), both funded by unseen international donors. The mission of this partnership was to circumcise 80% of HIV negative men (100,000 per year) over a five year period.

Partnerships between the global North and the global South are a tool used in global governance of aid to mobilise resources to particularly assist developing countries where the poor and vulnerable are concentrated. HIV/AIDS is a global disease, with efforts to fight it coordinated by international institutions like UNAIDS and World Health Organisation (WHO). The global organisations and donors are commended for supporting global scientific efforts in prevention and cure for infectious and chronic diseases and for being a platform that facilitates funding efforts to the developing countries. The view of HIV/AIDS as a global disease has been observed to bring some good but has also generated 'local pain' as approaches used to combat it are applied with assumptions of universal effectiveness.

Some partnerships have faced disappointing shortfalls and many fail before fulfilling their goals. There are few studies that analyse partnership functioning and processes, especially in Africa. Most of these studies explore what brings about synergy - producing more results than those of a single entity operation. Thus far, very few studies identified 'antagonism' in partnerships and few address partnership context issues in a more generalised way. There are, to my knowledge, few studies that explore global and local contextual environments that cause antagonism and the underlying causes thereof. This thesis aims to bridge this gap and to add to the knowledge of partnership functioning.

## Methods

This study used qualitative ethnographic design to explore the Botswana SMC partnership over three years. Data were collected in three research sites in Botswana; Gaborone city where national officers to the program operate; Hukuntsi and Mochudi villages which have two contrasting cultures to the tradition of initiation. The methods for data collection were observation, in-depth interviews (IDIs), focus group discussion (FGDs) and informal discussions. Thirty national and district SMC officers were observed in a three-day meeting. I also observed two SMC public campaigns where I interacted with a range of stakeholders. All in all, 39 IDIs and five FGDs were conducted for the whole study. Paper I and III draw on data from observation of the 30 officers, IDIs and FGDs while paper II adds experiences of program campaigns to the list.

## Results

Results of Paper I reveal that the Botswana SMC partnership experienced a range of partnership outcomes; *additive* – Botswana Government had been doing SMC without partnership, *synergistic* – more was achieved through the partnership and *antagonistic* – resistance that caused counter-productivity. A combination of inputs – planning together, developing training and implementing materials, giving financial resources, sharing skills, donating capital and medical equipment – helped push their target of circumcising 100,000 HIV negative men in a given year. However, the same resources brought tensions in the partnership, especially where there was no transparency and where international organisations used different reporting tools. Although there are tensions between partners, they are working together in strategising to address some challenges of the partnership and implementation. Pressure to meet the target caused tension and challenges between the in-country partners to the extent of international organisations retreating and not pursuing the mission further.

Paper II shows that program officers' consultation with traditional leaders was done in a seemingly superficial, non-participatory manner. While SMC implementers reported pressure to deliver numbers to the WHO, traditional leaders promoted circumcision through their routine traditional initiation ceremonies at breaks of two-year intervals. There are conflicting views on public SMC demand creation campaigns in relation to the traditional secrecy of circumcision within initiation.



Paper III reveals that the partnership experienced antagonistic results during operational processes and as the ultimate outcome. Target setting, financial power of the North, superficial ownership given to the South, and ignoring local traditional realities result in antagonism. There are three underlying causes of antagonism identified: 1. *therapeutic domination* – medical expertise given with arrogance; 2. *iatrogenic violence* – good intentions that cause unintended harm; 3. the *Trojan horse* – deceptive power positioned under the pretext of benevolence.

To tie the three papers together, I identify three main findings that were given less attention. First, all three in-country partners had attitudes that were counterproductive to the success of the partnership. Second, there was resistance at different levels by the recipient government and communities. Third, it was the international donors rather than the in-country partners who put pressure in partnership.

## **Discussion**

Results of Paper I reveal that external influences that come from the unseen international donors influenced the working of the in-country partnership, unfortunately crippling it from resolving implementation challenges as experienced within the context of partnership functioning. Global mechanisms used for accountability are sabotaged by the same global context where the exercise of power and financial leverage by international donors reign. A combination of inputs by partners brought some progress towards achieving set program goals. However, prioritising externally formulated programs and lack of appreciation for local symbolic funding undermined local efforts and gave blurriness in leadership and ownership of the program. Externally formulated goals and targets, as well as subsequent expectations from external donors placed the functioning and contextual interaction of the partnership at risk. Tensions around target, ownership, financial contribution and accounting caused antagonism, resulting in international partners withdrawing before accomplishing the mission.

Results for Papers II and III reveal that antagonism can be experienced at two levels: during the collaborative process and as the ultimate outcome of the partnership. The two papers also

show that the local and global context has not been harmonised in a way that inspires collaboration rather it create tensions. Ignoring to address contextual issues like the ideology of neoliberalism and traditional practices of collectivism caused continuous conflict and resistance. Lack of genuine community consultation and SMC program implementers' unwillingness to address traditional leaders' views of locally appropriate approaches to program implementation caused tensions and resistance.

Paper III specifically showed that inputs such as finance and oversupply of medical equipment can be a source of antagony. It is also observed that attitudes of the international donors bring antagony: *Therapeutic domination* – was shown in prioritising external approaches such as the MOVE project which was more concerned about numbers than other implementation realities, side-lining the local government's approach of integration. The international partners' lack of acknowledgment for Ministry of Health's (MH's) non-financial contribution indicated their belief in the superiority of their modes of involvement; *Iatrogenic violence* – was evident when MH was left with the sole financial and operational responsibility for all aspects of the program once the DPs pulled out; The *Trojan horse* – is illustrated by the international donors' approach that brought false hope of victory but was a vehicle for donor control.

Consistent throughout the three papers is that more can be achieved through partnerships than single actors acting alone or parallel, but attention needs to be given to partners' inherent attitudes as well as global and local contexts of partnerships to minimise antagony. Also, consultation at all levels would better be done in a genuine, participatory manner. Community's initial cooperation was a loud message for openness and flexibility while the ultimate resistance was a cry to be heard. The main conclusion of this study is that North-South partnerships should not only be between organisations but also between organisations and people in order to account for the context of local realities.

**List of abbreviations**

ABC	Abstinence, Be faithful, Condomise
ACHAP	African Comprehensive HIV/AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral therapy program
ARV	Anti-Retroviral therapy
BAIS IV	Fourth Botswana AIDS Impact Survey
BINAPS	Botswana National HIV/AIDS Prevention Support Project
BMCF	Bergen Model of Collaborative Functioning
CBO	Community Based Organisation
CDC	Centers for Disease Control and Prevention
DHMT	District Health Management Team
DMSAC	District-Multi-sectoral AIDS Committee
DP	Development Partner
FGD	Focus Group Discussion
GPHPE	Global Programme on Health Promotion Effectiveness
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IMF	International Monetary Fund
INGO	International Non-Governmental Organisation
MC	Male Circumcision
MDG	Millennium Development Goal
MH	[Botswana] Ministry of Health
MOVE	Models for Optimizing Volume and Efficiency
NACA	National [Botswana] AIDS Coordinating Agency
NSD	Norsk senter for forskningsdata [Norwegian Centre for Research Data]
OECD	Organisation for Economic Co-operation and Development
P4P	Payment for Performance
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
PVO	Private Voluntary Organisation
RCT	Randomized Controlled Trial
SMC	Safe Male Circumcision
TB	Tuberculosis
UHC	Universal Health Coverage Partnership
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
USD	United States Dollar
VMMC	Voluntary Medical Male Circumcision
VMSAC	Village Multi-sectoral AIDS Committees
WHO	World Health Organisation

## **List of Publications**

### **Paper I**

Katise, M., Daniel, M., & Mittelmark, M. B. (2016). Aspirations and realities in a North-South partnership for health promotion: lessons from a program to promote safe male circumcision in Botswana. *Globalization and Health*, 12(1), 1. doi:10.1186/s12992-016-0179-3

### **Paper II**

Katise, M., & Daniel, M. (2015). Safe male circumcision in Botswana: Tension between traditional practices and biomedical marketing. *Global Public Health*, 10(5-6), 739-756. doi:10.1080/17441692.2015.1028424

### **Paper III**

Katise, M., & Daniel, M., (2016) Exploring the underlying causes of antagonism in the safe male circumcision partnership in Botswana. *PLOS ONE*. *Article under review*.

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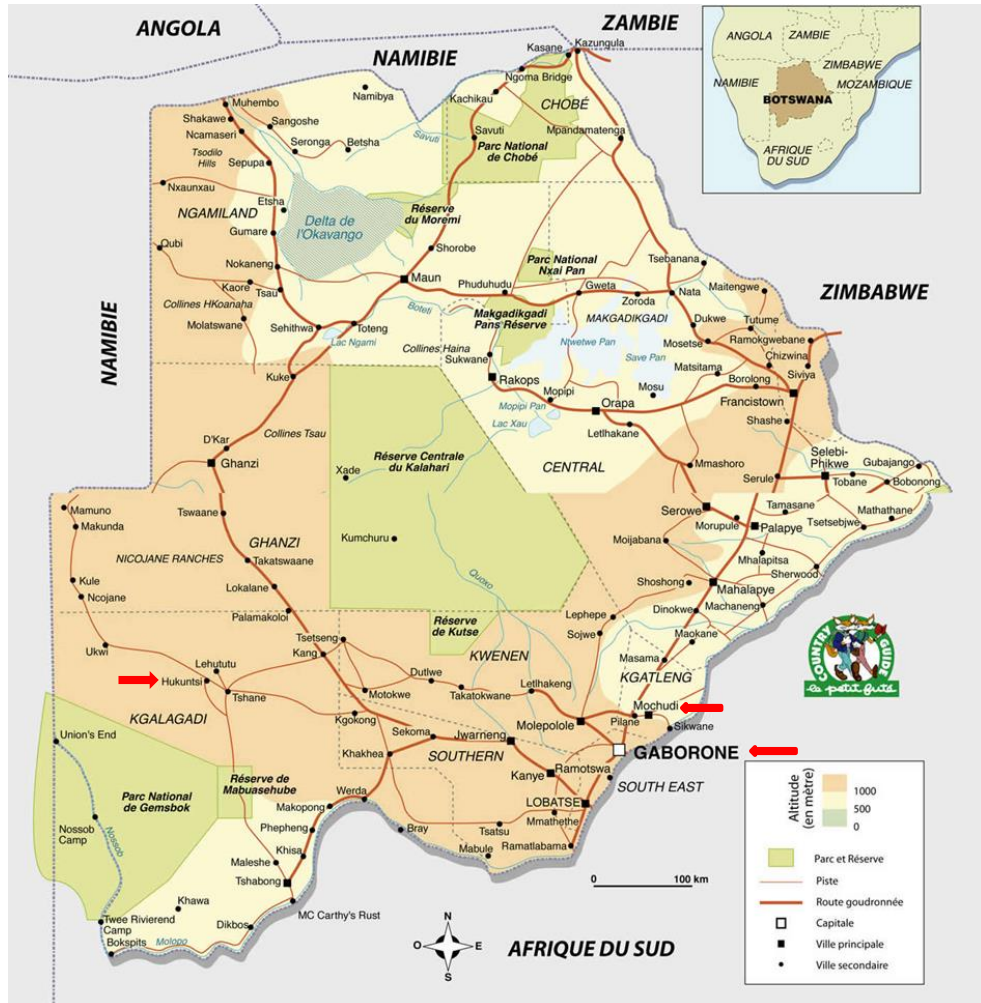
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## Map of Botswana



Source: <http://www.e-evasion.com/carte-botswana-images/>

Research sites: Gaborone, Mochudi, Hukuntsi



## **1 Introduction**

Partnership is a popular approach used in collaborative activities to achieve development goals. However, partnerships do not always work. There is little literature that explores partnership functioning. This thesis contributes to the body of knowledge of partnerships for health. It explores partnership functioning and cultural relevance in a North-South partnership in Botswana aiming to promote sexual health via Voluntary Medical Male Circumcision (VMMC) for HIV prevention. Partnership is an apparatus used in global health and development governance to address the world's complex challenges that affect multiple regions, including public health problems (Abrahamsen, 2006; Pattberg, 2012, p. 190).

### **1.1 Global context of partnerships**

In 2000, the world came together to set eight target oriented goals called Millennium Development Goals (MDGs) to address the world's health and development challenges. The MDGs have since been superseded by the 17 Sustainable Development Goals (SDGs) (UN, 2016a). The new SDGs advance the intentions of the (MDGs) (UN, 2014). This thesis is centred on goal number 17 of the SDGs: To "strengthen the means of implementation and revitalise the global partnership for sustainable development" (UN, 2015). Partnership is a collaboration of two or more organisations which have an agreed upon mission and contribute resources such as skills, money, capital, equipment and materials to achieve a set goal (Ashman, 2001; Barnes, Brown, & Harman, 2016; J. Hope Corbin, Mittelmark, & Lie, 2013). This goal, SDG 17, is an instrument through which resources are mobilised internationally to implement the global agenda and to particularly assist developing countries where the poor and vulnerable are concentrated (UN, 2016a). The goal for partnerships is therefore linked to all other goals including goal 3 (to ensure healthy lives and promote well-being for all, at all ages) that encompasses the fight of HIV (Caliari, 2014; UN, 2015, 2016a), which the partnership explored in this thesis aims to combat. In order to fulfil its targets, the sustainable development agenda requires partnerships between the private sector, governments, and civil society (UN, 2016b). Goal 17 has five targets including partnerships for finance, technology, capacity building, systemic issues and trade (UN, 2015, 2016a). The first four targets listed above are of particular interest to this thesis. Of importance to this thesis is also the Paris Declaration for Aid Effectiveness, developed by the OECD's Working Party on Aid Effectiveness in partnership with a large number of

developing countries in 2005 to serve as a road-map on ways to improve the quality of aid and produce better impact (Mawdsley, Savage, & Kim, 2014). Since most development aid uses partnerships as a mechanism to deliver resources, all adapt the Paris Declaration's partnership framework (Droop, Isenman, & Mlalazi, 2008). The Paris Declaration framework is formulated around five pillars: ownership, managing of results, mutual accountability, alignment and harmonisation (OECD, 2005). The deliberations of this thesis are connected to all five pillars, which overlap in focus. The first three are emphasised in Paper I and III and the last two illuminated in this thesis summary. To fulfil these, a series of implementation measures (targets) and monitoring systems are put in place to evaluate donors' and recipient countries' commitments (OECD, 2005). Since the SDGs are fairly new, most literature that analyses the development agenda refers to the MDGs, and so will this thesis (Droop et al., 2008; Fukuda-Parr, Yamin, & Greenstein, 2013; Saith, 2006; Sjöstedt, 2013; UN, 2014). Research on the progress of MDG8 uses case studies of partnerships formed to carry out other development goals like those on health, poverty, justice, etc.

Many North-South partnerships do not make it to the end of agreements (J. Hope Corbin & Mittelmark, 2008; J. Jones & Barry, 2011b), therefore this needs investigation. The functioning of North-South partnerships and a critical analysis on their implementation measures show both progress and pitfalls in regions like Sub-Saharan Africa and Asia (Waage et al., 2010; Waage et al., 2015). Specifically, analysis of the mechanisms used to make aid effective including ownership, managing for results and mutual accountability have revealed mixed progress and the challenges encountered need addressing. The trend in the series of reports by the MDG Gap task force shows that "there is conflict between national priorities to deliver on the commitments of goal 8" (UN, 2014, p. 1). Below, I reflect on the challenges that partnerships face using the lens of the five mechanisms.

## **1.2 Ownership of programs**

Firstly, ownership of programs by recipient governments is far from being realised. Ownership emphasises agency of the recipient countries, participation, strong leadership and use of local systems to deliver aid (UN, 2008b). It is used to counteract the top-down relationship observed over past decades between the global North and the global South (Barnes et al., 2016). United Nations (UN) agencies make efforts to put the concept of

ownership into practice in their program recommendations and funding conditions. Donor countries are cautioned to consider cultural practices and preferences during execution of programs while recipient countries are required to show commitment through financial contribution and taking the lead (Resch, Ryckman, & Hecht, 2015). In its recommendations for the implementation of VMMC, the World Health Organisation (WHO) writes that the program should be executed in a culturally appropriate way (UNAIDS, 2007; WHO/UNAIDS, 2007). Still critics observe that ownership is not realised in a number of partnerships because it is not evidently driven to accommodate cultural practices during implementation of programs (Booth, 2012; Campbell, Cornish, & Skovdal, 2012; Katisi & Daniel, 2015). Booth (2012) argues that the UN agencies use the concept as an established fact, not as an outcome to be constructed through the processes of implementation. It is therefore important to do research that investigates cultural realities that need to be considered for the realisation of program ownership by recipient governments (Barnes et al., 2016).

Ownership seems to be disproportionately linked with the level of recipient government's financial contribution. UN agencies have set standards for recipient governments to increase their financial contribution as a sign of ownership, commitment, shared responsibility and mutual accountability to programs is appreciated (Resch et al., 2015; UN, 2010). However, UN agencies are criticised for not considering different countries' starting points, for example: when stipulating local budget increase towards HIV/AIDS scale up (Resch et al., 2015; Saith, 2006). It is recorded that many African countries have attempted to increase their HIV/AIDS share of financial responsibility, but besides Botswana and Namibia, many poorer countries could not reach the WHO's set expectations (UNAIDS, 2014). International donors disregard to calculate the local countries' contribution of infrastructures even though it may be difficult to convert their value to monetary terms (J. Hope Corbin & Mittelmark, 2008). Ignoring this leaves room for an increase in the disproportion of financial contributions between partners, and intensifies the historical power over the South (Eyben & Savage, 2013). Seckinelgin (2012) argues that UN agencies uphold local countries' financial contribution more than other components that promote ownership, like local strategies for implementation, and cultural relevance. Buffardi (2013) pinpoints that it can be confusing when the beneficiary is given authority of ownership, therefore the expectation that recipient countries contribute more money (the usual source of ownership), makes sense. Saith (2006)

adds that partnership processes are complex and do not just require injection of material resources but knowledge and practice of relevant community approaches to programming.

### **1.3 Mutual accountability**

Secondly, mutual accountability emphasises transparency in the use of resources. (Droop et al., 2008). The Paris Declaration recommends that mutual accountability should be carried out at every level of the partnership. Donors and local governments have to account on all kinds of resource inputs, results or particular projects within the program being implemented (Droop et al., 2008). Partners make an effort to report on the required elements. However, there is inconsistency in reporting because of the different tools used by the donors and local partners (Buffardi, 2016; Droop et al., 2008). Mutual accountability is not genuine because there are power differentials with the donors dominating decisions (Buffardi, 2016; Droop et al., 2008). Most often the governments in the South are compelled to use the donor reporting tools, no matter how demanding, to protect funding. In Buffardi's (2016) case study of bilateral and multilateral donors in Peru, it is observed that individuals within the organisations queried multiple tasks because of having to account in different ways for different organisations.

### **1.4 Managing for results**

Thirdly, the principle of managing-for-results is only numerically driven and not considerate of contexts (Waage et al., 2010). Managing for results through set a target is regarded as one of the strengths of MDGs making them concrete and measurable, but it is seen by critics as only a prime for donors who want to see measurable returns while ignoring equity and overall health improvement of societies, intercountry differences, feasibility and financial affordability (Haines & Cassels, 2004; Waage et al., 2010). As it is, targets are only aggregated data using mathematical models. They therefore remain ambitious and imprecise when matched with local realities (Attaran, 2005; Sjöstedt, 2013; Waage et al., 2010). This is contradictory to the partnership framework principles, undermining national ownership of target and therefore challenging local commitment and political will (Waage et al., 2010). Target setting is crucial to measure and monitor success. The gap identified in the literature is that the methodology of setting targets is focused more on numerical data and does not use indicators to capture qualitative data as well (Fukuda-Parr et al., 2013).

## **1.5 Alignment**

Fourthly alignment, overlapping with ownership and mutual accountability, states that that donors should align their support with recipient countries' development priorities and local systems of operation (2005; UN, 2008b). Initially, alignment included following results-based strategies for recipient countries but now it has shifted to mutual accountability (Rogerson, 2005), hence the overlap in some literature. Critics observe that most donor organisations implement strategies that are parallel to the recipient countries' local systems for the reason that local strategies take long as they follow lengthy consultation processes (Hanefeld, 2010; Ramiah & Reich, 2006). Donors sometimes overlook the concept of alignment and employ their own foreign workers to avoid local government's procedures of fairness and contract conditions (Hanefeld, 2010). Another way of undermining alignment is illustrated in a study by Chimhutu and colleagues (2015), where donors gave extra allowances to selected health workers to drive maternal health care targets through a Pay-for-Performance system; this caused conflict between workers who were paid more than those who were not.

## **1.6 Harmonisation**

Lastly harmonisation means that donors and recipient countries coordinate, simplify procedures and share information to avoid duplication (UN, 2008b). Harmonisation requires that the national health policy and plan be consulted to map acceptable procedures (Kwamie & Nabyonga-Orem, 2016). There are some successes and pitfalls in applying harmonisation in partnerships. The study of the Universal Health Coverage partnership (UHC) in Guinea and Chad to assess the strengthening of national health policy development showed that policy dialogue improves harmonisation as ideas and information are exchanged and documented (Kwamie & Nabyonga-Orem, 2016, p. 365). However interaction of partners on aid management issues worked the opposite in both countries (Kwamie & Nabyonga-Orem, 2016). In Cheng's (2015) research of analysing the effective development and management of international cooperation and partnerships in the educational sector in Cambodia, he found that although policy records showed strategies of embedding aid management in the local system's way of operation "incompatibility exists between its aid

policies (based on international mainstream ideas) and its governance (rooted in Cambodian culture and traditions)”(Cheng, 2015, p. 235).

### **1.7 The health promotion aspect**

Using qualitative measures and a systems theory to explore partnership functioning and cultural relevance in HIV programming, this thesis refers to the five mechanisms described above as a thread that appears in its findings. The thesis’ focus on health fits within the scope of health promotion as embraced by the Ottawa Charter (Mittelmark, 2005; WHO, 1986). However, health promotion is a process that empowers people to increase control of factors that lead to health, rather than focussing on disease prevention. This thesis critically explores SMC and points to the fact that SMC could benefit more from health promotion approaches if the implementing partner organisations could engage full participation of the community. Health promotion focuses on resource approaches rather than risk factor approaches to health. Partnerships for health are a gateway to building the global capacity for health promotion by creating a platform for communities and individuals to have access to more health resources (Barnes et al., 2016; Tracy & McDonald, 2015). Approaching such partnerships from bottom up, rather than top to down, could promote people’s participation and use of agency as they build capacities to change psychosocial, economic and behavioural causes that affect their health (Tracy & McDonald, 2015).

## **2 Background**

This section gives a critical empirical and theoretical review of North-South partnerships for health. First it considers global governance structure of HIV/AIDS and local contexts in aid programming, and then situates the problem within the Botswana HIV/AIDS partnerships. Next, it explores literature on the state of global partnerships in global aid: giving a reflection on benefits and the general challenge. Further on literature review, it gives a critical look at partnership functioning - with a closer reflection on what brings synergy and what brings challenges. Existing research gaps in the field are then discussed followed by a presentation of research aim and objectives. This chapter ends with outlining the conceptual systems model used in this study. Embedded in the model is a critical review of cultural context and various partnership theoretical concepts on partnership antagonism.

### **2.1 Global context**

HIV/AIDS is a global disease governed by international institutions as an effort of global solidarity to address a problem that affects all regions of the world (Aginam, Harrington, & Yu, 2013; Seckinelgin, 2005). Global governance in aid is steered by international institutions like the United Nations (UN) and World Bank that seem to have power to enforce compliance (Barnes et al., 2016; Campbell et al., 2012). The governance structure of HIV/AIDS intervention, unlike the governance of aid in other humanitarian contexts, is very clearly delineated: it is headed by UNAIDS which is situated in Geneva (not New York where other UN bodies are located) to facilitate close collaboration with World Health Organisation (WHO) (Seckinelgin, 2005). This governance structure is influential in several of the large funds which contribute to the 'emergency' of HIV/AIDS, for example, the Global Fund for HIV, Malaria and TB; the President's Emergency Plan for AIDS Relief (PEPFAR) and of course the MDGs. In addition several philanthropists, like Bill & Melinda Gates and Bill Clinton, make significant donations to the HIV/AIDS emergency. The view of HIV/AIDS as a global disease has been observed to bring some good, but also 'local pain' (Campbell et al., 2012; Seckinelgin, 2008). Global organisations and donors are commended for supporting global scientific efforts on prevention and cure for infectious and chronic diseases and for being a platform that facilitates funding efforts to the developing countries (Campbell et al., 2012; Cooper, Kirton, & Schrecker, 2016). Fighting diseases of different

kinds including HIV/AIDS has been possible through them, although not without its challenges (Cooper et al., 2016). These global bodies have been criticised for their approaches to health and disease. UNAIDS has been blamed for exaggeration of the state of HIV in Africa to keep its business progressive and affluent (Seckinelgin, 2008). UNAIDS and WHO have been criticised for legitimising their interventions using the scientific rationality of medicine; the recipients – people affected and infected by HIV – have been seen as passively accepting the policy interventions. International donors' have been blamed for violation of human rights as access to their interventions is often distributed inequitably, excluding the most disadvantaged populations of the world by concentrating resources in urban or high density areas (Hein & Moon, 2016). Nguyen (2009) observes that the international organisations sometimes select countries of focus with bias towards oil mining and other resources, side-lining poorer countries and working against the principle of equity (Nguyen, 2005, 2009).

Another critique of the institutions in global governance for aid and international donor organisations is that embedded in them is the ideology of neoliberalism that focuses on individuals and does not consider them within their collective space, which interacts with and influences them (Fowler, 1998, 2000; Mawdsley, 2011; Mawdsley et al., 2014). Hofstede et al (2005) explain the difference between the individualistic and collectivistic societies. Individualism, in contrast to collectivism, believes that individuals grow up to care for themselves, express their own views, grow to have their own resources, choose whom to befriend and marry and relate to. In a collectivist society people work within networks that strive for harmony, expect loyalty to one another and community values, think as 'we,' share resources and communicate with high consideration to context (Hofstede et al., 2005). These two social structures are linked to ideology and discussed further under theory.

## **2.2 A call to consider local context**

It is important to consider local context when implementing interventions in health in communities where cultural practices are valued and embedded in development programs. Although there is not much literature that explores this argument, researchers in the field observe that consideration of cultural context is key (Aikins et al., 2010; Barnes et al., 2016; BeLue et al., 2009; Jing Liu et al., 2016). Biomedical interventions are seen as dominating and seemingly disconnected to actual lived experiences, political and cultural contexts of the



recipients of aid (Aveling, 2010; Campbell et al., 2012; Seckinelgin, 2012). Whereas cultural sensitivity is not completely embraced and practiced by donors in aid recipient countries, it is a practice in these donors' own countries of origin and even considered a priority. Purnell (2013) writes that cultural competence in health care is an important approach within the health system in the US and the broader globe. This approach appreciates that although the health provider may be an expert in experiments and formulation of health interventions, their approach may not fit well with the recipient's belief systems, dietary practices and their understanding of wellness. Therefore if the patient's socio-cultural and behavioural practices are not considered, then the treatment plan or the intervention may not work. Several articles that BeLue et al. (2009) review observe that if success needs to be attained in fighting the prolonged disease burden in Africa, critical attention has to be given to the manner in which society and culture construct concepts of health and disease. Some scholars see culture as a barrier to health interventions while others see it as an opportunity such that if sensitivity to contextual aspects is applied, both curative and preventative programs would be assured of sustainability, leading to behaviours of the older generations passed on to the upcoming generations (Barnes et al., 2016; Jacobs, Ir, Bigdeli, Annear, & Van Damme, 2012).

### **2.3 Research on VMMC - related to context**

It is important to explore research on VMMC that is related to context. Context needs to be considered both at research level, to inform policy makers, and at implementation level to ensure that local approaches are embraced. Much research carried out on VMMC thus far is biomedical, focusing on exploring the association between MC and HIV; or it involves acceptability studies in different countries (see Bailey et al., 2007; Kebaabetswe et al., 2003; Lukobo & Bailey, 2007; Mattson, Bailey, Muga, Poulussen, & Onyango, 2005; Wambura et al., 2011); or mathematical models used to estimate the impact of behaviour change and condom use (Andersson, Owens, & Paltiel, 2011). Very little research has been done on the sociocultural response and behavioural dynamics of the subjects who are recipients of the service. The few qualitative studies carried out in Africa reveal varying sociocultural factors inhibiting the expected response predicted through quantitative research. One study carried out in West African countries by Niang and Boiro (2007) found antagonistic relations between VMMC and cultural practices. Research in Tanzania among traditionally circumcising tribes shows that such cultures would embrace VMMC as long as it is done in a

culturally sensitive manner (Wambura et al., 2011). Another qualitative study on the impediments to the uptake of VMMC in Botswana by Sabone and colleagues (2013) found that in general, societies accept circumcision; however, the communities are against the fact that the VMMC program disturbs the social order. They also observed conflict between traditional initiation systems and VMMC. Respondents in Sabone's research reasoned that a consultative, collaborative process with traditional systems that practice initiation would bring better results (Sabone et al., 2013). There are attractive reasons to circumcise. Men in a qualitative study in Botswana mention hygiene, enjoyment of sex and low chances of contracting HIV as the common reasons for access of service (Wirth et al., 2015). Local socio-cultural practices and health behaviours within recipient countries need to be considered. If the partner organisations could work on this, then harmonisation, a part of the mechanism framework of the Paris Declaration, would be fulfilled (UNAIDS, 2008).

## **2.4 Partnerships**

### ***2.4.1 The state of partnerships for health in global aid***

In the public health arena, a partnership approach is widely advocated as an essential strategy. True partnership has many dimensions: joint commitment to long term interaction, shared responsibility for achievement, reciprocal obligations, equality, mutuality and balance of power. It is known that governments in the North, international donors agencies and UN bodies work through International Non-Governmental Organisations (INGOs) and Private Voluntary Organisations (PVOs) to facilitate the disbursement of aid from the global North to the global South (Ashman, 2001; Contu & Girei, 2014; Forte, 2014). INGOs and PVOs are set up in recipient countries to partner with Southern NGOs (private-private) or with governments (public-private) (Buse & Walt, 2000; Gold et al., 2012; Ratzan, 2007; Sinanovic & Kumaranayake, 2010). There are numerous benefits for these partnerships. To list a few: partnerships provide a means for giving financial, technological and pharmaceutical support, to show transfer to recipient countries, and of course are a unified front for fighting diseases of global concern (Buse & Harmer, 2007; Contu & Girei, 2014; N. Seth, 2014). Besides tangible benefits, partnerships are also meant to strengthen the local socio-political environment through promoting ownership, using local strategies to implementation and considering cultural relevance in programing (Abrahamsen, 2006; Crawford, 2003).

### ***2.4.2 True partnership is not easy to attain***

Many partnerships struggle to survive, yet alone thrive. The value of partnership across public and private sectors was a mantra enshrined in the MDG but in many ways partnerships are anaemic (Fehling, Nelson, & Venkatapuram, 2013; N. Seth, 2015). These partnerships encounter challenges that “are rarely described and discussed in published projects reports” (Maina-Ahlberg, Nordberg, & Tomson, 1997, p. 1229). The UN’s renewed strategy, the SDGs, therefore calls for a ‘revitalisation’ of partnership for development (N. Seth, 2015). However, simply calling for more effective partnerships for health does not address the fundamental barriers to successful partnership (Wouters & Cogolati, 2015).

There is difficulty in achieving true partnership when resources and power are unevenly distributed. Several researchers noticed these challenges between the North and the South. Scholars describe these challenges in different ways, placing emphasis on the power of the North over the South. These scholars use different concepts to express this power, among them: the new imperialism – the North’s new way of extending its power (Ferguson, 2006; Forte, 2014) – and unbalanced power relations (Fowler, 2000; Johnson & Wilson, 2006). Gosovic (2000) takes a step further by calling North-South partnerships a recolonisation of the South which creates intellectual dependency. Other scholars, for example Lewis (1998), focus on how power politics within partnerships compromise the work of INGOs. In this context, INGOs are seen to be experiencing an “identity crisis” as their decisions on implementation of programs may be perceived as dependent upon the dictates of their respective governments (D. J. Lewis, 1998). Consequently, it is argued that partnerships experience antagonism which is largely caused by the Northern partners (J. Hope Corbin & Mittelmark, 2008; J. Hope Corbin, Mittelmark, & Lie, 2015).

### ***2.4.3 Rhetoric in partnerships***

Partnerships have faced disappointing shortfalls. Yet provocatively, the North-South ‘connection’ for development has recently been described as a ‘divide’ and a ‘plague’ contributing to slow action for development (Johnson & Wilson, 2006). More specifically, McFalls (2010) argues that the rhetoric of partnerships revolves around the insincere ownership of programs by the South, and external agencies’ priorities that their set conditions and mathematically calculated targets are met, neglecting local realities . McFalls

(2010) assesses current partnerships in aid as not genuine, but as only deceptive strategies to “legitimise” the domination of the powerful under the pretence of benevolence . African states report that partnership relationships with the North are typically filled with tensions and frustration(Ashman, 2001).

In analysing four case studies of partnerships between PVOs and African NGOs, Ashman found that control by the U.S government as the donor is the root cause of ineffectiveness. “PVOs’ internal systems for financial and management controls are more attuned to demands of accountability....than to the demands of partnership...” (Ashman, 2001, p. 74). Kenworthy (2014) used multisided ethnographic approaches to examine local HIV responses for a community partnership program, the Gateway Approach. Kenworthy (2014) observes that local efforts to participate in making partnerships a reality are overcome by the powerful global agendas, leaving the community voice unheard and local realities ignored. He therefore appeals for the revision of the architecture of global agendas which, he says like many other researchers, have their governance founded in old power-driven strategies (see also Binka, 2005; Crawford, 2003; Harrison, 2007; McFalls, 2010).

Underlying causes for and possible solutions to the challenges have been addressed by various authors. Buse and Harmer (2007) outline seven habits that global public-private partnerships practice which inhibit performance and encourage external dominance instead of appreciating local systems. Among them they list: the imposition of external priorities and tilting the local ones; one sided decision making; and wasting resources by not maximising the use of existing local resources. Buse and Harmer (2007) suggest solutions for this well-defined global governance. In their recommendation for reform, Buse and Harmer (2007) emphasise among others: promoting genuine national ownership of programs by embracing more national planning processes than external ones; agreed standard operating procedures to ensure mutual accountability; and setting a more realistic target matched with available resources to avoid financial gaps. Although many researchers have brought out these similar points to caution global leaders about why public-private partnerships fail, the UN itself admits that the challenges persist (UN, 2008a, 2009, 2010, 2011, 2013). The most significant progress reported in most partnership literature is about pushing targets while other components of the partnership suffer (Waage et al., 2010).

## **2.5 Partnerships for health in the context of Botswana**

### ***2.5.1 The Botswana national HIV/AIDS operational framework for partnerships***

The Botswana Government has taken HIV/AIDS as a critical development challenge since the first reported case in 1985 and has set-up a local partnership structure to facilitate the implementation of HIV/AIDS programs. The partnership is set up to ensure participation from national to community level and for international resource mobilisation (NACA, 2009). To facilitate this, Botswana has developed a local operational document that provides strategic direction to the national response to HIV/AIDS, called the National Strategic Framework for HIV and AIDS 2010-2016 (NSF). The country has had several defined phases of its response to HIV, which it calls short term plans of action, since 1987. Most of the short term plans concentrated on clinical response until the development of the Medium Term Plan for 1997-2002 which provided a platform for a multi-sectoral national response from community level to national level.

The National AIDS Council is the highest national think tank chaired by the national head of state and comprising of political experts, national representatives of the country's chieftainship and expert professionals in the medical field (NACA, 2009). The lead coordination agency at national level is called National AIDS Coordination Agency (NACA) which is housed by the Ministry of Health (MH), and is a planning and financial resource agency for the government. At the community level are District Health Management Teams (DHMTs) that manage health centres in districts. In order to involve community participation, Botswana government formed District-Multi-sectoral AIDS Committees (DMSACs) and Village Multi-sectoral AIDS Committees (VMSACs). All health interventions and HIV/AIDS planning are integrated into the national development planning and budgeting.

Botswana, as a middle-income country, has established partnerships with international organisations within its internal structure. Ministry of Health through NACA has established long term collaborations with United States' Centers for Disease Control (CDC) and African Comprehensive HIV/AIDS Partnerships (ACHAP). Behind these international organisations are the unseen international donors: The President's Emergency Plan for AIDS Relief (PEPFAR) for CDC and Bill & Melinda Gates Foundation for ACHAP. These two

organisations have been operating in the country for over 15 years, CDC since 1995, and ACHAP since 2000, specifically co-implementing interventions on and research for Tuberculosis and HIV/AIDS (NACA, 2009). Because of their long standing partnership relationship with MH, they are called development partners (DPs). The DPs have worked with Botswana on HIV/AIDS strategies like, but not limited to the behavioural change program, Abstain, Be faithful, and Condomise (ABC); Anti-Retroviral therapy (ARV) drug implementation strategy; Prevention from Mother to Child Transmission (PMTCT) program and now the Voluntary Medical Male Circumcision Program (VMMC). The program is called Safe Male Circumcision (SMC) in Botswana and the partnership is discussed later.

While this thesis is about partnerships, and not about disease, it is vital to give an overview of HIV/AIDS status in Botswana to make sense of the partnership formation. Botswana was once declared the leader in HIV infection rates in Africa and is currently rated third after Lesotho and Swaziland (AVERT, 2015). In 2013, the fourth Botswana AIDS Impact Survey (BAISIV, 2013) estimated a national population prevalence rate of 18.5 percent. In 2015 UNAIDS recorded a prevalence rate of 22.2% among adults aged 15-49 years. Heterosexual sex is the common mode of HIV transmission. It is recorded that Botswana is leading in HIV treatment and care services in Africa, however, HIV prevention strategies have not been as effective (NACA 2015).

Intervention programs for diseases like HIV/AIDS are formulated at global level and recommended for local implementation. In 2007 WHO recommended that countries with high HIV infection rates and low level of traditional circumcision implement Voluntary Male Medical Circumcision (VMMC). This recommendation followed results of three randomised control trials (RCTs) experiments in the Orange Farm in South Africa, Kenya and Uganda that proved that circumcision can prevent HIV transmission from women to men through vaginal sex, at 61% chances of prevention (based on the South African results) (Andersson et al., 2011; Auvert et al., 2005; Bailey et al., 2007; Donoval et al., 2006; Gray et al., 2007). WHO esteems VMMC as safe, affordable and as having potential to give lifelong benefits (Aggleton, 2007; WHO, 2015). Although critics observe that WHO's recommendation for implementation of VMMC was hasty, involving inconclusive results (Dowsett & Couch, 2007), it is also appreciated that the WHO's energy shows commitment to the goal to combat HIV is of priority in the global arena (Seckinelgin, 2012). Following the RCTs' recommendations and acceptability studies for VMMC, interventions were carried out in different countries including Botswana. A review of thirteen VMMC

acceptability studies shows a median of 65% of uncircumcised men willing to circumcise; 71% of women willing that their partners be circumcised and 81% willing to circumcise their sons (Westercamp & Bailey, 2007). In Botswana, acceptability of VMMC showed that the people of Botswana highly embraced the proposed surgery, with 81% of the 238 uncircumcised men in the study willing to circumcise (Kebaabetswe et al., 2003). However, the study was done among non-circumcising tribes. Based on this acceptability study, Botswana adopted VMMC in 2007. Botswana adapted the program as Safe Male Circumcision (SMC) to distinguish its difference with traditional circumcision (Ministry of Health, 2010).

## **2.6 Partnership for SMC in Botswana**

Ministry of Health (MH) partners with two of the international in-country development partners – CDC funded by PEPFAR, and ACHAP funded by Bill and Melinda Gates Foundations – to implement SMC in Botswana. The mission of the partnership is set up around WHO's recommendation for Botswana to circumcise 80% of its HIV negative male population over a period of five years (100,000 men per year) in order to make an impact on its HIV infection rate (Ministry of Health, 2010, 2011). Critics observe that global health interventions are based solely on biomedical experiments and that global targets set for the recipients countries are only calculated using mathematical models, ignoring socio-cultural and behavioural realities (Campbell et al., 2012; Dowsett & Couch, 2007). For this reason, these global targets remain unrealistic and block ownership by local governments (Campbell et al., 2012).

### ***2.6.1 Approaches used in the SMC program***

There are two approaches used to implement SMC in Botswana; one locally initiated, and the other internationally imposed. Botswana government initiated to use a national integration strategy – an equitable implementation of the SMC program in all health centres in the country to ensure equal distribution of the intervention. The strategy for the integration approach is to make SMC part of the long term health programs in the country, embedded within the health system as one of the day to day health services. Regular health personnel in health centres would carry out the circumcision, and disseminate the program through

educational talks in clinics. The international program is the Models for Optimizing Volume and Efficiency (MOVE) approach, a PEPFAR founded method to push the public towards utilisation of the SMC. The MOVE approach uses television and radio advertisements, bill boards, newspapers and celebrity figures in the country to woo men for circumcision (PEPFAR, No date). PEPFAR uses neoliberalist approaches in its health implementation – biomedical marketing that sees health services as business products and views people as individual actors, hence uses an individualistic approach to convince them towards the health benefits (Finn, Nybell, & Shook, 2010). Such an approach ignores the tradition of collectivism within African communities and therefore causes a divide within the cultures or faces resistance (Campbell et al., 2012). It is noted that international programs are normally implemented as separate stand-alone entities and fail to integrate themselves within the local systems (Ramiah & Reich, 2006).

Although the acceptability rate for SMC in Botswana seemed high, the reality for implementation of the program proved otherwise. According to the records the maximum response of HIV negative men circumcised in any one year was only 39% of the 100,000 targeted in 2012 (WHO, 2015). Many of those who circumcised were school-going children of ages 13-18 mobilised through schools (Ministry of Health, 2011). These numbers were largely reached because of peer pressure influences (Ministry of Health, 2011). Older men were reported to hesitate and resist circumcising because of fear of pain, socio-cultural reasons (Ministry of Health, 2011; Sabone et al., 2013; Wirth et al., 2016) and this is discussed further under theory (context).

## **2.7 Literature review on partnership functioning**

### ***2.7.1 Global***

Health partnership strategy is a widely used but little studied area in global partnerships such as bilateral cross-country collaboration, and especially North-South partnerships. Much of the literature on partnerships focuses on global governance (Abrahamsen, 2006; Fowler, 2000) or on local community-based partnerships, for example community-academia partnerships. The other most researched topic on partnerships is power relations (Abrahamsen, 2006; Fowler, 2000; Kelly, Doyle, Weakliam, & Schönemann, 2015). Yet there are some studies that take a multidimensional approach (J. Hope Corbin & Mittelmark, 2008; J. Hope Corbin et al., 2013; J. Jones & Barry, 2011b; E. S. Weiss, Anderson, &



Lasker, 2002). There is little research that examines partnership functioning (J. Hope Corbin et al., 2013; A. Jones, 2016; Lister, 2000; Wouters & Cogolati, 2015).

Given that health partnerships generally face challenges, research of North-South partnership functioning and processes where successes and difficulties are documented for learning, is a public health priority. The following section will focus on research that has been done on partnership functioning at a global and local level.

There are a few studies that analyse partnership functioning and processes. These studies explore what brings about synergy – producing greater output than those of a single entity operation (Lister, 2000; Mawdsley et al., 2014) – and antagonism, where costs exceed benefits (J. Hope Corbin & Mittelmark, 2008). All in all, most studies repetitively show that sharing of power, a relationship that is built on trust, leadership effectiveness, transparency in communication, mutual accountability are found to bring about positive functioning (J.H Corbin, Jones, & Barry, 2016; J. Hope Corbin & Mittelmark, 2008; J. Hope Corbin et al., 2013; J. Jones & Barry, 2011b, 2016; H. A. Weiss, Quigley, & Hayes, 2000). I discuss a few studies to illustrate. Weiss (2002) developed a measure for partnership synergy while the concept of antagonism was added to partnership functioning by Corbin and Mittelmark (2008). I discuss synergy in this section and antagonism later under theoretical framework. E. S. Weiss et al. (2002) designed a study that examined the relationship between partnership synergy and elements of partnership functioning including: leadership, administration and management, partnership efficiency, nonfinancial resources, partner involvement challenges, and community-related challenges. Jones and Barry (2011a) used the measure developed by Weiss et al. (2002) and another measure developed by themselves to conduct a postal survey examining the relationship between synergy and partnership functioning factors in 40 health promotion partnerships extracted from a data base. Weiss et al. (2002) and Jones and Barry (2011a) agree that three elements are vital predictors of partnership synergy.

Firstly, collaborative or integrative leadership that practices shared power, distributed across partner organisations is a good element in generating synergy. Integrative leadership includes open communication about social, political and organisations' cultural contexts in a way that embraces the differences to maximise success. Corbin and Mittelmark established

that environmental context including organisational, global and local context in which partnership occurs can either inhibit or cultivate synergy (J. Hope Corbin et al., 2013).

Efficiency is the second ingredient of synergy. It includes timely open communication, transparency in accountability, timely plans and implementations (J. Jones & Barry, 2011a; E. S. Weiss et al., 2002). Where there is efficiency, goals are met timely; however, partners may omit proper consultation when driven by deliverables expected within given time frames (Mawdsley, 2011). International donors are blamed for making partner organisations work under pressure to adhere to their efficiency standards (Mawdsley, 2011).

The third element is trust. Jones and Barry (2011) add trust as the third most vital ingredient to synergy. They note that most partners assume that trust is already in place and do not necessarily invest in practically discussing it to ensure that it is understood and applied in partnerships. They conclude that all partnerships need training that includes the benefits of trust and the consequences of mistrust, as the two are interlinked and have effects on the partnership. Gagnon et al. (2016) and Lucero et al. (2016) establish that trust and good governance between research experts and community partners is of paramount importance. Trust is a necessary behavioural component in partnerships to enhance relational norms, and to develop positive informal monitoring mechanisms between partners (Aulakh, Kotabe, & Sahay, 1996).

Like many other studies on partnerships, though not necessarily on functioning, Weiss et al. (2002) and Jones and Barry (2011b) identify that power plays a significant role in determining the presence or absence of synergy (see also Ashman, Abrahamsen, Fowler, etc.). Both Jones and Barry (2011b) and Weiss et al. (2002) conclude that administration and management and other components of partnership functioning listed above in Weiss et al.'s (2002) study are not necessarily active ingredients for synergy. Miller et al. (2001) long established that there is a need for research that explores management and administration from the perspective of synergy. Lucero et al. particularly emphasise that it is important to continually demonstrate resilience and wisdom to maximise scarce capacity limits, scarce financial resources and limited time to bring about the best short-term and long-term outcomes. Elements that bring partnership synergy are not active in themselves and should not be taken for granted (J. Hope Corbin et al., 2013).

### ***2.7.2 Partnership functioning in the African context***

There is a lack of research literature on partnerships for health in Africa. Research on health partnerships in Botswana has been conducted largely on analysing ACHAP's efforts to assist Botswana (George et al., 2012; Ramiah & Reich, 2005, 2006). Ramiah and Reich (2006) came up with five challenges that ACHAP confronted in the first four years in managing its partnership with Botswana Government. Firstly, at the start in 2000, ACHAP did not involve a representative of Botswana in its governance and this blinded it from understanding motives, the complex social realities and value system sector of the public sector.

Botswana's way of governing was a shock to ACHAP - elaborate consultation with all sections of the community for consensus building in decision making (Moumakwa, 2011). Colonial memories of foreign control have fatigued African leaders, hence many foreign approaches to health governance face resistance (Alden & Schoeman, 2013). Ramiah and Reich (2006, p. 400) quote the president of the country and the Minister of Health who refuted ACHAP's approaches and stated that Botswana prides itself in managing donors. They said that they could not understand ACHAP's approach of bringing its own program on capacity building that could only be accepted by corrupt countries with poor financial management systems. This kind of reaction connects with the reaction of the political leaders in Tanzania towards the initial implementation of Payment for Performance ( P4P) in the health sector of Tanzania (Chimhutu et al., 2015; Songstad, Rekdal, Massay, & Blystad, 2011) where the high political leadership for Tanzania resisted the neoliberalist approach brought in by the international donors – advocating for Tanzanian values of operation to be considered. The international donors also stood firm on their approach and this created divisions and alliances. The Tanzanian community saw the P4P approach as unfair in the distribution of allowances and access to training that was given only to those workers identified with the program (Chimhutu et al., 2015). International donors ignore equity and bring unfairness in the recipient countries' systems (Campbell et al., 2012).

Secondly, ACHAP excluded government's technical and operational staff in implementation. Involving local frontline staff to work with foreign organisations in planning and implementation of programs can help partnerships promote consensus (Ramiah & Reich, 2006). Thirdly, ACHAP was rigid with its organisational governance structure and would not merge its management approaches with the local government. Ramiah and Reich

(2006) contend that partners must understand collaboration is a learning curve and needs adaptation of behaviour. The fourth observation was that ACHAP had a narrow approach to only focus on its defined current objective and not participate in other Government Health forums. ACHAP acted opposite to the requirement of alignment of programs to recipient countries' strategies and policy plans (Hanefeld, 2010; Rogerson, 2005). ACHAP could learn that a broad portfolio of activities helps external organisations learn from local governments (Distlerath & Macdonald, 2013). The fifth mistake was that ACHAP insisted on getting government to think like them. Success in partnerships comes with willingness to learn from each other, and an ability to anticipate, manage and channel conflict (Ramiah & Reich, 2006).

Openness, flexibility and willingness to learn through partnership processes can improve collaborations. In response to the challenges it faced, ACHAP started hiring *Batswana* (people of Botswana) into its governance structure as well as creating a consultative forum in 2004 that involves civil servants of high rank in the health sector and representatives from its international donors to involve Botswana Government in decision-making (George et al., 2012). In this way, efforts to work with local systems have been made but ACHAP still contends that local protocols delay implementation and has consequently set up parallel systems (George et al., 2012). This is common among international organisations who run parallel health services with local government systems, where participation in both systems by local representatives deplete their time and energy, affecting efficiency in public service delivery (George et al., 2012).

Contrariety, which opposes solidarity between partners, has been termed "antagony". J. Hope Corbin and Mittelmark (2008) used their results for exploring a Global Programme for Health Promotion Effectiveness to develop a systems model they call the Bergen Model of Collaborative Functioning (BMCF). When exploring the partnership in a Norwegian hospital's nutrition innovation, Corwin (2012) established that funding was the source of contention and complicated functioning. Corbin and Mittelmark called this "antagony" and therefore introduced it as a unique type of output, in addition to synergy and additive results, "representing unwanted and disturbing outcomes" (J. Hope Corbin & Mittelmark, 2008, p. 365 ). Their findings reveal that antagony can affect partnerships negatively as partners see such investment as a waste of time and resources. Elements that caused antagony included power projected by the North over the South, one way communication, unrealistic demands on local partners by the Northern partners (J. Hope Corbin & Mittelmark, 2008; J. Hope

Corbin et al., 2013). However, they also observe that antagonism can improve a partnership if partners reflect, learn from their mistakes and work on improving its functioning (J. Hope Corbin & Mittelmark, 2008).

What is further established is that as much as synergy in health promotion partnerships is both a process and a product (J. Jones & Barry, 2011b), antagonism is also not only an ultimate outcome but part of partnership processes that keeps feeding back into the collaborative activities. They argue that partners join efforts to meet certain goals and wish for the partnership to produce synergy (J. Jones & Barry, 2011a). However, when there is antagonism, partners could be willing to learn from their mistakes and improve their collaboration. When testing its utility in a North-South collaborative partnership in Tanzania, Corbin and Mittelmark (2008) note that antagonism emanates from: lack of trust of the Northern donors on the Southern partners; contentions on capacity building and skills sharing; diverse reporting systems used by different donor organisations drained the Southern partners; as well as inconsideration of what is appreciated as good service in the local context. Their conclusion is that the BMCF framework can be used in many facets of partnership functioning and appeal for research that can utilise this model to help partners learn and possibly improve their collaborations (J. Hope Corbin & Mittelmark, 2008).

## **2.8 Research gaps and study objectives**

Research gaps established in the literature review on partnership functioning above are interconnected giving three main gaps that are the focus of this thesis.

First, there is scanty literature that discusses partnership functioning. As indicated in the literature review above, research responding to the need for evidence-based strategies to improve health partnership functioning has only started to grow in recent years.

Second, there are few studies that explore the association between the global context brought in by the Northern partners and the local contexts embedded in the Southern partners' way of doing things.

Third there is lack of literature that explores underlying causes of antagonism in the North-South partnerships. Authors on partnership functioning appeal for research that explores

what makes partnership difficult and what causes antagonistic results. Synergy is appreciated and recommendations are made that partners should learn how to maximise elements that influence synergy to strive for better results. Antagonism comes with costs; therefore, revealing its underlying causes could help partners learn and change for the better. These research gaps offer opportunity for further development in the field of partnership functioning and contribution to this type of science.

### ***2.8.1 Aims and objectives***

The aim of this thesis is to generate knowledge that informs those responsible for global health related decisions, international donors, governments and partners at policy and implementation level on what elements bring good and bad partnership functioning. Specifically, the study explored context as well elements that bring synergy and antagonism into a partnership.

The three papers that form this thesis are anchored in this aim. The papers are not arranged according to the date of publication but according to the logical order of the issues as reflected in the theoretical framework. Paper II was published earlier than Paper I because data on the issue of socio-cultural context had already reached saturation. Saturation is when the data being collected show consistent commonalities without adding anything new (Bowen, 2008). This was possible to see as I was the only one doing data collection and analysis and could reflect and connect information from my triangulated methods. There were many related categories shown during the analysis process as well (Bowen, 2008). Paper I data were based on observation of the development of the partnership through time; therefore, data collection only ceased at the time the partnership dissolved in late 2014. The objectives of the thesis (below) form the themes of the papers.

In my study, I have used objectives instead of research questions. Three objectives are addressed in this study:

**Objective 1** is to use a systems model to establish how the functioning of the partnership on SMC in Botswana contributed to the outcome, including both synergy and antagonism (Paper I).

**Objective 2** is to explore the power of context, namely, responses to SMC in relation to male circumcision (MC) as part of traditional initiation practices in Botswana. More specifically, I

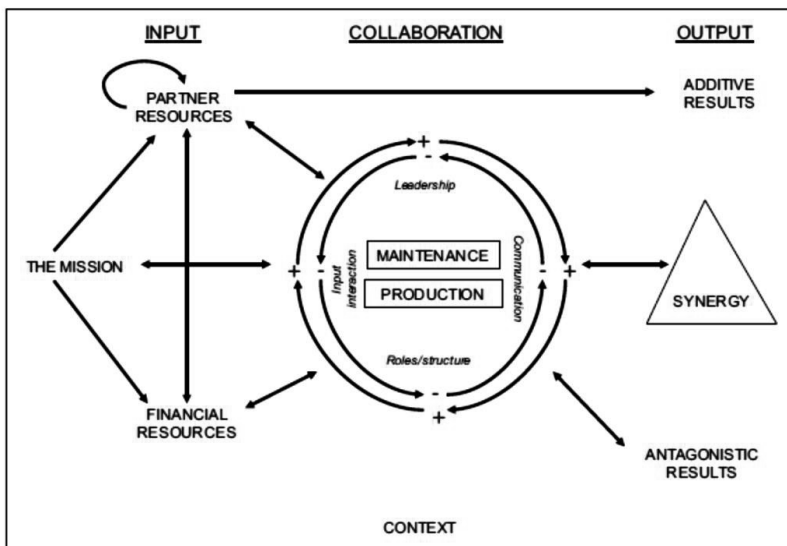
present the views of two communities (with contrasting cultural views on circumcision) on the SMC consultation, implementation procedures, and campaign strategies. (Paper II).

**Objective 3** is to illuminate the actions and processes in the SMC program that contributed to antagonism and to explore the evidence of antagonism within the conceptual framework of therapeutic domination, iatrogenic violence, and the Trojan horse (Paper III).

## 2.9 Conceptual framework

Conceptual frameworks help unravel complex phenomena. As discussed in the literature review section above, partnerships in health are complex and synergistic outcomes are difficult to attain, entangled in economic and dual social contexts - of the Global North and the Global South. For Paper I, I used a systems model, the Bergen Model of Collaborative Functioning (BMCF) (J. Hope Corbin & Mittelmarm, 2008) as an overarching framework to examine the processes and the functioning of the SMC partnership in Botswana. The BMCF model is a systems model that uses inputs, throughputs and outputs, and it is explained later in this section. It is illustrated in **figure 1**.

**Figure 1: The Bergen Model of Collaborative Functioning**



Adapted from Corbin et al. (2015, p. 4)

My three papers add to different parts of the model: collaboration processes, context and antagonism. Paper I adds to the model by discussing the functioning of a multilateral partnership that has a combination of public, bilateral government and private partnership. Paper II contributes to the development of the model by exploring the component of context; it exemplifies tensions between the global and local cultural context. Paper III expands on the concept of antagonism by tracing its genesis using three theoretical concepts: therapeutic domination, iatrogenic violence and the Trojan horse.

### ***2.9.1 Partnership functioning***

I chose to use the BMCF model because although it was developed from a case study in the west, the Global Programme for Health Promotion Effectiveness (GPHPE), it has been used to explore processes in an HIV/AIDS intervention program in Tanzania, Africa (J. Hope Corbin et al., 2013; Corwin et al., 2012). Paper I contributes to the use of this model to unravel partnership functioning from the Southern perspective and adds to the few studies that have used it.

The BMCF comprises inputs, the interaction of these inputs during the collaborative process and outputs. Inputs include the partnership's mission (selected approach to deal with a problem), partner resources (knowledge, skills, competence, etc.) and financial resources (funding and material inputs) (J. Hope Corbin et al., 2013). The collaborative context (or throughput section) of the partnership is analysed through the interaction – positive or negative – of four aspects that impact the maintenance (administrative) tasks and production tasks (related to partnership's mission), namely, leadership, communication, roles & structure and the inputs themselves (J. Hope Corbin et al., 2013).

The output of the partnership can be *additive results* (unaffected by collaboration of the partners), or *synergy*, where collaborating produces more than if the partners had not interacted with one another; or *antagonistic results*, where the costs of partnership exceed the benefits (J. Hope Corbin & Mittelmark, 2008; J. Hope Corbin et al., 2013). Additive results are things that could still be achieved without the partnership. This is based on the argument that a partnership is always built to tackle an existing problem where some action has been taken anyway. Synergy is what is achieved because of the “multiplicative interaction” of the partnership. Determinants of synergy include partner relationship ingredients like: trust and power, partnership assets, partnership characteristics, and



leadership (J. Jones & Barry, 2011b, p. 409). If synergy is achieved, this may have a positive feedback impact on partnership inputs and functioning (J. Hope Corbin et al., 2013). For the purposes of this study, I define antagony as any resistance within an interaction of two collaborative forces that causes interference, tensions, and counter-productivity. Reflecting on antagonistic results may also result in positive feedback (J. Hope Corbin et al., 2013). J. Hope Corbin and Mittelmark (2008) note that it is possible for a partnership to include both synergistic and antagonistic elements concurrently. Put in mathematical terms; synergy ( $2+2=5$ ); additive outputs ( $2+2=4$ ), or antagonistic results ( $2+2=3$  or  $0$ ) (J. Hope Corbin et al., 2013; Corwin et al., 2012).

J. Hope Corbin and Mittelmark (2008) record that nearly 50% of partnerships dissolve early and impulsively. They observe that resources, characteristics of partners, features of the partnership strategy and environmental factors can either support synergy or create antagony between partners (J. Hope Corbin & Mittelmark, 2008: p.365). Fowler (2000) adds other elements may cause antagonistic outcomes in partnerships such as: paternalistic behaviour of those with cash power; upholding the approach of the Northern rather than the Southern partners; hiring staff from the North because of capacity limitations of workers from the South, and the North's anxiety about loss of control. Corbin and Mittelmark (2008) argue that although more financial resources can improve the functioning of the relationship, funding can also complicate functioning: antagony is created if partners and funders view the partnership as a waste of financial resources and time. A study in Indonesia found that priority areas are defined by the multilateral agencies only, and are a reflection of their own concern in the governance field, not those of the local people (Crawford, 2003).

### ***2.9.2 Context***

As shown in the BMCF conceptual framework in figure 1, partnerships operate within contexts that may be environmental or socio-cultural that affect their ways of doing things (J. Hope Corbin et al., 2013). As discussed earlier, several authors have written on the global context in which HIV/AIDS partnerships occur (Aginam et al., 2013; Campbell et al., 2012; Nguyen, 2009; Seckinelgin, 2005) and others on the local context of the global South where the interaction of the global and the local takes place (Aveling, 2010; Campbell et al., 2012; Daniel, 2014). Some of the authors have addressed both. Two cultures underpin the events in Paper II - the culture of collectivism and the individualistic culture of neoliberalism.

Botswana has a culture of collectivism that affects both the political arena, strategies for program implementation and consultative processes in decision making. In collectivist culture, leaders at national, district or community level are to show value for the contribution of the least of the lay persons in the community (Schapera, 1970). Botswana has a saying *mafoko a kgotla a mantle otlhe* meaning “ideas that are shared collectively are of great value” (Moumakwa, 2011). Chiefs are of great fundamental influence to any events or developments in the community and are highly respected (Schapera, 1970). However, this has been diluted by modernisation (Moumakwa, 2011). Since the chiefs are such a central pillar in decision-making, if their voice is removed from consultation, the system of consultation becomes dysfunctional (Moumakwa, 2011). Structural and program-based developments in Botswana have been carried out through the chief’s consultative forums with the community, facilitated at a central gathering place called the *kgotla*. Failure to consult in this manner blocks the communities’ contribution and participation in development (Comaroff, 1985). Several authors observe that international organisations are not patient with the Botswana ways of consultation and decision-making processes (Distlerath & Macdonald, 2013; Ramiah & Reich, 2006). Organisations like ACHAP faced challenges because the board of governors and employees decided to override this cultural procedure (Ramiah & Reich, 2006). Progress was made only after considering using cultural approaches. The Botswana system of collectivism has been criticised for being time-consuming and inconsiderate of matters of emergency like health (for example in the implementation of Anti-retroviral therapy program (ART) to dying HIV/AIDS patients) (Distlerath & Macdonald, 2013; Ramiah & Reich, 2006).

Traditional initiation is a cultural practice in Botswana, which performs circumcision as a rite of affirmation. In Botswana, traditional initiation for men is conducted in the wilderness in selected sites and commonly during winter (Mosothwane, 2001). The initiates are separated from the community for skills-training and challenges and only men are allowed (Comaroff, 1985; Mosothwane, 2001). All initiates undergo circumcision at the same time; their collective endurance of the pain reflects masculine strength (Meissner & Buso, 2007; Mosothwane, 2001). One knife is used to circumcise all initiates as a rite of affirmation marking transformation to manhood (Comaroff, 1985; Mosothwane, 2001; Turner, 1969). Missionaries considered the practice barbaric and indecent and therefore enforced its abolishment during the twentieth century (Mosothwane, 2001). A few tribal communities, like the Bakgatla of Mochudi village, resisted the abolition of initiation (Mosothwane, 2001).

The practice went through a wave of changes throughout the years with some tribal chiefs disregarding it in fear of punishment and others reinstating it, sometimes without MC. The current tribal leadership of Mochudi has revived the practice and the community upholds it as a special identity of their tribe (Moumakwa, 2011; Setlhabi, 2014).

Neoliberalism is the ideology that dominates in global governance for aid. Neoliberalism is associated with laissez-faire economic liberalism – where individuals are freed from control by governments and can decide how they interact with the market, privatisation and free trade. International organisations like WHO, IMF and World Bank are in the neoliberal band (Harvey, 2005). Organisations like PEPFAR and Bill and Melinda Gates Foundation, whose establishment and funding source is in the North, are influenced by the same philosophy. Neoliberalism is manifest in health programs through the use of biomedical marketing approaches to win the interest of individuals in the health ‘product’. Biomedical marketing is a form of social marketing, but used to promote biomedical procedures and pharmaceuticals; for example, through campaigns in social media (Nelson, 2012). There is appreciation among researchers that neoliberalism does offer possible new methods of program implementation that carry in it the concept of efficiency – “dollars to numbers approach”. However, the approach is blamed for inconsideration of existing social structures and viewing their ways of doing things as the only efficient approaches (Ferguson, 2006; Finn et al., 2010).

### ***2.9.3 The underlying causes of antagony***

This thesis adapts three ideas that have been used in the partnership literature: therapeutic domination, iatrogenic violence and the Trojan horse. The three concepts are summarised below and more details are provided in Paper III.

Therapeutic domination, as in the doctor-patient relationship, occurs when the intervenor “claims obedience by virtue of the application of a scientifically valid, impersonal procedure ... in the context of crisis” (McFalls, 2010, p. 322) – effectively, expertise given with arrogance. Rottenburg (2009) describes therapeutic domination as a superior power position taken by those with the biomedical know-how to manage and direct treatment programs in countries that are poor and vulnerable to such powerful imposition. Mawdsley (2011) sees

aid as a strange gift that is unreciprocated, adopting a lopsided social order where the superior givers do not allow the recipient to show their dignified status by giving something back. Usually a gift implies obligation to give back something of equal value. Mawdsley (2011, p. 259) calls aid ‘negative giving’ which carries ‘symbolic domination’. The neoliberal approach that is used to deliver these gifts is individualistic and destroys the local collective action that recipient communities normally operate under (Rasmussen, 2013). “While the language of global HIV/AIDS policy is partnership (ownership, alignment and mutual accountability), the reality is closer to therapeutic domination with donors controlling the nature and extent of interventions” (Daniel, 2014, p. 418). Therapeutic domination shifts the sovereignty power of the indigenous government and gives it to organisations operating at global level, above national answerability (Rottenburg, 2009, p. 425).

Iatrogenic violence means good intentions that cause unintended harm. Iatrogenesis is a concept from the practice of medicine (meaning injury caused by a doctor) applied to the aid context by McFalls (2010) and termed *iatrogenic violence*: despite good intentions to give benevolent humanitarian services, aid can sometimes cause social disruption. This is the term used to refer to unintended antagonism in this paper. St-Pierre (2014) notes that the assistance brought by international organisations to developing countries blends the therapeutic, the commercial and the humanitarian. Although countries in the South are criticised for receiving external help without reflecting on consequences, some have resisted the power of the North in their country’s affairs (Alden & Schoeman, 2013). International organisations normally threaten to pull out services where there is resistance, and this St-Pierre (2014) calls iatrogenic imperialism.

The third idea, aid as a *Trojan horse*, conceptualises aid as a deceitful strategy (though accepted willingly by the recipient) to gain control of the recipient country’s approach to particular services. Antagonism arises from the strategic exercise of power by a more powerful partner, with a hidden agenda to control the partnership. Fowler (2000) uses the metaphoric phrase ‘Terminological Trojan horse of partnerships’ to describe the subtle power of the international donors from the North who come into the Global South with the deceptive tactic of empowering the weak and seeking to share responsibility of disease burdens but turn to bring false hope and destruction in many ways. Welcoming aid from the North into the global South allows an infusion of foreign concerns into the domestic approaches to

health and development processes (Fowler, 2000). But this act of welcoming also implies a degree of agency (Campbell et al., 2012). Critics see partnership within the new aid agenda as an instrument for deeper, wider and more effective penetration into the country's development choices (Abrahamsen, 2006; Esser, 2014).

### 3 Methodology

#### 3.1 Study Design

In this section, I firstly give a concise description of the philosophical positioning of my methodology and methods procedures. Secondly, I discuss the trustworthiness of my methodological choice showing how my analytical and interpretive processes are used to contribute to its reliability and dependability. I introduce these concepts in this chapter and discuss them in the section, Discussion Methodology, in Chapter 5. Limitations and strengths of the methods are also elaborated in Chapter 5.

I used a qualitative ethnographic enquiry to explore the SMC program in Botswana. Ethnography is a study design where the researcher explores the interactions of a particular phenomenon with culture, from the point of view of the participants of study (Silverman, 2016). Whereas qualitative research methods inclusive of ethnography, case study and phenomenology are all interested in examining social processes, insights and meanings (Creswell, 2007), among them ethnography stands out as an appropriate tool to use to deduce cultural meanings that inform people's responses and interpretations of their day-to-day lived experiences (Golbart & Hustler, 2005). "Ethnographies are necessary to describe complex phenomena, generate theoretical models and reframe questions" (Feuer, Towne, & Shavelson, 2002, p. 8 ). Although ethnography is a method commonly known to involve the researcher spending long periods of time in the field observing and participating in people's daily lives, scholars have now constructed rapid ethnography. Rapid ethnography "is a collection of field methods intended to provide a reasonable understanding of users and their activities given significant time pressures and limited time in the field" (Millen, 2000, p. 280). I used rapid ethnography. Although my research was conducted over a combined period of 17 months through 2012-2015, to observe and interview people on the SMC phenomenon, I had my research scheduled only within certain periods of each year where important events of the SMC intervention were taking place (see schedule of research). However, observations in newspapers, radio, television and in corridors were continuously made without scheduling, during research phases. Whereas ethnography continues making its mark in the research, it is, like all other research methods not immune to both external and internal limitations (Silverman, 2013). It is expensive, time-consuming and its results cannot be generalised to the larger population (Blomberg, Giacomi, Mosher, & Swenton-

Wall, 1993). Ethnography, like all qualitative research methods does not have clear cut guidelines which can be followed with accuracy like the gold standard of quantitative research (Hammersley, 2005). This on its own is a strength to be able to collect people's experiences with openness (Shavelson & Towne, 2004). As Creswell (2013) states, this way of research produces multiple realities. This leads me to discuss epistemology interactively with ontology and axiology, the former being elaborated.

### ***3.1.2 Epistemology***

Epistemology is the nature of knowledge and the interaction between the researcher and the stakeholders to achieve such knowledge (Mertens, 2008). It seeks to understand what and how knowledge is acquired. In the case of qualitative research, it is the production of knowledge which reflects the researcher's subjectivity and participants' own subjectivity in relation to a particular phenomenon, within their specific context (Stacy & Little, 2007). "The relationship between the researcher and the researched is not based on a power paradigm but involves a transformation and emancipation of both the participant and the researcher" (Chilisa, 2011, p. 36). Qualitative research is hinged on process theory which believes in giving explanations that tell a narrative about how a series of events develops to produce particular conclusions (Van de Van, 2007). Ethnographers acquire their knowledge by being active in the participants' context, spending lengthy periods in the field, so as to understand what is real within a certain political, social, economic and gender context. The knowledge of this research was generated from observing the partnership of the SMC program and the way the community responded to its implementation strategies over a period of 17 months. My interaction with the participants, (despite my being an educated Motswana woman studying in Norway, and they being within their socio-context, caught between modernisation and traditional practices of initiation) produced knowledge about the phenomenon of medical circumcision.

This interaction produced multiple realities as per the ontological stand. Ontology relates to the nature of reality and its features (Creswell, 2013; Mertens, 2008). The ontological stance of qualitative research is that social reality is historically bound but constructed based on the social context, hence multiple realities (Chilisa, 2011). Ontology rejects cultural relativism and establishes what is real (Mertens, 2008). Society has both objective and subjective reality; therefore, it is crucial to create meaning together. My research considered different

understandings of the MC phenomenon such as: the practice of traditional initiation; non-initiating cultures; the rationale of SMC; the global context of aid including the unseen donors; the in-country partners' response to global and cultural contexts; views from men and women. These different understandings emerge from different constructions of reality and truth; social constructionism contends that context and culture influence how people form their views on a phenomenon (Chilisa, 2011). Also, research has to be done right. Axiology is assumptions about rules and standards of social justice, upholding human rights and respecting cultural norms (Chilisa, 2011; Mertens, 2008). It is therefore crucial that researchers reflect on their values while carrying out the research (Creswell, 2007; Mertens, 2008). I carried out this research committed to social justice and guided by good morality and by the qualitative concept of reflexivity, discussed later.

### **3.2 Study setting**

Study sites are chosen because the specific features they hold contribute to the sample design (Ritchie, Lewis, Nicholls, & Ormston, 2013). There were three sites chosen for the study: Gaborone, Mochudi and Hukuntsi. Gaborone was chosen because it is the administrative centre of the SMC program where national officers are based and could inform the study about the functioning of the partnership. Mochudi and Hukuntsi villages were chosen to contribute the cultural explorations of the study with one practicing MC within traditional initiation and the other not. Data for all three papers were from all three areas, with Paper II emphasising data from Mochudi and Hukuntsi as communities with specific cultures; Papers I and III data are from all three sites with main respondents being national and district administrative officers of the program. **Table 1** provides details of population and HIV prevalence for each research site (located on the map, p. xvi).

#### **3.2.1 Gaborone**

Gaborone is the capital city of Botswana located in the South-eastern part of the country and 15km from the South African border (W. Seth, 2008). It is a major operational centre for central government including all ministries, main government departments, colleges and universities (Botswana Government, 2011). It also houses large commercial businesses like shopping centres, which employ many citizens and migrants. Gaborone has no tribal affiliation but is a recipient of all Batswana tribes as people of different communities, especially those close to the city, like Mochudi, migrate to the city. For the delivery of its



health services, Gaborone has the biggest referral hospital in the country with more than 15 health centres, public primary hospitals and clinics, 2 large private hospitals and several private clinics.

### ***3.2.2 Mochudi***

Mochudi is a semi-urban community situated in the Bakgatla tribal region, about 40km north-east of Gaborone. It is the centre for Kgatleng District council and is home to the district's Rural Administrative Centre (RAC) – a decentralised service point for most government departments in the district (MFDP, 2011). It is a well-developed village with seven public secondary schools, ten primary schools and good tarred roads (MFDP, 2011). Mochudi is a community of the Bakgatla tribe that has been practicing traditional initiation since the 1800s, with some groups of initiates going through traditional circumcision and others not (Comaroff, 1985; Sabone et al., 2013). The practice of traditional initiation made it an interesting study site to get cultural responses to the SMC program.

### ***3.2.3 Hukuntsi***

Hukuntsi is located in one of the most remote rural parts of Botswana, situated approximately 520 km west of Gaborone. It is one of the four major villages in the Kgalagadi Desert, and is the headquarters of the Kgalagadi North Sub-District. Hukuntsi is the least developed community among the three chosen research sites: with one primary hospital, a public clinic and one junior secondary school. Besides these basic developments, Hukuntsi has few economic attractions and little immigration. Although a larger population of Hukuntsi is Bangologa people, it is commonly known as a home of the Kgalagadi tribe, an adapted group identity to cater for other tribes within the community (Hermans & Nteta, 1995). Bakgalagadi tribe of Hukuntsi village has never practiced traditional initiation and circumcision (Comaroff, 1985). Its positioning in the less developed part of the country, as well as no practice of initiation, made it an interesting village to explore for cultural views on the SMC program.

**Table 1:** Merged tables on Population Distribution and HIV prevalence by district.

Sources: Botswana Population and Housing Census (PHPC, 2011) and BAIS IV (2013)

Name of Research Site and description	General Population	Males 19-49	Females 19-49	HIV prevalence among males 19-49 within district	HIV prevalence among females 19-49 years within district
Gaborone – capital city of Botswana	231,626 10%of general pop.	118,023	113,603	13.4%	19.8%
Mochudi – semi urban area, 40km from Gaborone	91,660	44,580	47,080	15.6%	23.8%
Hukuntsi – remote rural community, 700km from Gaborone	20,477	10,353	10,124	18.2%	18.1%

### 3.3 Selection of research participants

Selection of study participants is guided by the research question as well as access to the setting (Skovdal & Cornish, 2015). Ethnographers allow the field to inform their decision on how best to approach answering the research question (Silverman, 2013). Although I already had categories of participants in mind, I allowed the field to point specific individuals and groups of people as key participants to the study. Selection of participants was greatly influenced by the 2012 annual strategic planning meeting for the SMC partners that I was invited to attend and observe. This meeting gave me an overview of the program and covered key questions in my study therefore, guiding the relevant steps to take to elicit participants' experiences of the program from national level to community level. In this way, I used purposive sampling to effectively fulfil the aims of my study. The difference between sampling for qualitative and quantitative enquiry is that "the former is concerned with the purposive representation of character and the latter with statistical representation using random selection to represent population distribution" (Ritchie et al., 2013, p. 116). Bias of the qualitative researcher is a natural disadvantage of purposive sampling since decisions of who should participate is based on their judgement and control. Critics argue that findings of the research could be different if the participants are not the same (Devers & Frankel, 2000; Skovdal & Cornish, 2015). There are five main categories of participants: national lead officers of the program at MH, CDC and ACHAP; DHMTs in Mochudi and Hukuntsi;

MOVE implementing teams; traditional community leaders in Mochudi and Hukuntsi; men – the target population of the program – in all three research sites.

### ***3.3.1 National lead officers of the program***

All three organisations that formed the SMC partnership had national lead officers in the categories of coordinators/directors of the program as well as staff members responsible for different implementation sections. National lead officers were chosen because they had an understanding of the aims and objectives of the program as well as its origins. They also had experience that could inform the study on the different phases of program and partnership functioning. The thirty officers (observed at the strategic meeting) were of different categories: national project coordinators/directors for all three partners, regional coordinators, project management leaders, surgeons and medical officers, program coordinators at district level and program leaders from the CDC contracted companies. These were of great interest to give a thorough overview of the program nationally. It was crucial to interview the five top project leaders because they have authority to give in-depth and detailed descriptions of the partnership and inform the researcher on important events that shaped its functioning. They were also in a position to give an overview of the general response and experience of the specific tribal communities and cultures to the program. Out of the five, three were from MH where the project coordinator nominated the other two officers to participate. The other two of the five were from CDC and ACHAP.

### ***3.3.2 District Health Management Teams and Mochudi MOVE team***

District Health Management Teams (DHMTs) and MOVE teams manage the program at district level, the former being a government service team while the latter work for ACHAP or CDC. The DHMTs were selected because of their role as managers of different health programs who carry immense experience of how health management and implementing staff juggle different programs. MOVE teams were only focused on the implementation of SMC. Each of these had team members who only worked with administrative issues while others were direct implementers. DHMTs and MOVE teams represented the partnership at district level. These served as ideal participants as they could inform the research on the level of participation of staff from either side, availability of resources, communication and administrative exchanges between themselves, and testify on responses of community

members, as well as the partnership at district level. A group of five to seven participants comprised the Mochudi and Hukuntsi DHMT respectively; and six participants for the Mochudi MOVE team.

### ***3.3.3 Traditional Community Leaders***

For exploring the cultural relevance of SMC, the elders and chieftainship of the communities were the obvious informants. In Botswana, chiefs are the custodian of the culture; preserving culture is maintaining the community's identity and is taken as a community leader's role (Comaroff, 1985). Also, the setup of Botswana's operational structure for all types of programs is that the traditional leadership is contacted and informed first about all program intentions to help communities (Moumakwa, 2010). They, therefore, are watchdogs of how programs interact with the people's tradition. Altogether, 25 traditional leaders participated in Mochudi and three in Hukuntsi village.

### ***3.3.4 Men – the target population of the program***

Men are the target population of the program, therefore, automatically well-positioned to give in-depth descriptions of their experiences with the program and its interaction with their culture. The study included men of all ages eligible for the program (15-49). The traditional leaders mentioned also gave their personal experiences of the program. A total of ten men from two groups in Hukuntsi participated in the study through FDG and interviews; 30 men in Mochudi and 200 in Gaborone through participant observations in public campaigns.

## **3.4 Data collection and methods**

Data were collected over a total period of 17 months between December 2012 and July 2015. As discussed earlier, the study used rapid ethnography. I scheduled my data collection periods at different phases of the program. This is reflected in Table 2 on the cyclic order of fieldwork below. I moved between all three sites for follow-ups and cyclic interviews and would normally use a number of weeks within the given spread of time (given in months). The phases of data collection were: 1. December 2012 – February 2013; 2. June-August 2013; 3. January- August 2014; 4. May-August 2015. All three papers were written with data from all participants described above. However, data for Paper II had already reached saturation by 2014, hence its early publication. Data collection for Paper I and III reached completion in 2015. Different methods were used to collect data. "Methods are techniques or

procedures used to collect and analyse data” (King & Horrocks, 2010, p. 6). The research question, study approach and types of participants influence choice of methods (Creswell, 2013; Skovdal & Cornish, 2015). Ethnographic methods: interviews, FDGs, observation and participant observation were used.

### ***3.4.1 In-depth Interviews***

Interviews help explore individual points of view, meanings and perceptions of a phenomenon (DiCicco-Bloom & Crabtree, 2006; Skovdal & Cornish, 2015). I used a semi-structured interview guide to allow in-depth questioning to co-create meanings with interviewees; also allowing deeper exploration of the phenomenon and flexibility to include other information shared (Creswell, 2013), consequently giving me rich descriptions. However, caution had to be applied to ensure the interviewees kept to the subject discussed. In total, 39 interviews were conducted, eight of which were conducted with national lead officers of the program. Six interviews with men were scheduled and in-depth while the remaining 25 interviews were part of the 230 participants observed at MOVE campaigns, which were a mix of spontaneity and reference to the interview guide. The interview guide (see appendix ii) included topics to explore gaps between globally determined targets on HIV programming and local realities; the functioning of the partnership - seeking to identify synergy and antagonism; types of tensions that the partnership experienced.

### ***3.4.2 Focus Group Discussions***

Focus groups for qualitative research are groups of people with similar background and experience of the phenomenon of enquiry (Barbour, 2005; Creswell, 2007; Skovdal & Cornish, 2015). It is therefore crucial to ensure that every member of the group feels comfortable with the subject of discussion even if they may be meeting other members of the group for the first time (Barbour, 2005). Implementers of the program at district level, as well as traditional leaders in Mochudi and Hukuntsi, preferred to participate as groups in the study. I conducted five Focus Group Discussions (FGDs) altogether: 1. Hukuntsi DHMT with seven participants; Mochudi DHMT with five participants; Mochudi MOVE team with five participants; Mochudi traditional leaders with 25 participants; and Hukuntsi traditional leaders with five participants. It is noted that 25 is too large a number to be called an FGD, however, traditional protocol demanded that the elders be addressed as one. The advantage

of FGDs is that members probe each other's meanings on sharing information (Creswell, 2013), however, it is easy for group members to be passive and not participate more, especially if the group combination has people of different positions (Barbour, 2005; Krueger & Casey, 2014). In this study, all FGDs displayed hierarchy of one kind or the other. Senior and junior officers were combined together in the DHMT and MOVE teams. Traditional leader groups comprised senior and junior chiefs. Although this was not a challenge in Hukuntsi, in Mochudi only 10 respondents were active in the discussions. This is also partly because the group was too large; hence, shy members could easily hide.

### ***3.4.3 Observation and participant observation***

Observation methods can either be participatory or non-participatory. Participant observation is a method where the researcher spends time in the community to study people's lives in relation to the topic of study (Skovdal & Cornish, 2015). Participant observation is inherent in ethnographic studies with anthropological origin (Ritchie et al., 2013). However, different studies like educational and health studies now adapt the method and apply it in a rapid way, hence the term 'rapid ethnography' (Skovdal & Cornish, 2015). My participant observation approach was mostly scheduled but also rapid. I observed participants under a certain situation within a certain scheduled period of time and noted their responses, behaviours, conversations in relation to the atmosphere they were exposed to, the theme of the event as well as the timing. I observed 30 officers at the 2012 three-day meeting, and conducted participant observations at two MOVE campaigns in Mochudi and Gaborone. During the campaigns, I interacted with different stakeholders including SMC mobilisers, men coming in and out to listen to campaign messages, a few women accompanying men and officers conducting HIV testing on the site. The three-day meeting was restricted to observation only, while I was allowed to participate – ask questions and comment – in the MOVE campaigns. Generally, I observed how SMC was advertised: television advertisements, radio advertisements as well as societal responses to such advertisements and communications.

**Table 2: The Cyclic order of fieldwork**

Time	Participant/s	Approach
December 2012	30 participants for the 3 Day planning meeting for SMC: National SMC leaders and DHMT representatives	Observation Corridor chats
February to July 2013	MH, SMC Coordinator	Interview ( round 2 enquiry)
	CDC, SMC Coordinator	Interview ( round 2 enquiry)
	ACHAP, Programs Director	Interview ( round 2 enquiry)
	MH, SMC project manager	Interview ( round 2 enquiry)
	MH, North - SMC regional coordinator	Interview ( round 2 enquiry)
	ACHAP, MOVE team : 6 implementers	Focused Group Discussion 6
	DHMT – Hukuntsi: 7 officers	Focused Group Discussion – 7
	DHMT – Mochudi: 2 officers	Group discussion
	SMC MOVE Campaign - Mochudi : 15- 35 participants; 2 SMC mobilisers and men	Participant observation
2012 to 2015	Media	Observing adverts on TV, MOVE branding and poster adverts, Radio shows, reading news papers
June-August 2014	SMC MOVE Campaign - Gaborone : 100-350 mobile participants; 12 SMC mobilisers and men Women	Participant observation Interviews
January to July 2015	MH, SMC Coordinator CDC, SMC Coordinator ACHAP, Programs Director Women ( data not included in this thesis)	Interview (round 3 enquiry) Unsuccessful appointments for interviews Interviews
July 2015	CDC, SMC Coordinator ACHAP, Programs Director	Unsuccessful appointments for interviews

**Table 3: Demographic details of participants and data collection methods**

Role	Details	Method	Age	M	F
Leaders in Partner Organisations	MH National SMC Co-ordinator	IDI	40-60	1	
	MH National Project Advisor	IDI			1
	MH Northern Regional Co-ordinator	IDI			1
	CDC SMC Co-ordinator	IDI			1
	ACHAP Programs Director	IDI		1	
National and District SMC leaders	National and DHMT combined meeting	Observation 30	40-60	16	14
Implementers	ACHAP team Mochudi	FGD	25-50	3	2
	DHMT Hukuntsi	FGD	25-45	4	1
	DHMT Mochudi	FGD	25-50	-	5
Social Workers	Hukuntsi	FGD	25-40	9	-
Traditional leaders	Bakgatla Chief, Mochudi	IDI	40-80	1	
	Bakgatla traditional leaders, Mochudi	Group interview		25	
	Bakgalakgadi Chief, Hukuntsi	IDI		1	
Men	Mochudi	FGD	20-35	6	
Men	Mochudi	Participant observations	15-60	30	
Men	Hukuntsi	FGD	20-35	7	
Women	Hukuntsi	FGD	30-40	6	
Women	Gaborone	FGD	30-48	7	
Men	Gaborone	Participant observation	15-60	200	
<b>Total</b>				<b>316</b>	<b>25</b>

### 3.5 Data Analysis

The data analysis process has been extensively described in the papers. Data were reanalysed for each paper. Firstly, transparency on data storage and transcription is key in compiling data. Data was stored in a securely locked computer and notebooks. Three research assistants transcribed the data. In order to ensure accuracy and validate what was transcribed, the first author translated all transcribed data from Setswana to English and cross-checked those already transcribed in English to verify transcripts against audio recordings. Another aspect of research that increases reliability is consistency in the coding process (Parker, 2011). In my analysis, repetitive coding of a large portion of my data with a group of two other qualitative researchers, increased reliability. Creswell (2007) explains that for qualitative researchers, inter-coding agreement is based on whether two or more coders agree on codes used for the same passage in the text.

The analysis process was largely inductive with multiple quotations supporting the common themes that emerged among a team of three people involved in the analysis (Graneheim & Lundman, 2004). Daly et al.'s (2007) recommendation to make sure that there was not a drift or a shift in the definition and meaning of codes during the process of coding, was followed. The coding was accompanied by writing memos and code definitions. The codes were constantly cross-checked and compared as much as possible. Consistency in coding increased the reliability of my data (Golafshani, 2003). I used the scientific software of Nvivo that is highly recommended by qualitative researchers to manage and analyse the data (Pope & Mays, 2008). Following Attride-Stirling (2001) stages of data analysis, data are initially read to code topics raised by the participants. Then themes are abstracted from the coded sections and grouped into organizing themes, which are then further clustered to global themes. In view of these themes, time was taken to reflect on the data to relate the findings to the research question. In order to strengthen the objectivity of the data, the team discussed organising and global themes to reach a consensus throughout the analysis, ensuring stability and relevance. In accordance with Rapley (2010) and Silverman (2013) the global themes, which form the conclusion of my results in all three papers, are largely supported by the data. The tables showing basic themes, organising themes and global themes of each paper are attached in Appendix i.



### 3.6 Role of Researcher - Reflexivity

Constructivists acknowledge the influence of the researcher on the research process and therefore emphasize reflexivity reflecting biases and flaws during the process of the production of knowledge (Silverman, 2013). The rhetorical structure of an ethnographic narration, whether in a poetic or story form, should show thick descriptions, presenting details of emotions, beliefs and socio-cultural relationships “while examining cause and sequence that follow grand narratives” (Creswell, 2007, p. 194). In ethnography, the voices of individuals and the subjectivity of the researcher must be heard (Golbart & Hustler, 2005). The researcher’s reality is not necessarily the same as that of the participants of the study, neither is it the same as the readers’ realities (Creswell, 2007; Parker, 2011). The researcher’s knowledge could be influenced by her academic exposure and her social experiences (Creswell, 2013; Silverman, 2013).

It was crucial in my case, as a researcher conducting an ethnographic investigation in the country and tribal communities that I relate with, to have continuous reflexivity. I was aware that my biases could affect the quality of the data throughout the research process – data collection, data analysis, writing for publications (i.e. presentation of findings). During some review processes, both internal and external journal reviewers pointed out bias forcing me to reflect again. The description below explains the root of my biases that are now addressed through academic maturity.

“I will take the risk!” This statement that pumped continually in my mind was a warning that I am part of the social world that I was studying; the me “self” colliding with me “author” (Golbart and Hustler 2005). I determined in my heart that even though it is culturally sensitive and personally embarrassing, I would find a way to explore the acceptance of SMC in Botswana. This embarrassment came up frequently whenever I had to explain the topic of my research to Botswana, especially in their language. I realised the shame is internalised from my childhood upbringing. This internal shame blocked some of my interview attempts with men. One taxi driver expressed with astonishment, “Young as you are, a woman for that matter! Are you asking men, even old men..., about their penis?” It was hard to answer such a question. My embedded culture collided with the professional me. I was ever cautious about my selection of language, lest I “insult” the informants. For my male informants I always had to ask general and non-direct questions before striking on

what I really wanted to find out. This way, I managed to elicit rich data from culturally challenging contexts.

I have extensive experience working with international organisations in a different field and had to be aware of the biases I have from my experiences. I immensely support HIV interventions that may help my fellow countrymen, and wish they could be implemented quickly, but I am also an advocate of respect for local cultural views and wish foreign aid could respect people's cultures. Awareness of the role of emotions is key to note as a researcher (Creswell, 2007). I had to continuously block the emotional rage that kept choking me whenever I listened to the seemingly irreconcilable collision of Botswana's culture of initiation with the program of SMC. What do you do if you are a native who wants your country free of the HIV scourge, but at the same time want to maintain the cultural practices that teach morality and strong manhood? My father would always quote how initiation training curtailed their waywardness and strengthened them as men. I grew up appreciating evidence of such training from elderly men in my community. Their conduct, based on values developed through initiation, are models to all boys in the community at large. I always had to be aware of this strong cultural connection so as to avoid bias in my interpretation of data.

Rhetorical assumptions are grounded on the belief that the researcher has to show how he makes the account of his research persuasive and compelling, so that his findings achieve respectability, even to the positivist wing (Denzin, 2009). It is therefore important to share the analytical process of the study and demonstrate its credibility (reliability) and validity (dependability) which could then justify generalisability (transferability) (Creswell, 2007, 2013). The narrative of ethnographers needs to embed validation and credibility in order to be persuasive (Stacy & Little, 2007). While social researchers embrace this view, they recommend to use quantitative equivalents to explain the persuasiveness of qualitative studies (Creswell, 2007, 2013). The argument is that qualitative researchers who continue to use positivists' terminologies declare that qualitative research can be embedded in quantitative research (Creswell, 2007; Stacy & Little, 2007). Below, I address the questions of reliability, dependability and transferability to show how I tackled data collection and data analysis (Silverman, 2013).

### **3.7 Trustworthiness**

Trustworthiness is the criterion of ensuring rigour in qualitative research. Three constructs of satisfying rigour include reliability, validity and transferability (Guba & Lincoln, 1994) which are discussed using the qualitative terms below. As mentioned above, I reflect on the trustworthiness of my methodology in Chapter 5.

#### ***3.7.1 Reliability/Dependability***

The thick descriptions in ethnography should be shared in a way that demonstrates reliability. Reliability is the equivalent of internal validity in quantitative research, meaning how sound and truly reflective of the phenomena the findings are (Chilisa, 2011; Silverman, 2013). In quantitative terms, reliability is the extent to which results are steady and unswerving over time and truthful representation of the total population under study. The results can thus be replicated under a similar methodology because the research instrument is considered to be reliable and unchanging (Golafshani, 2003). This assumption of a rigid inflexible social world is contradictory to the qualitative/interpretive assumption that the social world is continuously shifting and the notion of replication is itself problematic (Hammersley, 2005; Silverman, 2013). In qualitative research, actual words of individuals are used to show the different perspectives of the phenomenon.

There is a challenge to show evidence and consistency of these multiple realities. For example in my study there were different constructions of MC. Cultures that practiced initiation believed that MC, carried out with initiates as a collective in the wilderness, is a symbol of strength, maturity and true manhood. The performance is done collectively to show support and collective endurance through life challenges. Medical MC (SMC) is a mechanical surgical procedure that sees the body as an entity and focuses on giving physical health. People are self-interpreting animals and therefore, they cannot be squared within a scientifically defined structure of meanings and defined analytical categories (Chilisa, 2011). People have interpretations they attach to a phenomenon, and these interpretations can be influenced by circumstances around them (Creswell, 2013). The researcher's responsibility is to show that a true picture of the phenomenon under study is being presented by sharing processes and procedures involved (Shenton, 2004). In ethnography, reliability can be enhanced through detailed field notes that are transcribed from an audio recorder, and

ensuring that pauses, and sounds are captured for transparency of how participants presented their views of the phenomenon (Creswell, 2007). Consistent use of topic guide as well as data collected by the same researcher also helps ensure dependability (Creswell, 2013).

### ***3.7.2 Validity/Credibility***

Validity is the determination of whether a measurement instrument in quantitative research has "credibility" and measures what it is supposed to measure (Kvale, 1994). According to Creswell (2009, p. 190) qualitative validity means "the researcher checks for the accuracy of the findings by employing certain procedures".

Hammersley (1990, p. 57) also postulates that validity is "the extent to which an account accurately represents the social phenomenon to which it refers". In order to operationalize the concept of validity in qualitative research, Lincon and Guba (1985) propose practices such as extensive work in the field and the triangulation of data of sources. Following the ethnographic approach to research, I spent a total of 17 months in the field investigating the subject. This gave me rich data that even reached saturation level. The 17 months are spread through December 2012 to July 2015. I followed the SMC program through its different phases. This allowed time for exploring different cultural responses to the program, checking inconsistencies in reporting and addressing biases (Creswell, 2013). In order to provide corroborating evidence, triangulation of methods is recommended to bring rigor and to support themes or perceptions (Creswell, 2013). I used different methods of study including observation, interviews and focus group discussion to ensure triangulation. These methods are discussed in more detail below. Multiple methods helped me cross-check consistency of responses from all approaches. The various data sources were analysed connecting different groups of participants from different sources of data. As Silverman (2013) recommends, themes that form the conclusions of the research in all three papers are supported with broad descriptive quotations from all different methods used, saturating data.

### ***3.7.3 Transferability/Generalisability***

Generalisability is driven by a positivist philosophy that believes that there is stable reality out there revealed through experiments and generalizable findings to the larger population

(Green & Thorogood, 2009). On the contrary, many qualitative researchers discard generalisability as a goal (Creswell, 2007). My results are not generalizable because I subjectively explore people's construct of meanings within their particular context. What is real is what they experience, which may be different from what the next person experiences, even within the same culture. Several qualitative studies on the topic taken together may produce generalisability. Had there been published qualitative research on the similar issues that I am exploring, I would explore similarities and contradictions to place my research within such studies. However, principles, like context and genuine partnership, are transferable.

### **3.8 Ethical considerations**

This study was granted ethical clearance by the Norwegian Social Sciences Data Services (NSD) and the Ministry of Health (MH) in Botswana (see appendices xi). MH granted two types of permits: one as a general acceptance of the topic and the other being permission to interview health workers at ministry level, district level and officers of development partners.

Participation in the study was voluntary. Signed informed consent was obtained from individuals and focus group participants as well as the observed participants (see appendix ix). In order to protect participants, anonymity was promised to individual participants, hence, vagueness in labelling participants in the results sections of all three papers. However, anonymity to the different partner organisations was not promised. Traditional protocol in Mochudi permitted that only the chief signs on behalf of participating community elders. The 25 individual elders participating upheld this protocol and, therefore, only gave verbal consent. At the end of it all, the willingness of participants to participate remains key to ethical conduct (Silverman, 2013). I had a dilemma on how to represent participants in the papers, especially the partner organisations. In Paper II, which was written first, I named the organisations as they are. However, in Papers I and III, I called them DPs so as to be vague in representation. Generally, I have been vague in labelling participants in the findings chapters to ensure anonymity of participants.

## 4 Results

In this chapter, I summarise findings from the three papers that contribute to this thesis. The papers are arranged systematically to show logic of content and do not necessarily follow dates of publication. The three articles are interlinked and blend together to produce the theme of this thesis: partnership functioning within a cultural context. Paper I analysed processes of the partnership which produced synergistic and antagonistic results; Paper II illuminates one of the antagonistic results which is tensions between the community and the biomedical marketing approaches used by the program; Paper III also takes the results for Paper I and reanalyses them further to investigate the types of antagonism that the partnership experienced at global level.

**Tables 4,5,6: Organising and global themes emerging from data analysis** (full analysis tables for all three papers can be found in Appendix i)

### *Table 4: Paper I Organising and Global themes*

Global themes for Paper I are the three parts of the BMFC model: Input, Throughput, Feedback mission and Output.

<b>Organising themes</b>	<b>Global themes</b>
Clear partner mission	<b>Input</b>
Approaches to the mission	
Financial resource contribution	
Partner resource contribution	
Clear partner roles	<b>Throughput</b>
Communication	
Input interaction	
Leadership	
Mission threatened	<b>Feedback mission</b>
Antagonism	<b>Output</b>

### *Table 5: Paper II Organising and Global themes*

Global themes for Paper II reveal the context of the partnership in relation to cultural interactions with the SMC implementation strategies.

<b>Organising themes</b>	<b>Global themes</b>
Secrecy	<b>Cultural circumcision taboos breached</b>
Male domain	
Language controversies	
Sexualising circumcision	<b>Public marketing</b>
Creating generational clashes	
The chief's voice is stronger	
Initial co-operation	<b>Consultation and participation</b>
Disillusionment, frustration and resistance	
Lack of genuine consultation	
Fear of HIV positive results	<b>HIV testing</b>

**Table 6: Paper III Organising and Global themes**

Evidence of the three global themes in Paper III - the underlying causes of antagony; therapeutic domination, iatrogenic violence and the Trojan horse, are seen throughout the four tensions/types of antagony below. For details, see discussion analysis in Paper III.

<b>Organising themes</b>	<b>Global themes – Types of antagony</b>
Tensions around the integration approach	<b>Antagony around approaches to the mission</b>
Tensions around MOVE implementation approach within the partnership	
Tensions around different reporting systems	
Tensions with community on MOVE approach	
National leadership of the program is questioned	<b>Antagony around local leadership and commitment</b>
DHMTs' commitment to program is queried	
Financial power defines ownership	<b>Antagony around financial power and ownership</b>
MH's role is confused	
Target setting is questioned	
There is irony in SMC public demand and equipment supply	<b>Antagony around the target</b>
Target not met – donors pull away resources	

#### **4.1 Paper I**

The first paper uses a systems model, the Bergen Model of Collaborative Functioning (BMCF), to establish how the Botswana SMC program functions as a North-South partnership. It specifically explores how the functioning of the partnership contributed to the outcome. The main informants of this paper were leaders of the program at national and district level, and some issues raised were validated by comments and responses from community members in all three sites. Four elements of the BMCF theoretical model are used to analyse data and assess the functioning of the partnership: 1.Input, 2.Throughput and 3.Output and 4. Feedback to mission, and these formed our global themes.

##### **4.1.1 Input**

Inputs are resources contributed by partners to implement the mission. The partners are clear about their mission to circumcise 80% of HIV negative men of ages 15-49, making a target of 100,000 men each year throughout a period of 5 years. There were two approaches used to achieve the mission: 1. a locally initiated integration approach whose intention was to

incorporate SMC into the whole health system, in all health centres around the country since 2009; 2. an externally formulated MOVE approach which was introduced by PEPFAR in 2011 to help speed up progress in pushing target. The MOVE approach focused only on a few selected districts in the country. Participants expressed that the resources brought into the partnership were more than what the government of Botswana could afford alone.

#### ***4.1.2 Throughput***

Partnerships have operational contexts that include managements and administrative tasks, communication and reporting tasks as well as activity based tasks on the ground. Resource distribution and utilisation, as well as interaction of different roles were evident as partners worked together. The MH was regarded as the owner, leader and coordinator of the program while other partners were support organisations and complemented the government's efforts to reach the mission. Much was achieved through resource and skill interaction of the partners: more men were reached; Government health workers gained new skills from the DPs; Botswana Government gained new resources that could be used permanently like health centre structures. However, there were several challenges: the MOVE and integration approach were competitively judged, with MOVE seen as quicker to achieve results than integration; staff resource distribution was a point of contention; permanence of program mattered more to Government while quick results were of priority to the DPs; local ownership and coordination efforts were not fully appreciated from the national leadership to the DHMTs; MH's structural and equipment contribution was disregarded and DPs' financial contribution seen as more valuable. In that way, the DPs expressed superiority and implied ownership claims. Most of all, failure to meet the target caused the greatest tension. WHO was criticised for setting an 'unrealistic' target, but MH was scapegoated for accepting it. Regardless of the conflicts and disagreements, the three partner organisations made strategic efforts to confront different challenges; however, the international donors funding the DPs minimised funding from 2013 and ultimately pulled out in 2014, cutting off the DPs' participation in the program.

#### ***4.1.3 Output***

The SMC partnership functioning produced all three types of results suggested by the BMCF systems model. The MH could still carry out circumcision even if the partnership was not formed, *additive*. However, the value of the partnership was shown in the difference it made



to achieve the mission. The partnership attained a lot of good or *synergistic* results: health centres were built contributing a permanent resource to the country, skills were gained by local people and most importantly more men were reached. The ultimate *antagonistic* outcome: the DPs pulling away was propelled by failure to meet the externally imposed target.

## **4.2 Paper II**

The second paper explores community responses to SMC program consultation processes, implementation procedures and campaign strategies in relation to circumcision as part of traditional initiation practices. The larger part of the data for this paper was collected from traditional leaders aged 45-80 and young men aged 20-45 in the two sites with specific cultures: Mochudi community of Bakgatla tribe, which is a circumcising culture and Hukuntsi community of the Bakgalagadi tribe, which is a non-circumcising culture.

### ***4.2.1 Cultural circumcision taboos breached***

Circumcision in some traditional cultures was treated with secrecy and viewed as a man's space. Therefore, public discussions about the subject of circumcision and the penis as a male private organ were not appreciated. Public discussions and activities that were regarded as breaching secrecy included research like mine (conducted by a woman), the MOVE advertisements on circumcision, celebrity's campaigns, and circumcision procedures performed by women in public clinics. Additionally, the SMC program's initial use of traditional initiation terms and phrases to advertise medical circumcision was detested by the house of chiefs at national level and village chiefs.

### ***4.2.2 Public marketing***

The public advertisements about SMC brought generational clashes in the community, breaching cultural silence about issues surrounding the penis. Furthermore, men of all ages, professionals and uneducated men had a general view that language used in the advertisements was sexualised. The advertisements were seen as more to attract men towards the intervention than educate them on the benefits of medical circumcision. While SMC partners intensified biomedical advertisements, the circumcising cultures were

recommending that chiefs should be used to persuade men to circumcise in a way that fits their traditions. Besides culture related taboos, men resisted circumcision because of fear of going through HIV tests.

#### ***4.2.3 Consultation and participation***

There were several reactions towards SMC by different cultures. The Bakgatla of Mochudi community initially embraced SMC with the anticipation that it would be considerate of their initiation protocols and standards, but the SMC program breached a number of these. The non-circumcising culture of the Bakgalagadi responded with resistance at the initial introduction of SMC in their community. They saw SMC as imposing practices of other cultures on them and very few turned up for circumcision until more consultation was done and clarity about the program given. Other initiating cultures (like the Herero) did not openly declare their stand about SMC nor guide officers on the best way to deal with them, but instead, practiced their initiation and circumcising ceremonies in silence. The SMC national and district officers were aware of these tensions and made an effort to address them, but superficially. The individualised neoliberal approach taken by the international organisations to market SMC as a product counteracted the culture of collectivism that initiation and circumcision are rooted in.

### **4.3 Paper III**

Paper III uses similar data sources as Paper I but illuminates the actions and processes in the SMC partnership that contributed to antagonism. The different tensions that lead to antagonism were: 1. antagonism around approaches to the mission; 2. antagonism around local leadership and commitment; 3. antagonism around financial power and ownership; 4. antagonism around target. The antagonism was mainly to deal with external donors' conditions and little to do with the internal collaboration of in-country partners. The paper establishes three causes of antagonism that run through the four themes above: iatrogenic violence, therapeutic domination and the Trojan horse. The Trojan horse and therapeutic domination are both about power, but the former is deceptive (illustrated by the understanding of 'ownership' from the recipient side and the donor side) and the latter is a particular form of power, that of 'expert' to the 'ignorant'. Iatrogenic violence: the intention of the donor is good, but the intervention causes social disruption and harm.

## **5 Discussion**

This chapter comprises discussion of methodology and results. The chapter first addresses methodological considerations, then focuses on significant implications of the findings that have not been discussed in Papers I, II and III.

### **5.1 Discussion of methodology**

In this section, I critically discuss limitations of my methods.

The qualitative research method, just like quantitative research, has shortcomings, and the important thing is for the researcher to be aware of the methodological flaws of their chosen paradigm so that these are addressed not only during research processes, but should be reflected on even after conclusions of the study. The ability of qualitative enquiry to use non-predefined alternative answers as in quantitative enquiry availed opportunity for the practice of ethnographic methods, allowing participants to share their experiences with SMC from any angle. However, the influence of the researcher on a study, choices made regarding methods, participants selection, data interpretation and analysis all affect research (Creswell, 2013; Malterud, 2001). Therefore, it is crucial to reflect on how these might have affected the different aspects of validity (Malterud, 2001).

#### ***5.1.1 Challenges with ethnographic design***

Ethnography as a method of study is credited for its ability to draw out participants' in-depth experiences, not only to hear what they say but to see what they do (Atkinson & Hammersley, 1994; Malterud, 2001). Because of time limitations, I applied rapid-ethnography (scheduled and specific to participants) instead of the traditional one. Although criticised for its narrowness, rapid ethnography helped me focus energy on particular participants, do specific observations within limited scheduled time and still get rich data (Millen, 2000; Skovdal & Cornish, 2015). My approach to adapt ethnographic enquiries to the field situation allowed me to make several follow-up enquiries throughout the years as the SMC program evolved. However, all data could not be included in the publication of the three papers. The space limitations in journal articles restricted me to reveal certain truths and omit other truths, for example: I was limited to describe all that I observed formally and

informally as an enhancement of what participants said. Also, data in the papers had to be narrowed down to particular themes which does not necessarily show all views from all categories of participants that I talked to in the whole study, like women and men's beliefs and myths about SMC (see table on participants). Beyond the three articles, more truths can be revealed out of the data.

### ***5.1.2 Challenges during data collection***

The researcher's physical presence in the field is a defining criterion for ethnography and it comes with challenges. It was not easy to get appointments on time with national, district and MOVE team officers; however, tapping into personal relationships to link me to the right people, as well as persistence, helped. Officers showed great support for the research, expressing that it will help in giving feedback. However, they had little time for interviews. This influenced content of the data, some questions not asked or not fully answered because of the rush. Missed questions are covered in interviews with other officers or in subsequent interviews. I had planned more participant observations in different MOVE campaigns, but several of them were cancelled last minute for different reasons. Additionally, the distance of Hukuntsi village from my place of abode disadvantaged the research in that not much community observation was done in the area as compared to the other two sites. However, collecting data from different levels of participants, and using different methods, brought data to saturation. Although DP interviewees were as generous in giving information as MH officers, they showed hesitance to participate in subsequent interviews after the period of reducing target between the end of 2013 to 2015. This was also due to the fact that there were new officers in the positions, for example, DP1 coordinator had moved. The research topic was regarded as sensitive by most participants. Community participants were easy to access, but not always free and willing to discuss the topic. Some interviews were aborted. It is vital to discuss specific issues with regard to reflexivity, validity, credibility and transferability.

### ***5.1.3 Role of the researcher/Reflexivity***

Reflexivity disputes the belief of a researcher as a neutral observer and is therefore a good tool in preparing for, reflecting and confronting the challenges of a qualitative enquiry. The researcher affects the research at all levels. The "researcher's background and position will affect what they choose to investigate, the angle of investigation...the findings considered

most appropriate, and the framing and communication of conclusions” (Malterud, 2001, p. 483). These influences should not be looked at negatively, but should be acknowledged (Malterud, 2001). It is these influences that motivate the researcher to fill the gap in the field (Atkinson & Hammersley, 1994). I was consciously and continuously reflexive and ensured that my past experiences with global donors did not influence my data collection and analysis. I started data collection with a few investigations and observations using a pre-drawn interview guide and open-ended questions. However, I allowed the field to inform me on what to ask before I could proceed. The 2012 three-day strategic meeting I attended informed the whole research, gave it direction and challenged me to reformulate the interview guide at different phases and with particular participants, without losing the focus of the research questions. This strategy reduced my influence on data collection, to explore informants’ real experiences without preconceptions. Reflexivity can also be practiced at data analysis and interpretation stages allowing others to review (Bradley, Curry, & Devers, 2007). I exercised this by involving two other researchers in the larger part of data analysis and having back and forth feedback with the co-authors on my papers about the competing conclusions of the study.

Participants regarded me as both an insider and an outsider at the same time (Gobo, 2010). I was viewed an insider as a fellow countryman, but an outsider as a researcher who seemed aloof from participants’ experiences. Officers at the 2012 three-day meeting kept showing awareness of my presence when commenting on discussions, e.g. “I know Masego will write this as a researcher but...I have to say my views on this issue.” However, they seemed free to debate issues transparently when reassured of anonymity. The elders in Mochudi community saw me as ‘their child’ because I come from another Bakgatla tribe that used to circumcise before arrival of the missionaries. They spoke freely against SMC and in defence of their culture, seemingly believing I was on their side. Although hesitant to talk to a woman about issues of “male secrecy” from the beginning, they opened up freely during the research process. I was also regarded as an advocate and asked to take their views to the SMC program officers so that their concerns could be addressed. Some participants viewed my research as one about ‘the penis’ and not the SMC program; therefore, my gender as woman, as well as my petite physical stature, was initially a stumbling block for them to participate. Some young men in the community were more erotic in their responses with attempts to win my attention to their romanticised conversations. This placed me in an

awkward position. I actively used the 'bracketing' approach to get the participants back to the real issues, as recommended by Creswell (2013).

#### ***5.1.4 Validity/Credibility***

Validity is a quantitative trustworthiness concept that intends to investigate if the research is true. Steps followed in this research affirm data validity. First, I used triangulation, which is recommended as a way to show reliability (Lincon & Guba, 1985; Pope & Mays, 2008). Four methods of inquiry were used: participant observation, interviews, FGDs and observations. Using multiple methods created opportunity to get participants' views from different angles. Second, data validation increases reliability (Bradley et al., 2007). Information that was incomplete was revisited, sampled quotes were verbally validated as true, and participants could confirm to me experiences that were applicable to the larger community. Doing cyclic interviews with a number of participants created an opportunity to validate data collected previously with the same participants and adjustments made accordingly. For example, most of the participants that were observed in the 2012 three-day planning meeting were interviewed later, while others took part in FGDs at a later stage (see table on cyclic fieldwork). Third, reaching saturation is a good indication for consistency in the truths about a phenomenon. This was realised through triangulation of data collected through different methods. Fourth, approaches and processes used in data analysis helped raise the reliability of the research (Creswell, 2013). The analysis team members separately used Thematic Network Analysis and came up with themes that were then compared and agreed upon. Data were reanalysed for every paper, to reach specific themes using inductive and deductive approaches. For example, to reach conclusions about types of antagonism in Paper III, data were analysed in three steps: first analysed in general, exploring partnership processes, which revealed antagonism; and then analysed again to establish the specific ways that created antagonism; and lastly deductively reanalysed to establish evidence for antagonism whose genesis is iatrogenic violence, therapeutic domination and Trojan horse. Conclusions for every paper were reached through a systematic analysis of data following the general research question to the specific research question of each paper. This brings us to discuss dependability.

### ***5.1.5 Reliability/Dependability***

Dependability is twofold. The first part is concerned with whether the data collected through the sample of the study are answering the research question(s), while the other part is whether the findings of the study can be applied in other settings (Golafshani, 2003; Malterud, 2001). Dependability is shown through the researcher's consistency in approaches to analysing data to answer the research question and reach conclusions (Lincon & Guba, 1985). The aim of the study is to explore synergy and antagonism between external and internal ideologies in implementing SMC through experiences of the Botswana community with the program. Together, the three papers answer the research question, but there are limitations. Results for Paper I show the need for internationally formulated programs to consider local realities, otherwise the opposite results in resistance. Narrowing this paper to particular global themes was a bottleneck to shedding more light on a wide variety of views from men and women of all ages. However, low response of men to circumcise (see table on targets) supports more resistance than acceptance of the program. The paper, therefore, shows reasons for the gap between target setting and target realisation at community level. Theoretical frameworks and theoretical concepts should be applied using the principles of grounded theory, an inductive approach, to reach conclusions (Skovdal & Cornish, 2015; Strauss & Corbin, 1994). Adhering to this principle, a systems model was used to analyse partnership processes for Paper II. The results revealed all aspects of partnership output: additive results synergy and antagonism. However, the pulling away of partners at the end reflected costs more than benefits (antagonism). Paper III used a deductive analysis approach, against the principles of grounded theory, to reach the conclusion that there are three types of antagonism in the partnership.

### ***5.1.6 Transferability***

Transferability of the results of the study confirms data dependability. However, it is argued that "No study, irrespective of the method used, can provide findings that are universally transferable" (Malterud, 2001, p. 485). One great limitation of this study is that the data sample was a small population, with specific age definition, within few communities. It therefore, like all qualitative research, cannot be representative of the larger population (Creswell, 2013; Skovdal & Cornish, 2015). The findings were obtained from three sites; a city with no specific culture, a semi urban community with a specific culture but great

influence of civilisation and a rural community with a specific culture. The results were not representative of a pure culture and cannot be universally applied squarely to other cultures. However, the use of triangulation and validation method confirmed similar responses of participants across all sites, therefore, these could be transferable to similar contexts within limits. Some studies from the Sub-Saharan Africa region have shown some similar responses as men in Botswana. A systematic review of similar studies as mine could strengthen the transferability of these results to a wider context, even regional. However, it should be noted that research questions and contexts in which participants respond differ. Qualitative truths change with time and there are often new experiences, even for a single person, in relation to the phenomenon (Creswell, 2013).

## **5.2 Discussion- Results**

This study has contributed extensively to the scientific study of partnerships. It has used the BMCF systems theory to analyse the Botswana SMC partnership. The findings contributed to this theory by exploring the concept of context further to show conflict between global and local context. The study then expands on one level of output in the BMCF model, antagonism - showing different types of antagonism in partnerships (financial, ownership, community tensions) - and elaborating on the underlying causes of such antagonism: therapeutic domination, iatrogenic violence and the Trojan horse. Tying the three papers together, I identified three main findings that account for the failure of the Botswana SMC partnership: 1. that all three in-country partners had attitudes that were counterproductive to the success of the partnership; 2. there was resistance at different levels by the recipient government and communities; 3. it is the international donors rather than the in-country partners who put pressure on the partnership.

### **5.2.1 Counterproductive attitudes**

First, all three in-country partners had attitudes that were counterproductive to the success of the partnership. The MH's program leaders and implementers had an attitude of complacency that made them give in to demands of international donors as well as compromise Botswana local standards of consultation with communities, while the DPs' and international donors had an attitude of knowing best. MH had a locally formulated SMC implementation strategy, the integration of SMC in health services nationwide, and the DPs



aligned their support with it, initially. Instead of realigning and strengthening the same strategy to be able to speed up meeting the target later, in 2011, MH allowed the DPs to establish a parallel program (MOVE) that then continuously caused tensions between the DHMTs and the MOVE implementation teams. At the 2012 strategic meeting, one MH's top official appealed for consideration of equity when implementing MOVE, but this was hardly followed-up and never attained. Scholars advise that Southern partners need to use radical approaches to ensure that people-centred health services are provided (St-Pierre, 2014). The components of alignment and harmonisation emphasised in the Paris Declaration's framework of aid effectiveness were underplayed in this case (UNAIDS, 2008). The recipient's own plans were not supported to the end and national administration system of equity was compromised (Rogerson, 2005). On the one hand, Alden and Schoeman (2013) argue that developing countries should stand against historical legacies of colonialism and imperialism that still prevail today and take the opportunity to use the proposed global set standards as reason for their resistance. St-Pierre (2014) makes us aware that while the South is in need of health interventions, the Northern companies are in need of business. The South should not be afraid of losing donations as long as their resistance is within the set requirements of global governance for aid, because, in that way, they stand a chance of getting their voices heard (St-Pierre, 2014). Nonetheless, the issue of trust, the North trusting the South, is shaky and makes alignment of programs to local approaches unstable (J. Jones & Barry, 2011b; Rogerson, 2005). Transaction costs and conditionality set by the donors make it complicated for one preferred strategy, especially local strategies of the Southern partners, to be followed (Ramiah & Reich, 2006). This makes it difficult for recipient countries to control their health agenda and, therefore, weakens recipients' 'ownership' of programs (Barnes et al., 2016; Ramiah & Reich, 2006). More often than not, international organisations implement strategies that work in parallel instead of in harmony with local systems of operation (Distlerath & Macdonald, 2013; Ramiah & Reich, 2005, 2006). In 2002, under their partnership on the ARV program, Botswana Government stood against ACHAP for overstepping its role of facilitator and turning itself into an implementer, but this took three years for them to cease this interference (Ramiah & Reich, 2005, 2006). Similar experience is noted in the study of South Africa's and Zambia's ARV programs through a private-civil society partnership, where policy formulation and program implementation was run by international actors and the program run parallel to the countries' internal systems

(Hanefeld, 2010). This approach was criticised for lack of sustainability, for overrepresentation of senior staff from US organisations; hence, funding that was promised Zambian government was not truly reflected. This takes away the states' sovereignty instead of building capacity (Hanefeld, 2010). Critics observe that for as long as a country largely depends on donor funding, it will be difficult to work against their conditions. In fact, under such conditions following country consultation and implementation mechanisms are only lip service (Hanefeld, 2010; Miranda et al., 2016).

The international organisations had an attitude of knowing best. In Paper III, I use Fowler's (2000) and McFalls' (2010) descriptions of such behaviour to expose underlying causes of antagonism: therapeutic domination, iatrogenic violence and the Trojan horse. These three causes of antagonism also reflect the attitude of knowing best. In the Botswana SMC case, the attitude of 'knowing best' comes at two levels: that the SMC program was regarded as 'better' than the traditional circumcision as it is hygienic and medically safe, and that the MOVE approach was regarded as a better approach than the MH's integration approach to mobilising men for circumcision.

These attitudes increase in degree of intensity.

### ***5.2.1.1 Therapeutic domination***

First, therapeutic domination is the arrogance of knowing best, as in the doctor-patient relationship. The one who dominates is not aware that their pride undermines local knowledge and strategies. Therapeutic domination was visible when MH revealed confusion over its identity – whether it was 'owner,' 'parent,' or 'baby. The fact is, even though an owner, MH needed support and its level of financial contribution was lower than that of the DPs when its principle of equity was compromised by MOVE. Second, when the integration approach seemed slow to push the target of circumcising 100, 000 men in a year, PEPFAR introduced the MOVE approach through DP1. Much attention was given to the MOVE approach for mobilisation since 2011 when it was introduced and the MH's integration approach was suppressed. MOVE also had inequity in distribution of services. Indeed financial power makes survival of aid partnerships grossly dependent on the decisions and interests of the international donors (Crawford, 2003). Critics argue that the fancy leadership/ownership phrases given the recipient countries are just a facade to cover the continuous exercise of power by the international financial agencies (Crawford, 2003). The implication here is that while the language of global HIV/AIDS policy is partnership, the

reality is closer to therapeutic domination with donors controlling the nature and extent of interventions for the “good” of the recipient (McFalls, 2010).

### ***5.2.1.2 Iatrogenic violence***

The second attitude is the intention to do good but unintentionally causing harm (iatrogenic violence). Iatrogenic violence overlaps with therapeutic domination on inequity in distribution of services and when the SMC program, especially the MOVE approaches to marketing, caused disruption in the cultural customs. McFalls (2010) argues that humanitarian intervention on a genuine existing problem can cause havoc instead of help, the harm being unintended. The creation of dependency and stripping local people of their agency is a form of iatrogenic violence (Daniel, 2014). Secondly, the abrupt withdrawal of donors’ resources and implementation support caused operational disruption, “the pain” and the “violence”.

### ***5.2.1.3 Trojan horse***

The third attitude, the Trojan horse carries within it deception, power and control. This links with what I have discussed in the introduction – that HIV is treated as an emergency and implementation of services is done under some pressure. The deceptive gift was evident when MOVE excited MH as a tool for success, but also caused destruction by pulling away. One obvious falsehood of this gift was that US pharmaceutical companies were benefiting from this humanitarian service by oversupply of surgery kits yet blaming MH for misuse of funds. Pharmaceutical companies pushed their commercial agenda through the false gift (St-Pierre, 2014). Guilhot (2005) describes external agencies as pretending to be ‘catalysts’ under the pretext that they are quickening processes to achieve locally set goals, yet exerting their external control. These findings characterise how the domineering power of the North over the South is concealed (Fowler, 2000).

### ***5.2.2 Resistance by recipient***

Trojan horse implies the deception of the donor is welcomed by the recipient, yet Botswana demonstrated resistance on a number of different levels. The first level of resistance was with the national leadership: While literature notes that WHO valued SMC as a powerful intervention to HIV prevention and even implemented it as emergency with inconclusive results (Aggleton, 2007), Botswana national leadership seemed to see SMC as a non-

emergency/non-crucial program and did not give it much attention. The national leaders expressed that they were too busy to attend to this and asked DPs and MH to talk to the village chiefs and trust their decisions. The second level of resistance was on use of local funds: although Botswana is praised for contributing much on HIV/AIDS interventions through its GDP (Resch et al., 2015), when DPs demanded the amount of government's contribution to SMC, the MH coordinator reported that government preferred to raise funds from other international donors besides the mentioned DPs. The government counted its infrastructure and availability of staff as a huge contribution. The third level of resistance was on coordination: MH was irritated by the DP's persistence that they change their way of coordinating the north and south regions and stood their ground to not change it. *It has been a bitter relationship in the past, it is better now*, said a DP1 officer. The fourth level of resistance was the DHMTs not prioritising a prevention program: The DHMT officers made it clear that they prioritised attending to ill patients rather than SMC. Resistance was evident when DPs interfered with the Botswana socio-cultural aspects. For example, both MH and DHMTs appreciated the DPs medical help in carrying out the surgery, but MH questioned the effectiveness of bringing young US Peace Corps volunteers to talk about the sensitive topic of circumcision with older men in the community when Botswana young people had not succeeded in this. The fifth level of resistance was community's hesitance to take up SMC: Traditional leaders wanted initiation protocols adhered to. Also men in the community resisted SMC because of pain, fear of HIV testing and the fact that they had always had their foreskins and never contracted HIV.

It is important that the recipient's governance structure is genuinely consulted at all levels before the implementation of interventions so that implementation is made with the knowledge of local priorities as well as local management and implementation approaches. Many global health initiatives are formulated externally by international organisations like UNAIDS and WHO and recommended to the global South for implementation by the global South as an already assembled package (Ashman, 2001). The scenery of consultations is such that country representatives who participate in the WHO high level forums sign in for interventions with little chance to consult with their own countrymen of all levels (WHO/UNAIDS, 2007). NACA (2009) share that Botswana prevention programs through the years have been given less attention than cure of disease, and there are measures being put in place to address this. However, developing countries' budget constraints limit them such that they prioritise cure over prevention (Resch et al., 2015). Rifkin (1996) explains that

target-oriented programs tend to dominate and control because they value the cost of time over and above the value of negotiations; hence, they rush implementations leaving the communities behind. WHO encourages that recipient governments' systems of management and coordination be respected (WHO/UNAIDS, 2007). However, this seems to be only lip service. International organisations believe that their management strategies are quick and efficient while recipients tend to follow long processes and procedures (Distlerath & Macdonald, 2013; Ramiah & Reich, 2006).

### ***5.2.3 Pressure from external donors***

The third finding (linked to the fifth level of resistance above) is that it is the international donors rather than the in-country partners whose demand of target fulfilment and accounting procedures put pressure in the partnership. Such pressure made in-country partners seemingly ignore contextual issues: the local culture of collectivism that stresses genuine consultation with the community and adherence to the protocols of traditional initiation (Ramiah & Reich, 2006). Many respondents representing the international in-country partners (DPs) are concerned that the program ignored genuine consultation with the community and consideration of community members as real partners. Many said similar words like DP1 top officer:

*.. looking back I will never do a program like this again ... I would start with the key partner who is the people of Botswana, the beneficiaries and the cultural structures like the community leaders or the religious leaders.*

In many of their responses, the DPs showed that even though they could understand and appreciate Botswana's resistance to the program at all levels and wished to change, they had pressure from donors to account for donated monies and had little time to address such concerns. Donors and designers of medical programs like this one should know that people live within a social cultural context and reason with their cultural standards and expectations before accepting externally imposed programs (Skovdal et al., 2011). International private, bilateral or non-governmental organisations tend to work as puppets for their funders; their voices are silenced by donors' demands and so they fail to make genuine impact through capacity building, following local systems of working and relevant approaches prescribed by communities (Kenworthy, 2014; D. Lewis, 1998). These in-country implementing organisations are 'caught' between donors and recipients – donors, on the one hand, telling them what to do and yet, on the other hand, their own understanding is that the donor's

wishes will not be effective. These implementing organisations also try to make adaptations so that the program will be more effective (Thamuku & Daniel, 2013). This probably depends on the structure between the donor and the implementer. What matters more to donors is dollar-to-numbers rather than sustainability of programs (Ashman, 2001). Donors' sanctions for not fulfilling targets are linked to market-like sanctions (Rogerson, 2005). MH could not get the DPs to hold back their vigorous MOVE strategy and reconsider consulting communities first, but when the partners left the program they planned to take in the communities as true partners to formulate implementation strategies with them and *hopefully get a positive speedy response from men*, said MH lead officer.

### **5.3 Implications of the study**

The implications of the study are that the effectiveness on sustainability of health programs is compromised by lack of genuine consultation with recipient countries at all levels (national to community) and all stages (planning, design, implementation, evaluation). The local people's way of understanding disease is understudied, therefore, underestimated. There is lack of rigorous qualitative studies that complement acceptability studies for every health intervention. Multidisciplinary models of research on disease that include qualitative studies to capture people's perspectives towards disease as well as local approaches could inform design of interventions. Also, the monitoring system used for the Paris Declaration's mechanism of operation like harmonisation, alignment, ownership, mutual accountability and results captures only numbers, but not local perspectives. The evidence of antagonism in the SMC program in Botswana has implications for North-South health partnerships theory and practice. The South's attitude of complacency silences their voices. The global governance structure, like OECD, is weak in ensuring that Northern partners adhere to the principles laid out by the Paris Declaration to ensure true partnership.

As to theory development, the results of this study have suggested root causes of antagonism that partnership planners and managers should be alert to. As to practice, evidence for iatrogenic violence has highlighted the need for partnership interventions to prevent good partner intentions accidentally producing bad outcomes. Evidence for the Trojan horse and therapeutic domination have highlighted the need for vigilance at the stage of establishing a partnership, to prevent more powerful partners from developing and taking action on hidden

agendas. As an appeal, researchers should consider exploring measurement of antagonism in partnerships just as they have done for synergy.

#### **5.4 Limitations**

This thesis has not included all data collected from 2012 to 2015, therefore misses the views of other community members like women and men who preferred circumcision, myths around circumcision and other observations data kept in field notes. This undermines the strength of the ethnographic method, to show data of long experience in the field. However, ethnography has developed such that it can be done in scheduled times and confined to specific issues like organisational and cultural ethnography in this case. Selection of data for the three papers also makes the analysis biased. It is acknowledged that purposive sampling used may have narrow views of the larger community of Botswana. Also, open-ended questions allow room for expression of passionate and emotional views that may not be a general view of the communities or organisations represented. While reflexivity was systematically applied throughout data collection, it is possible that the first author's gender, as a woman, may have restricted responses by men; the objections quoted above show that the involvement of women is considered culturally insensitive. Whereas all partner organisations are given equal opportunities to participate in the research, the MH was more forthcoming in allowing several officers to be interviewed. MH was also more available for interviews at different phases as the partnership evolved. In that way, some partners have not had a chance to give their full views and experiences at different phases of the partnership. However, each organisation had given its frank overall view of the partnership in the initial three-day planning meeting that the researcher attended, and in immediate second interviews. Although it was evident that most decisions affecting implementation and partnership relations had an influence of the external donors' pressures, the first author was not able to access them for direct interviews.

Although this study may be used as a learning resource, the exploratory nature of this study makes the results not generalizable. However, lessons learnt, like the need for genuine consultation, are valuable for other countries to consider. The study also gives important insightful lessons on partnership functioning for aspects that can be embraced and those that can be avoided. The findings of this study are particularly relevant for rural settings and do

not give the perspective of how this is working in larger and urban communities. The response given by the cultures represented in this study may not necessarily represent the views of other ethnic groups within the country.

## **5.5 Conclusion**

This study explored the context of the SMC partnership in Botswana as well elements that brought synergy and antagonism in the partnership. First, inputs like financial resources, “ownership” and the target influenced the outcome of the partnership. A combination of inputs by partners brought progress towards achieving set program goals. Although there were tensions between partners, they were working together in strategising to address some challenges of the partnership and implementation. Pressure to meet the expectations of the international donors caused tension and challenges between the in-country partners to the extent of DPs retreated and did not pursue the mission further. Second, it is important to consider recipients’ context at all levels and perform genuine consultation before implementation of health programs. It seems SMC was hurried, therefore, national leadership and district implementers did not prioritise it and also since SMC was seen as a prevention program it was not seen as important as cure-focused interventions; therefore, much effort on negotiations and convincing had to be done. Consultation at all levels was done in a seemingly superficial, non-participatory manner. Community’s initial cooperation was a loud message for openness and flexibility, while the ultimate resistance was a cry to be heard. Third, the pressure to achieve the set target, the link between financial contribution and ownership expectations, caused an antagonistic outcome. The study has contributed enlightenment that the functioning of the visible in-country partnership was significantly influenced by the less visible global context such as the target setters and donors. The three underlying causes of antagonism; therapeutic domination, iatrogenic violence and the Trojan horse, constituted attitudes, hidden intentions and unintended actions that influenced program implementation and caused harm at different levels.



## References

- Abrahamsen, R. (2006). The power of partnerships in global governance. *Third World Quarterly*, 25(8), 1453-1467. doi:10.1080/0143659042000308465
- Aggleton, P. (2007). "Just a snip"?: a social history of male circumcision. *Reproductive Health Matters*, 15(29), 15-21. doi:10.1016/S0968-8080(07)29303-6
- Aginam, O., Harrington, J., & Yu, P. K. (2013). *The global governance of HIV/AIDS: intellectual property and access to essential medicines*. Northampton: Edward Elgar Publishing Inc.
- Aikins, A. G., Unwin, N., Agyemang, C., Pascale, A., Campbell, C., & Arhinful, D. (2010). Tackling Africa's chronic disease burden: from the local to the global. *Globalization and health*, 6(5), 1-11. doi:10.1186/1744-8603-6-5
- Alden, C., & Schoeman, M. (2013). South Africa in the company of giants: the search for leadership in a transforming global order. *International Affairs*, 89(1), 111-129. doi:10.1111/1468-2346.12007
- Andersson, K. M., Owens, D. K., & Paltiel, A. D. (2011). Scaling Up Circumcision Programs in Southern Africa: The Potential Impact of Gender Disparities and Changes in Condom Use Behaviors on Heterosexual HIV Transmission. *Aids and Behavior*, 15(5), 938-948. doi:10.1007/s10461-010-9784-y
- Ashman, D. (2001). Strengthening North-South partnerships for sustainable development. *Nonprofit and Voluntary Sector Quarterly*, 30(1), 74-98. doi:10.1177/0899764001301004
- Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. *Handbook of qualitative research*, 1, 248-261.
- Attaran, A. (2005). An immeasurable crisis? A criticism of the Millennium Development Goals and why they cannot be measured. *Plos Med*, 2(10), e318. doi:10.1371/journal.pmed.0020318
- Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, 1(3), 385-405. doi:10.1177/146879410100100307
- Aulakh, P. S., Kotabe, M., & Sahay, A. (1996). Trust and performance in cross-border marketing partnerships: A behavioral approach. *Journal of international business studies*, 27(5), 1005-1032.
- Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., & Puren, A. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLOS Medicine*, 2(11), e298. doi:10.1016/S0968-8080(07)29303-6
- Aveling, E. L. (2010). The impact of aid chains: relations of dependence or supportive partnerships for community-led responses to HIV/AIDS? *Aids Care-Psychological and Socio-Medical Aspects of Aids/Hiv*, 22, 1588-1597. doi:10.1080/09540121.2010.507954
- AVERT. (2015). *Global Information and Advice on HIV and AIDS: HIV and AIDS in Botswana*. Retrieved from <http://www.avert.org/>: <http://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/botswana>
- Bailey, R. C., Moses, S., Parker, C. B., Agot, K., Maclean, I., Krieger, J. N., . . . Ndinya-Achola, J. O. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *The Lancet*, 369(9562), 643-656. doi:10.1016/S0140-6736(07)60312-2

- BAISIV. (2013). Botswana AIDS Impact Survey IV accessed 12 June 2016. Retrieved from [http://www.cso.gov.bw/templates/cso/file/File/BAIS%20IV%20PRELIMINARY%20RESULTS%20Nov%202013\(1\).pdf](http://www.cso.gov.bw/templates/cso/file/File/BAIS%20IV%20PRELIMINARY%20RESULTS%20Nov%202013(1).pdf)
- Barbour, R. S. (2005). Making sense of focus groups. *Medical education*, 39(7), 742-750. doi:10.1111/j.1365-2929.2005.02200.x
- Barnes, A., Brown, G. W., & Harman, S. (2016). Understanding global health and development partnerships: Perspectives from African and global health system professionals. *Social Science and Medicine*, 159(p), 22-29. doi:doi:10.1016/j.socscimed.2016.04.033
- BeLue, R., Okoror, T. A., Iwelunmor, J., Taylor, K. D., Degboe, A. N., Agyemang, C., & Ogedegbe, G. (2009). An overview of cardiovascular risk factor burden in sub-Saharan African countries: a socio-cultural perspective. *Globalization and health*, 5(10), 1-10. doi:10.1186/1744-8603-5-10
- Binka, F. (2005). Editorial: North–South research collaborations: a move towards a true partnership? *Tropical Medicine & International Health*, 10(3), 207-209. doi:10.1111/j.1365-3156.2004.01373.x
- Blomberg, J., Giacomi, J., Mosher, A., & Swenton-Wall, P. (1993). Ethnographic field methods and their relation to design. In D. Schuler & A. Namioka (Eds.), *Participatory design: Principles and practices* (pp. 123-155). New Jersey: Lawrence Erlbaum Associates Publishers.
- Booth, D. (2012). Aid effectiveness: bringing country ownership (and politics) back in. *Conflict, Security & Development*, 12(5), 537-558. doi:10.1080/14678802.2012.744184
- Botswana Government. (2011). *Population and housing census: preliminary results brief*. Retrieved from Government Press: <http://ecastats.uneca.org/>
- Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*, 8(1), 137-152. doi:10.1177/1468794107085301
- Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health services research*, 42(4), 1758-1772.
- Buffardi, A. L. (2013). Configuring ‘country ownership’: patterns of donor-recipient relations. *Development in Practice*, 23(8), 977-990. doi:10.1080/09614524.2013.841862
- Buffardi, A. L. (2016). Mediating multiple accountabilities: variation in formal and perceived accountability among international and domestic actors in the health sector in Peru. *Third World Quarterly*, 1-15. doi:10.1080/01436597.2015.1120640
- Buse, K., & Harmer, A. M. (2007). Seven habits of highly effective global public–private health partnerships: practice and potential. *Social Science & Medicine*, 64(2), 259-271. doi:10.1016/j.socscimed.2006.09.001
- Buse, K., & Walt, G. (2000). Global public-private partnerships: part I—a new development in health? *Bulletin of the World Health Organization*, 78(4), 549-561. doi:10.1590/S0042-96862000000400019
- Caliari, A. (2014). Analysis of millennium development goal 8: a global partnership for development. *Journal of Human Development and Capabilities*, 15(2-3), 275-287. doi:10.1080/19452829.2014.883371
- Campbell, C., Cornish, F., & Skovdal, M. (2012). Local pain, global prescriptions? Using scale to analyse the globalisation of the HIV/AIDS response. *Health & place*, 18(3), 447-452. doi:10.1016/j.healthplace.2011.10.006

- Cheng, I.-H. (2015). Developing and managing international cooperation and partnerships for educational development in Cambodia: transforming aid effectiveness into development effectiveness. In I.-H. Cheng & C. Sheng-Ju (Eds.), *International education aid in developing Asia* (pp. 221-237). Taiwan: Springer.
- Chilisa, B. (2011). *Indigenous research methodologies*. Los Angeles: Sage Publications.
- Chimhutu, V., Tjomsland, M., Songstad, N. G., Mrisho, M., & Moland, K. M. (2015). Introducing payment for performance in the health sector of Tanzania- the policy process. *Globalization and health*, *11*(38), 2-10. doi:10.1186/s12992-015-0125-9
- Comaroff, J. (1985). *Body of Power Spirit and Resistance: The Culture and History of a South African People*. Chicago: The University of Chicago Press.
- Contu, A., & Girei, E. (2014). NGOs management and the value of 'partnerships' for equality in international development: What's in a name? *Human Relations*, *67*(2), 205-232. doi:10.1177/0018726713489999
- Cooper, A. F., Kirton, J. J., & Schrecker, T. (2016). *Governing global health: challenge, response, innovation*. London: Routledge.
- Corbin, J. H., Jones, J., & Barry, M. M. (2016). What makes intersectoral partnerships for health promotion work? A review of the international literature. *Health Promotion International*, *1*(23), 1-22. doi:10.1093/heapro/daw061
- Corbin, J. H., & Mittelmark, M. B. (2008). Partnership lessons from the Global Programme for Health Promotion Effectiveness: a case study. *Health Promotion International*, *23*(4), 365-371. doi:10.1093/heapro/dan029
- Corbin, J. H., Mittelmark, M. B., & Lie, G. T. (2013). Mapping synergy and antagonism in North-South partnerships for health: a case study of the Tanzanian women's NGO KIWAKKUKI. *Health Promotion International*, *28*(1), 51-60. doi:10.1093/heapro/dar092
- Corbin, J. H., Mittelmark, M. B., & Lie, G. T. (2015). Grassroots volunteers in context: rewarding and adverse experiences of local women working on HIV and AIDS in Kilimanjaro, Tanzania. *Global health promotion*, *0*(0), 1-10. doi:10.1177/1757975915569514
- Corwin, L., Corbin, J. H., & Mittelmark, M. B. (2012). Producing synergy in collaborations: a successful hospital innovation. *The Innovation Journal*, *17*(1), 2-16.
- Crawford, G. (2003). Partnership or power? Deconstructing the 'partnership for governance reform' in Indonesia. *Third World Quarterly*, *24*(1), 139-159. doi:10.1080/713701365
- Creswell, J. W. (2007). *Qualitative inquiry & research design: choosing among five approaches*. London: SAGE Publications.
- Creswell, J. W. (2009). *Research designs: qualitative, quantitative and mixed methods approach* (3 ed.). United States: Sage Publications.
- Creswell, J. W. (2013). *Qualitative enquiry & research design: choosing among five approaches* (3 ed.). London: SAGE.
- Daly, J., Gibbs, L., Welch, N., Small, R., Hughes, E., & Willis, K. (2007). Generating best evidence from qualitative research: the role of data analysis. *Public Health*, *31*, 545-550. doi:10.1111/j.1753-6405.2007.00141.x
- Daniel, M. (2014). Iatrogenic violence? Lived experiences of recipients of aid that targets vulnerable children in Makete, Tanzania. *Forum for Development Studies*, *41*(3), 415-431. doi:10.1080/08039410.2014.962601
- Denzin, N. K. (2009). The elephant in the living room: or extending the conversation about the politics of evidence. *Qualitative Research*, *9*(2), 139-160. doi:10.1177/1468794108098034

- Devers, K. J., & Frankel, R. M. (2000). Study design in qualitative research--2: Sampling and data collection strategies. *Education for health, 13*(2), 263.
- DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education, 40*(4), 314-321. doi:10.1111/j.1365-2929.2006.02418.x
- Distlerath, L. M., & Macdonald, G. (2013). The African comprehensive HIV/AIDS partnerships-a new role for multinational corporations in global health policy. *Yale Journal of Health Policy, Law, and Ethics, 4*(1), 9.
- Donoval, B. A., Landay, A. L., Moses, S., Agot, K., Ndinya-Achola, J. O., & Nyagaya, E. A. (2006). HIV-1 target cells in foreskins of African men with varying histories of sexual transmitted infections. *American journal of clinical pathology, 125*(3), 386-391. doi:10.1309/JVHQVDJDYKM58EPH
- Dowsett, G. W., & Couch, M. (2007). Male circumcision and HIV prevention: Is there really enough of the right kind of evidence? *Reproductive Health Matters, 15*(29), 33-44. doi:10.1016/s0968-8080(07)29302-4
- Droop, J., Isenman, P., & Mlalazi, B. (2008). *Paris Declaration on Aid Effectiveness: study of existing mechanisms to promote mutual accountability between donors and partner countries at the international level: a study report Retrieved from <http://www.oecd.org/dataoecd/47/33/43163465.pdf> Accessed.* Retrieved from Oxford:
- Esser, D. E. (2014). Elusive accountabilities in the HIV scale-up: 'ownership' as a functional tautology. *Global public health, 9*(1-2), 43-56. doi:10.1080/17441692.2013.879669
- Eyben, R., & Savage, L. (2013). Emerging and submerging powers: Imagined geographies in the new development partnership at the Busan fourth high level forum. *The Journal of Development Studies, 49*(4), 457-469. doi:10.1080/00220388.2012.733372
- Fehling, M., Nelson, B. D., & Venkatapuram, S. (2013). Limitations of the Millennium Development Goals: a literature review. *Global public health, 8*(10), 1109-1122. doi:10.1080/17441692.2013.845676
- Ferguson, J. (2006). *Global Shadows: Africa in the neoliberal world order*. Durham: Duke University Press.
- Feuer, J. M., Towne, L., & Shavelson, J. R. (2002). Scientific culture and educational research. *Educational Researcher, 31*(8), 4-14. doi:10.3102/0013189X031008004
- Finn, J. L., Nybell, L. M., & Shook, J. J. (2010). The meaning and making of childhood in the era of globalization: challenges for social work. *Children and Youth Services Review, 32*(2), 246-254. doi:10.1016/j.childyouth.2009.09.003
- Forte, M. C. (2014). Imperial Abduction Lore and Humanitarian Seduction. In M. C. Forte (Ed.), *Good Intentions: Norms and Practices of Imperical Humanitarianism* (Vol. 4, pp. 1-31). Canada: Alert Press.
- Fowler, A. (1998). Authentic NGDO partnerships in the new policy agenda for international aid: Dead end or light ahead? *Development and Change, 29*(1), 137-159. doi:10.1111/1467-7660.00073
- Fowler, A. (2000). Introduction beyond partnership: getting real about NGO relationships in the aid system. *IDS bulletin, 31*(3), 1-13. doi:10.1111/j.1759-5436.2000.mp31003001.x
- Fukuda-Parr, S., Yamin, A. E., & Greenstein, J. (2013). The power of numbers: a critical review of millennium development goal targets for human development and human rights. *Journal of Human Development and Capabilities, 15*(2-3), 105-117. doi:10.1080/19452829.2013.864622
- Gagnon, E., O'Sullivan, T., Lane, D. E., & Paré, N. (2016). Exploring partnership functioning within a community-based participatory intervention to improve disaster resilience *Journal of Higher Education Outreach and Engagement, 20*(2), 25-54.

- George, G., Reardon, C., Gunthorp, J., Moeti, T., Chingombe, I., Busang, L., & Musuka, G. (2012). The Madikwe Forum: a comprehensive partnership for supporting governance of Botswana's HIV and AIDS response. *African Journal of AIDS Research, 11*(1), 27-35. doi:10.2989/16085906.2012.671252
- Gobo, G. (2010). Ethnography. In D. Silverman (Ed.), *Qualitative research: issues of theory, method and practice* (3 ed.). London: SAGE Publishers.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The qualitative report, 8*(4), 597-607.
- Golbart, J., & Hustler, D. (2005). Ethnography. In B. Somech & C. Lewin (Eds.), *Research methods in the social sciences* (pp. 16-23). London: Sage Publications.
- Gold, J., Hellard, M., Lim, M., Dixon, H., Wakefield, M., & Aitken, C. (2012). Public-private partnerships for health promotion. *American Journal of Health Education, 43*(4), 250-253. doi:10.1080/19325037.2012.10599243
- Gosovic, B. (2000). Global intellectual hegemony and the international development agenda. *International social Science journal, 52*(166), 447-456. doi:10.1111/1468-2451.00275
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today, 24*(2), 105-112.
- Gray, R. H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., . . . Chen, M. Z. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *The Lancet, 369*(9562), 657-666.
- Green, J., & Thorogood, N. (2009). *Qualitative methods for health research* (2 ed.). London: Sage Publication Ltd.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research, 2*, 163-194.
- Guilhot, N. (2005). *The democracy makers: human rights and international order*. New York: Columbia University Press.
- Haines, A., & Cassels, A. (2004). Can the millennium development goals be attained? *Bmj, 329*(7462), 394-397.
- Hammersley, M. (1990). *Reading ethnographic research: a critical guide*. London: Longman.
- Hammersley, M. (2005). Close encounters of a political kind: the threat from the evidence-based policy-making and practice movement. *Qualitative Researcher Journal, 1*(2-4), 1-18.
- Hanefeld, J. (2010). The impact of Global Health Initiatives at national and sub-national level—a policy analysis of their role in implementation processes of antiretroviral treatment (ART) roll-out in Zambia and South Africa. *AIDS care, 22*(sup1), 93-102. doi:10.1080/09540121003759919
- Harrison, T. (2007). The role of contestation in NGO partnerships. *Journal of International Development, 19*(3), 389-400. doi:10.1002/jid.1373
- Harvey, D. (2005). *A brief history of neoliberalism*. Oxford: Oxford University Press.
- Hein, W., & Moon, S. (2016). *Informal norms in global governance: human rights, intellectual property rules and access to medicines*. London: Routledge.
- Hermans, J., & Nteta, D. (1995). *Barile: The People of Botswana* (Vol. 2). Gaborone: National Museum.
- Hofstede, G., Hofstede, G. J., & Minkov, M. (2005). *Cultures and organizations: software of the mind* (Vol. 2). New York: Citeseer.

- Jacobs, B., Ir, P., Bigdeli, M., Annear, P. L., & Van Damme, W. (2012). Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy and Planning*, 27, 288–300. doi:10.1093/heapol/czr038
- Jing Liu, J., Davidson, E., Bhopal, R., White, M., Johnson, M., Netto, G., & Sheikh, A. (2016). *Adapting health promotion interventions for ethnic minority groups: a qualitative study*. Southampton: NIHR Library.
- Johnson, H., & Wilson, G. (2006). North-South/South-North partnerships: closing the mutuality gap. *Public Administration and Development*, 26(1), 71-80. doi:10.1177/0899764001301004
- Jones, A. (2016). Envisioning a Global Health Partnership Movement. *Globalization and health*, 12(1), 1. doi:10.1186/s12992-015-0138-4
- Jones, J., & Barry, M. M. (2011a). Developing a scale to measure synergy in health promotion partnerships. *Global health promotion*, 18(2), 36-44. doi:10.1177/1757975911404762
- Jones, J., & Barry, M. M. (2011b). Exploring the relationship between synergy and partnership functioning factors in health promotion partnerships. *Health Promotion International*, 26(4), 408-420. doi:10.1093/heapro/dar002
- Jones, J., & Barry, M. M. (2016). Factors influencing trust and mistrust in health promotion partnerships. *Global health promotion*, 0(0), 1-9. doi:10.1177/1757975916656364
- Katisi, M., & Daniel, M. (2015). Safe male circumcision in Botswana: Tension between traditional practices and biomedical marketing. *Global public health*, 10(5-6), 739-756. doi:10.1080/17441692.2015.1028424
- Kebaabetswe, P., Lockman, S., Mogwe, S., Mandevu, R., Thior, I., Essex, M., & Shapiro, R. L. (2003). Male circumcision: an acceptable strategy for HIV prevention in Botswana. *Sexually Transmitted Infections*, 79(3), 214-219. doi:10.1136/sti.79.3.214
- Kelly, E., Doyle, V., Weakliam, D., & Schönemann, Y. (2015). A rapid evidence review on the effectiveness of institutional health partnerships. *Globalization and health*, 11(1), 1. doi:10.1186/s12992-015-0133-9
- Kenworthy, N. J. (2014). Participation, decentralisation and déjà vu: Remaking democracy in response to AIDS? *Global public health*, 9(1-2), 25-42. doi:10.1080/17441692.2013.879728
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London: Sage.
- Krueger, R. A., & Casey, M. A. (2014). *Focus groups: A practical guide for applied research*. Singapore: Sage publications.
- Kvale, S. (1994). 10 Standard Objectives to Qualitative Research Interviews. *Journal of Phenomenological Psychology*, 25(2), 147-173. doi:10.1163/156916294x00016
- Kwamie, A., & Nabyonga-Orem, J. (2016). Improved harmonisation from policy dialogue? Realist perspectives from Guinea and Chad. *BMC Health Services Research*, 16(4), 357. doi:10.1186/s12913-016-1458-7
- Lewis, D. (1998). Development NGOs and the challenge of partnership: changing relations between North and South. *Social policy & administration*, 32(5), 501-512. doi:10.1111/1467-9515.00111
- Lewis, D. J. (1998). Interagency partnerships in aid-recipient countries: Lessons from an aquaculture project in Bangladesh. *Nonprofit and Voluntary Sector Quarterly*, 27(3), 323-338. doi:Doi 10.1177/0899764098273004
- Lincon, Y. S., & Guba, E. G. (1985). *Naturalist Enquiry*. California: SAGE Publishing.
- Lister, S. (2000). Power in partnership? An analysis of an NGO's relationships with its partners. *Journal of International Development*, 12(2), 227.

- Lucero, J., Wallerstein, N., Duran, B., Alegria, M., Greene-Moton, E., Israel, B., . . . Pearson, C. (2016). Development of a mixed methods investigation of process and outcomes of community-based participatory research. *Journal of mixed methods research*. doi:10.1177/1558689816633309
- Lukobo, M., & Bailey, R. (2007). Acceptability of male circumcision for prevention of HIV infection in Zambia. *AIDS care*, 19(4), 471-477. doi:10.1080/09540120601163250
- Maina-Ahlberg, B., Nordberg, E., & Tomson, G. (1997). North-South health research collaboration: challenges in institutional interaction. *Social Science & Medicine*, 44(8), 1229-1238. doi:10.1016/S0277-9536(96)00311-5
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358(9280), 483-488. doi:10.1016/S0140-6736(01)05627-6
- Mattson, C. L., Bailey, R. C., Muga, R., Poulussen, R., & Onyango, T. (2005). Acceptability of male circumcision and predictors of circumcision preference among men and women in Nyanza Province, Kenya. *AIDS care*, 17(2), 182-194. doi:10.1080/09540120512331325671
- Mawdsley, E. (2011). The changing geographies of foreign aid and development cooperation: contributions from gift theory. *Transactions of the Institute of British Geographers*, 37(2), 256-272. doi:10.1111/j.1475-5661.2011.00467.x
- Mawdsley, E., Savage, L., & Kim, S. (2014). A 'post-aid world'? Paradigm shift in foreign aid and development cooperation at the 2011 Busan High Level Forum. *The Geographical Journal*, 180(1), 27-38. doi: 10.1111/j.1475-4959.2012.00490.x
- McFalls, L. (2010). Benevolent dictatorship: the formal logic of humanitarian government. In D. Fassin & M. Pandolfi (Eds.), *Contemporary states of emergency: the politics of military and humanitarian interventions*. New York: Zone Books.
- Meissner, O., & Buso, D. L. (2007). Traditional male circumcision in the Eastern Cape - scourge or blessing? *South African Medical Journal*, 97(5), 371-373.
- Mertens, D. M. (2008). *Transformative research and evaluation*. New York: Guilford press.
- MFDP. (2011). *Botswana tenth National Development Plan* retrieved 20 June 2016. Retrieved from [http://www.nationalplanningcycles.org/sites/default/files/country\\_docs/Botswana/ndp\\_botswana.pdf](http://www.nationalplanningcycles.org/sites/default/files/country_docs/Botswana/ndp_botswana.pdf)
- Millen, D. R. (2000). *Rapid ethnography: time deepening strategies for HCI field research*. Paper presented at the Proceedings of the 3rd conference on Designing interactive systems: processes, practices, methods, and techniques.
- Ministry of Health. (2010). *Safe male circumcision: additional strategy for HIV prevention: A national strategy*. Retrieved from Gaborone:
- Ministry of Health. (2011). *Progressive Report on the Response to Safe Male Circumcision for HIV Prevention Strategy*. Retrieved from Gaborone Botswana:
- Miranda, J. J., Bernabé-Ortiz, A., Diez-Canseco, F., Málaga, G., Cárdenas, M. K., Carrillo-Larco, R. M., . . . Ponce, V. (2016). Towards sustainable partnerships in global health: the case of the CRONICAS Centre of Excellence in Chronic Diseases in Peru. *Globalization and health*, 12(1), 1. doi:10.1186/s12992-016-0170-z
- Mittelmark, M. B. (2005). Charters, Declarations, World Conferences: Practical significance for health promotion practitioners 'on the ground'. *Promotion and Education*, 12(1), 4. doi:10.1177/10253823050120010102
- Mosothwane, M. N. (2001). An ethnographic study of initiation schools among the Bakgatla ba ga Kgafela at Mochudi 1874-1988. *Pula Botswana Journal of African Studies*, 1(15), 144-165.

- Moumakwa, P. C. (2010). *The Botswana Kgotla system: a mechanism for traditional conflict resolution in modern Botswana: case study of the Kanye Kgotla*. (Master's Thesis in Philosophy of Peace and Conflict Transformation ), University of Tromsø, Tromsø.
- Moumakwa, P. C. (2011). The Botswana Kgotla system: a mechanism for traditional conflict resolution in modern Botswana: case study of the Kanye Kgotla.
- NACA. (2009). *The Second Botswana National Strategic Framework for HIV and AIDS 2010-2016*. Retrieved from Gaborone:
- Nelson, B. (2012). Business and science: In the market. *Nature*, 487, 261–263. doi:doi:10.1038/nj7406-261a
- Nguyen, V.-K. (2005). Antiretroviral globalism, biopolitics and therapeutic citizenship. In A. Ong & S. J. Collier (Eds.), *Global Assemblages: Technology, Politics and Ethics*. London: Blackwell.
- Nguyen, V.-K. (2009). Government-by-exception: Enrollment and experimentality in mass HIV treatment programmes in Africa. *Social Theory & Health*, 7(3), 196 -217.
- Niang, C. I., & Boiro, H. (2007). " You can also cut my finger!": social construction of male circumcision in West Africa, a case study of Senegal and Guinea-Bissau. *Reproductive Health Matters*, 22-32. doi:10.1016/S0968-8080(07)29312-7
- OECD. (2005). *The Paris Declaration on AID Effectiveness: Five Principles for Smart AID access date 07 April 2016*. Retrieved from [www.oecd.org](http://www.oecd.org):  
<http://www.oecd.org/dac/effectiveness/45827300.pdf>
- Parker, M. (2011). *The science of qualitative research*. New York: Cambridge University Press.
- Pattberg, P. H. (2012). *Public-private partnerships for sustainable development: Emergence, influence and legitimacy*. Northampton USA: Edward Elgar Publishing.
- PEPFAR. (No date). PEPFAR's best practices for Voluntary Medical Male Circumcision site operations: A service guide for site operations accessed 28 July 2016. Retrieved from  
[https://www.usaid.gov/sites/default/files/documents/1864/pepfar\\_best\\_practice\\_for\\_vmmc\\_site\\_operations.pdf](https://www.usaid.gov/sites/default/files/documents/1864/pepfar_best_practice_for_vmmc_site_operations.pdf)
- PHPC. (2011). Population & housing census: preliminary results brief accessed 15 June 2016. Retrieved from  
<http://ecastats.uneca.org/aicmd/Portals/0/Census%202011%20Preliminary%20%20Brief%20Sept%2029%202011.pdf>
- Pope, C., & Mays, N. (2008). *Qualitative research in health care*: Wiley. com.
- Ramiah , I., & Reich, M. R. (2005). Public-Private Partnerships And Antiretroviral Drugs For HIV/AIDS: Lessons From Botswana. *Health Affairs*, 24(2), 545-551. doi:doi: 10.1377/hlthaff.24.2.545
- Ramiah , I., & Reich, M. R. (2006). Building effective public–private partnerships: Experiences and lessons from the African Comprehensive HIV/AIDS Partnerships (ACHAP). *Social Science & Medicine*, 63(2), 397–408. doi:doi:10.1016/j.socscimed.2006.01.007
- Rapley, J. (2010). Some Pragmatics of Data Analysis. In D. Silverman (Ed.), *Qualitative research: issues of theory, method and practice* (3 ed.). London: SAGE Publishing.
- Rasmussen, L. M. (2013). “To donors, it's a program, but to us it's a ministry”: the effects of donor funding on a community-based Catholic HIV/AIDS initiative in Kampala. *Canadian Journal of African Studies / Revue canadienne des études africaines*, 47(2), 227-247. doi:10.1080/00083968.2013.829952
- Ratzan, S. C. (2007). Public-private partnerships for health. *Journal of Health Communication*, 12, 315-316. doi:10.1080/10810730701331739



- Resch, S., Ryckman, T., & Hecht, R. (2015). Funding AIDS programmes in the era of shared responsibility: an analysis of domestic spending in 12 low-income and middle-income countries. *The Lancet Global Health*, 3(1), 52-61. doi:10.1016/S2214-109X(14)70342-0
- Rifkin, S. B. (1996). Paradigms lost: toward a new understanding of community participation in health programmes. *Acta Tropica*, 61, 79-92.
- Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. London: Sage.
- Rogerson, A. (2005). Aid harmonisation and alignment: Bridging the gaps between reality and the Paris reform agenda. *Development Policy Review*, 23(5), 531-552. doi:10.1111/j.1467-7679.2005.00301.x
- Rottenburg, R. (2009). Social and public experiments and new figurations of science and politics in postcolonial Africa 1. *Postcolonial Studies*, 12(4), 423-440. doi:10.1080/13688790903350666
- Sabone, M., Magowe, M., Busang, L., Moalosi, J., Binagwa, B., & Mwambona, J. (2013). Impediments for the uptake of the Botswana government's male circumcision initiative for HIV prevention. *The Scientific World Journal*, 2013, 1-7. doi:10.1155/2013/387508
- Saith, A. (2006). From universal values to Millennium Development Goals: lost in translation. *Development and Change*, 37(6), 1167-1199. doi:10.1111/j.1467-7660.2006.00518.x
- Schapera, I. (1970). *A handbook of tswana law and custom*. UK: Frank Cass & Co Ltd.
- Seckinelgin, H. (2005). A global disease and its governance: HIV/AIDS in sub-Saharan Africa and the agency of NGOs. *Global Governance: A Review of Multilateralism and International Organizations*, 11(3), 351-368.
- Seckinelgin, H. (2008). *International politics of HIV/AIDS: Global disease - local pain*. London: Routledge.
- Seckinelgin, H. (2012). The global governance of success in HIV/AIDS policy: Emergency action, everyday lives and Sen's capabilities. *Health & place*, 18(3), 453-460.
- Seth, N. (2014). *Goal 17—Enabling a sustainable future through the joint action of countries and communities: a revitalized global partnership for sustainable development*. Retrieved from <http://unchronicle.un.org/article/goal-17-enabling-sustainable-future-through-joint-action-countries-and-communities/>; <http://unchronicle.un.org/article/goal-17-enabling-sustainable-future-through-joint-action-countries-and-communities/>
- Seth, N. (2015). Strengthen the means of implementation and revitalize the global partnership for sustainable development. *UN Chronicle*, 51(4), 40-43. doi:10.18356/4db709e5-
- Seth, W. (2008). *Botswana and its people*. San Luis Potos: New Africa Press.
- Setlhabi, G. K. (2014). I took an allegiance to secrecy: complexities for conducting ethnographic research at home. *Africa*, 84(2), 314-334. doi:10.1017/S0001972014000059
- Shavelson, J. R., & Towne, L. (2004). What drives scientific research in education. <https://aps.psychologicalscience.org/index.php/uncategorized/what-drives-scientific-research-in-education.html> Retrieved 11.09.2014, from American Psychological Society Observer
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75.

- Silverman, D. (2013). *Doing qualitative research: A practical handbook*. London: SAGE Publications Limited.
- Silverman, D. (2016). *Qualitative research*. London: Sage.
- Sinanovic, E., & Kumaranayake, L. (2010). The motivations for participation in public-private partnerships for the provision of tuberculosis treatment in South Africa. *Global public health*, 5(5), 479-492. doi:10.1080/17441690902942498
- Sjöstedt, M. (2013). Aid Effectiveness and the Paris Declaration: A Mismatch Between Ownership and Results-Based Management? . *Public Administration and Development*, 33, 143-155. doi:10.1002/pad.1645
- Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., & Gregson, S. (2011). Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Globalization and health*, 7(13), 1-14. doi:doi:10.1186/1744-8603-7-13
- Skovdal, M., & Cornish, F. (2015). *Qualitative Research for Development: A Guide for Practitioners*. UK: Practical Action Publishing.
- Songstad, N. G., Rekdal, O. B., Massay, D. A., & Blystad, A. (2011). Perceived unfairness in working conditions: The case of public health services in Tanzania. *BMC Health Services Research*, 11(34), 1-15. doi:10.1186/1472-6963-11-34
- St-Pierre, É. (2014). Iatrogenic imperialism: NGOs and CROs as agents of questionable care. In M. Forte (Ed.), *Good intentions: norms and practices of imperial humanitarianism-the new imperialism* (Vol. 4, pp. 37-56). Montreal, Canada: Alert Press.
- Stacy, C. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, 17(10), 1316-1328. doi:10.1177/1049732307306927
- Strauss, A., & Corbin, J. (1994). *Grounded theory methodology*. Hagen: Fernuniversität.
- Thamuku, M., & Daniel, M. (2013). Exploring responses to transformative group therapy for orphaned children in the context of mass orphaning in Botswana. *Death studies*, 37(5), 413-447. doi:10.1080/07481187.2012.654594
- Tracy, J., & McDonald, R. (2015). Health and disability: partnerships in health care. *Journal of Applied Research in Disabilities*, 28(1), 22-32. doi:10.1111/jar.12135
- Turner, V. (1969). *The Ritual Process: Structure and Anti-Structure*. London: Routledge and Keegan Paul.
- UN. (2008a). Delivering on the global partnership for achieving the Millennium Development Goals retrieved fom. Retrieved from <http://www.un.org/millenniumgoals/pdf/MDG%20Gap%20Task%20Force%20Report%202008.pdf> 20 July 2016
- UN. (2008b). The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action Retrieved from <http://www.oecd.org/dac/effectiveness/34428351.pdf>
- UN. (2009). Strengthening the global partnership for development in a time of crisis. Retrieved from [https://books.google.no/books/about/Strengthening\\_the\\_Global\\_Partnership\\_for.html?id=SUssd-WvJckC&redir\\_esc=y](https://books.google.no/books/about/Strengthening_the_Global_Partnership_for.html?id=SUssd-WvJckC&redir_esc=y)
- UN. (2010). The global partnership for development at a critical juncture. Retrieved from [http://www.un.org/millenniumgoals/pdf/10-43282\\_MDG\\_2010%20\(E\)%20WEBv2.pdf](http://www.un.org/millenniumgoals/pdf/10-43282_MDG_2010%20(E)%20WEBv2.pdf)
- UN. (2011). *The Global Partnership for Development: Time to Deliver*. Retrieved from New York:
- UN. (2013). The global partnership for development: the challenge we face. Retrieved from [http://www.un.org/millenniumgoals/2013\\_Gap\\_Report/MDG%20GAP%20Task%20Force%20Report%202013\\_English.pdf](http://www.un.org/millenniumgoals/2013_Gap_Report/MDG%20GAP%20Task%20Force%20Report%202013_English.pdf)

- UN. (2014). The state of the global partnership for development. *Millennium Development Goal 8*. Retrieved from [http://www.un.org/millenniumgoals/2014\\_Gap\\_Report/MDG%20Gap%20Task%20Force%20Report%202014\\_Executive%20Summary\\_English.pdf](http://www.un.org/millenniumgoals/2014_Gap_Report/MDG%20Gap%20Task%20Force%20Report%202014_Executive%20Summary_English.pdf)
- UN. (2015). Sustainable development knowledge platform: goal 17. Retrieved from <https://sustainabledevelopment.un.org/sdg17>
- UN. (2016a). Sustainable development: open working group proposal for sustainable development goals. Retrieved from <https://sustainabledevelopment.un.org/focussdgs.html>
- UN. (2016b). UN Sustainable Development: Goal 17: revitalize the global partnership for sustainable development. Retrieved from <http://www.un.org/sustainabledevelopment/globalpartnerships/>
- UNAIDS. (2007). *Male circumcision: context, criteria and culture (Part 1)*. Retrieved from Geneva:
- UNAIDS. (2008). The Paris Declaration of Aid Effectiveness.
- UNAIDS. (2014). *The Gap Report*. Retrieved from Geneva:
- Van de Van, A. H. (2007). *Engaged Scholarship: A Guide for Organisational and Social Research*. Oxford: Oxford University Press.
- Waage, J., Banerji, R., Campbell, O., Chirwa, E., Collender, G., Dieltiens, V., . . . Kingdon, G. (2010). The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting after 2015. *The Lancet*, 376(9745), 991-1023. doi:10.1016/S0140-6736(10)61196-8
- Waage, J., Yap, C., Bell, S., Levy, C., Mace, G., Pegram, T., . . . Kock, R. (2015). Governing the UN Sustainable Development Goals: interactions, infrastructures, and institutions. *The Lancet Global Health*, 3(5), e251-e252. doi:10.1016/S2214-109X(15)70112-9
- Wambura, M., Mwangi, J. R., Mosha, J. F., Mshana, G., Mosha, F., & Chagalucha, J. (2011). Acceptability of medical male circumcision in the traditionally circumcising communities in Northern Tanzania. *BMC Public Health*, 11(1), 373. doi:10.1186/1471-2458-11-373
- Weiss, E. S., Anderson, R. M., & Lasker, R. D. (2002). Making the most of collaboration: exploring the relationship between partnership synergy and partnership functioning. *Health Education & Behavior*, 29(6), 683-698. doi:10.1177/109019802237938
- Weiss, H. A., Quigley, M. A., & Hayes, R. J. (2000). Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *Aids*, 14(15), 2361-2370. doi:10.1186/1471-2458-11-373
- Westercamp, N., & Bailey, R. (2007). Acceptability of male circumcision for prevention of HIV/AIDS in sub-Saharan Africa: a review. *Aids and Behavior*, 11(3), 341-355. doi:10.1007/s10461-006-9169-4
- WHO. (1986). The Ottawa Charter for Health Promotion: *World Health Organisation*. Accessed 12 July 2016. Retrieved from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>
- WHO. (2015). Voluntary medical male circumcision for HIV prevention in 14 priority countries in East and Southern Africa Progress brief. Retrieved from <http://www.who.int/hiv/pub/malecircumcision/brief2015/en/>

- WHO/UNAIDS. (2007). *New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications*. Retrieved from Geneva:  
<http://www.who.int/hiv/topics/malecircumcision/en/index.html>
- Wirth, K. E., Semo, B., Ntsuape, C., Ramabu, N. M., Otlhomile, B., Plank, R. M., . . . Ledikwe, J. H. (2015). Triggering the decision to undergo medical male circumcision: a qualitative study of adult men in Botswana. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 28(8), 1007-1012. doi:10.1080/09540121.2015.1133797
- Wirth, K. E., Semo, B., Ntsuape, C., Ramabu, N. M., Otlhomile, B., Plank, R. M., . . . Ledikwe, J. H. (2016). Triggering the decision to undergo medical male circumcision: a qualitative study of adult men in Botswana. *AIDS care*, 1-6. doi:10.1080/09540121.2015.1133797
- Wouters, J., & Cogolati, S. (2015). Taking Sustainable Development Goal 17 seriously. the world bank's legal framework for providing global public goods. *Social Science Research Network*. doi:10.2139/ssrn.2718044





RESEARCH

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# Aspirations and realities in a North-South partnership for health promotion: lessons from a program to promote safe male circumcision in Botswana

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## Abstract

**Background:** International donors support the partnership between the Government of Botswana and two international organisations: U.S. Centers for Disease Control and Prevention and Africa Comprehensive HIV/AIDS Partnership to implement Voluntary Medical Male Circumcision with the target of circumcising 80 % of HIV negative men in 5 years. Botswana Government had started integration of the program into its health system when international partners brought in the Models for Optimizing Volume and Efficiency to strengthen delivery of the service and push the target. The objective of this paper is to use a systems model to establish how the functioning of the partnership on Safe Male Circumcision in Botswana contributed to the outcome.

**Methods:** Data were collected using observations, focus group discussions and interviews. Thirty participants representing all three partners were observed in a 3-day meeting; followed by three rounds of in-depth interviews with five selected leading officers over 2 years and three focus group discussions.

**Results:** Financial resources, “ownership” and the target influence the success or failure of partnerships. A combination of inputs by partners brought progress towards achieving set program goals. Although there were tensions between partners, they were working together in strategising to address some challenges of the partnership and implementation. Pressure to meet the expectations of the international donors caused tension and challenges between the in-country partners to the extent of Development Partners retreating and not pursuing the mission further.

**Conclusion:** Target achievement, the link between financial contribution and ownership expectations caused antagonistic outcome. The paper contributes enlightenment that the functioning of the visible in-country partnership is significantly influenced by the less visible global context such as the target setters and donors.

**Keywords:** Safe male circumcision, Botswana, Partnership, Donors, Finance, Ownership, Target, Synergy, Antagony

## Background

### Partnerships for health

The Botswana Safe Male Circumcision (SMC) program is a North-South partnership aiming to promote sexual health via voluntary medical adult male circumcision [1, 2]. The Botswana SMC program was established to help meet a particular public health target – the prevention of HIV via the medical circumcision of 80 % of HIV negative men.

As important as HIV prevention is, the research reported here is not about progress in meeting that target. Rather, this is a study of how the Botswana SMC program functions as a North-South partnership. Such research is urgently needed, because many North-South health partnerships function poorly, and they fail to meet their goals [3, 4]. By studying what factors promote and inhibit good partnership functioning in existing projects like the Botswana SMC program, the aim is to generate knowledge that may help future North-South health partnerships better meet their goals.

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Medical male circumcision is recommended by the World Health Organization (WHO) for countries that have high prevalence of HIV infections and low practice of male circumcision [1, 2, 5]. Randomised control trials provide evidence that the removal of the foreskin reduces chances of men acquiring HIV through heterosexual relationships by 50–60 % [6–8]. In 2014, Botswana recorded an HIV prevalence rate of 25 % [9], and Botswana is therefore one of the countries in which male circumcision is a major public health goal.

Global health issues like HIV call for global solutions. In modern public health practice for HIV prevention as for other health priorities, countries are expected to contribute the resources and expertise at their disposal. This approach recognises that only by combining resources can global society hope to achieve significant public health improvements. But how should countries cooperate in health development initiatives? A discredited approach of the past is the North-South donor-recipient model, with well-endowed Northern donor countries paying the bills for development in the South, and therefore making the decisions [10–12]. Since the late 1980's, the preferred approach is the North-South partnership model [12, 13]. Yet as reviewed below, effective North-South partnerships are difficult to mount and maintain, despite the best intentions of all parties.

A well-functioning partnership approach to development has become so important that all of aid development adopts the Paris Declaration's partnership framework. The Paris Declaration was signed in 2005 by the development Ministers of well over 100 countries and the heads of key international development organisations, agreeing international standards for ethical partnership on several dimensions: ownership, mutual accountability, managing for results, alignment, and harmonization [14, 15]. Authentic partnership implies a joint commitment to long term interaction, shared responsibility for achievement, reciprocal obligation, equality, mutuality and balance of power [16]. The idea is that partners with common interests and diverse resources can create synergy if resources are pooled to achieve partners' common vision.

### True partnership is difficult

Even if partnership is the preferred model of North-South collaboration, it has long been observed that true partnership is difficult to achieve and maintain when resources are unevenly distributed [17]. Power is unevenly distributed in most North-South partnerships [18], including AIDS prevention partnerships [19–21]. Northern and Southern partners may have very different ideas about the meaning of partnership, as the term is value-laden and has many possible meanings [22]. North-South cooperation that is genuinely meant by the North to be a partnership may be perceived by the South to

function in the donor-recipient mode [23]. Scepticism about Northern motives is fed by findings that at least some Northern actors use the idea of partnership in a rhetorical or an instrumental way [24, 25]. Persistent North-South asymmetry and perceived Northern domination has been reported in the literature right from the beginning of the North-South health partnership experiment [4, 11, 26]. A typical irritation is Northern partners' emphasis on Southern partners' accountability, experienced by Southern partners as a stripping away of their managerial autonomy [12]. Manifestations of North-South power imbalance can be quite direct; in his study of a Dutch-Sri Lankan partnership, Fernando [27] cites a statement made by an obviously frustrated Sri Lankan NGO leader to the Dutch partners:

*"As long as we agree, you say that the money belongs to both of us. But the moment we disagree, you say that the money belongs to you" ( [27], p.1).*

### Research on partnership processes: a public health priority

Given the difficulties of health partnerships generally, and North-South partnerships in particular, research on North-South partnership processes and functioning is a public health priority. In a recent review of the effectiveness of North-South partnerships, Kelly et al. [28] conclude that the quality and rigour of the evidence base is thin. They emphasise that research is needed especially at the level of individual partnerships and the bodies that facilitate them. Kelly et al. [28] point to the need for indicators and frameworks that address the benefits and values of the partnership model of cooperation. They also emphasise the need for research on pathways (processes) that lead to effective partnerships. Others have also called for more and better quality North-South partnership research, and extend Kelly et al's critique and call for new research in several important ways. Yassi et al. [29] call for a 'communities of practice' research mentality whereby Northern partners seek multi-directional learning – how can North partners improve their own functioning? Murphy et al. [30] have described practical tools to help North-South partnerships study the ethics of collaboration, with a view to ensuring benefits to all partners. Holmarsdottir and colleagues [31] call for the practical use of conceptual frameworks of North-South partnership to provide guidance about partnership practices, and point to the need for a critical stance in the conduct (and study) of North-South partnerships, given the "paucity of empirical studies that have been undertaken to both documents and deconstruct the collaborative process..." ([31], p280-281). Corbin and Mittelmark [3] describe a systems approach to the study of partnership processes, and a systems analysis of a North-South AIDS prevention partnership has addressed



a number of the points of critique mentioned above [32–34]. It is observed that the proposed mechanisms or principles for accountability formulated for partnership effectiveness in the Paris Declaration are experiencing challenges and therefore need addressing [14]. Below we discuss ownership; mutual accountability - that poses expectations on financial contribution by the South; managing for results - that is outcome focused [3, 4, 17, 24, 33, 35].

### **Mechanisms for accountability in partnerships**

Ownership of programs by the recipient countries is overemphasised by UN agencies as a way to work against the observed imbalance of power between the North and the South experienced over the past decades. Ownership was added to the definition of partnerships in the 2005 Paris Declaration for Aid Effectiveness, and since then the term has become a buzz word echoed from all stakeholders [20]. International donors attempt to put the concept of ownership into practice, for example, though efforts to ensure that donor efforts are aligned to fit the local administrative and strategic systems [36]; promote domestic funding, and refine conditions to measure the commitment of domestic Governments to increase budgets towards HIV/AIDS scale-up programs [21]. Such efforts to cultivate ownership by the Global South follow events from the United Nations General Assembly of 2011, where UNAIDS appealed for shared responsibility in terms of increasing long term domestic and international funding towards health scale up programs, emphasizing that recipient countries should be held accountable for rising domestic investments on health [21, 37].

Mutual accountability and transparency in the use of development resources is vital in aid partnerships ([14], p4). The level of financial contribution is seen as an indicator of the recipient country's commitment to the development programs [21]. Many African countries, in spite of low levels of income, have attempted to increase their share of AIDS expenditure to show commitment and ownership [38]. Only Botswana and Namibia had spending levels on HIV/AIDS sufficiently high to cover their full program requirements in the year 2013 ([21]: p.e56). Regardless of these local efforts, international investment in HIV/AIDS interventions continues to increase [37]. Seckinelgin [39] critiques the idea of promoting funding as if it is the only way to succeed in health interventions. He argues that putting significant funding into ineffective intervention structures will not yield effective results within a given space of time. For example he critiques programs that do not encourage behaviour change in those infected or affected by HIV but emphasise only spending more money. His contention is that although increasing funding on HIV

prevention programs is crucial, it does not change people's behaviour automatically therefore the right mechanisms of program implementation remain the most important aspect for success [39]. Partnership promotes other components of ownership like the political environment, local strategies to implementation and cultural relevance [10, 24]. McFalls assesses current partnerships in aid as not genuine, but as only deceptive strategies to "legitimise" the domination of the powerful under the pretence of benevolence [25].

Managing for results calls for measuring progress and assessing results [15]. The Paris declaration is clear that reporting outcome of results is vital to measure success [15]. The global aid environment, and more generally, health and development initiatives use targets and indicators to map success. For example setting numerical targets for programs was the norm and requirement for implementation of MDGs. Even the global agenda post MDGs still emphasis that target setting is critical for tracking success [40]. The commission led by Waage and colleagues to analyse MDG 1–7 note that "The use of results based framework is regarded as one of the strengths of the MDGs, and has certainly appealed in an aid context with the desire of donors to see measurable returns on investment" ([35], p1000). Fuduka- Parr and colleagues [41] explain that targets are actually used to monitor progress, to reward or punish recipient country and policymakers. While UN agencies see the target approach as powerful, critics see progress in quantitative achievements of some goals but observe numerous gaps that hamper achievements. Targets and measures are not easily conceptualised by local implementers and this is largely associated with measurement, ownership and leadership [35]. Several critics observe that the quantitative, target oriented programs as well as measures used side-line other important objectives like equity and quality in reporting tools. This makes interventions focus on 'doing things right' rather than 'doing the right things' ([36], p153), and this can only be addressed through inclusion of qualitative measures [35, 41, 42]. Given such challenges on the implementation of the mechanisms for accountability the recommendation by Corbin and colleagues to study partnership functioning and processes needs to be considered [3].

There is little research that examines the functioning of these partnerships and their authenticity [11, 33]. There are a few studies that analyse the functioning of partnerships including Weiss et al., Jones and Barry, and Corbin et al. [3, 33, 43, 44]. In analysing partnership between the North and one organisation in the South, Corbin et al. [33] observed that there was sharing of power between the partners; Jones et al. [43] emphasise the importance of trust and good leadership as key to success in partnership functioning; Weiss et al. [44]

established that leadership effectiveness was a key ingredient to partnership synergy while administration and management did not really show any significant contribution to positive functioning. Power imbalance is the common finding in most literature on partnerships in general, especially between North and South [11]. Mawdsley et al. [18] argue that partnerships in international health initiatives frequently involve, on the one hand, blurry ownership of health programs by the Global South and, on the other hand, pressure from donors to ensure their conditions, expectations and targets are met. More positively, partnerships have been documented that stimulate the Southern partners to develop and increase their competence in population and reproductive health [45]. In their analysis of partnerships Bailey and Dolan [46] find the good and the bad. While Southern partners benefit from skills brought in by the North, gain capital benefits like infrastructure development, and develop a greater voice in the process, capacity building is still seen as a one way flow from the north [46].

**The case**

The case in this study is the Botswana Safe Male Circumcision program. In adapting VMMC, Botswana calls it Safe Male Circumcision (SMC) program. This research attempts to answer the call above (for analysing partnership functioning) by exploring the functioning of the partnership between the government of Botswana’s Ministry of Health (MH) and two international organisations: U.S. Centers for Disease Control and Prevention (CDC); and Africa Comprehensive HIV/AIDS Partnership (ACHAP) to implement Voluntary Medical Male Circumcision VMMC [1]. The WHO recommended to VMMC implementing countries that 80 % of HIV negative men be circumcised by 2016 in order to make a

significant impact on the countries’ current infection rates [47]. The two international organisations have worked with Botswana Government in many HIV intervention programs for a long time now, hence the Government calls them Development Partners (DPs) [48]. Their long term partnership with Botswana is set out in Botswana’s National Strategic Framework for HIV and AIDS 2010–2016 (NSF) [48], a locally developed document that provides strategic direction on the national response to HIV/AIDS [48]. Behind these Development Partners are the unseen international donors: PEPFAR which funds CDC and Bill and Melinda Gates Foundation for ACHAP. Different authors in partnership list different dimensions of partnership functioning including partnership culture, administrative and management roles, leadership, professional expertise, financial resources and nonfinancial resources, challenges with partner involvement and challenges that are community related [33, 43, 44]. We captured different partner roles and resource contribution in the partnership for SMC in Botswana. See Table 1.

This paper contributes to the scanty literature on the functioning of partnerships between the North and the South. The aim of the paper is to use the Bergen Model of Collaborative Functioning (BMCF) to explore achievements and challenges of the partnership on a Safe Male Circumcision (SMC) program in Botswana, while making efforts to attain the set target. Specifically we establish how the mission and functioning of the partnership contributed to the actual outcome.

**Conceptual framework**

*The Bergen Model of Collaborative Functioning (BMCF)*

We use a systems model, the Bergen Model of Collaborative Functioning (BMCF) [3] as a framework

**Table 1** Partner roles and resource contribution

Partner roles and resource contribution	Ministry of health MH	Development partner 1 CDC	Development partner 2 ACHAP	PEPFAR	Bill and Melinda gates foundation
Financial contribution/In country donor	✓	✓	✓		
Development Partner (in the country)		✓	✓		
Coordinator and owner of program	✓				
International donor				✓	✓
Provides scientific expertise and skills		✓			
Provides training of staff on surgery	✓	✓	✓		
Provides training of staff on demand creation		✓	✓		
Provider of implementation staff for surgery	✓	✓	✓		
Provider of general medical equipment	✓				
Provides MC surgery kits		✓			
Marketing and advertisement of MOVE (large scale)		✓			
Provider of staff for mobilisation (Demand Creation)		✓	✓		
Provider of infrastructure nationally	✓				

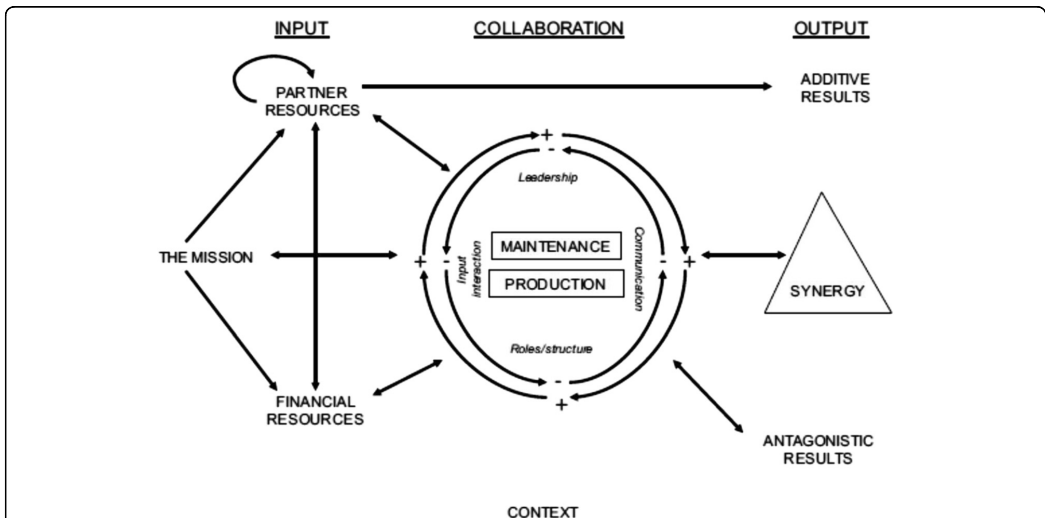
to examine the operationalisation of the SMC partnership in Botswana. The BMCF is shown in Fig. 1. We choose to use this model because it has been used before in assessing an HIV/AIDS partnership in the global South, [3, 32–34] and also that it addresses functioning. The BMCF model is useful in illustrating the contextual process within the partnership [34]. Inputs include the partnership’s mission (selected approach to deal with a problem), partner resources (knowledge, skills, competence, etc.) and financial resources (funding and material inputs) [33]. The collaborative context (or throughput section) of the partnership is analysed through the interaction – positive or negative – of four aspects that impact the maintenance (administrative) tasks and production tasks (related to partnership’s mission), namely, leadership, communication, roles & structure and the inputs themselves [33].

The output of the partnership can be *additive results* (unaffected by collaboration of the partners); or *synergy*, where more is produced by collaborating than if the partners had not interacted with one another; or *antagonistic results*, where the costs of partnership exceed the benefits [3, 33]. Additive results are things that could still be achieved without the partnership. This is based on the argument that a partnership is always built to tackle an existing problem where some action has been taken, anyway. Synergy is what is achieved because of the “multiplicative interaction” of the partnership. Put in mathematical terms it is  $2 + 2 = 5$  [33]. Determinants of synergy include partner relationship ingredients like

trust and power, partnership assets, partnership characteristics, and leadership ([43]: p. 409). If synergy is achieved this may have a positive feedback impact on partnership inputs and functioning [33]. Reflecting on antagonistic results may also result in positive feedback [33]. Corbin and Mittelmark [3] note that it is possible for a partnership to include both synergistic and antagonistic elements concurrently. Corbin and Mittelmark’s theoretical contribution to the BMCF is the enlightenment on how context, specifically cultural and societal context, as well as partnership processes and partner contributions interact both positively and negatively to influence partnership functioning [34]. In assessing the volunteers’ participation in the organisation, they identified that positive results are generated by: the experience of social connectedness; seeing volunteering as opportunity for public recognition and for expressing passion to help others [34].

**The Bergen model of collaborative functioning: Fig. 1 should fit here**

Corbin and Mittelmark [3] record that nearly 50 % of partnerships dissolve early and impulsively. They observe that resources, characteristics of partners, features of the partnership strategy and environmental factors can either support synergy or create antagonism between partners ([3]: p.365). Fowler [4] adds other elements that may cause antagonistic outcomes in partnerships such as: paternalistic behaviour of those with cash power; upholding the approach of the Northern rather than the



**Fig. 1** The Bergen Model of Collaborative Functioning: Adapted from Corbin JH, Mittelmark MB, Lie GT. Grassroots volunteers in context: rewarding and adverse experiences of local women working on HIV and AIDS in Kilimanjaro, Tanzania. *Global health promotion*. 2015;1757975915569514

Southern partners; hiring staff from the North because of capacity limitations of workers from the South, and the North's anxiety about loss of control. Corbin and Mittelmark [3] argue that although more financial resources can improve the functioning of the relationship, funding can also complicate functioning; antagonism is created if partners and funders view the partnership as a waste of financial resources and time. A study in Indonesia found imbalance in the governance of the partnership, adapting a top down approach, where priority areas were defined by the multilateral agencies only and were a reflection of their own concern in the governance field, not those of the local people [24].

## Methods

Given the dynamism of partnerships and our intention to explore views of administrative and implementing officers at different levels we chose qualitative methods to achieve a broad and diverse understanding of the working of partnerships in the SMC program in Botswana.

### Research sites

There were three research sites based on the location of the different partners at national and district level. National Leading officers for the major partners, MH and DPs were in Gaborone, the capital city. Local implementing/administrative officers, District Health Management Teams DHMTs were in the other two sites, Mochudi and Hukuntsi villages. These villages were purposefully selected as two villages with contrasting population and geographic sites: the former being highly populated and close to the city where services are easily accessed; and the latter being sparsely populated and in one of the remote areas of the country.

### Participants and recruitment

Groups of participants from national to districts level took part in the study. Although participants at national and district level were not promised anonymity of their organisations, for confidentiality reasons we refer to MH partners as DP1 and DP2. Participants comprised leading officers working for the three partner organizations, MH and its DHMTs, DP1 and DP2. The SMC lead officer in MH introduced the first author to all the partners through a 3 day annual planning and strategy meeting that she was invited to attend in 2012. Observation in the meeting created a platform for the first author to establish rapport, enabling direct contact with leading officers from partner organisations to set interview times. DHMT representatives that attended the 3-day meeting were not gatekeepers at district level; therefore the higher officers at the DHMTs were approached directly using permission from MH. In that way access to the district health officers was granted. The first

author had personal links to both communities, which made it easy to access the participants.

### Data collection

The first author spent approximately 18 months in Botswana between December 2012 and August 2015 collecting data and observing the different phases of the SMC partnership. The research question set out to explore the functioning and contextual interaction of the SMC partnership in Botswana. The research used three qualitative research methods: observation, one-on-one interviews and focus group discussions (FDG). Non-participant observation was used during the partners' 2012 planning meeting since the researcher was not allowed to comment but just listen and take notes. Follow-ups were only allowed outside the meeting room where the researcher could have informal conversations with the participants. The 2012 planning meeting informed the research on the fundamental themes to explore within the parameters of the research questions. Data from the meeting influenced the direction of the data collection for the rest of the research project: who to ask what, and where, and also guided the drawing of the interview and FGD guide, as well as the observations guide (adjustments made on the ground). This included topic guides and questions on: the mission of the partnership; leadership of the partnership, partners' resource contribution; partners' roles; general functioning of the partnership and of SMC implementation.

Data were collected through a 3 year period and with great attempt to do it in a cyclic manner (with follow-ups of the same key informants where possible); and following important incidences in the partnership processes. We used an observation guide at the 2012 partners' planning meeting where 30 participants from all three organisations gathered, interview guides for rounds of interviews with key national officers leading the program within each organisation (three lead officers at MH and one from each of the DPs). A total of eight interviews were conducted with the national officers, including three follow-up interviews with one lead MH officer over the years. Three FGDs comprising five to nine participants were carried out with the Mochudi and Hukuntsi DHMT teams respectively, as well as the Mochudi MOVE team. For interviews and FGDs we developed a semi-structured topic guide. We asked questions like; What is the mission of the partnership? What roles do different partners play? What resources do partners contribute?

The range of data collection methods employed generated diverse data and was also a good source of triangulation, linking what is discussed at national level with what took place at district level and on the

ground. All data were collected from December 2012–2015. Data for all three parts of the BMFC theoretical framework, inputs, throughputs and output were covered throughout the period of data collection in a progressive way. For example there were new resources contributed or withdrawn at different times, repetitive activities run throughout the years, negative and positive outputs realised at different phases of the partnership.

### Data analysis

The observation session for the 3-days-review and planning meeting was recorded as detailed written notes following the preference of the participants. All other interviews and focus group discussions were audio recorded with permission from the participants. Three research assistants transcribed the data. In order to ensure accuracy and validate what was transcribed the first author translated all transcribed data from Setswana to English and cross checked those already transcribed in English to verify transcripts against audio recordings. NVivo ten qualitative data management computer software was used to manage and analyse data, hence all data were imported into the software for coding using Attride-Stirling's Thematic Network Analysis [49]. The data analysing team comprised two PhD students as well as the first and second author. The various data sources were analysed connecting different groups of participants. Following Attride-Stirling's [49] stages of data analysis, data were initially read to code topics raised by the participants. Then basic themes were abstracted from the coded sections and grouped into organizing themes, which were then further clustered to global themes. In view of these themes, we reflected on our data to get an understanding of the working of the partnership in question, relating our findings to our research question. In order to strengthen the objectivity of the analysis, the team discussed organizing and global themes to reach a consensus throughout the analysis, ensuring stability and relevance.

### Results

The findings are presented according to the BMCF as our theoretical framework. Four elements of the model being: 1. Input, 2. Throughput and 3. Output and 4. Feedback to mission, form our global themes. Basic and organising themes that emerged from the analysis are presented in Table 2.

#### Input

##### *The partners' mission*

The Government of Botswana has an established national strategy and a framework of operation for all

health initiatives, called the National Strategic Framework (NSF) that is reviewed every 4 years. The NSF comprises all ministries, with MH being the lead ministry; long term development partners like DP1 and DP2; civil society organisations and NGOs; and the private sector. The same development partners were partners in the SMC program. Several officers explained this. An example follows:

*We, the DPs are always in the country. We are here to help with all HIV/AIDS intervention strategies.*  
(Lead officer 5 in Gaborone, during the second round interview).

All partners were clear about their mission: to get HIV negative men of ages 13–49 circumcised in order to reduce HIV infection rate in the country. They were also all working towards a target of circumcising 80 % of HIV negative men by the year 2016, which is 100 000 men in a year. They divided the target between them. The partners were also clear about their commitment to the mission. One DP1 participant explained their commitment towards achieving the mission:

*So we have at best 40 % of the 100 thousand target that is to be covered. At best 40 % of the target is our aim as DP1.*

One DP2 officer at the 3-day meeting added:

*We aim for 25 % of the target...*

Although the MH did not state a percentage they were aiming for within the 80 % target, they explained that their aim was to integrate SMC in the health system nationwide, establishing it as a long term program, not just up to year 2016. The 80 % target by 2016 was defined as a project within the Government's long term program.

##### **Approaches to the mission**

There were two approaches used in implementing SMC in Botswana: The integration of SMC in the whole health system that was locally planned and designed; and the MOVE approach that was externally introduced through DP1, and adopted in 2012 in parallel to integration. At the beginning of SMC implementation between 2007 and 2009 all partners worked together to develop and implement integrating SMC in the whole health system. Lead officer 3 explained:

*Government's long term plan is to integrate SMC into the normal health system. We worked on this with our partners from the beginning.*

**Table 2** Themes emerging form data analysis: Applying the Bergen Model of Collaborative Functioning

Basic themes	Organising themes	Global themes
1. Botswana government HIV National Strategic Framework (NSF) lead by NACA 2. All ministries, development partners CBOs, NGOs and private sector are part of the NSF 3. MH, DP1, DP2 are three main partners in the SMC program 4. DHMT works at district level 5. All partners involved throughout the planning process since 2007 6. All partners target HIV negative men aged 15–49 years to circumcise through SMC 7. All partners aim to have circumcised 80 % of HIV negative men by year 2016	Clear Partner Mission	Input
8. Botswana government integrated circumcision within health services nationwide since 2007 9. DPs introduced MOVE project in 2011 to help government push set target in selected areas	Approaches to the mission	
10. DP1 viewed as a major financial contributor: more monetary funds; sub-constructs companies; built 2 permanent clinics; provides surgery kit; provides mobile clinics and transport 11. DP1 contributes funds and funds medical personnel and transport 12. MH contributes funds; provides health structures nationally; provides medical equipment and transport	Financial Resource Contribution	
13. DPs deployed medical staff to Government health centers to do SMC 14. DPs deployed staff moved to form dedicated MOVE teams 15. DP1 brings in special scientific expertise 16. MH's avails its medical staff nationally to participate in SMC	Partner Resource Contribution	
17. MH as owner, coordinator, chair, provider of space and financing 18. DP1 as technical advisor, expert, advertising, mobilisation, provider of clinics structures and main donor 19. DP2 as donor, implementer and community mobiliser	Clear Partner Roles	Throughput
20. Partners developed short term and long term communication strategies; training manuals and reporting system together	Communication	
21. Development partners use different reporting systems than MH's 22. Development partners do not report to MH systematically 23. Reporting between partners was not transparent 24. Development partners reported directly to their international donors 25. The Government reported all donor funds usage to OECD 26. Way of accountability give blurry structure	Input Interaction	
<i>Financial resources</i> 27. More finances spent but less numbers of circumcised men causes conflict 28. MH's financial contribution queried to be not transparent 29. Ownership seems linked to finance contribution 30. MH's ownership of the program is questioned 31. MH sees structures as big contribution		
<i>In-kind resources</i> 32. Donors keep sending more equipment for circumcision 33. Lots of equipment is wasted 34. There is inconsistency on balance sheet for number of circumcision instruments, wasted and remaining 35. MH is blamed for not taking care of such equipment		
<i>Partner resources</i> 36. MH viewed as a weak coordinator at times 37. MH ownership is queried 38. Government health centers is blamed to be participating little in circumcision 39. MH feels MOVE strategy naturally creates dependency on government health staff 40. Districts prioritised attending to ill patients than circumcision 41. DHMTs blamed for not prioritising SMC 42. Health centers viewed SMC as the DPs' program		
43. Partners consulted with the national traditional leadership at planning stage 44. MH is seen as a leader and owner 45. There is not enough support from the highest national leadership to influence men for circumcision 46. MH's placements of coordination leadership is queried 47. DHMTs are said to not take leadership role accordingly	Leadership	
48. DPs blame MH for setting the target high 49. DPs blame MH for not putting enough effort and resources to push the set target 50. MH is frustrated about the mathematical model used by WHO to set country target 51. Unattainable target is seen as the highest risk in program implementation 51. MH and DPs express frustration that the 80 % target is not attained regardless of their massive efforts 51. DPs report pressure from donors on reconciling dollar to numbers	Mission threatened	Feedback mission
52. DPs indicate that the donors will cut down on the funds 53. International donors reduce funding support to Botswana		
54. DP2 pulls away its employed doctors gradually from 2013 and leaves a gap in implementation 55. DP1 pulls away its financial and technical assistance abruptly in 2014 and leaves a gap in implementation	Antagony	Output

Lead officer 1 in round 2 interview explained the integration target per health facility:

*We expect clinics to circumcise one client per day or 5 clients per kilometre through our integration strategy.*

The integration strategy did not circumcise enough men to approach the target yet MH had an obligation to meet target by 2016. The new MOVE project was introduced by DP1 in 2011 to help push target. All partners embraced it and MH viewed it as great help. Lead officer 3 explained:

*....but then this idea of the MOVE project came in in 2011....It was introduced by PEPFAR through DP1. Through move MC is marketed and advertised to get many numbers of men to circumcise at the same time.*

Lead Officer 1 also expressed appreciation of MOVE:

*The Government is not enough alone. We are weak alone...you see? We welcome the development partners to fill in the gaps..., you see... With targets set, Government needs assistance.... We appreciate the MOVE project because there is a lot of good in it; to help us reach the numbers.*

However, MOVE was not covering the whole country so issues of equity were of concern to the MH: In giving the official opening speech at the 3-day meeting, an invited high official commented on the need for demand creation of the program nationwide. He said:

*Government emphasises equity. We need to strive for equity, not just a few districts for the MOVE project but all districts. Circumcision, circumcision, circumcision is our breath.*

#### **Resources**

Resources include financial, capital and staff resources. MH appreciated partner resource contribution in both the integration and MOVE implementation strategies. Lead officer 1 explained:

*Because of challenges of resources we thought the idea of combining resources with DPs was a good one.*

#### **Financial resources**

The DPs contributed financial resources towards achieving the mission. The MH also contributed its national funds and mobilised other international funding support besides DP1 and DP2 partner contributions. Although it was not possible for the first author to access partners' contract agreements, it was communicated clearly that for

MOVE implementation, the DPs contributed massive monetary resources to help push target. DP1 was said to be the main financial contributor. The impact of resource contribution by development partners was experienced even at implementation level. One DHMT officer stated this in an FGD:

*Many people turn up for circumcision when the MOVE teams from the DP1 contractors come. They come with lots of resources you see...last time they were here they brought vehicles which were used to fetch people from settlements around to come here in the hospital for circumcision. They also have lots of staff. We don't, we are overwhelmed with many other duties. Not just circumcision.*

#### **Partner resources (skills)**

Partner resources include skills and other in-kind resources other than money. The MH availed all its health facilities and medical equipment in the whole country to do circumcision. The health facilities and some of the medical equipment were used by the MOVE dedicated teams as well. DP1 provided mobile clinics and constructed two main permanent clinics in the capital city; and brought in 80 Peacecorp Volunteers specifically to push the SMC target. At the time of the data collection in 2012 they were promising 'clinics in the box,' fully equipped mobile trucks. DP2 also gave funding, provided about 30 foreign medical doctors and a number of nurses to do the surgery, and paid community mobilisers to recruit men for circumcision. Lead officer 4 explained further on DP1 contribution:

*So what we bring to the table as DP1 is a level of scientific knowledge that many organisations don't have....Prepex study... but we also bring in experience from other countries on how partnerships work and how coordination can occur and how systems can be built...monitoring and implementing change...that kind of a thing.*

The DPs supported the integration program by deploying staff to government health centers around the country. One of the MH officers explained:

*When we started the integration program, the DPs deployed their staff (seconded doctors and nurses) to government health centers to work with our nurses and doctors in circumcision.*

When MOVE implementation started more doctors were employed by the DPs to form dedicated teams for both static and mobile clinics. Lead officer 1 explained this:

*When they promised dedicated MOVE teams and we know that in Botswana we have skeletal staff.....just the few of us, why would we refuse?*

Additionally, DP1 outsourced contractors, some to do training, one to do marketing and demand creation and others to carry out the surgery. This appeared to be the main difference between integration and MOVE. One MH officer explained:

*When the MOVE idea came in it overpowered the original one. In MOVE, DPs brought in demand creation strategies like adverts on TV and radio, public campaigns, mobile clinics for circumcision and staff to do the job. So we cover many people at a time. Integration is a long term program and is not as fast as MOVE.*

Lead officer 5 explained further on their contribution to bring speed to the project:

*We serve as catalysts to government..basically making it do things faster because we are always focusing on cost effectiveness. We have brought in 30 medical doctors to help move target.*

Lead officer 5 added:

*We provided 30 doctors to train other staff and to do surgery in dedicated clinics.*

The government staff that was already employed continued to participate in SMC through the integrated program with the health system.

#### **Throughput**

The context for partnership operation comprises maintenance/administrative tasks which in this case included development of communication strategies, training and reporting systems; and production task which are implementation activities like periodic funds injection, equipment purchases, demand creation activities and the surgery (circumcision). As the inputs interact during production and maintenance activities through time, roles and power struggles are manifested. This is shaped by the interaction of roles, input, leadership and communication. There can be both positive and negative experiences as the partners interact to work together. We therefore present such interaction, some of which overlap.

#### **Clear partner roles (roles/structure)**

All officers interviewed defined the partners' roles the same way: MH as owner, coordinator, provider of

structures and equipment, staff for the integration program and financing; DP1 as an in-country donor, technical advisor, expertise provider, advertising, mobilisation, provider of clinics structures; DP2 as an in country donor, organisation and provider of implementing staff for the MOVE program. Although there was manifestation of power struggle during maintenance and production activities, the roles did not change, for example government still maintained its role as the custodian and owner of the program. See Table 1 for roles.

#### **Communication**

Strategic documents were developed together at national level. All partner representatives explained that they had worked together as partners from the inception of the program in terms of strategizing on the implementation approach and developing strategic documents: communication strategies, monitoring and evaluation plan 2010–2016 and the reporting systems. Lead officer 1 explained this:

*Year 2007–2008 was a planning period. As the other presenter stated all operational documents were developed then. We formulated these together....The integration of SMC in all health centres started in 2009.*

Lead officer 1 made the hierarchy of the partnership clear:

*We, MH, started the SMC project as "parental states"<sup>1</sup> but with the partners participating. We started with trainings, formulation of strategies and so on. Development Partners have always taken part in SMC from the beginning with government leading.*

Another of the DP2 participating officers clarified that the documents were developed in consultation with the traditional leadership at national level. He said:

*Remember we got guidance from the House of Chiefs on what circumcision is called in Setswana [Botswana national language]. We tried to engage those who could help in proper language.*

The government clinicians on the ground were also involved early in the program. They took part in developing the SMC curriculum. One officer representing DP1 explained as he argued that doctors need to be involved more:

*So you see..., when we were developing the curriculum that time we were getting a lot of input from the clinicians as to how we can improve it.*



Whereas at planning stage the partners agreed on the same reporting systems and communication strategies, there seemed to be divisions and differences at implementation level. There were queries that the DPs were using their own separate manuals for implementation and own reporting system different from the initial ones formulated. One officer queried this during the 3-day meeting:

*We need to fast track the issue of the different training manuals so that we have a document that is standardized. The manuals between MH and DPs have differences here and there.... we need something standardised.*

MH further explained that the DPs were not reporting consistently to them as the coordinating organisation in the partnership. DPs admitted that they were using different reporting systems.

#### **Input interaction**

##### **Partner resources (staff)**

The partners discussed and worked on strategies for working together. Staff resources were a challenge to government, therefore they appreciated that partners could provide staff to support the integration program. Lead officer 1 said:

*Our districts had a challenge to take circumcision in at a massive scale. So it was good for us that the DPs seconded their staff to the health centers.*

However, the deployed DP staff queried that they were assigned other duties in government health centers and this interfered with strengthening the SMC program. It seems the MOVE project helped address these queries and maximised focus on the mission.

Lead officer 5 explained how they solved the problem:

*Forming dedicated teams was the best arrangement for the MOVE project so that we can focus and push target.*

Even though the MOVE teams were separated to work alone, resources continued to be shared to support the mission. Government supported MOVE teams with vehicles and other medical equipment. However, during FGDs all DHMT staff expressed that there is continuous tension between MOVE staff and government health management staff on provision of resources. One said:

*You know the MOVE team sometimes needs vehicles for mobilisation of other activities. But we cannot*

*always provide them with vehicles. Most of the time our transport is committed to other health duties, transporting sick patients...and then we are seen as not supportive of SMC.*

DPs also complained about lack of commitment by DHMT staff, which they called “dependency.” The “dependency” seemed to be caused by the fact that the health personnel in the clinics did not regard SMC as a “priority” program compared to ailing patients. Several officers have reiterated this throughout the years, both at national and DHMT levels. One said:

*SMC is not a priority within Government clinics. When there is a diarrhoea outbreak or a bleeding patient or something, that is what is given attention. SMC clients are made to wait or return.*

Another said:

*If you go to the district these days the districts are not seeing SMC as anything.*

Following up this issue at district level with the DHMTs, many expressed the same thing in both group discussions and FGDs. An example follows:

*You see, it is not that we are not taking SMC serious. This is a prevention program. But sick patients are a priority to us. Also, we are understaffed in clinics and so we have to prioritise...but we try.*

A DPI officer added:

*There is evidence that when DHMT coordination is leading and participating, things move, but when it is not there, little moves. We need a way to make DHMT own the program.*

DPs also questioned the placement of regional coordinators within MH, suggesting that the north coordinator's office should move to the north. However MH argued that this would not work efficiently for national coordination. One MH officer responded to this:

*This is not the first time I hear of this suggestion. You wouldn't be happy if I do that to your office.*

There was no query on the DPs' staff performance. However, some DPs staff roles were not clear to MH. When one of the leading officers in MH was asked about Peace-Corp volunteers he answered:

*About Peace-Corp I do not know what they are doing. I really don't know if they can make any impact when Batswana youth are failing.*

A year following these interviews, the *Peace-Corp* volunteers had stopped working for SMC. Although none of the officers at national or district level made any comment about the MOVE team doctors, they were all foreign employees.

#### **Financial and technical resources**

MH appreciated the massive financial resource contribution by DPs regardless of reported delays to fulfil promised funds on time. However the high level of funding gave the partner a wedge to question issues of ownership, defining a blurred relationship between partners. DPs queried that they contributed more money to SMC than government and that they were transparent about what they gave but MH was not. Lead officer 5 queried lack of transparency from MH:

*The Government is supposed to govern... You see now we say DP1 brings so much money to the program, DP2 has so much money... The Government keeps quite, that's why we are asking can the Government tell us what its budget is... This is one question I have never gotten an answer for.*

The conversation below between two officers at the 3-day meeting shows more questioning on government's level of contribution of financial resources.

Lead officer 1:

*So, in terms of funding circumcision, the Government of Botswana has money. The Government creates its funding pot from all over, I cannot exhaust the list. For example 19 million pula is projected to come from (an international organisation mentioned).*

Lead officer 4:

*How does Government make its plan then? Is it donors first, then Government.*

Lead officer 1:

*You are supporting me. Don't ask me what I have, bring what you have....The Government provides all clinic structures, we provide staff, and we provide equipment.*

MH further explained that besides external support government gives out funds from its own internal

budget. MH also asked the meeting participants to be aware that government has offered infrastructure, equipment and its medical staff for implementation of SMC. Contrary to resources as key to SMC implementation, several officers from DHMTs reported that even where MOVE brought lots of resources, men still showed resistance. This was explained more even in later interviews (round 2 and 3) and also witnessed at the MOVE campaigns. One DHMT officer said:

*I do not think the main issue should be resources only as you see it. You know even during large MOVE campaigns here in Francistown [second largest city] where we have all resources in place men come to listen in quite large numbers we still have a few turning up to circumcise.*

Whereas DPs felt they were using more resources yet getting poor results and whereas there were few numbers of men circumcising than expected, external donors still spent more money on supplying circumcision equipment (kits). In her presentation, one officer from MH reported that there was wastage of equipment in the clinics because the numbers turning up for circumcision does not match the massive number of equipment purchased. She reported:

*...78 000 kits were bought and given out; 33 000 kits were used therefore 45 000 remain. But only 25 000 were accounted for... This means 20 000 kits are missing or wasted. Hundreds of kits are sent to districts yet only a few SMCs are done in a month. We overestimated numbers.*

Lead officer 4 responded to this presentation with concern:

*This exact issue is the same thing we are going to be nailed about as we account to the ambassador and to Washington DC.*

#### **Blurred roles and structure**

Whereas MH was not managing partners' funds and transparency between partners on utilisation of such funds was limited, the MH still had to account for all funds as received country funds to the program. In this way, accountability seemed to be in one direction. MH officer 1 explained the dilemma that the Government faces when reporting OECD, having to act as a parent who protects the partnership:

*When the high office in MH reports to OECD he reports all funding as the Botswana basket. He cannot tell them that most of the donor funds are spent on*

*overheads, paying contracted companies and administration, not on the client, even though this may be true. He has to speak like a parent, in a way that would bring more support in the future.*

The Government has to account for funds without knowing the details of the DPs budgets.

*It is not easy to ask "how much are you paying your Coordinator?" It is an internal thing. That is how it is and that is the life we have to live... We have to account and have to ensure that we are not blamed.*

### **Leadership**

In the 3-day meeting, there was a reflection that the partners appreciated the administrative leadership of the program (officers leading). However, there were queries especially on MH as the owner, host and leader of the program. This is presented under resources above. Ownership is also understood in terms of commitment. During the meeting and the round of interviews, development partners expressed that the levels of commitment to the program differ within the MH's different levels; with high commitment at national level but little commitment at district level. Meanwhile the MH viewed these as teething problems of a new program: Lead officer 2 explained:

*...with a new program you will always experience a challenge in the first 2 years of implementation.*

Another officer saw it as a common problem on vertical programs. During interview 2 in Gaborone, Lead officer 3 said:

*All health programs start as vertical programs and have challenges, but the aim is to see to it that these programs are integrated within the existing system.*

In addition, country leadership is considered important in international partnerships. There were comments of appreciation for the support from some of the Botswana political leaders in high positions. One Member of Parliament was regarded as a champion because he circumcised under SMC and was campaigning for the program in his constituency. Some politicians at community level were also cited as supporting the program. However, commitment of the country leadership was questioned by all three partners. There was a conversation on this issue among all the three partners. One said:

*But in my opinion have you ever seen the high leadership of this country coming out and saying "citizens of Botswana lets circumcise."*

The house laughed at this comment. Lead officer 3 responded:

*Do not mention higher leadership when talking about this program.*

The same officer shared that the higher office at MH is working on getting the influence of the national leadership. Another officer his experience with Members of Parliament:

*The committee we met at parliament said "Our hands are full, consult with the community. Whatever the chiefs say is what the communities do..."*

It seemed that consultation with the high political leadership was done superficially. One officer shared feedback from the House of Chiefs:

*We also talked to the House of Chiefs and they complained that they are not being involved in the program. They said they needed adequate information to articulate issues that are to be addressed.*

Although there was contention on resources and the target partners made an effort to find solutions to the problems. For example, during the 3-day meeting they divided into several groups to discuss how to address the challenge of high 'unachievable' target; different demand creation strategies to recruit more men; how to strengthen DHMTs to be more involved in SMC. Financial tensions were not addressed in the groups. However, the cyclic interviews following the meeting (in 2013 to 2014) not reveal much implementation of the brainstormed ideas.

### **Feedback on the mission**

Feedback on the mission was experienced at different phases of the partnership. As partners met annually they reviewed the mission and strategized on improving their approaches to implementation. However, pressure from donors resulted in the DPs retreating. During the 3-day strategic meeting, the participants assessed risks to the program goal achievement. The 80 % set target was the first thing to be listed as a risk. There were debates around this target with questions as to why MH accepted it while it was not realistic to Botswana setting. It was explained that WHO used mathematical models to calculate the target for Botswana. A sample conversation on the target follows:

*Officer 1: There was pressure of 100 000 not being negotiable or debatable... If these directives are not realistic they have to correct themselves on the way. You cannot achieve by just demanding the plan.*

Officer 2: *Yaah we were being forced to achieve something that is not achievable.*

Officer 1: *...there is an option that we could increase the number of years but maintain the target but this will affect impact. Although the targets are not negotiable, they cannot be reached.... It's a risk.*

Officer 3: *It's even worse that we did not even achieve 50 %... The DPI target was 30 000 but we met only 9 000.*

Nonetheless, partners appreciated their efforts in working on the mission together. They appreciated that the pressure was really from beyond themselves. Lead officer 5 commented:

*My comrades at MH... we are all really doing the best we possibly can but we are being pressurized from above by our superiors.*

The target still had to be reached according to WHO requirements and external donors' expectations. The pressure of expectations fuelled the tension regardless of the partners understanding of the target being unrealistic. There were several complaints from the development partners that MH was not taking the lead in implementation speed as the owner of the program. The integration strategy was blamed to be slow. One officer from DP1 queried:

*...In the integrated sites where there are no development partners, the performance is down.*

This was also revealed in the MH statistical report during presentations at the meeting. The integrated sites had attained just over 4700 men between 2011 and 2012 while the MOVE sites reached over 37,000 men in the same period. Hence 100,000 men were not reached. Whereas partners blamed this on MH for not putting in more financial resources the officers at implementation level had a different view that there were other individualised and community or peer collective reasons why men were not coming for SMC. They appealed that these community reasons should be considered.

#### **The mission threatened**

In 2012, the development partners were already expressing possibilities of withdrawing from the program because of low target achievement. Although MH claimed ownership; it felt like a weakling when partners mentioned possibilities of withdrawing their services. Lead officer 1 expressed:

*You can't wean a baby overnight. You can't do it just like that. It should be a process.*

Lead officer 4 then promised:

*We are not weaning the baby; we are not weaning Government now. So do not worry.*

Lead officer 4 added later in interview round 2:

*We certainly know one of our competitive advantages is money, and that's great but you can throw money out to a problem and it does not solve a problem, which we are learning and that is why we are opting to stop if we are not successful.*

#### **The mission unaccomplished - Partners compelled to pull out (Year 2014)**

The DPs ultimately ceased their services, DP2 withdrew slowly from 2013 till February 2014 and DP1 later in 2014.

The Government seemed frustrated when development partners ceased activities. At the same time it empathised and expressed appreciation of why they pulled away. Lead officer 1 explained in round 3 interview in 2014:

*Yeah I mean we are required to account for every dollar used. They would calculate a certain number of circumcisions to dollars....so the development partners have to account for this..... We reached only about 39 % of the set target in 2012..... It is not their choice to be pulling out. They have pressure from the donors... the donor pulled away... They feel their funds are not used efficiently.*

The departure of the DPs set back the performance of the program to the time it started, without the MOVE project. Additionally this called for more expenses from MH to cover the gaps created by MOVE. The same officer explained:

*Since DP1 pulled out men are coming to the facilities for circumcision but there is not enough staff there to circumcise them. So we are back to square one. We are experiencing the very slow numbers we were experiencing when we started... Government Development partners pulled out from dedicated clinics. Now it is expensive for Government.*

#### **The mission revisited -MH revisits the SMC strategy**

The MH seemed ready to face the reality of true consultation with communities alone. The officer explained:

*We are now back to the basics to tell the truth. We have lost the support of partners as a country. But we are not going to sit back and say VMMC is not possible in Botswana. We are not giving up... We are thinking of addressing these basic issues. Like this year we really want each district to ensure that we are involving the local authorities...*

The officer confessed that they missed important community consultation from the beginning:

*We really missed it. We missed the behavioural issues... and the cultural issues. We should be one in this issue with the tribal leaders such that when I leave here and go to Ramotswa, the chief should not see me as Ministry of Health, but as one with his community, to help the community.....they should be saying we are in this together...*

Although it was not carried out, the development partners had also vocalised the need for true consultation with communities before they pulled away: One of the officers from the 3-day meeting had earlier expressed:

*We need some kind of synergy between what the SMC does and the traditional practices out there.*

Lead officer 1 mentioned deploying youth as one of the issues to be revisited:

*...when you talk about demand creation, we have learnt lessons from MOVE. We now know that we cannot use young people to talk to older men. It doesn't work.*

Other issues raised during discussions on why the target was not reached concern men's fear of pain, peer influences, and the need for women involvement.

## Output

### Additive results

Additive results are things that could have still happened without the partnership. In the findings MH revealed that circumcision had always been part of the services of the Botswana health system, just not offered at a massive scale as the partnership pushed.

### Synergy

Synergy refers to the positive impact or difference made through the partnership that could have otherwise not been achieved. The partnership created a platform for availability of professional scientific skills that resulted in more trained local staff on surgery and program implementation. At resource level, there were added permanent

structures within the health system DP1 constructed two main clinics that could have otherwise not been. The table below reflects that through integration approach alone government would not reach the numbers that MOVE pushed for. The synergy produced can serve as a motivation to reinvest more resources on the program. The government is motivated to rethink strategy even though the partners had pulled away. As quoted above, the government would like to consider involving the community more (Table 3).

The target was to circumcise 100 thousand HIV negative men from 2012 till 2016. Figures confirmed with WHO [50] Progress Brief: Voluntary Medical Male Circumcision for HIV Prevention in 14 priority countries in East and Southern Africa.

### Antagony

Antagony occurs when the partnership is viewed as a waste of time and resources; it is the outcome of partnership dysfunction where costs are more than benefits. When external donors felt they were spending more money but not achieving target they pulled away the DPs from the program without completing the mission.

## Discussion

### Input

The BMCF provides a framework for systematically examining the operationalisation of the partnership for SMC. The mission was to circumcise 80 % of HIV negative men in a 5 year period for HIV prevention. Corbin et al. ([33]: p.52) describe the mission as an "agreed-upon approach ... to address a specific problem." The partners were all working towards accomplishing the target of circumcising 80 % of HIV negative men by 2016. The first approach, integration, was a locally developed idea that they worked on together from the beginning; but the MOVE approach was externally formulated by PEP-FAR as a complete package to implement with little or no flexibility. Concerning inputs MH contributed finance, health structures and medical equipment, and availed its medical staff for implementation. Both the development partners contributed human resources for capacity

**Table 3** Showing figures achieved through partnership

Year	Numbers reached
2007–2009	planning period
2009	5424 with integration only
2010	5773 with integration only
2011	14,661 with integration and MOVE
2012	38,005 with integration and MOVE
2013	46,793 with integration and MOVE
2014	30,033 with integration and MOVE

building and implementation of the program. The bulk of financial resources were reported to come from the DPs. Several authors on partnerships caution that resources offered by the North to the South deserve appreciation since they help bring change to some extent, regardless of being an instrument of control [4, 13, 24, 51].

The target which defined the mission caused challenges that ran through all components of partnership functioning, and caused failure to achieve the same. The target was not locally defined to include local realities, but was calculated using mathematical models and recommended by WHO. Waage et al. [35] recommend that it is important to ensure that targets that are set internationally are easy to translate nationally. All the three partners queried the target of circumcising 100 000 men per year. The expectation that the recipient would act in a certain predictable way was the greatest pit-fall of the mission [17]. Expected reciprocal response from communities, in the form of massive numbers circumcising did not materialise for different local reasons (see [52]). This is similar to what occurred with the millennium development goals that believe in creating targets to motivate but actually undermine the mission [35]. Respondents to Sjostedt's study on aid effectiveness assessing NGOs using three different aid modalities in Tanzania, Cambodia and Zanzibar "...voiced concerns about whether or not the strict focus on results—and especially on reporting them—in fact channeled aid into easily measurable activities at the expense of more complex and long-term processes with potentially higher, but less easily measured, impacts." ([36], p153). It is acknowledged that partners made strategic efforts to push the target but the same efforts also created conflict. For example, deployment of DPs' staff to Government health centers and later separating them to form MOVE teams was appreciated as creating focus, yet also blamed for creating Government's dependency on DPs. DHMTs' priorities were ill patients. Waage et al. [35] observe that the focus on target rather than broader goals has contributed to countries distancing themselves from a global agenda that is seen as irrelevant in their particular development situation.

### Throughput

The functioning of the partnership is revealed through communication, input interaction, leadership, and partner roles. Each of the four elements shaping the collaborative context worked well at some stage in the partnership, but turned to be a source of contention through time. Although there were tensions between the in-country partners, they were working together in strategising to address some challenges of the partnership and implementation. Pressure from external donors undermined such efforts. Firstly, there was cooperation and agreement

in the planning process where common implementation and reporting strategy were developed. However this did not live up to planned ideals at implementation level as DPs used different training tools, report tools and reported inconsistently to MH. Communication became a problem. Although in their studies, Weiss and colleagues [44] did not find that partner involvement challenges had any effect on synergy, they argue that less partner involvement in agreed strategies and goals, as well as lack of cooperation reduces synergy [44].

Secondly, the leadership of the program was clearly seen as MH's. MH claimed and was referred to as a chair, coordinator and owner. Complementary to the leadership, DPs viewed themselves as 'catalysts' to help the government speed up the SMC scale up and as partners adding to resources necessary for successful implementation. However, the MH leadership role was questioned and contested through time. When MOVE superseded the integration approach, who owned and led the project became confused. WHO makes it clear that ownership of programs should be through participation of national leadership [5, 53]. The highest leadership of the country was criticized for not supporting the program as its "face" [24]. Members of Parliament reported being busy and having no capacity to participate. However, it is the political leadership that signed the MDGs and are rightfully challenged to show high participation [53]. Kenworthy [54] argues that recipient countries turn to endorse external new and exciting programs that they may not have the capacity to 'own' and sustain. It is very obvious that human resources for health in Botswana, although a factor beyond this partnership, need addressing. Human health resources is critical in combating all health challenges therefore national policies as well as global governance should consider that developing countries need additional health workers to manage workload, since the workforce is already overloaded with multiple tasks [55, 56].

He adds that the fancy leadership/ownership phrases given the recipient countries are just a facade to cover the continuous exercise of power by the international financial agencies. Additionally DPs questioned the placement of MH national coordinators, suggesting change. They also queried DHMTs' participation and leadership, questioning their priorities. Power and control of how things should work is in the nature of Northern partners [24]. In fact, DP1 confirmed that they brought in training on how the partnership and coordination should work. This goes with Abrahamsen's observation that "...western countries and the institution of global governance still hold considerable sway over African states due primarily to their aid dependency and general economic weakness" [10]. Even though recipient countries are placed at the driver's seat for driving the MDGs, critics

observe that the recommended health programs often clash with in-country priorities [35].

Thirdly, there seemed to be clear roles and structure of the partnership. However the same also proved to be problematic. Ownership is defined by different leadership roles. Although all partners identified MH as owner, in practice ownership was measured according to the level of financial contribution. The DPs' high level of funding mystified ownership and caused tension. Corbin et al. [33] contend that symbolic funding, (e.g. MH's contribution in terms of health structures and own employed staff) should have been seen as in-kind financial contribution [33]. However the same authors find this as a difficult issue because converting the cost of local in-kind contribution to dollars can be problematic. International donors (who were not 'leading' the partnership) controlled use of 'donated' financial resources. Whereas there seemed to be little transparency on the DPs' use of funds, MH as 'owner' had to account for all program funds to OECD. MH also had to account for the imbalance in the usage of surgical equipment. The structure of the partnership seemed lopsided. In fact, as in most North-South partnerships, accountability seems to always be one-sided [13, 35]. This could also be explained by an observation of Corbin and Mittelmark [3] that partners may choose the route of blurry accountability if they experience that working mutually absorbs substantial resources and that consensus building procedures take a long time.

#### **Output and feed back to mission**

Our findings show all levels of output in the BMFC: additive results through a revelation that MC was not a new thing that was brought in by the partnership, but that it has always been one of the health services given to the public. The partnership attained synergistic outcome as well, that is  $2 + 2 = 5$ , where more results achieved through the partnership at integration and MOVE phases, which could have never been without the partnership. Types of synergy like shared knowledge between partners, shared resources and problem solving were evident in the partnership [43]. There was continued feedback into the mission throughout the through-process as synergistic and antagonistic results were realised. Partners met annually to reflect on results and strategise on solutions. When the integration approach did not achieve sufficient output, in 2011 the partners agreed to strengthen the program by bringing in the MOVE approach. Although greater output was achieved through MOVE the contention on not meeting the target in 2012 resulted in antagonism (DPs cutting down the financial and partners resources in 2013 and finally withdrawing in 2014). It is observed that external donors (PEPFAR and Bill and Melinda Gates Foundation) had

greater influence on the functioning of the in-country partnership as vertical interaction (feedback) with them was demanded. This is a confirmation of the power of those holding the purse, the North, being greater than those with a begging bowl, the South [10]. The result was discord between in-country partners, with accusations on wasting time and money. Pressure from the Northern donors caused the DPs to withdraw from the partnership and the cost was a drastic decline in numbers of men coming for MC. The global context in which HIV/AIDS programs operate tends to be prescriptive, undermining locally initiated strategies and creating dependency [57]. Although the global health apparatus has an important context for developing interventions and mobilising resources for support, it cannot be successful without local participation. This implies that neither global nor national policies for health programs should be treated as absolute, but there has to be a genuine integration of indigenous and international strategies that if applied, could salvage massive resources that continue being lost as a result of vertical control [57, 58]. Also international organisations, like the DPs in this case, need to be given agency such that they play an advisory role to their international donors informing them of realities on the ground that cannot be overlooked.

According to the BMFC model antagonism feeds in and out the collaborative process of the partnership and can be used positively to improve progress. Corbin et al. [33] argue that antagonism can create an opportunity for partners to reflect on what went wrong and what could have been done differently. In this case, although left alone, MH was now reconsidering its whole approach, learning from the partnership mistakes and preparing to revisit and improve its integration approach to implementation. In fact, there has been debates over time on whether vertical programmes that attend to one problem at a time are effective or whether all health problems should be assimilated into the larger primary health care system, as the integration approach attempted [59]. The challenge of cost effectiveness is still to be addressed [59].

#### **Limitations**

Whereas all partner organisations were given equal opportunities to participate in the research, the MH was more forthcoming in allowing several officers to be interviewed. MH was also more available for interviews at different phases as the partnership evolved. In that way some partners have not had a chance to give their full views and experiences at different phases of the partnership. However, each organisation had given its frank overall view of the partnership in the initial 3-day planning meeting that the researcher attended, and in immediate second interviews. Although it was evident that most decisions affecting implementation and partnership

relations had an influence of the external donors' pressures the first author was not able to access them for direct interviews. Systematic reflexivity was applied throughout the data collection and analysis stages. The results cannot be generalised to all countries, however they give important insightful lessons on partnership functioning for aspects that can be embraced and those that can be avoided. This paper does not look at factors that have led to particular outcomes, especially antagonism or the nature of antagonism, and this will be followed.

## Conclusion

This paper used a systems model to explore the functioning of the SMC partnership in Botswana. It has assessed different achievements and challenges that the partnership was facing. We conclude that external influences that come from the unseen international donors influenced the working of the in-country partnership, unfortunately crippling it from resolving implementation challenges as experienced within the context of partnership functioning. The experience of SMC partnership in Botswana showed that key influences on the success or failure of partnerships are financial resources, "ownership" and the target. The very mechanisms used for accountability by the Paris Declaration are sabotaged by the same global context where the exercise of power and financial leverage by international donors reign. A combination of inputs by partners brought progress towards achieving set program goals. However, prioritising externally formulated programs and lack of appreciation for local symbolic funding undermined local efforts and gave blurriness in leadership and ownership of the program. Pressure to meet the expectations of the international donors caused tension and challenges between the in-country partners and caused the DPs to retreat, and not pursue the mission further. Externally formulated goals and targets, as well as subsequent expectations from external donors placed the functioning and contextual interaction of the partnership at risk. Tensions in achieving the target, financial and in-kind resources and ownership queries resulted in DPs withdrawing before accomplishing the mission. All in all the key contribution of the study to the BMFC theory is that the functioning of the visible in-country partnership is significantly influenced by the less visible global context such as the target setters and donors.

## Endnotes

<sup>1</sup>"Parental states" is not proper English, but is a direct translation from Setswana language phrase used by Government officers to show that the Government is the leader/the host /he owner/the one responsible for the program and other partners fall under their authority. That is why one of the officers referred to Government as a "parent" in one of the quotations below.

## Abbreviations

ACHAP, Africa Comprehensive HIV/AIDS Partnership; BINAPS, Botswana National HIV/AIDS Prevention Support Project; CDC, Centers for Disease Control and Prevention; DHMT, District Health Management Team; MC, Medical Circumcision; MH, Ministry of Health; MOVE, Models for Optimizing Volume and Efficiency; OECD, Organization for Economic Cooperation and Development; PEPFAR, President's Emergency Plan for AIDS Relief; PSI, Population Services International; SMC, Safe Male Circumcision; USAID, United States Agency for International Development; VMMC, Voluntary Medical Male Circumcision

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## Availability of data and materials

Not applicable.

## Authors' contributions

MK designed and carried out the research, analysed and interpreted the results, carried out the literature review and drafted the manuscript. MD advised in the design of the research, guided in the interpretation of the results, recommended literature and edited the manuscript. MBM contributed extensively in interpreting data and the application of the theoretical framework, revising critical concepts and editing manuscript up to final draft. All authors read and approved the final manuscript.

## Competing interests

The authors declare that they have no competing interests.

## Consent for publication

All authors have approved the manuscript for submission.

## Ethics approval and consent to participate

This study was granted ethical clearance by the Norwegian Social Sciences Data Services (NSD) and the Ministry of Health (MH) in Botswana. MH granted two types of permits: one as a general acceptance of the topic and the other being permission to interview health workers at both Ministry level, district level and officers of development partners. Signed informed consent was obtained from individuals and focus group participants as well as the observed participants. The authors have deliberately been vague in labelling participants in the findings chapter to protect anonymity of officers interviewed. Although the participants seemed free in expressing their views in the presence of the first author, there was still limited openness in discussing sensitive issues.

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## References

1. Ministry of Health. Safe male circumcision: additional strategy for HIV prevention: a national strategy. Gaborone: Government of Botswana; 2010.
2. WHO. Progress in scale-up of male circumcision for HIV prevention in eastern and Southern Africa: focus on service delivery. Switzerland: WHO; 2011.
3. Corbin JH, Mittelman MB. Partnership lessons from the Global programme for health promotion effectiveness: a case study. *Health Promot Int*. 2008;23(4):365–71.
4. Fowler A. Introduction beyond partnership: getting real about NGO relationships in the aid system. *IDS Bull*. 2000;31(3):1–13.
5. WHO/UNAIDS. New data on male circumcision and HIV prevention: policy and programme implications. Geneva: World Health Organisation; 2007.
6. Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *Lancet*. 2007;369:643–56.
7. Gray RH, Kigozi G, Serwadda D, Makumbi F, Waiya S, Nalugoda F, et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet*. 2007;369(9562):657–66.



8. Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLoS Med.* 2005;2(11):e298.
9. WHO. Global Health Observatory (GHO) data: HIV/AIDS prevalence in sub-Saharan Africa. Access 16 Apr 2016. Retrieved from: [http://www.who.int/gho/urban\\_health/outcomes/hiv\\_prevalence/en/](http://www.who.int/gho/urban_health/outcomes/hiv_prevalence/en/). WHO; 2016.
10. Abrahamsen R. The power of partnerships in global governance. *Third World Q.* 2006;25(8):1453–67.
11. Lister S. Power in partnership? An analysis of an NGO's relationships with its partners. *J Int Dev.* 2000;12(2):227.
12. Ashman D. Strengthening North-South partnerships for sustainable development. *Nonprof Volunt Sec Q.* 2001;30(1):74–98.
13. Johnson H, Wilson G. North-South/South-North partnerships: closing the 'mutuality gap'. *Public Adm Dev.* 2006;26(1):71–80.
14. Droop J, Iseman P, Mlalazi B. Paris declaration on aid effectiveness: study of existing mechanisms to promote Mutual Accountability (MA) between donors and partner countries at the international level: a study report. 2008.
15. OECD. The Paris Declaration on AID Effectiveness: Five Principles for Smart AID. Access 07 Apr 2016. Retrieved from: [www.oecd.org/dac/effectiveness/45827300.pdf](http://www.oecd.org/dac/effectiveness/45827300.pdf). 2005.
16. Fowler AF. Authentic NGDO partnerships in the new policy agenda for international aid: Dead end or light ahead? *Dev Change.* 1998;29(1):137–59.
17. Maxwell S, Riddell R. Conditionality or contract: perspectives on partnership for development. *J Int Dev.* 1998;10:257–68.
18. Mawdsley E, Savage L, Kim SM. A 'post-aid world'? Paradigm shift in foreign aid and development cooperation at the 2011 Busan high level forum. *Geogr J.* 2014;180(1):27–38.
19. UNAIDS. Report on the global AIDS epidemic. Geneva: UNAIDS; 2010.
20. Esser DE. Elusive accountabilities in the HIV scale-up: 'Ownership' as a functional tautology. *Glob Public Health.* 2014;9(1-2):43–56.
21. Resch S, Ryckman T, Hecht R. Funding AIDS programmes in the era of shared responsibility: an analysis of domestic spending in 12 low-income and middle-income countries. *Lancet Glob Health.* 2015;3(1):52–61.
22. Harrison T. The role of contestation in NGO partnerships. *J Int Dev.* 2007;19(3):389–400.
23. Binka F. Editorial: North-South research collaborations: a move towards a true partnership? *Tropical Med Int Health.* 2005;10(3):207–9.
24. Crawford G. Partnership or power? Deconstructing the partnership for governance reform in Indonesia. *Third World Q.* 2003;24(1):139–59.
25. McFalls L. Benevolent dictatorship: the formal logic of humanitarian government. In: Fassin D, Pandolfi M, Fassin D, Pandolfi M, editors. *Contemporary states of emergency: the politics of military and humanitarian interventions*. New York: Zone Books; 2010.
26. Gaillard JF. North-South research partnership: is collaboration possible between unequal partners? *Knowl Policy.* 1994;7(2):31–63.
27. Fernando SUH. Uneasy encounters: relationships between Dutch donors and Sri Lankan NGOs. Amsterdam: University of Amsterdam; 2007.
28. Kelly E, Doyle V, Weakliam D, Schönemann Y. A rapid evidence review on the effectiveness of institutional health partnerships. *Glob Health.* 2015;11(1):1.
29. Yassi A, Zungu M, Spiegel JM, Kistnasamy B, Lockhart K, Jones D, et al. Protecting health workers from infectious disease transmission: an exploration of a Canadian-South African partnership of partnerships. *Glob Health.* 2016;12(1):1.
30. Murphy J, Hatfield J, Afsana K, Neufeld V. Making a commitment to ethics in Global Health Research Partnerships: a practical tool to support ethical practice. *J Bioethical Inq.* 2015;12(1):137–46.
31. Holmarsdottir HB, Desai Z, Botha LR, Breidlid A, Bastien S, Mukoma W, et al. COMPARE forum: the idea of North-South and South-South collaboration. *Compare: A J Comparative Int Dev.* 2013;43(2):265–86.
32. Corbin JH, Mittelmark MB, Lie GT. Scaling-up and rooting-down: a case study of North-South partnerships for health from Tanzania. *Glob Health Action.* 2012;5:18369.
33. Corbin JH, Mittelmark MB, Lie GT. Mapping synergy and antagonism in North-South partnerships for health: a case study of the Tanzanian women's NGO KIWAKKUKI. *Health Promot Int.* 2013;28(1):51–60.
34. Corbin JH, Mittelmark MB, Lie GT. Grassroots volunteers in context: rewarding and adverse experiences of local women working on HIV and AIDS in Kilimanjaro, Tanzania. *Glob Health Promot.* 2015 [Epub ahead of print].
35. Waage J, Banerji R, Campbell O, Chirwa E, Collender G, Dieltiens V, et al. The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting after 2015. *Lancet.* 2010;376(9745):991–1023.
36. Sjöstedt M. Aid effectiveness and the Paris declaration: a mismatch between ownership and results-based management? *Public Adm Dev.* 2013;33:143–55.
37. UNAIDS. Joint United Nations Programme on HIV/AIDS: HIV investments. Geneva: UNAIDS; 2010.
38. UNAIDS. The gap report. Geneva: UNAIDS; 2014.
39. Seckinelgin H. A global disease and its governance: HIV/AIDS in sub-Saharan Africa and the agency of NGOs. *Glob Governance: A Rev Multilateralism Int Org.* 2005;11(3):351–68.
40. Nicole BE, Barry C, Min HL, Wonhyuk L, Mukesh K. Post-2015 Development agenda: goals, targets and indicators: special report. Retrieved from Waterloo Canada; 2012.
41. Fukuda-Parr S, Yamin AE, Greenstein J. The power of numbers: a critical review of millennium development goal targets for human development and human rights. *J Hum Dev Capabilities.* 2013;15(2-3):105–17.
42. Attaran A. An immeasurable crisis? A criticism of the millennium development goals and why they cannot be measured. *PLoS Med.* 2005;2(10):e318.
43. Jones J, Barry MM. Exploring the relationship between synergy and partnership functioning factors in health promotion partnerships. *Health Promot Int.* 2011;26(4):408–20.
44. Weiss ES, Anderson RM, Lasker RD. Making the most of collaboration: exploring the relationship between partnership synergy and partnership functioning. *Health Educ Behav.* 2002;29(6):683–98.
45. Oni G, Fatusi A, Tsui A, Enqueslassie F, Ojengbode O, Agbenyega T, et al. Strengthening public health education in population and reproductive health through an innovative academic partnership in Africa: The Gates partners experience. *Glob Public Health.* 2011;6(2):193–209.
46. Bailey F, Dolan AM. The meaning of partnership in development: lessons for development education. *Policy Pract-A Dev Educ Rev.* 2011;13(Autumn):30–48.
47. WHO. Global uptake on the health sector response to HIV. Geneva: World Health Organization; 2014.
48. NACA. The Second Botswana National Strategic Framework for HIV and AIDS 2010–2016. Gaborone; 2009.
49. Attridge-Stirling J. Thematic networks: an analytic tool for qualitative research. *Qual Res.* 2001;1(3):385–405.
50. WHO. Voluntary medical male circumcision for HIV prevention in 14 priority countries in East and Southern Africa Progress brief access date 12 March 2016. Retrieved from <http://www.who.int/hiv/pub/malecircumcision/brief2015/en/>. 2015.
51. Bradley M. On the agenda: North-South research partnerships and agenda-setting processes. *Dev Pract.* 2008;18(6):673–85.
52. Katsi M, Daniel M. Safe male circumcision in Botswana: tension between traditional practices and biomedical marketing. *Glob Public Health.* 2015;10(5-6):739–56.
53. UN. The State of the Global Partnership for Development. New York: United Nations; 2014.
54. Kenworthy NJ. Participation, decentralisation and déjà vu: Remaking democracy in response to AIDS? *Glob Public Health.* 2014;9(1-2):25–42.
55. Chen L, Evans T, Anand S, Boufford JJ, Brown H, Chowdhury M, et al. Human resources for health: overcoming the crisis. *Lancet.* 2004;364(9449):1984–90.
56. Anand S, Bärnighausen T. Human resources and health outcomes: cross-country econometric study. *Lancet.* 2004;364(9445):1603–9.
57. Campbell C, Cornish F, Skovdal M. Local pain, global prescriptions? Using scale to analyse the globalisation of the HIV/AIDS response. *Health Place.* 2012;18(3):447–52.
58. Seckinelgin H. *International politics of HIV/AIDS: Global disease - local pain*. London: Routledge; 2008.
59. Mills A. Vertical vs horizontal health programmes in Africa: idealism, pragmatism, resources and efficiency. *Soc Sci Med.* 1983;17(24):1971–81.







## Safe male circumcision in Botswana: Tension between traditional practices and biomedical marketing

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Botswana has been running Safe Male Circumcision (SMC) since 2009 and has not yet met its target. Donors like the US Centers for Disease Control and Prevention and Africa Comprehensive HIV/AIDS Partnership (funded by the Gates Foundation) in collaboration with Botswana's Ministry of Health have invested much to encourage HIV-negative men to circumcise. Demand creation strategies make use of media and celebrities. The objective of this paper is to explore responses to SMC in relation to circumcision as part of traditional initiation practices. More specifically, we present the views of two communities in Botswana on SMC consultation processes, implementation procedures and campaign strategies. The methods used include participant observation, in-depth interviews with key stakeholders (donors, implementers and Ministry officials), community leaders and men in the community. We observe that consultation with traditional leaders was done in a seemingly superficial, non-participatory manner. While SMC implementers reported pressure to deliver numbers to the World Health Organization, traditional leaders promoted circumcision through their routine traditional initiation ceremonies at breaks of two-year intervals. There were conflicting views on public SMC demand creation campaigns in relation to the traditional secrecy of circumcision. In conclusion, initial cooperation of local chiefs and elders turned into resistance.

**Keywords:** voluntary medical male circumcision; traditional initiation; biomedical interventions; cultural practices

### Introduction

Voluntary medical male circumcision (VMMC) is esteemed by UNAIDS and World Health Organization (WHO) as a great contribution towards the reduction of HIV infections. The motivation to use VMMC for HIV prevention originates from three large-scale randomised control trials (RCTs) in Rakai, Uganda; Kisumu, Kenya and Orange Farm, South Africa which concluded that VMMC reduces the risk of men acquiring HIV through vaginal sex by 50–60%, is safe and has potential to give lifelong benefits (Avert et al., 2005; Bailey et al., 2007; Gray et al., 2007). WHO made policy recommendations that countries with high HIV prevalence (specifically African countries) and low prevalence of male circumcision (MC) scale up VMMC as a priority in HIV prevention (WHO, 2007). While critics note hastiness in pushing to implement VMMC, the very energetic response by WHO and UNAIDS demonstrates the motivation and deep desire to control this longstanding pandemic (Dowsett & Couch, 2007). However, VMMC adds

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to the number of HIV/AIDS strategic programmes that are not initiated locally but are negotiated into African countries by external bodies (UNAIDS, 2010).

Botswana is included among the 14 countries of southern and eastern Africa that follow the WHO recommendations on the implementation of VMMC (Ministry of Health, 2010; UNAIDS, 2010). After initial reports of a positive response in terms of numbers of males being circumcised (UNAIDS, 2010) subsequent reports by WHO and UNAIDS show that, although Kenya and the Gambella region in Ethiopia have achieved over 85% of their targets, most countries are far from meeting their targets for 2016 (WHO, 2014). A qualitative study done by USAID in the Turkana county of Kenya revealed that younger and urban men spoke of increasing acceptance of circumcision, while older men were resistant to accept it because of cultural issues (Macintyre et al., 2013). The social and cultural context in the countries implementing VMMC might contribute to the reasons why targets are not being met. Very little research has been carried out to explore communities' views on VMMC or to examine tensions between existing social and cultural MC practices and the introduction of biomedical MC.

The objective of this paper is to explore responses to VMMC in relation to MC as part of traditional initiation practices in Botswana. More specifically, we present the views of two communities (with contrasting cultural views on circumcision) on the VMMC consultation and implementation procedures, and campaign strategies.

### ***Biomedical marketing***

Social marketing is increasingly used in public health to promote behaviour change (Grier & Bryant, 2005) and has been widely used in the promotion of condom use for HIV prevention in developing countries (Sweat, Denison, Kennedy, Tedrow, & O'Reilly, 2012). Biomedical marketing is a form of social marketing but used to promote biomedical procedures and pharmaceuticals for example through campaigns in social media (Nelson, 2012). Biomedical marketing related to VMMC typically involves accelerating service delivery through mass campaigns that make use of innovative communication and education media strategies (WHO, 2011). The public health establishment, which includes UNAIDS, WHO, World Bank, IMF (Ferguson, 2006; Jilberto, 2004) as well as US institutions like CDC and Bill and Melinda Gates Foundation, makes extensive use of biomedical marketing. The focus of biomedical marketing is a central characteristic of a neoliberalist approach that encourages individuals' application of their entrepreneurial freedom and skills in the market economy as opposed to collective decisions (Finn, Nybell, & Shook, 2010; Harvey, 2005). The purpose of marketing is to increase the take-up of services by using enticing strategies that are intended to generate demand, increase coverage and uptake rapidly (Finn et al., 2010). However, such strategies seem to face challenges in collectivist cultures. Even so, the HIV field that heavily relies on results from large-scale biomedical prevention trials has built its intervention strategies around the neoliberal approach (Rosengarten & Michael, 2009). Biomedical marketing strategies for VMMC seem to work in mobilising more men for circumcision in countries like Kenya, while they have had very little impact in other African countries like Botswana (Macintyre et al., 2013; NACA, 2013; WHO, 2014). This contradicts predictions by the Botswana-based acceptability study of 2003 which concluded that 81% of males in Botswana would be willing to circumcise through VMMC (Kebaabetswe et al., 2003). Although biomedical marketing has had little success in some countries, the advantage of such a strategy is that it gives individuals freedom of choice for health services (Finn et al., 2010). However, authors like Dowsett and Couch

(2007) and Aggleton (2007) argue against the insensitivity of recommendations from randomised controlled trials to people's cultural and taboo practices, sexual orientations and social phenomena. In fact, the WHO (2007) technical consultation report recommends sensitivity to culture and drawing on local language and symbols, but the 2011 WHO progress report in the scale-up of MC for HIV prevention in Eastern and Southern Africa focuses on service delivery – and does not capture cultural or social issues (WHO, 2011).

Many HIV/AIDS prevention strategies are exclusively based on evidence from biomedically and epidemiologically driven behavioural research agendas. In their contention against these biomedical decisions, Lock and Nguyen (2010, p. 18) argue that scientists work with pre-conditioned ways of seeing and understanding, hence 'health-related matters are routinely objectified as technical problems to be solved through the application of technology and the conduct of science'. Scientific evidence exerts little or superficial effort in considering local social and cultural realities (Aggleton, 2007). Several social scientists, including Dowsett and Couch (2007), Lock and Nguyen (2010) and Parker (2001), advocate that in order to examine the efficacy and effectiveness of the RCTs, they should be considered as a social phenomenon with real human settings, and the local social realities, psychological, behavioural and sexual responses of the research subjects should be incorporated fully when making decisions about medical interventions. Additionally, Campbell, Skovdal, Mupambireyi, and Gregson (2010) encourage sensitivity to cultural factors when implementing HIV prevention strategies.

Much of research carried out on VMMC thus far is biomedical, focusing on exploring the association between MC and HIV; or it involves acceptability studies in different countries (see Kebaabetswe et al., 2003; Lukobo & Bailey, 2007; Wambura et al., 2011); or mathematical models used to estimate the impact of behaviour change and condom use (for example Andersson, Owens, & Paltiel, 2011). Very little research has been done on the sociocultural response and behavioural dynamics of the subjects who are recipients of the service. The few qualitative studies carried out in Africa reveal varying sociocultural factors inhibiting the expected response predicted through quantitative research. One study carried out in West African countries by Niang and Boiro (2007) found antagonistic relations between VMMC and cultural practices. Research in Tanzania among traditionally circumcising tribes shows that such cultures would embrace VMMC as long as it is done in a culturally sensitive manner (Wambura et al., 2011). Another qualitative study on the impediments to the uptake of VMMC in Botswana by Sabone and colleagues (2013) found that in general, societies accept circumcision; however, the communities were against the fact that the VMMC programme disturbs the social order. They also observed conflict between traditional initiation systems and VMMC. 'Participants observed that the government would have better outcomes if the MC strategy had taken aboard the traditional initiation systems through a collaborative process' (Sabone et al., 2013, p. 3).

### *Male circumcision in Botswana*

In Botswana traditional initiation for men was conducted in the wilderness in selected sites and commonly during winter (Mosothwane, 2001). The initiates were separated from the community for skills training and challenges and only men were allowed (Comaroff, 1985; Mosothwane, 2001). All initiates underwent circumcision at the same time; their collective endurance of the pain reflected masculine strength (Meissner & Buso, 2007; Mosothwane, 2001). One knife was used to circumcise all initiates

(Meissner & Buso, 2007) as a rite of affirmation marking transformation to manhood (Comaroff, 1985; Mosothwane, 2001; Turner, 1969). Missionaries considered the practice barbaric and indecent and therefore enforced its abolishment during the twentieth century (Comaroff, 1985; Mosothwane, 2001). A few tribal communities like the Bakgatla of Mochudi village resisted the abolition of initiation (Mosothwane, 2001). The practice went through a wave of changes throughout the years with some tribal chiefs disregarding it in fear of punishment and others reinstating it, sometimes without MC. The current tribal leadership of Mochudi has revived the practice and the community upholds it as a special identity of their tribe (Setlhabi, 2014).

VMMC represents a new phase in the context of MC in Botswana. External funding has supported biomedical marketing in the media including, bill-board, radio and TV advertising. In addition, a pop artist has been contracted as the campaign ambassador to attract men into the programme. Dedicated clinics have been set up in selected areas in addition to general public health centres where MC is conducted in hygienic, clinical conditions throughout the year by both female and male medical practitioners. Procedure in the clinics follows WHO recommendations (Ministry of Health, 2010). UNAIDS (2013, p. A7) records that in 2012 in Botswana the HIV prevalence rate for adults 15–49 years was 23%. External organisations like the US Centres for Disease Control and Prevention (CDC) and Africa Comprehensive HIV/AIDS Partnership (ACHAP) funded by the Bill and Melinda Gates Foundation partner with the Government of Botswana's Ministry of Health (MH) to scale up VMMC and encourage HIV-negative men of ages 13–49 to circumcise. The programme in Botswana is called safe male circumcision (SMC). The acceptability study that was done by Kebaabetswe et al. (2003) among 15 ethnic groups in the country contributed to the decision for implementation of SMC in Botswana. The study included a total of 605 respondents of which 238 were uncircumcised men; among these men 61% stated they were willing to circumcise and this percentage increased to 81% after they received further information on MC (Kebaabetswe et al., 2003, p. 214). This study largely covered the traditionally non-circumcising tribes (Kebaabetswe et al., 2003). Botswana progress reports from MH and external organisations like CDC and ACHAP reflect very low numbers of circumcisions were performed among HIV-negative males: only 39% of the 2012 annual target was circumcised (NACA, 2013).

## **Methods**

This study used ethnographic methods to explore the cultural relevance of SMC for HIV prevention in Botswana.

### ***Research sites***

Besides collecting data in Gaborone, the capital, from the leaders of the partner organisations, two rural research sites were purposefully selected in order to contrast responses of tribes that conduct or do not conduct traditional MC and initiation. Mochudi, a village 40 km to the east of Gaborone, is home to the Bakgatla tribe which practices initiation and MC while Hukuntsi, a village in the remote western part of the country, is home to the Bakgalagadi tribe which does not practice initiation or MC (Box 1).



<b>Botswana</b>	The country
<b>Motswana</b>	One citizen
<b>Batswana</b>	Many citizens
<b>Setswana</b>	Language and culture
Kgosi	Chief
Kgotla	Chief's meeting place/traditional court
<b>Terminology related to initiation</b>	
Bogwera	Initiation school for boys
Thupiso	Initiation
Go rupa	Male circumcision within initiation
Go kgaola letlalo la borre	To cut the foreskin
Laoro la borre	Male surgery
Regiment	Cohort of age-mates initiated together
<b>Initiation and male circumcision</b>	
<b>Tribes that do</b>	<b>Tribes that do not</b>
Bakgatla, Batlokwa, Balete, Baherero	Bakgalagadi, Bangwato
Kgatleng – place of the Bakgatla	Hukuntsi – main village of Bakgalagadi
Mochudi – main village of Bakgatla	

Box 1. Botswana-specific terminology.

### *Participants and recruitment*

Data were collected from four groups of participants. The first group included leaders from the three partner organisations, namely MH SMC Co-ordinator, CDC SMC Co-ordinator and ACHAP Programmes Director. In addition, the MH Project Adviser (adviser on technicalities and current research) and the MH Northern Regional Co-ordinator (oversees implementation in the northern part of country) were included. All leaders were contacted directly to arrange meetings. The second group of participants included implementers in the two rural research sites. The ACHAP team in Mochudi was contacted through the District Health Management Team (DHMT). Contact with the DHMT in both Mochudi and Hukuntsi was facilitated through MH. Third, social workers who advise men about participation in SMC were included. The fourth group of participants included traditional leaders. The intention was to interview only the chief in each of the rural research sites (in each case they had been contacted directly by the first author), but on the agreed day of the interview with the Bakgatla chief in Mochudi, the first author was introduced by the chief to the group of 25 traditional leaders who happened to be meeting the chief that day. See Table 1 for details.

### *Data collection*

Data were collected through participant observation (for example at meetings between the partner organisations; at SMC marketing campaigns), in-depth interviews (IDIs) and focus group discussions (FGDs). The leaders of the partner organisations and the chiefs

Table 1. Details of participants and data collection methods.

Role	Details	Method	M	F
Leaders in partner organisations	MH National SMC Co-ordinator	IDI	1	
	MH National Project Adviser	IDI		1
	MH Northern Regional Co-ordinator	IDI		1
	CDC SMC Co-ordinator	IDI		1
	ACHAP Programs Director	IDI	1	
Implementers	ACHAP team Mochudi	FGD	3	2
	DHMT Hukuntsi	FGD	4	1
Social workers	Hukuntsi	FGD	6	
Traditional leaders	Bakgatla Chief, Mochudi	IDI	1	
	Bakgatla traditional leaders, Mochudi	Group interview	25	
	Bakgalakgadi Chief, Hukuntsi	IDI	1	
Total			42	6

were interviewed individually in their own offices. Data were collected from the implementers and the social workers through focus group discussions (see Table 1 for details). The first author, who collected all the data, is a woman. Interviewing men on issues that deal directly with the most secretive part of their body came with opposition at village level. This being anticipated, the first author dressed very conservatively and followed all customary protocol. The meeting with the Bakgatla traditional leaders was not planned and, given the taboos surrounding the topic, the participants initially resisted. However, as the interview continued they became fully engaged and rich data were generated; the interview ended with the traditional leaders asking the first author to be their envoy to the MH. It was too large a group to be called a focus group discussion, although several of the leaders responded to each issue. In all the data collection, topic guides were used to explore issues such as the leadership of the SMC strategy, differences and overlaps between SMC and traditional initiation practices, the consultation processes and response at different levels of the community, the response of the community towards the uptake of SMC, the impact of the demand creation strategies and the community response.

### ***Data analysis***

All interviews and focus group discussions were audio recorded with permission from the participants. They were later transcribed by research assistants and, where necessary, translated from Setswana into English by the first author. The transcripts were then imported into NVivo 10 (a computer software package designed for qualitative data management) and analysed following the steps in Attride-Stirling's (2001) Thematic Network Analysis. The data analysis team comprising the first author and two Ph.D. students read the transcripts several times to acquaint themselves with the data. Each of them created labels to represent similar re-occurring codes, and text segments were inductively coded. Basic themes were abstracted and refined from the coded text segments and clustered to form the organising and then the global themes. The team discussed organising and global themes to reach a consensus, strengthening the objectivity of the data. The last two groups of themes can be seen in Table 2. Links between the themes were then explored and cross-analysed across communities and

Table 2. Themes emerging from data analysis.

Organising themes	Global themes
Secrecy	} Cultural circumcision taboos breached
Male domain	
Language controversies	
Sexualising circumcision	} Public marketing
Creating generational clashes	
The chief's voice is stronger	
Initial cooperation	} Consultation and participation
Disillusionment; frustration and resistance	
Lack of genuine consultation	
	HIV testing

different groups of participants. Information from reviewed literature was used to contextualise the analysis.

### **Ethics**

Research clearances were obtained from the Norwegian Social Sciences Data Services and MH in Botswana. At MH level, we had to acquire two written permits: one was a general acceptance of the topic of the research, and the other was permission allowing the interviewing of health personnel. At the organisational level, ACHAP and CDC accepted the MH permits as appropriate ethical clearance. Informed consent was obtained from individual and focus group participants of all organisations that we sought data from and from the leaders of participating village communities. At community level the chief signed the consent form and gave verbal permission to interview the traditional leaders. This reflects customary ethical protocol where the chief consents on behalf of his elders (who we have called traditional leaders). Culturally, this is a highly sensitive research exploration; therefore, substantial effort was made to assure confidentiality to informants.

### **Findings**

Our exploration of responses to SMC in relation to circumcision as part of traditional initiation practices is presented according to themes emerging from the data analysis. Organising themes were grouped under four global themes: cultural circumcision taboos breached, public marketing, consultation and participation, and HIV testing.

#### ***Cultural circumcision taboos breached***

##### *Secrecy*

Traditional leaders clearly described cultural circumcision as a secret domain not to be shared with women. They expressed astonishment and initially objected that a woman researcher asked for general information about the cultural practice of initiation and circumcision. During discussions with 25 elders of Mochudi, one elder spoke loudly as he threw arms in the air, as if to say go away: 'We never did those things... These are the things we are not allowed to ask about. You cannot just ask about that'. The words of wrath expressed by this first respondent were reiterated in a discussion with a taxi driver

later in the year: 'Young as you are, a woman for that matter! You are asking men, even old men..., about their penis'?

Breaching of secrecy was also questioned in the public campaign approaches and the circumcision surgical services done in public clinics. One elder said:

We know our tradition differently. We gather first for initiation in the wilderness. It is a special training for men... We are not initiated in the village; we are initiated in the wilderness. They are talking about it [the penis] anyhow in public. In initiation men are recruited house to house. Things concerning initiation are a secret.

In fact, initiating communities' collaboration with the SMC implementing teams for medical circumcision seemed to threaten the secrecy practiced and maintained within the traditional initiation ceremonies. At the same time, the practice of secrecy was viewed as working against the SMC programme's intentions to publicise activities and campaigns to win the public. This conflict left both parties frustrated. One of the partners explained the implementers' adjustment of SMC procedures to comply with cultural expectations of secrecy with a tone of frustration:

you don't tell anybody, you don't advertise, you don't say anything that you will be at a particular village doing circumcision because there is an initiation going on. No you don't. So that's how it is. We see it as a challenge. Truly speaking, with tribes in our country which are doing initiation we seriously have a challenge.

#### *Male domain*

Traditionally, circumcision was distinguished as a male domain. This was strictly upheld in traditionally circumcising cultures. Upholding such cultural principles caused conflict between the traditional and the biomedical provision of circumcision. One of the partners expressed such conflict as frustrating. The SMC programme used women health personnel to circumcise, but women were not allowed in the traditional initiation practices. This was revealed through stipulated requirements forwarded by the chief of Ramotswa village to the SMC team assigned to circumcise the graduating regiment:

And then what happened last year with the Balete? They organized their own traditional initiation. They told us they didn't even want to see a lady during circumcision, totally no ladies that side. So we complied... The tent was pitched in between the village and the initiation site, far from the initiation site.

Here culture proved to be strong in dictating to SMC to comply with its taboos. One elder in Mochudi also explained that initiation was not a woman's space:

We do come to the hospital for circumcision. But it should be men who circumcise men.... Well some say it is ok for women to circumcise men. No, it is against tradition.

#### *Language controversies*

One officer explained that different tribes used specific language phrases to describe and explain traditional initiation and performances related to it like circumcision. SMC health personnel struggled to find the right words to use for medical circumcision, and their attempts to adapt to traditional phrases misrepresented traditional meanings and led to serious controversies ending in publicly demonstrated protests by chiefs.

One elder expressed unhappiness in the misuse of the traditional phrase 'go rupa' that means circumcision within initiation, contesting it as wrongly used by the SMC team to mean removing the foreskin:

E1: They are just beating about the bush using our language to attract men. Haven't you seen it on TV?

Researcher: I have seen it

E1: No, answer and say you have seen the advert showing men heading the ball calling men for 'Go rupa!' I want you to say that if you have seen it. That is a wrong phrase!

Another elder added:

No no no... Then let them use the word 'thupiso' [initiation] in their own communities, not here. They really hurt us. I do not want this phrase 'go rupa' [circumcision within initiation] used on radio to mean just cutting the foreskin. SMC is not about initiation.

Meanwhile one of the partners spoke at length about how difficult it had been for them to find the appropriate word to use for SMC even when they had consulted with the house of chiefs. He described the controversies:

So they came here, the chiefs, very angry with us. They met with [Ministry of Health] They gave us instructions not to talk about 'go rupa'. They instructed us to use the phrase 'go kgaola letlalo la borre' [to cut the male foreskin]... We complied. A few years down the line we were blamed by the same House for using the phrase 'go kgaola letlalo la borre'. They said to us 'these words that you are using are insults, you are insulting us'.

Contradictions revealed in these controversies of language use left the MH in a dilemma. One officer said: 'So we ended up using the phrase loaro lwa borre [the male surgery]. It does not make sense but we have just decided to use it'.

### **Public marketing**

#### *The chief's voice is stronger*

In several instances the chief's voice proved to be stronger and commanded obedience to the traditional standards rather than the SMC approach to public marketing. This was seen as a stumbling block to the progression of SMC. One officer said:

that is where the gap is currently. And I think it is really haunting us. The circumcising tribes in the country, Batlokwa, Balete, Bakgatla are giving us a very big challenge ... of resistance to this government program. And we cannot convince the chiefs there, we just can't. Our main target group of men 25 years and above is hard to reach because the chiefs are very clear, they are going to wait for the next Bogwera [initiation school].

One of the marketing campaigns made use of a pop singer called Vee as the public face to promoting SMC. The elders clearly explained that the community would rather listen to the chief than to different voices in the SMC campaigns. They appealed that the Ministry should be informed to use the rightful respected cultural community figures to address and probably win the community. One elder advised:

I would say Ministry of Health should talk to the chiefs. They should ask the chiefs to call the public on their behalf. The chief could make arrangements with his people to participate in SMC without giving up the culture. Let it come from the chief; [he emphasized very strongly and even stood up]. We will listen to the chief. Not Vee.

The 25 elders appealed to the research team to go as their messenger to MH and express their displeasure about the SMC programme:

We have expressed that we thought Ministry of Health was going to help. Now they send us Vee and young people to insult us. They should respect our culture and not confuse it. Go and tell them to come and talk to our chief.

The traditional elders were actually protective of the culture and felt threatened that SMC had come to undermine the chief's voice – they were acting as the custodians of culture. One of the elders said: 'Now it is as if the government's programme is uplifted and Bakgatla tradition is lowered'. This was reported as causing disgruntlement among the custodians of culture.

#### *Generational clashes*

Biomedical marketing strategies were reported to be causing generational clashes – between adults and children. Public campaigns were viewed as contributing to children's waywardness in contrast to initiation practices which built and moulded personhood. One man said: 'You know our children no longer listen to us. They listen to Vee's music in public'. One of the 25 elders described how SMC public talks about the male penis caused children to unintentionally disrespect their elders:

They do their education on radio. It is embarrassing. When a child gets home he asks 'Papa, it is said that all males have to cut the foreskin, do we have to go Papa!' How do you answer that? ...These adverts just raise questions in the listeners' minds.

#### *Sexualising circumcision*

Comments from traditional elders, professionals and other community members revealed strong dissatisfaction in the sexual language used to appeal to men for circumcision. Six social workers who work as advocates of SMC in Hukunsi district saw Vee's SMC campaigns as sexualized and only benefiting the campaigners themselves. This made the community question the quality of the campaigns. One social worker said:

I think that Vee's campaigns benefit Vee himself moneywise. It does not benefit the masses, what we question is the quality of information they give people. They just make the whole thing colourful; it swipes people's emotions without their understanding. It creates confusion in the masses. It's all about enjoying sex and prevention of cervical cancer.

Another social worker also questioned quality:

I don't know... How exactly are the men benefiting out of this? We are just told about the 60% chances of reduction. The rest is just additional colourful attractions like 'If you are circumcised you will enjoy sex more'. Male circumcision is sexualized.

The health personnel saw Vee campaigns as captivating the public but questioned the strength of the campaign in getting men to actually circumcise. One of the Mochudi-based ACHAP team members said:

with Vee I would say we use him to pull a crowd and get people to register for circumcision but at the end of the day we don't see those numbers. But of course Vee is a crowd puller.

The elders of the community viewed the language used in Vee's campaigns, radio talks, television advertisements and the use of celebrities as disgusting and conflicting with culture. Leaders did not want the approach of talking publicly about the male penis and appealing to men publicly for circumcision. This undermined the cultural practice of respect to men. One elder emotionally expressed his hatred towards public announcements for circumcision:

I hate it when it is announced on radio that all Bakgatla men who want to go for initiation should go for SMC. Vee's music and dancing is disgusting. This MC campaign done by Vee is insulting us.

### ***Consultation and participation***

#### *Initial cooperation*

Initially, the community embraced SMC and cooperated with the health teams in anticipation that it would complement their culture. The community elders explained: 'So in our Sekgatla initiation there is circumcision to prove manhood. That is why when SMC was introduced Bakgatla responded well through their initiation regiments'.

This initial cooperation was affirmed by one of the ACHAP team members, who explained:

From the beginning the leadership were receiving and supporting the SMC programme. In 2009 they had a group of men for initiation. They brought everyone from the wilderness to the clinic for circumcision. Even though not all of them circumcised... Kgatleng as compared to other districts had large numbers of circumcision through the help of this initiation, especially in 2009.

One of the partners revealed the numbers that circumcised in 2009: 'Many men were circumcised. 53% of the 300 men were circumcised. That is more than 150. It's a big number to us'.

#### *Disillusionment, frustration and resistance*

Later events revealed that SMC partners' consultation with traditional leaders was done with a seemingly superficial, non-participatory approach. Local leaders were disappointed by the fact that practices surrounding the traditional rite of circumcision were not adhered to, as they expected. Interestingly, both the SMC implementers and the traditional leaders expected compliance by the other party to their own strategies, which left the issue controversial and men declining medical circumcision. The implementing officers explained the change from embracing the programme to rejection of programme between the period 2009 and 2011.

but over time like in the year 2011 when they went for initiation, they did not come for circumcision at the clinic because of many challenges with the culture ... like the use of

clinics for circumcision, HIV testing. Also they have a special time in which it is done. You see, they believe that circumcision should only be done in winter.

Other reasons were forwarded to explain why the initial enthusiasm of regiments to circumcise through SMC died out. Traditional leaders argued that SMC breached the practice of secrecy and private space for initiation as it was done in public clinics. They were also disillusioned by some SMC perceived procedural requirements like HIV testing; hence many refused to undergo the procedure. The regiments' resistance to circumcise was later transferred into a collective decision of the community. This emerged in the fact that none of the regiments came for circumcision through SMC in 2011, their next year of initiation.

#### *Lack of genuine consultation*

Lack of genuine consultation caused resistance beyond circumcising cultures. Bakagagadi, a non-circumcising culture residing in the village of Hukuntsi, also had resisted SMC at its initial introduction. A traditional leader explained that they viewed SMC as government imposing other cultures into their culture:

We wondered when this SMC came. We do not want other cultures transferred to our culture. Bakgatla and Balete are people who do circumcision culturally. Why couldn't they go to them? Our men here never did that. How could I speak to the tribe about this?

#### *Another form of resistance*

The Herero culture, which practice private traditional circumcision for individual males, were reported to ignore SMC campaigns in silence and, instead, to continue their private traditional circumcision. An officer narrated this with frustration:

Now we have a challenge which is coming out clearly with the Herero culture, what happens that side is that they do things in silence. They are not coming out to say don't come in to our village. They use traditional circumcisers from their fellow tribes in Namibia to do home based circumcision on boys at a particular time, collect their earnings and go back.

The same concern was raised in the SMC partners' planning meeting and particularly by the officer responsible for that particular area when she said:

because it is their secret and done so privately we have not even accessed their way of circumcising, and it may be hard to get the right information about how it is done so that we could collaborate. It is the hearsay you know. I have not personally sat with the traditional circumcisers to get the explanation. We hear from other Hereros that have information.

The clear lack of consultation resulted in a dilemma as to the right approach.

There was an indication that when the health personnel explained SMC clearly to the communities, men showed interest to participate. This was explained by an officer in Hukuntsi:

When I got here there was this talk of bringing a foreigner, a different culture to their culture, but after explaining ... now I think people are starting to understand why circumcision is being brought to the area. They are now slowly coming.



A traditional leader also added: 'But now we see our men are slowly going there to circumcise'. In both cases of Bakgatla and Bakgalagadi tribes, communities show resistance when the programme breached their cultural taboos.

### *Genuine consultation crucial*

It seems partners, in their frustration, realised that consultation with the communities was crucial. An officer admitted this and recommended the need to consult the communities through their leaders:

So that's the main challenge, the main reason why we are not succeeding. I think looking back I will never do a programme like this again ... I would start with the key partner who is the people of Botswana, the beneficiaries and the cultural structures like the community leaders or the religious leaders.

### *HIV testing*

Elements of the minimum package for SMC that include counselling and voluntary HIV testing were repeatedly mentioned as other barriers that blocked men from circumcising. HIV testing, in particular, seemed to scare men away even if they would opt for circumcision. One of the partners said:

You see most people these days are scared to test for HIV, which also chases them away. Some are scared to go to the hospital for SMC, not that they do not want to circumcise. They do. They are scared.

The perceived procedures that had to be followed like HIV testing and injections were a challenge to the regiments (although it is not compulsory HIV testing is offered in all health centres and campaign points). The SMC procedures were viewed as confusing men. One of the community leaders said: 'Our men are now refusing to circumcise. This SMC is confusing our culture'.

### **Discussion**

This study reveals the challenges international organisations and MH faced to meet their targets. It reveals frustrations on both sides in the interaction between communities and programme partners. The frustrations are rooted in the different underlying assumptions and ideologies. There was collision of different underlying beliefs and views on MC. Traditional circumcision is deeply interwoven within the concept of collectivism and masculinity. Even though MH made attempts to work with villages to incorporate SMC into part of the initiation practice, its individual-based procedure and marketing strategies still breached the requirements of secrecy and the collective nature of the rite. This is not all surprising because the strategic recommendations for VMMC come from part of the global public health establishment, WHO, which like others, has a neoliberal bent (Harvey, 2005). Aggleton (2007) contends that cultural MC is a performance connected to deep-seated beliefs and ideologies. It is not just a simple prevention technology.

Finn et al. (2010) argue that the introduction of neoliberalism put some governments under pressure since its emphasis on individual empowerment compelled them to change their social structures. Even though neoliberalism offers possible new perspectives, it has been criticised for intruding into local contexts in different ways raising new and challenging questions on implementation of practices (Ferguson, 2006; Finn et al., 2010).

The study reveals that some of the marketing strategies for SMC in Botswana focus on the market and the individual; marketing phrases are fashioned to make sure that individuals want the product (Finn et al., 2010). In opposition to collectivism, neoliberalism sets processes that favour privatisation of services – the primacy of individual as opposed to collective responsibility (Finn et al., 2010). The enticing language used in marketing SMC to generate demand (Hankins, Forsythe, & Njeuhmeli 2011) brought discomfort to community leaders. ‘Disgusted’ and ‘Frustrated’ were the terms uttered by the traditional leaders towards the marketing of individualised SMC – working against the local tradition of collectivism (Comaroff, 1985). This indeed is what McFalls (2010) calls ‘iatrogenic violence’ – medical intervention that violates societal practice. Even though SMC disturbs the cultural equilibrium, global health politics would still view the SMC implementation strategy as ethical because medical intervention is exempted from ethical critique as it is dedicated to saving human life (McFalls, 2010). The biomedical marketing approach serves as an advantage and a rival to the culture as well as an impediment to men’s response to circumcise.

Planning for SMC was based on the assumption of acceptability as per Botswana’s acceptability study on medical circumcision (Kebaabetswe et al., 2003). While VMCM would be accepted by both circumcising and non-circumcising communities, the top-down management and lack of input from the community worked against its acceptability in practice. Community responses to the actual implementation depict lack of acceptability. Acceptance of interventions is shaped by the complex local context. Dowsett and Couch (2007) contend that medical interventions that concern human behaviour and societal networks are bound to fail if such decisions are based only on clinical trials and cross sectional surveys. The voice of social researchers has demonstrated that embracing the social context is paramount in implementing ‘foreign’ biomedical interventions specifically those that concern men’s sexuality (Parker, 2001). Notwithstanding published studies done years back by Heald (2002) and the recent study by Sabone and colleagues (2013) that advocate for sensitivity to local understandings of male sexuality, WHO and international donors still seem to resist reflecting on these but continue to impose their top-down global agendas.

There were two types of resistance to SMC. One tribe counterattacked, while the other was shocked and confused. The Bakgatla tribe initially cooperated but resisted SMC out of disillusionment; the Bakgalagadi, a non-circumcising tribe, were confused about foreign practice ‘being imposed’ into their culture. Other tribes referred to by the respondents include the Herero who ignored the SMC campaigns and carried out its cultural practices secretly; another, Balete, negotiated so that SMC was conducted on their terms. In all these communities SMC workers were frustrated by the low turn-up of men for circumcision. Even though the SMC workers claim that the communities were consulted, it is clear that consultation with custodians of culture was done in a superficial manner. International interventions’ consultations are often presented as preconceived proposals where the ‘process is not an attempt to ascertain the outcome and priorities, but rather to gain acceptance for an already assembled package’ (Botes & van Rensburg, 2000, p. 43). Rifkin (1996) explains that target-oriented programmes tend to dominate and control because they value the cost of time over and above the value of negotiations hence they rush implementations leaving the communities behind. Designers of medical programmes like this one should know that people live within a social cultural context and reason with their cultural standards and expectations before accepting externally imposed programmes (Skovdal et al., 2011). We concur with anthropologists’ and

sociologists' views that efficiency of programmes would be maximised by embracing sociocultural contexts in implementation (Aggleton, 2007; Dowsett & Couch, 2007).

In order to avoid disillusion, frustration and resistance, genuine community consultation is crucial. Community's initial cooperation was a loud message for openness and flexibility while the ultimate resistance was a cry to be heard. SMC programme leaders could have avoided language controversies, the breaching of cultural taboos like secrecy and male domain spaces if they had genuinely explored crucial cultural observances and aligned their biomedical approach to circumcision within the operations of the existing cultural environment. Comaroff (1985) explains that circumcision is an integral part of initiation that is done in seclusion of males being initiated with a high level of secrecy about what the cohorts experience when in the wilderness. In agreement with Niang and Boiro (2007) and Sabone et al. (2013), our study reveals antagonism between the cultural practice of secrecy in circumcision proceedings and the SMC strategy that has no restrictions to participants in their procedures. Collision between the biomedical approaches and the requirements of traditional practices in Mochudi and Ramotswa discredited the assumption that, in places where male persons are expected to be circumcised traditionally, there is high desire to conform and get circumcised under VMMC for HIV prevention (UNAIDS, 2007). While the assumption could be true, we notice that discrediting the voice and opinions of chiefs is a fundamental mistake since they are the traditional medium used to convince the community for participation (Comaroff, 1985). This study suggests an urgent need for a high level of cultural sensitivity, embracing and incorporating cultural taboos when biomedical interventions are to be carried out. In fact, the tension between traditional and public health strategies is likely to emerge with other new biomedical HIV prevention strategies, if cultural conditions are not taken into consideration.

While the sociocultural concerns are paramount to the success of SMC programme, it should be appreciated that these programmes operate within a set of constraints, some of which might be flexible and others which are more rigid. These constraints include funding environment, indicators used to measure success and time for scale required to achieve the desired outcome (i.e. infections averted). The traditional leaders therefore need to be challenged to ensure that men's enactment of the socially constructed versions of manhood does not place men at a disadvantage by inhibiting them from taking advantage of life-saving HIV services (Skovdal et al., 2011). The perception of men is that HIV testing is mandatory within SMC and they do not want to go for HIV testing. This puts them at risk of not taking timely advantage of knowing their HIV status and benefiting from the SMC HIV prevention service (Skovdal et al., 2011). Given the pointers on how to make HIV prevention services more culturally acceptable, MH and its implementing partners need to prioritise preparation of communities and participatory consultation prior to implementation so that resources are channelled towards relevant approaches suggested by communities. In agreement with Skovdal et al. (2011) and Aggleton (2007), we argue that incorporating societal values on male sexuality and adapting male friendly services is vital in shaping sexual practices relevant to HIV transmission and prevention.

We propose a future research agenda that focuses on exploring a step by step relevant and effective approach that communities could structure for advice and guidance to the VMMC programme donors and implementers. Such community-defined strategies could help save on a lot of resources that are otherwise used without much results.

### Limitations of the study

While reflexivity was systematically applied throughout data collection, it is possible that the first author's gender, as a woman, may have restricted responses by men; the objections quoted above show that the involvement of women is considered culturally insensitive. Also, open ended questions allow room for expression of passionate and emotional views that may not be a general view of the communities or organisations represented. While the results may not be specifically generalisable they do provide an insight into cultural reasons for the resistance to SMC. Also, the lessons learnt, like the need for genuine consultation, are valuable for other countries to consider. The findings of this study are particularly relevant for rural settings and do not give the perspective of how this is working in larger and urban communities. The response given by the cultures represented in this study may not necessarily represent the views of other ethnic groups within the country.

### Conclusion

The findings from this study show substantial cultural resistance to and superficial participation in SMC in Botswana both in circumcising and non-circumcising cultures. Issues that have generated resistance include the public marketing campaigns, the sexualized language and the fact that implementing health staff includes women. Chiefs and traditional leaders at first cooperated with SMC but later discouraged their men from participating. Cultural resistance has a significant impact on the SMC programme. This study particularly reveals consequences of superficial consultation and how biomedical interventions fail to take full advantage of sociocultural channels to maximise demand for health services. VMMC does not fit well in the two cultural settings examined in this study.

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### Disclosure statement

No potential conflict of interest was reported by the authors.

### References

- Aggleton, P. (2007). 'Just a snip'? A social history of male circumcision. *Reproductive Health Matters*, 15(29), 15–21. doi:10.1016/S0968-8080(07)29303-6
- Andersson, K. M., Owens, D. K., & Paltiel, A. D. (2011). Scaling up circumcision programs in southern Africa: The potential impact of gender disparities and changes in condom use behaviors on heterosexual HIV transmission. *AIDS and Behavior*, 15, 938–948. doi:10.1007/s10461-010-9784-y
- Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research*, 1, 385–405. doi:10.1177/146879410100100307
- Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., & Puren, A. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 Trial. *PLOS Medicine*, 2(11), e298. doi:10.1371/journal.pmed.0020298.st003

- Bailey, R. C., Moses, S., Parker, C. B., Agot, K., Maclean, I., Krieger, J. N., ... Ndinya-Achola, J. O. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *The Lancet*, 369, 643–656. doi:10.1016/S0140-6736(07)60312-2
- Botes, L., & van Rensburg, D. (2000). Community participation in development: Nine plagues and twelve commandments. *Oxford University Press and Community Development Journal*, 35, 41–58.
- Campbell, C., Skovdal, M., Mupambireyi, Z., & Gregson, S. (2010). Exploring children's stigmatisation of AIDS-affected children in Zimbabwe through drawings and stories. *Social Science & Medicine*, 71, 975–985. doi:10.1016/j.socscimed.2010.05.028
- Comaroff, J. (1985). *Body of power spirit and resistance: The culture and history of a South African people*. Chicago, IL: The University of Chicago Press.
- Dowsett, G. W., & Couch, M. (2007). Male circumcision and HIV prevention: Is there really enough of the right kind of evidence? *Reproductive Health Matters*, 15(29), 33–44. doi:10.1016/S0968-8080(07)29302-4
- Ferguson, J. (2006). *Global Shadows: Africa in the neoliberal world order*. Durham, NC: Duke University Press.
- Finn, J. L., Nybell, L. M., & Shook, J. J. (2010). The meaning and making of childhood in the era of globalization: Challenges for social work. *Children and Youth Services Review*, 32, 246–254. doi:10.1016/j.childyouth.2009.09.003
- Gray, R. H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., ... Chen, M. Z. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. *The Lancet*, 369, 657–666. doi:10.1016/S0140-6736(07)60313-4
- Grier, S., & Bryant, C. A. (2005). Social marketing in public health. *Annual Review of Public Health*, 26, 319–339. doi:10.1146/annurev.publhealth.26.021304.144610
- Hankins, C., Forsythe, S., & Njeuhmeli, E. (2011). Voluntary medical male circumcision: An introduction to the cost, impact, and challenges of accelerated scaling up. *PLOS Medicine*, 8(11), e1001127. doi:10.1371/journal.pmed.1001127
- Harvey, D. (2005). *A brief history of neoliberalism*. Oxford: Oxford University Press.
- Heald, S. (2002). It's never as easy as ABC: Understanding of AIDS in Botswana. *African Journal of AIDS Research*, 1(1), 1–10. doi:10.2989/16085906.2002.9626539
- Jilberto, A. E. F. (2004). The political economy of neoliberal governance in Latin America: The case of Chile. In J. Demmers, A. E. F. Jilberto, & B. Hogenboom (Eds.), *Good governance in the era of global neoliberalism: Conflict and depoliticisation in Latin America, Eastern Europe, Asia and Africa* (pp. 33–55). London: Routledge.
- Kebaabetswe, P., Lockman, S., Mogwe, S., Mandevu, R., Thior, I., Essex, M., & Shapiro, R. L. (2003). Male circumcision: An acceptable strategy for HIV prevention in Botswana. *Sexually Transmitted Infections*, 79, 214–219. doi:10.1136/sti.79.3.214
- Lock, M., & Nguyen, V. K. (2010). *An anthropology of biomedicine*. West Sussex: Wiley Blackwell.
- Lukobo, M. D., & Bailey, R. C. (2007). Acceptability of male circumcision for prevention of HIV infection in Zambia. *AIDS care*, 19, 471–477. doi:10.1080/09540120601163250
- Macintyre, K., Moses, N., Andrinopoulos, K., Bornstein, M., Ochieng, A., Muraguri, N., ... Bertrand, J. T. (2013). *Exploring aspects of demand creation and mobilisation for male circumcision in Turkana, Kenya*. Baltimore, MD: USAID.
- McFalls, L. (2010). Benevolent dictatorship: The formal logic of humanitarian government. In D. Fassin & M. Pandolfi (Eds.), *Contemporary states of emergency: The politics of military and humanitarian interventions* (pp. 317–334). New York, NY: Zone Books.
- Meissner, O., & Buso, D. L. (2007). Traditional male circumcision in the Eastern Cape – scourge or blessing? *South African Medical Journal*, 97, 371–373.
- Ministry of Health. (2010). *Safe male circumcision: Additional strategy for HIV prevention: A national strategy*. Gaborone: Government of Botswana.
- Mosothwane, M. N. (2001). An ethnographic study of initiation schools among the Bakgatla ba ga Kgafela at Mochudi 1874–1988. *Pula Botswana Journal of African Studies*, 1, 144–165.
- NACA. (2013). *National AIDS council report HIV and AIDS program performance: October to December 2012 quarterly report*. Gaborone: Ministry of State President.
- Nelson, B. (2012). Business and science: In the market. *Nature*, 487, 261–263. doi:10.1038/nj7406-261a

- Niang, C. I., & Boiro, H. (2007). 'You can also cut my finger!': Social construction of male circumcision in West Africa, a case study of Senegal and Guinea-Bissau. *Reproductive Health Matters*, 15, 22–32. doi:10.1016/S0968-8080(07)29312-7
- Parker, R. (2001). Sexuality, culture, and power in HIV/AIDS research. *Annual review of anthropology*, 30, 163–179. doi:10.1146/annurev.anthro.30.1.163
- Rifkin, S. B. (1996). Paradigms lost: Toward a new understanding of community participation in health programmes. *Acta Tropica*, 61(2), 79–92. doi:10.1016/0001-706X(95)00105-N
- Rosengarten, M., & Michael, M. (2009). Rethinking the bioethical enactment of medically drugged bodies: Paradoxes of using anti-HIV drug therapy as a technology for prevention. *Science as Culture*, 18, 183–199. doi:10.1080/09505430902885565
- Sabone, M., Magowe, M., Busang, L., Moalosi, J., Binagwa, B., & Mwambona, J. (2013). Impediments for the uptake of the Botswana Government's male circumcision initiative for HIV Prevention. *The Scientific World Journal*, 2013, 1–7. doi:10.1155/2013/387508
- Setlhabi, G. K. (2014). I took an allegiance to secrecy: Complexities for conducting ethnographic research at home. *Africa*, 84, 314–334. doi:10.1017/S0001972014000059
- Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., & Gregson, S. (2011). Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Globalization and health*, 7(13), 1–14. doi:10.1186/1744-8603-7-13
- Sweat, M. D., Denison, J., Kennedy, C., Tedrow, V., & O'Reilly, K. (2012). Effects of condom social marketing on condom use in developing countries: A systematic review and meta-analysis, 1990–2010. *Bulletin of the World Health Organization*, 90, 613–622.
- Turner, V. (1969). *The ritual process: Structure and anti-structure*. London: Routledge and Keegan Paul.
- UNAIDS. (2007). Male circumcision: Context, criteria and culture (part 1). *Feature Stories*. Retrieved from <http://www.UNAIDS.org/en/resources/presscentre/featurestories>
- UNAIDS. (2010). *Report on the global AIDS epidemic*. Geneva: Author.
- UNAIDS. (2013). *Report on the global AIDS epidemic*. Geneva: Author.
- Wambura, M., Mwanga, J. R., Mosha, J. F., Mshana, G., Mosha, F., & Chagalucha, J. (2011). Acceptability of medical male circumcision in the traditionally circumcising communities in Northern Tanzania. *BMC Public Health*, 11, 373. doi:10.1186/1471-2458-11-373
- WHO. (2007). *New data on male circumcision and HIV Prevention: Policy and programme implications*. Geneva: Author.
- WHO. (2011). *Progress in scale-up of male circumcision for HIV prevention in eastern and southern Africa: Focus on service delivery*. Geneva: Author.
- WHO. (2014). *Global uptake on the health sector response to HIV*. Geneva: Author.







**Exploring the underlying causes of antagonism in the safe male circumcision partnership  
in Botswana**

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<b>2005</b>	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
<b>H</b>	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
<b>2006</b>	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teorihistorisk framstilling.
<b>V</b>		

	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.
	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consciousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Empirical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
<b>2006</b>	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
<b>H</b>	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children's psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects
	Mykletun, Amstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.
<b>2007</b>	Singhammer, John, Dr. philos.	Social conditions from before birth to early adulthood – the influence on health and health behaviour
<b>V</b>	Janvin, Carmen Ani Cristea, PhD	Cognitive impairment in patients with Parkinson's disease: profiles and implications for prognosis
	Braarud, Hanne Cecilie, Dr. psychol.	Infant regulation of distress: A longitudinal study of transactions between mothers and infants
	Tveito, Torill Helene, PhD	Sick Leave and Subjective Health Complaints

	Magnussen, Liv Heide, PhD	Returning disability pensioners with back pain to work
	Thuen, Elin Marie, Dr.philos.	Learning environment, students' coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
	Solberg, Ole Asbjørn, PhD	Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo
<b>2007</b>	Søreide, Gunn Elisabeth, Dr.philos.	Narrative construction of teacher identity
<b>H</b>	Svensen, Erling, PhD	WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
	Øverland, Simon Nygaard, PhD	Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
	Eichele, Tom, PhD	Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
	Børhaug, Kjetil, Dr.philos.	Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
	Eikeland, Thorleif, Dr.philos.	Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarne beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
	Wadel, Carl Cato, Dr.philos.	Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
	Vinje, Hege Forbech, PhD	Thriving despite adversity: Job engagement and self-care among community nurses
	Noort, Maurits van den, PhD	Working memory capacity and foreign language acquisition
<b>2008</b>	Breivik, Kyrre, Dr.psychol.	The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.
<b>V</b>	Johnsen, Grethe E., PhD	Memory impairment in patients with posttraumatic stress disorder
	Sætrevik, Bjørn, PhD	Cognitive Control in Auditory Processing
	Carvalho, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
<b>2008</b>	Brønneck, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
<b>H</b>	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.

	Kjønniksen, Lise	The association between adolescent experiences in physical activity and leisure time physical activity in adulthood: a ten year longitudinal study
	Gundersen, Hilde	The effects of alcohol and expectancy on brain function
	Omvik, Siri	Insomnia – a night and day problem
<b>2009</b>	Molde, Helge	Pathological gambling: prevalence, mechanisms and treatment outcome.
<b>V</b>	Foss, Else	Den omsorgsfulle væremåte. En studie av voksnes væremåte i forhold til barn i barnehagen.
	Westrheim, Kariane	Education in a Political Context: A study of Knowledge Processes and Learning Sites in the PKK.
	Wehling, Eike	Cognitive and olfactory changes in aging
	Wangberg, Silje C.	Internet based interventions to support health behaviours: The role of self-efficacy.
	Nielsen, Morten B.	Methodological issues in research on workplace bullying. Operationalisations, measurements and samples.
	Sandu, Anca Larisa	MRI measures of brain volume and cortical complexity in clinical groups and during development.
	Guribye, Eugene	Refugees and mental health interventions
	Sørensen, Lin	Emotional problems in inattentive children – effects on cognitive control functions.
	Tjomsland, Hege E.	Health promotion with teachers. Evaluation of the Norwegian Network of Health Promoting Schools: Quantitative and qualitative analyses of predisposing, reinforcing and enabling conditions related to teacher participation and program sustainability.
	Helleve, Ingrid	Productive interactions in ICT supported communities of learners
<b>2009</b>	Skorpen, Aina	Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser
<b>H</b>	Øye, Christine	
	Andreassen, Cecilie Schou	WORKAHOLISM – Antecedents and Outcomes
	Stang, Ingun	Being in the same boat: An empowerment intervention in breast cancer self-help groups
	Sequeira, Sarah Dorothee Dos Santos	The effects of background noise on asymmetrical speech perception
	Kleiven, Jo, dr.philos.	The Lillehammer scales: Measuring common motives for vacation and leisure behavior
	Jónsdóttir, Guðrún	Dubito ergo sum? Ni jenter møter naturfaglig kunnskap.
	Hove, Oddbjørn	Mental health disorders in adults with intellectual disabilities - Methods of assessment and prevalence of mental health disorders and problem behaviour

	Wageningen, Heidi Karin van	The role of glutamate on brain function
	Bjørkvik, Jofrid	God nok? Selvaktelse og interpersonlig fungering hos pasienter innen psykisk helsevern: Forholdet til diagnoser, symptomer og behandlingsutbytte
	Andersson, Martin	A study of attention control in children and elderly using a forced-attention dichotic listening paradigm
	Almås, Aslaug Grov	Teachers in the Digital Network Society: Visions and Realities. A study of teachers' experiences with the use of ICT in teaching and learning.
	Ulvik, Marit	Lærerutdanning som danning? Tre stemmer i diskusjonen
<b>2010</b>	Skår, Randi	Læringsprosesser i sykepleieres profesjonsutøvelse. En studie av sykepleieres læringserfaringer.
<b>V</b>	Roald, Knut	Kvalitetsvurdering som organisasjonslæring mellom skole og skoleeigar
	Lunde, Linn-Heidi	Chronic pain in older adults. Consequences, assessment and treatment.
	Danielsen, Anne Grete	Perceived psychosocial support, students' self-reported academic initiative and perceived life satisfaction
	Hysing, Mari	Mental health in children with chronic illness
	Olsen, Olav Kjellevoid	Are good leaders moral leaders? The relationship between effective military operational leadership and morals
	Riese, Hanne	Friendship and learning. Entrepreneurship education through mini-enterprises.
	Holthe, Asle	Evaluating the implementation of the Norwegian guidelines for healthy school meals: A case study involving three secondary schools
<b>H</b>	Hauge, Lars Johan	Environmental antecedents of workplace bullying: A multi-design approach
	Bjørkelo, Brita	Whistleblowing at work: Antecedents and consequences
	Reme, Silje Endresen	Common Complaints – Common Cure? Psychiatric comorbidity and predictors of treatment outcome in low back pain and irritable bowel syndrome
	Helland, Wenche Andersen	Communication difficulties in children identified with psychiatric problems
	Beneventi, Harald	Neuronal correlates of working memory in dyslexia
	Thygesen, Elin	Subjective health and coping in care-dependent old persons living at home
	Aanes, Mette Marthinussen	Poor social relationships as a threat to belongingness needs. Interpersonal stress and subjective health complaints: Mediating and moderating factors.

Anker, Morten Gustav	Client directed outcome informed couple therapy
Bull, Torill	Combining employment and child care: The subjective well-being of single women in Scandinavia and in Southern Europe
Viig, Nina Grieg	Tilrettelegging for læreres deltakelse i helsefremmende arbeid. En kvalitativ og kvantitativ analyse av sammenhengen mellom organisatoriske forhold og læreres deltakelse i utvikling og implementering av Europeisk Nettverk av Helsefremmende Skoler i Norge
Wolff, Katharina	To know or not to know? Attitudes towards receiving genetic information among patients and the general public.
Ogden, Terje, dr.philos.	Familiebasert behandling av alvorlige atferdsproblemer blant barn og ungdom. Evaluering og implementering av evidensbaserte behandlingsprogrammer i Norge.
Solberg, Mona Elin	Self-reported bullying and victimisation at school: Prevalence, overlap and psychosocial adjustment.
<b>2011</b> <b>V</b>	
Bye, Hege Høvik	Self-presentation in job interviews. Individual and cultural differences in applicant self-presentation during job interviews and hiring managers' evaluation
Notelaers, Guy	Workplace bullying. A risk control perspective.
Moltu, Christian	Being a therapist in difficult therapeutic impasses. A hermeneutic phenomenological analysis of skilled psychotherapists' experiences, needs, and strategies in difficult therapies ending well.
Myrseth, Helga	Pathological Gambling - Treatment and Personality Factors
Schanche, Elisabeth	From self-criticism to self-compassion. An empirical investigation of hypothesized change processes in the Affect Phobia Treatment Model of short-term dynamic psychotherapy for patients with Cluster C personality disorders.
Våpenstad, Eystein Victor, dr.philos.	Det tempererte nærvær. En teoretisk undersøkelse av psykoterapeutens subjektivitet i psykoanalyse og psykoanalytisk psykoterapi.
Haukebø, Kristin	Cognitive, behavioral and neural correlates of dental and intra-oral injection phobia. Results from one treatment and one fMRI study of randomized, controlled design.
Harris, Anette	Adaptation and health in extreme and isolated environments. From 78°N to 75°S.
Bjørknes, Ragnhild	Parent Management Training-Oregon Model: intervention effects on maternal practice and child behavior in ethnic minority families
Mamen, Asgeir	Aspects of using physical training in patients with substance dependence and additional mental distress
Espvik, Roar	Expert teams: Do shared mental models of team members make a difference

	Haara, Frode Olav	Unveiling teachers' reasons for choosing practical activities in mathematics teaching
<b>2011</b>	Hauge, Hans Abraham	How can employee empowerment be made conducive to both employee health and organisation performance? An empirical investigation of a tailor-made approach to organisation learning in a municipal public service organisation.
<b>H</b>	Melkevik, Ole Rogstad	Screen-based sedentary behaviours: pastimes for the poor, inactive and overweight? A cross-national survey of children and adolescents in 39 countries.
	Vøllestad, Jon	Mindfulness-based treatment for anxiety disorders. A quantitative review of the evidence, results from a randomized controlled trial, and a qualitative exploration of patient experiences.
	Tolo, Astrid	Hvordan blir lærerkompetanse konstruert? En kvalitativ studie av PPU-studenters kunnskapsutvikling.
	Saus, Evelyn-Rose	Training effectiveness: Situation awareness training in simulators
	Nordgreen, Tine	Internet-based self-help for social anxiety disorder and panic disorder. Factors associated with effect and use of self-help.
	Munkvold, Linda Helen	Oppositional Defiant Disorder: Informant discrepancies, gender differences, co-occurring mental health problems and neurocognitive function.
	Christiansen, Øivin	Når barn plasseres utenfor hjemmet: beslutninger, forløp og relasjoner. Under barnevernets (ved)tak.
	Brunborg, Geir Scott	Conditionability and Reinforcement Sensitivity in Gambling Behaviour
	Hystad, Sigurd William	Measuring Psychological Resiliency: Validation of an Adapted Norwegian Hardiness Scale
<b>2012</b>	Roness, Dag	Hvorfor bli lærer? Motivasjon for utdanning og utøving.
<b>V</b>	Fjermestad, Krister Westlye	The therapeutic alliance in cognitive behavioural therapy for youth anxiety disorders
	Jenssen, Eirik Sørnes	Tilpasset opplæring i norsk skole: politikeres, skolelederes og læreres handlingsvalg
	Saksvik-Lehouillier, Ingvild	Shift work tolerance and adaptation to shift work among offshore workers and nurses
	Johansen, Venke Frederike	Når det intime blir offentlig. Om kvinners åpenhet om brystkreft og om markedsføring av brystkreftsaken.
	Herheim, Rune	Pupils collaborating in pairs at a computer in mathematics learning: investigating verbal communication patterns and qualities
	Vie, Tina Løkke	Cognitive appraisal, emotions and subjective health complaints among victims of workplace bullying: A stress-theoretical approach



	Jones, Lise Øen	Effects of reading skills, spelling skills and accompanying efficacy beliefs on participation in education. A study in Norwegian prisons.
<b>2012</b>	Danielsen, Yngvild Sørebo	Childhood obesity – characteristics and treatment. Psychological perspectives.
<b>H</b>	Horverak, Jøri Gytte	Sense or sensibility in hiring processes. Interviewee and interviewer characteristics as antecedents of immigrant applicants' employment probabilities. An experimental approach.
	Jøsendal, Ola	Development and evaluation of BE smokeFREE, a school-based smoking prevention program
	Osnes, Berge	Temporal and Posterior Frontal Involvement in Auditory Speech Perception
	Drageset, Sigrunn	Psychological distress, coping and social support in the diagnostic and preoperative phase of breast cancer
	Aasland, Merethe Schanke	Destructive leadership: Conceptualization, measurement, prevalence and outcomes
	Bakibinga, Pauline	The experience of job engagement and self-care among Ugandan nurses and midwives
	Skogen, Jens Christoffer	Foetal and early origins of old age health. Linkage between birth records and the old age cohort of the Hordaland Health Study (HUSK)
	Leveresen, Ingrid	Adolescents' leisure activity participation and their life satisfaction: The role of demographic characteristics and psychological processes
	Hanss, Daniel	Explaining sustainable consumption: Findings from cross-sectional and intervention approaches
	Rød, Per Arne	Barn i klem mellom foreldrekonflikter og samfunnsmessig beskyttelse
<b>2013</b>	Mentzoni, Rune Aune	Structural Characteristics in Gambling
<b>V</b>	Knudsen, Ann Kristin	Long-term sickness absence and disability pension award as consequences of common mental disorders. Epidemiological studies using a population-based health survey and official ill health benefit registries.
	Strand, Mari	Emotional information processing in recurrent MDD
	Veseth, Marius	Recovery in bipolar disorder. A reflexive-collaborative exploration of the lived experiences of healing and growth when battling a severe mental illness
	Mæland, Silje	Sick leave for patients with severe subjective health complaints. Challenges in general practice.
	Mjaaland, Thera	At the frontiers of change? Women and girls' pursuit of education in north-western Tigray, Ethiopia

	Odéen, Magnus	Coping at work. The role of knowledge and coping expectancies in health and sick leave.
	Hynninen, Kia Minna Johanna	Anxiety, depression and sleep disturbance in chronic obstructive pulmonary disease (COPD). Associations, prevalence and effect of psychological treatment.
	Flo, Elisabeth	Sleep and health in shift working nurses
	Aasen, Elin Margrethe	From paternalism to patient participation? The older patients undergoing hemodialysis, their next of kin and the nurses: a discursive perspective on perception of patient participation in dialysis units
	Ekomás, Belinda	Emotional and Behavioural Problems in Children: Self-perception, peer relationships, and motor abilities
	Corbin, J. Hope	North-South Partnerships for Health: Key Factors for Partnership Success from the Perspective of the KIWAKKUKI
	Birkeland, Marianne Skogbrott	Development of global self-esteem: The transition from adolescence to adulthood
<b>2013</b>	Gianella-Malca, Camila	Challenges in Implementing the Colombian Constitutional Court's Health-Care System Ruling of 2008
<b>H</b>	Hovland, Anders	Panic disorder – Treatment outcomes and psychophysiological concomitants
	Mortensen, Øystein	The transition to parenthood – Couple relationships put to the test
	Årdal, Guro	Major Depressive Disorder – a Ten Year Follow-up Study. Inhibition, Information Processing and Health Related Quality of Life
	Johansen, Rino Bandlitz	The impact of military identity on performance in the Norwegian armed forces
	Bøe, Tormod	Socioeconomic Status and Mental Health in Children and Adolescents
<b>2014</b>	Nordmo, Ivar	Gjennom nåløyet – studenters læringserfaringer i psykologutdanningen
<b>V</b>	Dovran, Anders	Childhood Trauma and Mental Health Problems in Adult Life
	Hegelstad, Wenche ten Velden	Early Detection and Intervention in Psychosis: A Long-Term Perspective
	Urheim, Ragnar	Forståelse av pasientagresjon og forklaringer på nedgang i voldsrate ved Regional sikkerhetsavdeling, Sandviken sykehus
	Kinn, Liv Grethe	Round-Trips to Work. Qualitative studies of how persons with severe mental illness experience work integration.
	Rød, Anne Marie Kinn	Consequences of social defeat stress for behaviour and sleep. Short-term and long-term assessments in rats.
	Nygård, Merethe	Schizophrenia – Cognitive Function, Brain Abnormalities, and Cannabis Use

	Tjora, Tore	Smoking from adolescence through adulthood: the role of family, friends, depression and socioeconomic status. Predictors of smoking from age 13 to 30 in the "The Norwegian Longitudinal Health Behaviour Study" (NLHB)
	Vangsnes, Vigdis	The Dramaturgy and Didactics of Computer Gaming. A Study of a Medium in the Educational Context of Kindergartens.
	Nordahl, Kristin Berg	Early Father-Child Interaction in a Father-Friendly Context: Gender Differences, Child Outcomes, and Protective Factors related to Fathers' Parenting Behaviors with One-year-olds
<b>2014</b>	Sandvik, Asle Makoto	Psychopathy – the heterogeneity of the construct
<b>H</b>	Skotheim, Siv	Maternal emotional distress and early mother-infant interaction: Psychological, social and nutritional contributions
	Halleland, Helene Barone	Executive Functioning in adult Attention Deficit Hyperactivity Disorder (ADHD). From basic mechanisms to functional outcome.
	Halvorsen, Kirsti Vindal	Partnerskap i lærerutdanning, sett fra et økologisk perspektiv
	Solbue, Vibeke	Dialogen som visker ut kategorier. En studie av hvilke erfaringer innvandrerdømmere og norskfødte med innvanderforeldre har med videregående skole. Hva forteller ungdommenes erfaringer om videregående skoles håndtering av etniske ulikheter?
	Kvalevaag, Anne Lise	Fathers' mental health and child development. The predictive value of fathers' psychological distress during pregnancy for the social, emotional and behavioural development of their children
	Sandal, Ann Karin	Ungdom og utdanningsval. Om elevar sine opplevingar av val og overgangsprosessar.
	Haug, Thomas	Predictors and moderators of treatment outcome from high- and low-intensity cognitive behavioral therapy for anxiety disorders. Association between patient and process factors, and the outcome from guided self-help, stepped care, and face-to-face cognitive behavioral therapy.
	Sjølie, Hege	Experiences of Members of a Crisis Resolution Home Treatment Team. Personal history, professional role and emotional support in a CRHT team.
	Falkenberg, Liv Eggset	Neuronal underpinnings of healthy and dysfunctional cognitive control
	Mrdalj, Jelena	The early life condition. Importance for sleep, circadian rhythmicity, behaviour and response to later life challenges
	Hesjedal, Elisabeth	Tverrprofesjonelt samarbeid mellom skule og barnevern: Kva kan støtte utsette barn og unge?

<b>2015 V</b>	Hauken, May Aasebø	« <i>The cancer treatment was only half the work!</i> » A Mixed-Method Study of Rehabilitation among Young Adult Cancer Survivors
	Ryland, Hilde Katrin	Social functioning and mental health in children: the influence of chronic illness and intellectual function
	Rønsen, Anne Kristin	Vurdering som profesjonskompetanse. Refleksjonsbasert utvikling av læreres kompetanse i formativ vurdering
	Hoff, Helge Andreas	Thinking about Symptoms of Psychopathy in Norway: Content Validation of the Comprehensive Assessment of Psychopathic Personality (CAPP) Model in a Norwegian Setting
	Schmid, Marit Therese	Executive Functioning in recurrent- and first episode Major Depressive Disorder. Longitudinal studies
	Sand, Liv	Body Image Distortion and Eating Disturbances in Children and Adolescents
	Matanda, Dennis Juma	Child physical growth and care practices in Kenya: Evidence from Demographic and Health Surveys
	Amugsi, Dickson Abanimi	Child care practices, resources for care, and nutritional outcomes in Ghana: Findings from Demographic and Health Surveys
	Jakobsen, Hilde	The good beating: Social norms supporting men's partner violence in Tanzania
	Sagoe, Dominic	Nonmedical anabolic-androgenic steroid use: Prevalence, attitudes, and social perception
	Eide, Helene Marie Kjærgård	Narrating the relationship between leadership and learning outcomes. A study of public narratives in the Norwegian educational sector.
<b>2015 H</b>	Wubs, Annegreet Gera	Intimate partner violence among adolescents in South Africa and Tanzania
	Hjelmervik, Helene Susanne	Sex and sex-hormonal effects on brain organization of fronto-parietal networks
	Dahl, Berit Misund	The meaning of professional identity in public health nursing
	Røykenes, Kari	Testangst hos sykepleierstudenter: «Alternativ behandling»
	Bless, Josef Johann	The smartphone as a research tool in psychology. Assessment of language lateralization and training of auditory attention.
	Løwik, Camilla Margrethe Sigvaldsen	Common mental disorders and work participation – the role of return-to-work expectations
	Lehmann, Stine	Mental Disorders in Foster Children: A Study of Prevalence, Comorbidity, and Risk Factors
	Knapstad, Marit	Psychological factors in long-term sickness absence: the role of shame and social support. Epidemiological studies based on the Health Assets Project.

<b>2016</b> <b>V</b>	Kvestad, Ingrid	Biological risks and neurodevelopment in young North Indian children
	Sælør, Knut Tore	Hinderløyper, halmstrå og hengende snører. En kvalitativ studie av håp innenfor psykisk helse- og rusfeltet.
	Mellingen, Sonja	Alkoholbruk, partilfredshet og samlivsstatus. Før, inn i, og etter svangerskapet – korrelerer eller konsekvenser?
	Thun, Eirunn	Shift work: negative consequences and protective factors
	Hilt, Line Torbjømsen	The borderlands of educational inclusion. Analyses of inclusion and exclusion processes for minority language students
	Havnen, Audun	Treatment of obsessive-compulsive disorder and the importance of assessing clinical effectiveness
	Slåtten, Hilde	Gay-related name-calling among young adolescents. Exploring the importance of the context.
	Ree, Eline	Staying at work. The role of expectancies and beliefs in health and workplace interventions.
	Morken, Frøydis	Reading and writing processing in dyslexia
<b>2016</b> <b>H</b>	Løvoll, Helga Synnevåg	Inside the outdoor experience. On the distinction between pleasant and interesting feelings and their implication in the motivational process.
	Hjeltnes, Aslak	Facing social fears: An investigation of mindfulness-based stress reduction for young adults with social anxiety disorder
	Øyeflaten, Irene Larsen	Long-term sick leave and work rehabilitation. Prognostic factors for return to work.
	Henriksen, Roger Ekeberg	Social relationships, stress and infection risk in mother and child
	Johnsen, Iren	«Only a friend» - The bereavement process of young adults who have lost a friend to a traumatic death. A mixed methods study.
	Helle, Siri	Cannabis use in non-affective psychoses: Relationship to age at onset, cognitive functioning and social cognition
	Glabek, Mats	Workplace bullying and expulsion in working life. A representative study addressing prospective associations and explanatory conditions.
	Oanes, Camilla Jensen	Tilbakemelding i terapi. På hvilke måter opplever terapeuter at tilbakemeldingsprosedyrer kan virke inn på terapeutiske praksiser?
	Reknes, Iselin	Exposure to workplace bullying among nurses: Health outcomes and individual coping
	Chimhutu, Victor	Results-Based Financing (RBF) in the health sector of a low-income country. From agenda setting to implementation: The case of Tanzania

Ness, Ingunn Johanne	The Room of Opportunity. Understanding how knowledge and ideas are constructed in multidisciplinary groups working with developing innovative ideas.
Hollekim, Ragnhild	Contemporary discourses on children and parenting in Norway. An empirical study based on two cases.
Doran, Rouven	Eco-friendly travelling: The relevance of perceived norms and social comparison

