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Faculty of Community and Health Sciences

The Barriers and enabling factors for the uptake of Voluntary Medical Male Circumcision among “Coloured” males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality.

Jonathan Cockburn

Student Number: 3309278

A mini-thesis submitted in partial fulfilments of the requirements for the degree of Masters in Public Health at the School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape.

Supervisor: Prof Brian Van Wyk

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Barriers

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ABSTRACT

Voluntary Medical Male Circumcision (VMMC) has been proven to reduce heterosexual HIV transmission to men by approximately 60%. It has been argued that achieving 80% circumcision coverage among males aged 15–49 years within five years and maintaining this coverage rate in subsequent years, could avert 3.4 million new HIV infections within 15 years and generate treatment and care savings of US$16.5 billion. As a result the South African Government plans to circumcise 4.3 million males aged 15 and 49 years by the 2015/2016 financial year. However, in the Western Cape the uptake for circumcision has been poor.

While there is not a great deal of knowledge out there about the reasons for the uptake (or lack thereof) of VMMC in the Western Cape, current research focus on Xhosa males predominantly. However, there is limited research on circumcision among the "Coloured" population of the Western Cape. As the "Coloured" population is the largest group in the Western Cape, this gap in research and knowledge is worth noting.

The current study aimed to explore the barriers to and enablers of uptake of VMMC among "Coloured" males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality.

Methodology

The study adopted a qualitative design; semi-structured interviews were conducted with seven key informants, and two focus group discussions with men who had undergone VMMC and men who had chosen not to volunteer to undergo VMMC. Thematic analysis was used to analyse the data.

Results

The key enablers to uptake of VMMC were: the desire for improved hygiene; the reduction in the risk of contracting other STIs; the reduction in the risk of contracting HIV; the role of partners and family members who can encourage males to access services; the perceived improvement in the males' sexual experience and performance; and cultural reasons and religious injunction.

On the other hand the key barriers that discouraged "Coloured" participants from accessing the services include: fear, particularly the fear of pain; the experience of the health services

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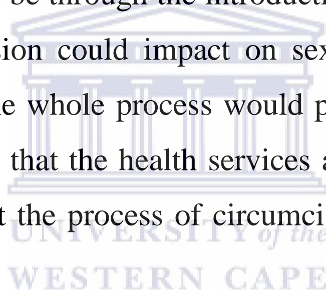
and the role of health staff; the six week healing period in which males cannot have sex; the unwillingness to alter the body that they were born with; role of partners and family as discouragers of uptake; the influence of gangsterism on the ability of males to access services offered on a different gang's 'turf'; and, substance abuse.

The recommendations in this study focus largely on the need to expand the coverage of VMMC in the Cape Town Metropolitan Municipality and to increase the uptake among "Coloured" males between the ages of 15 and 49 years. . These recommendations essentially involve the need to break down the barriers and to accentuate the enablers.

To this end social mobilisation campaigns should not focus solely on HIV prevention but rather on hygiene and improved sexual experience and appearance as well as the cultural and religious aspects.

With regard to the barriers it is essential that any social mobilisation engages with the fear of pain. On method to do this would be through the introduction and expansion of the PrePex™ device. The fear that circumcision could impact on sexual performance and the fear of embarrassment and discomfort the whole process would potentially bring would need to be allayed. In addition it is essential that the health services and health staff are orientated and trained in a way that ensures that the process of circumcision is as easy as possible for the clients.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DECLARATION

I declare that *The Barriers and enabling factors for the uptake of Voluntary Medical Male Circumcision among "Coloured" males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality* is my own work, that it has not been submitted before for any degree or assessment in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

Full Name: Jonathan Terrence Cockburn Date: 17 April 2016

Signed:

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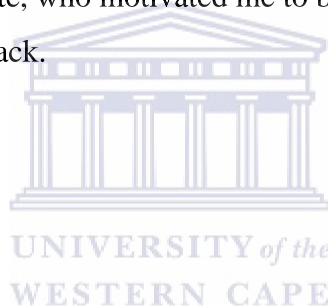

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CHAPTER 1: INTRODUCTION

1.1 Background

South Africa has a generalised HIV epidemic, "with an antenatal prevalence of around 30%" (South African National AIDS Council [SANAC], 2011: 13). A generalised epidemic is one where over 5% of the population has contracted the disease and the HSRC HIV/AIDS national survey 2012 indicates that the HIV prevalence is 12.2% (95% CI: 11.4–13.1) (Shisana et al., 2014: 35). The HIV epidemic became generalised when it starting spreading to the general population in the late 1980s (Karim et al., 2009). South Africa's epidemic is largely driven by sexual transmission, initially between men who have sex with men and then between men and women (Karim et al., 2009). In the National Strategic Plan for 2012-2016 (NSP 2012-2016) SANAC estimates that the 2009 HIV prevalence was 17.8% among adults (SANAC, 2012). HIV and AIDS remains the most important and significant contributor to mortality in South Africa (Pillay-Van Wyk et al., 2013). As a result a number of different HIV prevention approaches have been implemented in South Africa. These include education and awareness campaigns to impact on social norms and gender based violence as well as biomedical interventions such as voluntary medical male circumcision (VMMC) (NSP, 2012).

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Various randomized control trials (RCTs) have shown that voluntary medical male circumcision (VMMC) reduced heterosexual HIV transmission to men by approximately 60 percent (Auvert et al., 2005; Bailey et al., 2007). These results are further supported by cross-sectional surveys of males in Orange Farm, South Africa (the site of the first high volume VMMC site in South Africa) which indicated a 76% reduction in HIV acquisition risk among those receiving Voluntary Medical Male Circumcision (VMMC) compared with uncircumcised males (Auvert, 2011).

This compelling evidence has led to leading international health agencies, including UNAIDS and WHO, setting a global target of circumcising 20 million men in 14 high-priority countries, including South Africa, by 2015 in order to achieve a population-level reduction in HIV incidence (UNAIDS & WHO, 2011: 7). Modelling studies done in 2009–2011 showed that in these 14 priority countries, achieving 80% circumcision prevalence among males aged 15–49 years within five years ("catch-up"), and maintaining this coverage rate in subsequent years

("sustainability"), could avert 3.4 million new HIV infections within 15 years and generate treatment and care savings of US$16.5 billion (Sgaier et al., 2014). As a result, the South African Government plans to circumcise 4.3 million males aged 15 and 49 years by the 2015/2016 financial year (DOH, 2012: 44).

In the Western Cape, however, the uptake for circumcision has been poor as can be seen Figure 1 below. In 2011/2012 the target for the Western Cape, set by the National Department, was 58 515 medical male circumcisions (DOH, 2012: 44). The total number of circumcision done in this period was 2 078 (Western Cape DOH, 2013). The target for 2012/2013 for the Western Cape was originally set by National DOH at 70 218 (DOH, 2012). This target was adjusted to 35 000 at the request of the provincial health department and 7 410 Medical Circumcisions were done (Western Cape DOH, 2013). As a percentage of the National Target the Western Cape's original target for 2012/2013 was 11.7% (DOH, 2012: 44) and the achievement was 1.3% of the 568 000 circumcisions conducted during this period (Loykissoonlal, 2013). In 2013/2014 there was an increase to 17 028 circumcisions out of a target of 70 000. In 2014/2015 the target for the Western Cape was increased to 117 000 and the actual number of circumcisions conducted was 15 498. This is a decrease from the previous years and illustrates the challenges faced by the VMMC programme in the Western Cape.

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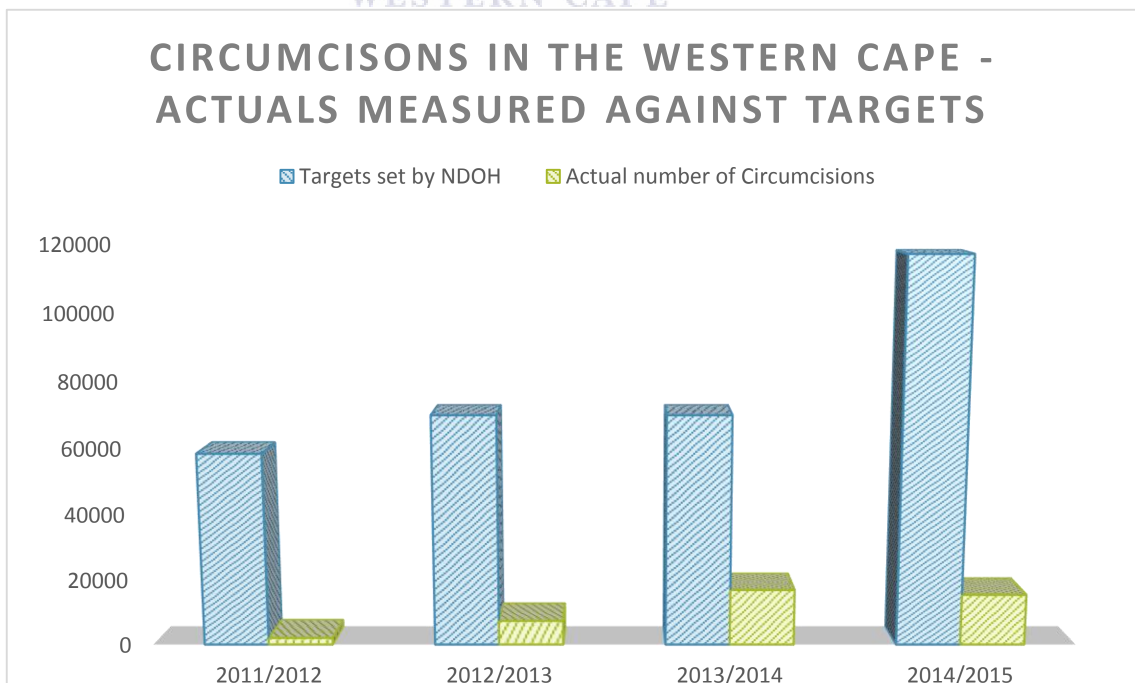

Figure 1: A graph illustrating the actual circumcisions in the Western Cape measured against the targets that were set by the National Department of Health.

1.2 Problem Statement

It is clear from the above results that there is a significant disconnect between the expected demand and the uptake of VMMC among men (DOH, 2012). As a result it is critical that in-depth exploration of the discrepancy between expectation and demand be conducted. This is especially pertinent when one considers that in the recent HSRC survey only 26.4% of "Coloured[1]" respondents self-reported being circumcised (Shisana et al., 2014: 44).

While there has been research on acceptability and uptake of VMMC in South Africa – particularly Gauteng and Kwa-Zulu Natal - there is very little research on the barriers to and enablers of uptake in the Western Cape. There has been some research done on acceptability of VMMC among Xhosa males in the Western Cape (and the role that traditional circumcision plays in this) (Maughan-Brown et al., 2011; Mark et al., 2012), but there are a number of questions that remain unanswered and areas that warrant further study particularly among "Coloured" males as this is the largest group of uncircumcised males in the Western Cape. While a very recent study by Toefy et al. (2015) touches on the enablers of uptake of VMMC among "Coloured" males, its primary focus was on understanding the sexual behaviour of men and their female partners after VMMC in the Western Cape.

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[1] The term "Coloured" is a label that is given to people in South Africa who have mixed ethnic origins. As Mohamed Adhikari puts it "the term Coloured is used to refer to those people who regard themselves as Coloured" (2005: xv). However the use of the term "Coloured" is complicated by a revisionist lobby who reject the term (Adhikari, 2005) and as such it has been decided to place the word between quotation marks in this thesis. In addition it have been decided to capitalise the term throughout as this is in line with the recent conventions.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In their seminal study "The relationship between male circumcision and HIV infection in African populations", Bongaarts et al. (1989) noted that HIV prevalence appeared to be much higher among cultural groups with no tradition of circumcision than among circumcising ethnic groups. This geographic analyses was taken forward by Moses et al. (1994: 209) who suggested that male circumcisions should be considered "as an effective intervention to reduce HIV transmission" as a result of the preliminary findings. These initial studies resulted in a great deal of academic interest and further studies. This led to two important systematic reviews. In the first review, Weis et al. concluded that the studies showed that there was a substantial protective effect against HIV from VMMC and therefore recommended that randomised control trials be conducted to test their conclusions in a more systematic and rigorous way (Weis et al., 2000). However, Connolly et al.'s systematic review, which has focused on South Africa, concluded that there was no protective value against HIV from VMMC (Connolly et al., 2009). However, it is clear that this contrary finding could relate to the study design and sample selection as many of the men in the study were traditionally circumcised, and well after sexual debut. A further systematic review was conducted by Wamai et al. (2011) confirmed that VMMC provides greater than 60% protection for female to male transmission.

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2.2. Randomised Control Trials and early acceptability studies

Three randomised control trials were conducted in South Africa, Kenya and Uganda, respectively. Men who were part of the circumcision group had a 60% (South Africa), 53% (Kenya), and 51% (Uganda) lower incidence of HIV infection compared with men who were not circumcised (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007).

One of the limitations of the methodology of the RTC in South Africa was that they ended the trial early as they felt that that they had an ethical obligation to circumcise the control group once they felt that they had proof of the effectiveness of the intervention (Auvert et al., 2005). While this may have been an ethically sound decision, it was limiting as this was intended to be a long term study of the effectiveness of the intervention. Of course the long term effect can be determined through other studies but not through this one.

While proving the effectiveness of the intervention was important, acceptability of VMMC was also a vital aspect. In order for any intervention to be important it was important that there was genuine willingness of men to come to present for circumcision. Lagarde et al. (2003) conducted a cross sectional study in the Westonaria district in Gauteng South Africa in which they found that over 50% of the males' sample who were uncircumcised indicated that they would be willing to be circumcised. In a similar study conducted in the Hlabisa sub district in KwaZulu Natal 51% of uncircumcised men and 68% of women "favoured male circumcision of themselves or their partners" (Scott et al., 2005: 304). In this study the fear of pain was the most frequently cited reason for not being willing to circumcise (Scott et al., 2005: 309). This study is somewhat limited by the small sample size of 100 men and 44 women (Scott et al., 2005: 304).

A wide ranging review of acceptability in Southern Africa the across 13 studies from 9 countries the "median proportion of uncircumcised men willing to become circumcised was 65%" (Westercamp and Bailey, 2007: 341). This review also looks at a number of factors that influence acceptability. The most important of these was hygiene and the authors found that improved hygiene was in of the most important enablers. The authors also found that men believed that circumcision improved sexual satisfaction as well as making it easier to use a condom. In addition, Westercamp and Baily (2007) noted that in the majority of Southern Africa, circumcision was culturally acceptable and, in many parts, was already being practiced in a traditional way.

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A serious limitation of the review by Westercamp and Bailey (2007) is that, in the South African context, it merely reviews the finding of Lagarde et al. (2003) and Scot et al. (2005) and extrapolates these findings to the general South African population even though these studies are specific to KwaZulu-Natal and Gauteng. This is not sufficient in terms of the research problem outlined in the introduction above, as findings with regard to the Western Cape are required.

2.4 Later acceptability studies

Peltzer et al. (2014) noted that perceptions had somewhat shifted in the more recent years. They found that better knowledge about the benefits of male circumcision was positively associated with the acceptability of male circumcision and that there was increasing acceptability among younger men and boys.

In recent formative qualitative research conducted by McCann Health in preparation for the development of a national marketing campaign the researchers interviewed 1200 male respondents. They identified that the primary benefits of VMMC identified by the respondents were better hygiene (56%), improved health (54%) and the reduction of risk of contracting HIV (52%) (McCann, 2015). The key barriers to VMMC were identified as a fear of pain (57%), fear of infection (37%) and the long healing process post the circumcision (37%) (McCann, 2015).

2.5 Acceptability in the Western Cape

There are four studies that focus on the key aspect of acceptability of VMMC in the Western Cape. These are studies by Maughan-Brown et al. (2011), Maughan-Brown and Venkataramani (2012), Mark et al. (2012) and Toefy et al. (2015). The first three of these studies look at circumcision among Xhosa males and in combination they offer a reasonably thorough understanding about the acceptability of VMMC among Xhosa males in Cape Town. The last one by Toefy et al. (2015) is focused on "Coloured" men and women and focusses on their sexual behaviour after the circumcision. As part of the last-mentioned study the participating men were asked for reasons why they volunteered to undergo circumcision.

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The first study done by Maughan-Brown et al. (2011) showed that there was strong support for traditional circumcisions among Xhosa men. This study indicated that 89% of respondents favoured traditional circumcision as the only acceptable circumcision method. The authors conclude that full circumcision[2] is associated with there was a 7% decrease in the likelihood of testing positive for HIV. They extrapolate from these findings and conclude that there are no HIV protective benefits from a partial circumcision as the study showed that there was not a difference in HIIV prevalence between those who were partially circumcised and those who not circumcised at all.

[2] In traditional circumcision the amount of the foreskin that is removed varies greatly depending on the traditional surgeon. This can vary from the removal of a small piece of the foreskin to the complete removal of the foreskin. The complete removal of the foreskin is referred to as a full circumcision and anything less than the full removal of the foreskin is referred to as a partial circumcision.

In the study by Mark et al. (2012) the authors take a more conservative approach and recommend that further research needs to be done to determine whether there are HIV protective benefits of a partial circumcision.

One of the findings of the Maughan-Brown et al. study was that strong cultural support for traditional circumcision can “stymie efforts to promote early and medical circumcisions” (2011: 503). In terms of circumcision as a HIV prevention tool, traditional circumcision is potentially problematic. Firstly, as mentioned above traditional circumcisions are not always full circumcisions which limit the benefits in terms of HIV prevention. In addition, traditional circumcision often happens many years after sexual debut which limits its effectiveness as a HIV prevention tool as transmission of HIV may happen before circumcision. Another finding of this study was that being informed about the protective benefits of male circumcision was associated with a higher perception of HIV risk and thus a higher likelihood of using condoms at last sex (Maughan-Brown and Venkataramani, 2012).

Maughan-Brown and Venkataramani (2012) did not investigate the barriers to or enablers of the uptake of Medical Male Circumcision among those who are not circumcised. They do offer an interesting insight about the issue of risk compensation and advocate strongly that there be continued education among women to ensure that they remain aware of the need to protect themselves. While the Maughan- Brown and Venkataramani study (2012) points to the need for “continual risk reduction education efforts among women to counter risk compensation associated with male circumcision” (2012: 7), it does not directly illustrate the reasons for and barriers to or enablers of the uptake of medical male circumcision among those who are not circumcised.

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In contrast to the Maughan- Brown and Venkataramani study, Mark et al. (2012) investigated the levels of acceptability of VMMC as an HIV/AIDS intervention among Xhosa men in Cape Town. The findings of this study emphatically showed that traditional circumcision was universally practiced among Xhosa men. The majority of the men enrolled reported being traditionally circumcised (74%) and 50 out of 51 uncircumcised men were planning to have traditional circumcisions (Mark et al., 2012).

Toefy et al. (2015) focusing on “Coloured” males, found that the primary motivators for men who underwent medical circumcision were reasons that relate to improved hygiene and well as the reduction of the risks of contracting STIs other than HIV. In addition, in this particular

study a large number of males who underwent circumcision did so as a result of religious reasons related to recent conversion to Islam or the desire to marry Muslim women.

The McCann (2015) research referenced in the previous section also identified that the three key enablers of circumcision in the Western Cape were in descending order: the reduction of HIV risk, the reduction of the risk of contracting STIs and better hygiene.

2.6 Critical appraisal of literature focussing on acceptability in the Western Cape

One of the limitations of the study conducted by Maughan-Brown et al. (2011) was that the sample for the model comprised only circumcised males. There are a number of potential issues with this. One of these is that there is a likelihood of those who underwent traditional circumcision becoming proponents of and advocates for the traditional approach. However, the study by Mark et al. (2012) includes uncircumcised men and the results show that among uncircumcised men 80% were unwilling to undergo medical male circumcision. In addition the absence of uncircumcised men in the Maughan-Brown et al. (2011) study has a negative effect on the study as the links between circumcision and HIV status cannot be fully understood without comparing the HIV prevalence among the circumcised to the uncircumcised.

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Another limitation is that the key question that the Maughan-Brown and Venkataramani (2012) based their findings on the question "Have you ever heard that removing a man's foreskin reduces the risk of him getting HIV?'' (p.3). The authors assumed that the participants in the survey understand this to mean circumcision.

An additional limitation in the Maughan-Brown and Venkataramani (2012) study was that the sample comprised relatively few uncircumcised men (n=43; 8%) (2012: 3). This seems to indicate a certain degree of selection bias as those who are aware that circumcision is protective against HIV are more likely to be circumcised. Therefore it is likely that the findings are somewhat skewed.

Another study limitation related to the selection of the participants. Participants were selected at a Voluntary Counselling and Testing (VCT) site. This means that there is potential for selection bias as these were men who were engaged in health seeking behaviour and therefore the results cannot be applied to the general population.

The study by Toefy et al. (2014) primary focus was on the sexual experiences of participants post the six week healing period. While the males were asked to give an indication as to their reasons for volunteering for MMC, this was not the key focus of the study and therefore lacks sufficient depth. In addition, there was a very high proportion of Moslem males in the study which had an impact on the results.

2.7 Conclusions

While there is little reasons about the reasons for the uptake (or lack thereof) of VMMC in the Western Cape, all research as it currently stands appears to focus on Xhosa males. The biggest gap of all currently is around VMMC among "Coloured" men. There is little to no information available. In the recent review conducted by Ledikwe et al. (2014: 144) the authors note that:

> Understanding the contextual barriers and facilitators of VMMC for the …target population in each priority country is important in generating demand.

CHAPTER 3: METHODOLOGY

3.1. Aims and Objectives

This study aimed to explore the barriers to and enablers of the uptake of Voluntary Medical Male Circumcision (VMMC) among "Coloured" males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality, in the Western Cape province of South Africa.

The objectives of the study were:

- To explore the physical, social, cultural and economic barriers, both perceived and experienced, to the uptake of VMMC among "Coloured" males.
- To explore the enabling factors, both perceived and experienced, which led to "Coloured" men presenting for VMMC.

3.2. Study Design

This was an exploratory qualitative study. The first reason for the choice of study design is that the focus of this study is on a holistic understanding of the barriers and enablers. This is a qualitative approach rather than the measurement of the phenomena which would require more of a quantitative approach (Baum, 1995). This holistic understanding is necessary, as it will potentially place the issue of VMMC in its cultural and socio-economic context.

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The second reason is that context is one of the key elements to understanding the barriers and enablers to the uptake of VMMC. The context will help to explain the personal nuances and in different point of views about this complicated intervention. Qualitative evidence is context sensitive (Jack, 2006). In terms of this study it is expected that the perceptions about and feelings towards VMMC (i.e. the context) will be key to understanding the barriers and enablers.

Jack (2006: 279) notes that qualitative research can be an effective way to "address gaps in our understanding of an issue and it can provide a new perspective on a situation". In terms of this proposed research study this is particularly relevant because of the fact that there are no studies which look specifically at the barriers to and enablers of uptake of VMMC among "Coloured" men in the Western Cape.

A key advantage of the qualitative approach is that the research is much easier to understand for people who are not researchers (Baum, 1995). Jack (2006: 281) takes this even further in her belief that “qualitative research can play a role in program evaluation through the identification of barriers, enablers and unanticipated outcomes, allowing decision makers to identify factors that contribute to program success or failure”. In many ways this aptly summarises the intention and motivation behind both this research study and also the choice of a qualitative approach.

3.3. Study population and Sampling

The research setting was the Western and Northern sub-districts of the Cape Town Metropolitan Municipality in the Western Cape Province. There were two main target groups. The first group was “Coloured” men and youth who presented for VMMC and underwent the procedure; and the second group was uncircumcised “Coloured” men and youth.

The men and youth who were presenting for VMMC were accessed through the circumcision sites of the SACTWU Worker Health Program in the Western and Northern Sub-districts. This service was delivered in partnership with the City of Cape Town Health Department and the Provincial Government of the Western Cape Department of Health.

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Uncircumcised men were accessed through the mobilisers who identified those that indicated that they were interested in VMMC at the time.

The study population consisted of “Coloured” males between the ages of 15 and 49 years living in the areas outlined above. Two focus group discussions were conducted with purposively selected “Coloured” males.

The sampling focussed on ensuring that there is a proportionate sample from different ages and, socio-economic groups.

In terms of selection of the group of recently circumcised male, all men who experienced adverse events (AEs) as a result of the surgery were excluded from the sample as their opinions would have potentially been negatively influenced by this experience.

3.3.1 Focus groups

The first focus group discussion was held with eight "Coloured" males who had volunteered to undertake VMMC in the previous two years. These males were identified through the records of the organisations that are responsible for conducting VMMC in these sub districts, namely TB HIV Care Association, SACTWU and DOH. These organisations deliver services from sites in Salt River, Woodstock and Delft. Eligible males were then approached by the researcher or his assistant to get an indication of their willingness to participate in the research.

The research assistant is a coloured man in his forties who is fluent in Afrikaans and English. He works as a facilitator at the SACTWU Worker Health Program. As per the definition of "Coloured" earlier, the participants were identified as "Coloured" through their identification of themselves as "Coloured".

The second FGD was conducted with 8 participants who had been approached by mobilisers to undergo circumcision within the last two years and chose to remain uncircumcised. These clients were identified using the records of the organisations involved in social mobilisation for circumcision, namely SACTWU and Careworks. They were recruited by either by the mobiliser or telephonically by the research assistant.

3.3.2. Key Informants

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After the FGDs the sampling was more theoretical. The selection of the participants for the in depth interviews as well as the selection of the key informants were influenced by the ideas and nascent themes that emerged from the initial analysis of the FGDs. As Ritchie et al. (2003: 80) put it "the researcher samples people…on the basis of their potential contribution to the development and testing of theoretical constructs".

Six key informants were identified based on their experience and their positions within the provincial department of health or organisations in the Western Cape that are involved in the provision of VMMC services and the demand creation and social mobilisation for VMMC.

These included:

- The regional manager of an NGO responsible for the provision of VMMC services in the Western Cape who was closely involved in service provision and demand creation
- The Community Liaison manager for the same NGO, who responsibility it is to manage a team of social mobilisers who work to recruit males for VMMC.

- A nurse who was a member of one of the provincial Department of Health VMMC teams working at the substructure level in the provision of VMMC services.
- A Health Promoter/ Social Mobilisation practitioner in the provincial department of health who is part of the team responsible for social mobilisation across programmes.
- The regional co-ordinator of an NGO funded to do social mobilisation and demand creation specifically for VMMC in the Western Cape.
- The Communications and Advocacy Manager of a third NGO, which is also involved in service provision and social mobilisation for VMMC.

In addition to the above key informants, the research also selected one of the participants of the first focus group discussion with circumcised males. He was identified and approached as it was clear during the discussion that he had carefully considered the issues at hand and had a number of strongly held beliefs and positions with regard to VMMC.

3.5. Data Collection

Data was collected from two focus group discussions (FGDs) undertaken as well as seven in-depth interviews with key informants. It was expected that a combination of these discussions and interviews would provide a rich source of information.

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The focus group discussion with circumcised males was approximately 1 hour and 30 minutes long and the focus group discussion with the uncircumcised males was approximately 1 hour and 15 minutes long. A set of questions was used to guide the discussions. While there were many similar questions in the two sets, they were each tailored to the groups concerned with a different emphasis. These questions and prompts can be found in Appendices 1 and 2.

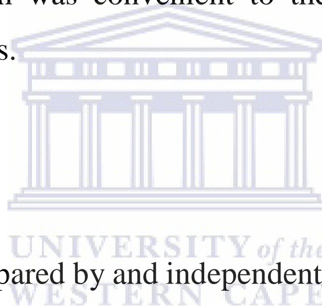
The participants of the focus group discussions were reimbursed for transport to and from the venue and were provided with a light meal after the discussion. The interviewer was provided with translation assistance by the research assistant who was fluent in Afrikaans. The researcher's assistant also acted as a note-taker during the discussions and assisted in recording non-verbal cues from the participants.

The focus group discussions and the key informant interviews were digitally recorded and were transcribed by an independent transcriber as well as the researcher.

These discussions enabled the researcher to get rich information on VMMC based on a range of group opinions, views and perceptions using open-ended questions. This method provided an opportunity for every member of participating group to give their views in an interactive manner (Liamputtong & Ezzy, 2005); thereby stimulating the participants to divulge detailed information as they are reminded of facts that might have otherwise been forgotten in the process if the data was to be collected from the participants individually.

The in-depth interviews enabled the researcher to solicit a deeper understanding on the barriers to and enablers of VMMC uptake. By conducting the FGDs prior to the key informant interviews, the interviewing was able to ask more specific and relevant questions.

In depth interviews were held with seven key informants. The researcher contacted these key informants in person, by email or telephonically. All agreed to be interviewed and they were provided with the participant information sheet as well as the consent forms. Interviews took place at a time and place which was convenient to the key informants. There were no difficulties securing the interviews.



3.6. Data Analysis

A transcript of each FGD was prepared by and independent transcriber fluent in Afrikaans and interview was transcribed and the data was collated. The responses that were collected were then categorised based on an open coding of the responses. Through this process it was possible to become familiar with the data, and therefore to index and chart the themes that emerged from the data (Pope & Mays, 2000).

This thematic analysis allowed for comparisons between and within the themes and categories especially in terms of the relative importance of the different factors.

A photograph of the coding and analysis process can be found below.

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3.7 Credibility and trustworthiness

Rigour in qualitative research can be achieved by systematic and reflexive research design, data collection, interpretation, and communication (Mays & Pope, 1995). Thus it can be said that in many ways rigour is about producing good quality research that can be considered to be credible and dependable (Robson, 2011). There are a number of methods to achieve this.

One of these is through the triangulation of methods. This was possible through the FGDS and the seven key informant interviews which assisted to increase validity by corroborating descriptions and testing points of view and assumptions that arose.

In addition the researcher, as a means of member checking, summarised the key points at the end of the focus group discussions to verify his understanding and interpretation of their perceptions and opinions. The researcher also took the opportunity to discuss the focus group discussions with his colleague who assisted him to check on his interpretation and understanding of what took place.

The researcher also approached two of the key informants after the interviews to verify whether his understanding of what was said in specific contexts was indeed correct.

Reflexivity is one of the most important measures as it has increasingly "entered the qualitative lexicon as a way of emphasising the importance of self-awareness, political/cultural consciousness and ownership of one's perspective" (Patton, 2002: 299). In other words reflexivity requires self-reflection that is critical and context bound as well as self-knowledge. If one is able to examine one's beliefs and perspectives, one can account for this when designing interviews and when analysing and interpreting the data. One way to do this is to look for competing conclusions when interpreting the data (Malterud, 2001). This was a constant concern for the researcher because of his position at that time, where he was in senior management in an organisation funded to provide circumcision services.

Another method in which the rigour of the study was maintained was to ensure that it had internal validity. This was done by ensuring that the study design decisions were coherent and logical, that recorded data was maintained in a way that was above reproach and that transcriptions were accurate and available. Furthermore ensuring internal validity was achieved through a clear audit trail where a full record of activities was kept (Robson, 2011). This was also a key to achieving conformability (Creswell & Miller, 2000).

3.8. Ethics Considerations

Approval and ethics clearance was obtained from the University of the Western Cape Senate. All participants were provided with detailed information about the study. Each participant who agrees to take part in the study received an information sheet (Appendix 7). Informed consent was taken from each participant (Appendix 8) and they were explicitly given the option not to participate with no adverse consequences to themselves (Appendix 9). In addition, focus group participants signed a focus group confidentiality binding form. This form was issued and

discussed to ensure that participants were aware of their responsibilities in terms of making sure that conversations from the focus groups remained confidential.

Participants were informed that the outcome of this study will serve to inform the Provincial Department of Health and its designated VMMC partners to make informed decisions about ways in which to improve uptake of VMMC.

Whilst no harmful impact was experienced, any issues that emerged from the interview that required intervention would have been referred to the bargaining council health care facilities which were staffed by counsellors and by a social worker. The same would have applied had there been an inability to control any negative feelings that might have emerged in the course of the discussions or interviews.

At the end of the Focus Group Discussion with the group of men who had chosen not to be circumcised, they were given the contact details of sites were circumcision could be accessed in the event that they had changed their minds about being uncircumcised.

A high level of confidentiality was strictly adhered to during the study. All study materials, including participant information forms, consent forms, digital recordings and transcribed materials are kept in a secure environment that will only be accessed by the researcher. Transcribed material does not include patient's proper names but their chosen pseudonyms or a pseudonym allocated by the researcher. All those involved in assisting the researcher with the research were informed of the importance of ensuring privacy of personal information. At the end of the study, and after a reasonable period following the completion of the researcher's mini-thesis, the consent forms and tapes will be destroyed.

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CHAPTER 4: RESULTS

4.1. Description of Study Participants

The first focus group discussion was held with eight "Coloured" males who had volunteered to undertake VMMC in the previous two years, they ranged in age from 17 to 48 years. The second focus group was with participants who, even though they had been approached by mobilisers advocating circumcision, had chosen to remain uncircumcised.

The selection of the participants for the in depth interviews as well as the selection of the key informants were influenced by the ideas and nascent themes that emerged from the initial analysis of the FGDs. These interviewees included one of the participants in the focus group discussion for uncircumcised males as well as relevant staff from the Department of Health, implementing partner NGOs and an NGO involved in social mobilisation for VMMC.

4.2 Summary of Themes

These focus group discussions and interviews resulted in a number of findings. A brief summary of these findings will be presented before exploring these in more depth.
These findings could broadly be categorised as *enablers* and *barriers* to the uptake of circumcision.

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<u>*Enablers*</u>

- The desire for better hygiene and easier hygiene practices.
- The belief that circumcision reduces the risk of contracting HIV or other STIs.
- The role of partners and family members in encouraging males to present for circumcision.
- The perceived improvement in sexual performance and experience as a result of undergoing MMC.
- The role of culture and religion in encouraging males to undergo circumcision.
- The perceived improvement in the appearance of the penis after circumcision.

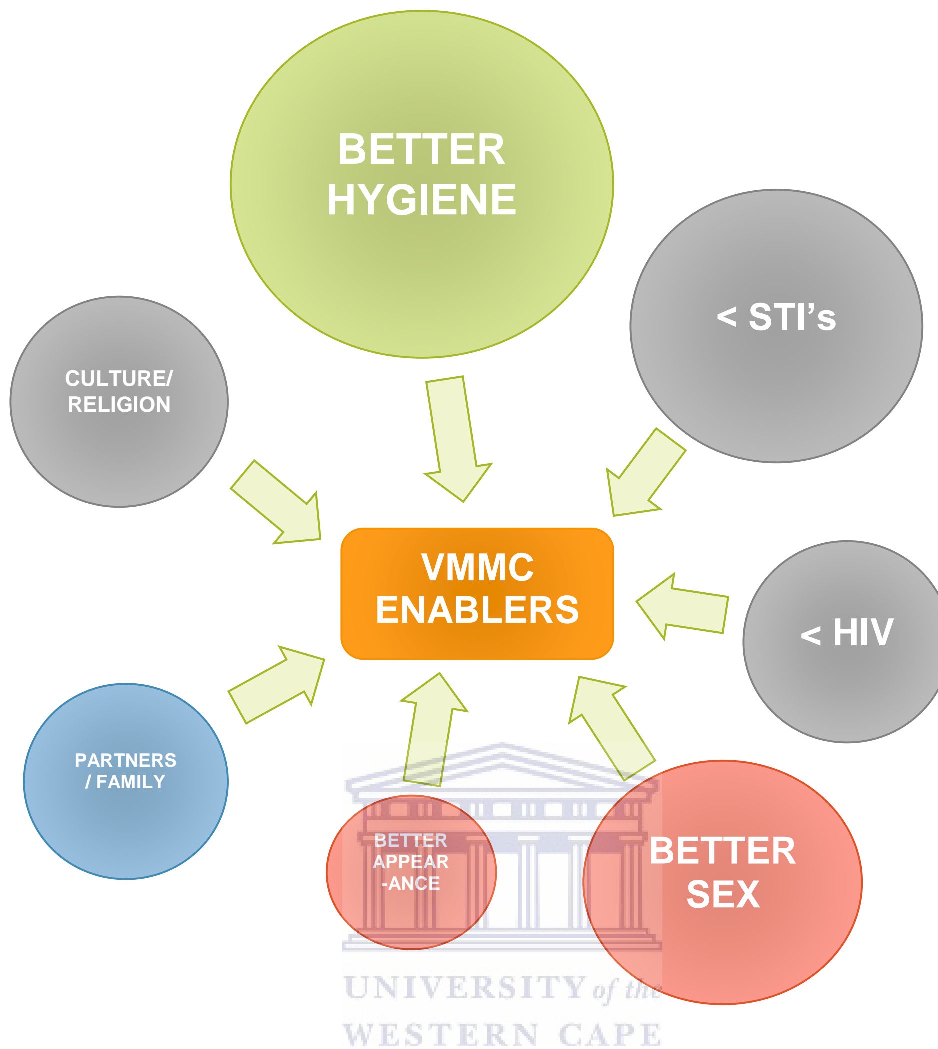

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Figure 2: An illustration of the enablers of circumcision where the relative size of the enabler reflects its importance.

<u>*Barriers*</u>

- A multifaceted barrier to uptake of VMMC is fear. There are a number of fears that come into play including the fear of discomfort and embarrassment, the fear of complications and adverse events, the fear of a possible impact on sexual performance and enjoyment and, finally, the fear of pain. The males' negative experience of the health services is also a barrier. These included sites that are poorly organised and with bad patient flow and long waiting times. And also includes the issues with the follow up process as well as the poor treatment of clients by some staff.
- The six week healing period during which recently circumcised men cannot have sex.

- The strong belief among many men that they are comfortable with the way that there body is and they see no reason to alter it.
- Substance abuse can play a role in stopping males from going through with the procedure.
- Partners and family members can also discourage males from volunteering for circumcision.
- Gang violence is also a barrier to accessing health services in certain parts of the Cape Town Metropolitan Municipality. This is because of the “turf wars” between gangs. A male from one area will be unwilling to travel to a circumcision site in an area controlled by a different gang.

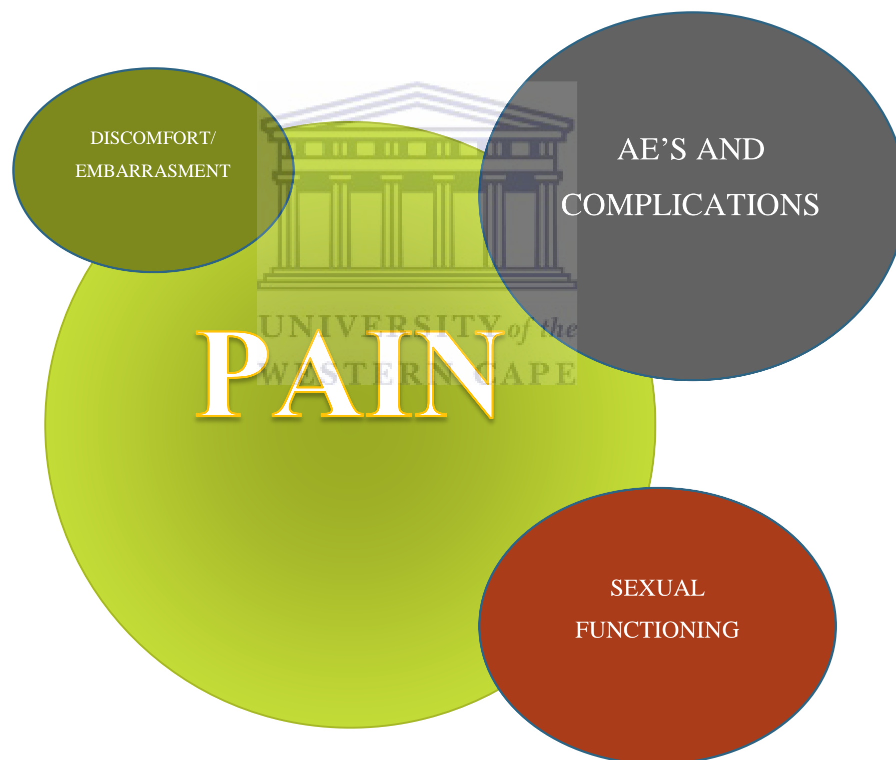


Figure 3: An illustration of the primary barrier to circumcision – namely fear. The relative size of the component reflects its importance in contributing to the barrier of fear.

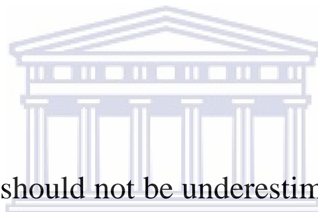
To understand these enablers and barriers, more detailed explorations and discussions of the findings are described in turn.

4.3. Enablers of the uptake of VMMC

Enablers are the factors or specific circumstances which contribute to the decision of males to present themselves for circumcision. These enablers need to be compelling because, as an employee of one of the implementing partners put it, “I mean this is an elective procedure – this guy is not sick”. In other the words there is no clear or present medical reason that immediately requires the procedure to be done.

The findings of this study show the number of factors which influence the decision by males to undergo VMMC. These enablers include: hygiene; the risk of contracting HIV and other STIs; the role of partners and families; improved sexual experience and performance; the role of culture and religion; as well as the perceived improvement in the appearance of the penis.

4.3.1. Hygiene



The role of hygiene as an enabler should not be underestimated. It was discussed by members of the focus groups and well as all the key informants. Essentially, hygiene as a factor is linked to smegma - which is the white substance produced under the foreskin that plays an important role in keeping the glans moist and acting as a lubricant in sexual intercourse (Jayathunge et al., 2014). Good hygiene practices for uncircumcised men would normally involve the cleaning of the penis under the foreskin twice a day but this tends to not happen and there can be a build-up of smegma which begins to smell.

As one of the key informants who was uncircumcised graphically explains:

> *It’s cottage cheese. The smell is there. Uncircumcised guys, especially if you’ve washed in the morning and you go through the day, sweating and urinating and I mean this is what a lot of guys do, and they mustn’t tell me they don’t do this, when they go to urinate, they use their hand and I normally smell and it doesn’t smell lekker [good], you know.*

The uncircumcised males who took part in the focus group discussion saw also saw hygiene as a key enabler:

My experience of hygiene is that yes, I do see a problem, especially if I'm urinating, I will find that the urine spills a bit and this is being honest and I've heard that guys who were circumcised, they have no problem with urinating. Sometimes you urinate and because of the foreskin, it does make some sort of splash, so that to me is a negative, not being circumcised, but then again, I have a very flexible foreskin, so I can move it and move it up and it looks like it's actually circumcised. I think it's, it can be better, hygienically, to be circumcised.

In the focus group for circumcised males there was not a great deal of discussion about hygiene. However, at least half of the participants indicated that hygiene was one of the reasons that they underwent VMMC. While a number of them indicated that they "missed" their foreskins, they were all very pleased that the hygiene issues were no longer a factor. In fact there was a general sense of relief and great satisfaction that they no longer had to worry about the cleanliness of their penises. As one of the participants of a focus group discussion for circumcised males explains:

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So hygiene for everyone is important. That stuff no longer gets trapped under the foreskin. I got tired of like dipping and cleaning. And like now, I just wash.

The role of hygiene as an enabler was also raised by several key informants. One of the implementing partners conducting circumcision conducted a survey with those who consented to the procedure and hygiene emerged as a significant factor in the decision to circumcise:

What we really found out is that they are coming for hygiene purposes. The primary issue is not HIV. For them they want to be clean and also they want the added benefit of HIV prevention but as I say the primary thing is, basically, for them it is hygienic.

The significant role of hygiene as a factor was emphatically supported by an employee for a different implementing partner who is tasked exclusively with social mobilisation of clients:

Mostly I would say that they think it is more hygienic. I think that this is something that they know – I don't think it is something that they are told although I don't really know. But it is definitely hygiene that is important to them – why they are coming.

4.3.2. Risk of Contracting HIV and other STIs

The reduction of the risk in contracting HIV and other STIs is another enabler to the uptake of VMMMC. The fact that circumcision reduces the risk of males contracting HIV from their female partners by 60% appears to be well known among both the circumcised and uncircumcised men participating in the current study. However, it is worth noting that most of the respondents, including the key informants indicated that the potential reduction in the risks of contract STIs were more of an enabler than the reduced risk of contracting HIV. In their interview a key informant employed by DOH clearly indicated that this was the case:

Besides the benefits for MMC there is no cultural barrier for Coloured males. So I think the fact that that cultural barrier does not exist is a factor. Obviously the 60% reduction in contracting HIV and the reduction in the risk of contracting STIs (is significant). I would see STI's as the most significant factor.

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In fact the contraction of an STI was a clear motivator for one of the circumcised men who took part in the focus group discussion. In his case it can be seen that it was actually a combination of both a concern about the STI that he contracted as well as the potential risks of getting HIV.

Ek het een keer met 'n ander girl geslaap en toe agterna, aan die punt, het ek sulke puisies gekry. Toe gaan ek na die kliniek en hulle gevra om te kyk, want ek is bekommerd, want ek wil nie klomp puisies and knoppe hê. Toe gaan ek sommer vir my 'status' [HIV test]. En ek was baie bly dat ek het niks gekry nie; toe is al dit [STI] sommer weg. Toe het ek ook besluit om 'n besnydenis te kry.

(One time I slept with another girl and afterwards there were pimples on the head of the penis. I went to the clinic and asked them to look at it because I was worried because I did not want pimples and sores on my penis. Then I went to check my [HIV] status and I was very happy that I did not get anything. Then it [the infection] was all gone. Then I also decided to get a circumcision.)

In fact it would be fair to say that, even if the reduction of the risk of acquiring HIV and other STI's, was not the most powerful enabler, it was certainly perceived to be one of the real benefits of the decision to become circumcised. This was mentioned by a number of the participants who were circumcised. One of these circumcised men expressed it in the following way – it is worth noting that he was also noting that the protective effect of circumcision is not 100%:

It is exactly like HIV and AIDS. You can still contract it. A girl can be not clean, so all these STI's, all these diseases, you must also keep in mind. Sex is pleasure, but there is also a negative thing about it. So you must always consider the next thing. Circumcision helps with this.

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4.3.3. Role of Partners and Family

The role of partners and family members is complex and multi-faceted. They can certainly be an enabling factor but, as will be evident in the section of the results on the barriers, they can also put pressure on boys and men not to circumcise.

What was particularly noteworthy from the focus groups discussions with both the circumcised and uncircumcised males was the number of them that acted against the wishes of their partners or their family members. A number of circumcised men had gone for circumcision against the wishes of their partners and family; and equally there were men in the uncircumcised group who had resisted the efforts of their partners or family members to get them to go for the procedure.

While the partners may be either enablers or barriers, there is a strong sense from the key informants that they could be significant enablers. A mobiliser working for one of the implementing NGOs sees persistent young female partners as playing an important role:

> *Young females in partnerships can often help us to get their partners to the procedure. Some of their girlfriends nag them as well. That is what I have observed. They literally nag them – "You have to have it done, you have to have it done".*

An employee of one of the implementing partners conducting circumcision also indicated that partners were important influencers. He also raised an interesting point that the partners are more likely to be barriers at a certain time of the year:

> *I think that they facilitate it in my view (laughs). I am laughing because during December some guys are like "No! Six weeks without sex in December" and I do that that sometimes the partners play a role by saying "No – not in December - you can do it some other time".*

The point about the significance of December will be explored further in the section on the discussion of the barriers.

A key informant from an NGO involved in mobilisation sees women generally and mothers in particular as being able to play a significant role in encouraging males to present for circumcision:

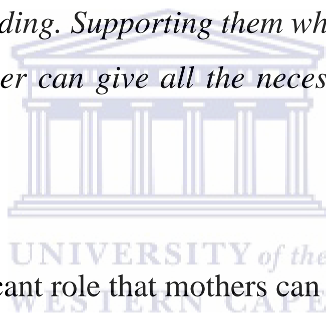
> *So let us not only focus on men let us look at women as well as they can play a big role in motivating their partners again. They also have got sort of control over the young boys as well. So that is the reason that we have realised that in some places the 15, 16, 17 and 18 year olds are always accompanied by their mothers.*

An employee of one of the implementing partners conducting circumcision recounted an occasion when a girlfriend of one of the males brought both her boyfriend and her brother to the circumcision site.

So – and also if I may – there was one case where a girlfriend took the –you know – the boyfriend and the brother to circumcision which was quite funny for us. So she was holding (laughs) the brother on one side – so this was in Hout Bay – and the boyfriend on the other side.

Partners and mothers are not just seen as important in encouraging the young males to come forward for the circumcision but also in providing the necessary support and assistance, not only for the procedure, but also for the subsequent period of healing. A senior manager of one of the implementing partners conducting circumcision sees this as being one of the key factors:

What I have noticed with the Coloured community is that they are coming with their partners to get it done. They are getting the support from their family – they come with their partners, with their parents and with their female relatives sometimes. So they get the support and understanding. Supporting them when they get to the facility and post-operatively. So the partner can give all the necessary support that a person would need.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She goes on to discuss the significant role that mothers can play in the process as they provide support to younger males during the period of healing that is necessary after the procedure.

Mothers are very important. You will get a teen who is so private about their private parts. They sign their own consent but now as much as they have signed it becomes a problem when it comes to follow ups. They don't attend to the wounds as they should and they come back with AEs. Mothers can instil that in them. So the mother must be there listening to the post-operative wound care instructions.

A participant in a focus group for circumcised males gives an interesting account of what happened when he told his mother than he had been circumcised. While she was clearly not a motivator for him to go for the procedure, it is clear that the experience that her one son had will, in all likelihood, lead to her being more involved in the decision of her younger son.

I don't live with them, so they didn't even know, but when I told my mom, she just laughed. She made a joke. She said oh, "het jy alles afgesny?" (Did you cut everything off?). She was quite funny about it, but I think she wants to – (pauses) I have a nine year old brother, so when I had mine done, she actually showed more interest in having him done as well. But I think she will probably wait until he is a bit older.

4.3.4. Improved Sexual Experience and Performance

The perceived improved sexual experience and performance was a significant result that came out of the focus group discussions. While it was not something that was commented on much by key informants many of the males believed that it had significantly improved the sexual experience for both partners as well improving the sexual performance of circumcised men.

A participant in a focus group for circumcised males who has sex with men had felt that reduced sensitivity of the penis meant that sex was better after the circumcision than before.

I was circumcised in 2010, but that was partial. It was done privately, but I could see this was a partial thing because it looked like more foreskin should come off and then I came to (name of implementing partner) and the whole thing was done properly. So and it was April this year (2014)… Well, there is a difference, because when I was uncircumcised, my penis was much more sensitive and that was one of the reasons why, so I can say it is better now.

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The reduced sensitivity was mentioned by and number of participants and they all saw this as a positive thing as they felt that they were able to continue longer before ejaculating. As one of the participants in the circumcised group put it:

After six weeks, I decided I got really had the urge to have sex. I called a friend and she came over and normally my foreskin, it chokes my penis and when I put in the girl, it hurt me. The feeling, it comes quick and you ejaculate, but when I had sex now … I lasted longer. It was very much enjoyable and I did it more than once. That is what's so nice about it and she was actually surprised at how long I lasted.

Not only did the circumcised males indicate that the sexual experience was better for them and their partners but there was also the indication that their partners were more sexually adventurous. A participant in a focus group for circumcised males put it in the following way:

> *With one of my partners – she is my ex-girlfriend, but she didn't know my foreskin was removed ... If we meet up, there is only one thing that is going to happen and I told her do you know my foreskin is removed, but this is like afterwards - after we had had sex. Then she is back on it again. Now I am thinking like a lot of females prefer penises where their foreskins have been removed, because now she is done something that I have never seen her done you know.*

When clarifying this point with the group, it was apparent that the circumcised men were much more likely to receive oral sex from their heterosexual partners now than they were circumcised than before. There was also agreement among the group of circumcised men that the circumcision resulted in their ability to repeat the sexual act more often and with a quicker interval between erections. A participant in a focus group for circumcised males explains it in the following way:

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> *The foreskin has been removed. It is not wet anymore, it's drier. I find like say I have had an orgasm, I can get a quicker arousal and the "oomph" to do it again, whereas normally prior, I would do it and once I had my orgasm, then I wouldn't bother. But now like ten minutes later I am ready again.*

The whole issue of the improved sexual experience and performance was discussed in the focus group discussion for uncircumcised males and one of the participants indicated that what he had heard about this had almost motivated him to undertake MMC, particularly because of the experience of his son. It is interesting that he notes that his wife is also encouraging him to go for these reasons:

> *I've also heard a lot of guys saying that their sexual experiences are better because of being circumcised. For number one they say, the penis is not as sensitive and the foreskin is not there, it takes longer for them to ejaculate, they were saying they are able to have more events of, sexual events, like you're having an event now and then*

very soon after that you're ready to go again. This is what some guys are saying and they're saying it's not being like that, when they were not circumcised. I've heard this and I was tempted quite a few times to say, just go for this thing and maybe that's the case, it might work for you. I must say, my wife has brought this up and said why don't you go for circumcision, you know what I'm saying? My son was circumcised and according to him, he's better off, sexually.

One of the participants in the discussion, who has sex with men also indicated that there were benefits for those who had oral sex as well.

Well, to be honest, if I had to perform oral sex on a guy, if I found there to be some kind of residue or smell, I'd be like, okay, go wash yourself beforehand, but I've never encountered that, maybe because the ones I've dealt with always go wash, but I must say, with circumcised men, you don't need to worry about it, it's just go for it and it's easier and you can see everything.

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4.3.5. The Role of Culture and Religion

One of the factors that emerged very strongly from the focus groups discussion with circumcised males as well as the key informant interviews was the importance of culture and religion, specifically Islam, as a reason for people being willing to circumcise.

Muslim males, who for whatever reason, have not undergone circumcision are very willing to volunteer for circumcision. A participant in a focus group for circumcised males explains it in this way.

Yes, from an Islamic point of view, it has got to be done. Mostly for health purposes, but it must be done and where the friends is concerned, there is no need for negativity about it.

An employee of one of the implementing partners conducting circumcision indicates that it is especially common in those who convert to Islam and then need to be circumcised in order to fulfil the requirements of the religion:

Just to also say – a few of them because they are converting to Islam because it is a prerequisite that they circumcise would come to us for those reasons but it is a handful of them…From what they tell us it is quite expensive to do it privately so they then come to us for circumcision.

In addition there are those men who become involved in relationships with Muslim women. A key informant from an NGO involved in mobilisation states:

In some instances men will be in relationships with Muslim women and that is one of the requirements when you are going to marry a Muslim woman - you must be circumcised so that is also a driving factor in the Western Cape…So many Coloured men have seen MMC as an opportunity because some of them wanted to be circumcised but because of the financial implications did not.

Another enabler in this regard is when the culture of one groups of boys is able to influence others in their friendship circle. This sort of indirect peer pressure can be very powerful. A key informant from an NGO involved in mobilisation explains it further:

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If Coloured boys have good friendships with Muslim boys they get influenced and they become very eager to do the circumcision because for Muslims it is more about purity as well. He also wants to get it done because my friend is peeled (Circumcised) and I also want to be.

4.3.6. Perceived Improvement in Appearance of the Penis

There is a general belief and impression which was apparent among both the circumcised and uncircumcised males that the appearance of the circumcised penis is better than that of an uncircumcised penis. It is interesting that this is a particularly strongly held belief among uncircumcised men.

The following exchange during the discussion with a focus group of uncircumcised males illustrates this point:

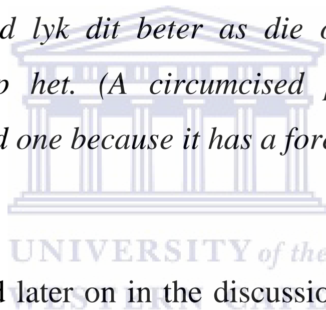
UC FGD P2*:* *A circumcised penis looks better.*

UC FGD P4*:* *Okay, to be honest, I'm actually curious how would I look circumcised, but then I (would) want to have the foreskin back again.*

UC FGD P7*:* *I want a situation where you can zip on your foreskin and zip it off.*

UC FGD P1: *Let's be honest, my son is circumcised, he's been very arrogant about it, braggish about it, walking around in the bathroom in front of me, it does look nicer, for me, but that still doesn't - you know what I'm saying.*

UC FGD P8: *Circumcised lyk dit beter as die onge-circumcised is, want jy jou foreskin op het. (A circumcised penis looks better than an un-circumcised one because it has a foreskin on it.)*



These sentiments were reinforced later on in the discussion when one of the uncircumcised participants noted:

> *If I should go ahead with the circumcision, it would probably be just because of (the fact that), I admire someone who is circumcised because most of my boyfriends are circumcised. So for me it's weird seeing somebody else who is circumcised, then I just look at it as oh, okay, this is the whole thing.*

An employee of one of the implementing partners conducting circumcision is also quite clear about this as a factor but is not clear as to whether or not this is a significant enabler:

> *I do think there it is also a factor because having seen the circumcised penises it does look – cosmetically it looks even better than traditional circumcision and uncircumcised penises.*

4.4. Barriers

Much like the enablers the barriers that prevent people from presenting for circumcision are multifaceted and powerful. On the whole the barriers that prevent “Coloured” males from presenting for circumcision in the Cape Town Metropolitan Municipality are similar to those among other groups in South Africa who do not practice cultural circumcision.

4.4.1. Fear

Fear is a multi-faceted barrier that prevents males from volunteering for medical male circumcisions throughout the country. This is no different among “Coloured” males in the Western Cape. This is not surprising considering the nature of the surgery that is under discussion here. Many of these fears are very strong and emotive.

There are a number of things that males fear from a fear of the discomfort and potential embarrassment that could arise from exposing oneself to a stranger, to the very real fear of complications and adverse events. In addition there is the fear that there could be a negative impact on both sexual performance and the sexual experience. But perhaps the most pervasive fear of all is the fear of the pain that is associated with the procedure.

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Fear of discomfort and embarrassment

There is a common feeling among many of the uncircumcised men that they would not want to have to expose themselves. In fact it was also mentioned in the focus group discussion with the circumcised men as being a barrier that some of them needed to overcome before presenting for circumcision.

One of the key informants made this point:

> *For some it may be a more general thing of that they don’t want to be touched down there – fiddled with. Or operated on down there. There is an embarrassment. I think men in general are egotistical when it comes to their penises. They don’t want to feel inadequate when it comes to size.*

A participant in the focus group for uncircumcised men supported this assertion:

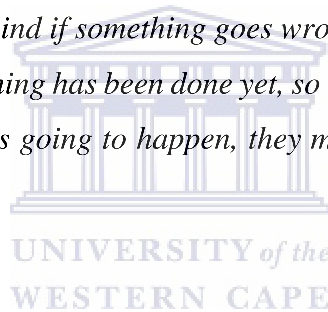
> *That has come up with me because, so it's people that, that is a barrier, you know. Who is going to say what. People feel like they are totally going to say they have a small penis, or feel uncomfortable because they have a big penis.*

<u>*Fear of complications and adverse events*</u>

Another powerful barrier is the fear of complications and adverse events. This fear is obviously amplified because of the fact that the operation is on the penis. This was mentioned by both the circumcised and uncircumcised groups as well as many of the key informants.

A participant in a focus group for circumcised males gives an indication of how he felt on the day and what he was worried about.

> *Scared. I thought in my mind if something goes wrong. You think of all the weird stuff in your head, because nothing has been done yet, so it is uncomfortable and somewhere in your mind, something is going to happen, they might just cut the wrong part off or something.*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<u>*Fear of an impact on sexual performance*</u>

One of the most powerful fears that was brought up in the discussions was the fear that the circumcision would have a negative impact on sexual performance. Considering that this issue relates to what most of the participants considered to be an important part of their manhood, one can understand how this fear has particular resonance.

In some ways the fear relates to the fear of complications and adverse events because the belief was that this would happened as a result of something going wrong. For many of the uncircumcised men there was also the sense that it was unnecessary to change something, which had potential impact on one's manhood and functioning, when everything was working fine. The following extract from a circumcised illustrates this:

> *My feelings on the day? Ek was baie bang gewees. Hoekom is die mense op en af. Ek het mos ander mense wat hier saam gesny het. Hulle is op en af. Die een bring my 'n*

storie van binne af. Ek was ompad om om te draai, maar toe keer hulle my en sê ek moet hier inkom. Toe gaan ek maar weer in. Maar daar waar hulle die are so en wat hulle my inject, ek dink gaan die ding eendag opstaan. Vroumense hulle kom mos en speel met jou penis en dan kan dit nie opstaan nie, niks nie. Toe dink ek sal die ding eendag opstaan en hoe gaan ek maak as dit nie opstaan nie. Wat gaan my partner sê. Maar toe ek klaar was en ek huistoe gaan, die aand, toe staan hy nogals.

My feelings on the day? I was very scared. I was wondering why the people were walking up and down. I was with other people who came for the circumcision. They are up and down. And then one brings me a story from inside. I was about to turn around and leave and then they said that I had to go in. So I went in. But I went to where they were injected. I thought that I would get and erection. But afterwards the women (nurses) come and they play with your thing and it does not get an erection. Nothing. Then I worried that I would not be able to get an erection again. What would my partner say? But when I was finished I went home, and that evening I had an erection.

The fear and concern about sexual performance are also seen is this extract from a participant in a focus group for circumcised males:

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Men think it's a piece of their body that they let go of. When they hear the word cut, fear immediately pops up and I have been asked so many questions (by) people... So they will ask will I still be able to have kids, not knowing that the circumcision takes place at the penis head…There are all those concerns, but I think the most prominent one is will they still be able to perform sexually. They are more concerned about whether they will be more or less of a man. They equate that to their masculinity and then there is obviously the pain factor as well. So it's a lot of things that people consider.

<u>Fear of pain</u>

The fear of pain mentioned in the previous quotation is all pervasive and is another barrier identified by the uncircumcised males, the circumcised males and all the key informants. This fear is obviously stronger in some than in others. It is linked to some degree to the fear of pain

of the injection particularly because the method use to administer the local anaesthetic requires an injection at the bottom of the shaft of the penis. If the person who is administering this injection is not skilled it can be a very painful process.

An employee of one of the implementing partners conducting circumcision indicates that pain is a significant factor. This belief is supported by other key informants in similar positions.

> *For me, the first that comes to mind is the perceived pain. Believe it or not but guys are scared of pain and needles. And once the process is explained that there will be ring block and where there is needles involved guys tend to be afraid.*

This is supported by another key informant who is involved primarily with circumcision with DOH.

> *Pain is a barrier even though we tell them that they are going to be anesthetised they don't necessarily understand what this means. And the fact that there is an injection involved is a deterrent… It is the injection around this area that they fear – an injection around the genitalia. Clients may be deterred by what they hear from others that have done it about any pain that is experienced or other discomfort.*

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When there is a problem with the anaesthetic, particularly related to substance abuse, which is a barrier that will be discussed later, there can be situations where the clients feel pain during the procedure and their reaction can drive others away. In this quote from a key informant from an NGO involved in mobilisation it is clear that some participants had left the circumcision site as they were fearful. The reference to the fact that they had "to collect the files" meant that they had to collect the patient folders of the clients from the chairs as they had left the venue. Before circumcision Males are registered, folders are completed and the males carry there folders from station to station.

> *I was once in Mitchells Plein and some of these guys are addicts and I have heard from other doctors that if you are on drugs when they put in the anaesthetic it is not enough and you will feel pain. And I have heard guys screaming while the procedure is being*

conducted. I don't want to lie to you, there was one Saturday in Mitchell's Plein we had to collect the files from the chairs because that guy was screaming so much.

A participant in a focus group for circumcised males who went to a circumcision site in Delft told of a similar experience on the day that he was circumcised,

C FGD P5: *It was a weird day, but it was a good day, maar baie anders (but very different). Party mense het omgedraai en uitgeloop. Ek het maar net so gekyk. (Some people turned around and walked out of the room. I just watched.)*

INTERVIEWER: *Hoekom het hulle uitgegaan? (Why did they go outside?)*

C FGD P5: *Want hier binne as hulle ingaan, dan hoor hulle hoe skree hulle. (Because when they went into the room they heard how the others were screaming). So I thought I am also going to go now. But this guy that was with me, he won't go in first. I was in first.*

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A participant in a focus group for uncircumcised males illustrates how the accounts from recently circumcised men about the pain involved have influenced his decision and have stopped him from presenting for a circumcision

They just told me, I was asking them how was it to go for a circumcise and they told me it's very painful, the pain is very sore and such stuff, so I think no, I won't go now, maybe later on, to there.

The power of this fear is illustrated by one of the participants in the uncircumcised groups who indicates that even though his wife is encouraging him and there is the perceived potential of an improved libido and sexual performance, the fear of the pain is so strong it is stopping him from presenting for a circumcision.

Ja, I've got about 5 kids, but my wife, she actually wanted me to go for this because at the moment I've got a very low sex drive. She thinks maybe I go for that, maybe it will

be better for me and the sex drive will be better because at my age, it's going a bit low now, maybe come once, I take about an hour before I can, how can I say, do the second, so if I must say, I would like to do it, but just the pain, just the pain.

A key informant who is uncircumcised indicates how the fear of pain outweighs the benefits and causes him to rationalise his decision not to circumcise.

Pain is one of the issues that concerns me, that also worries me, but I think I've been quite fine with my penis for quite a long time now and I just felt, why, why must I go, even though I heard it reduces HIV, it makes you cleaner, I just felt that, you know, I've been fine with my penis, so I don't want any changes to my penis. I've been fine, everything has been great up until so far.

4.4.2. Health Services

Another barrier to the uptake of circumcision is the experience of the patients of the health services and the health staff. Accounts of the experiences of those that have been circumcised have the potential to negatively influence those who may be thinking about accessing these services.

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Circumcision site

One of the issues is the experience of the clients at the circumcision sites. This can include waiting times and poor site organisation

A key informant from an NGO involved in mobilisation sees it as being a significant factor:

In the Western Cape we have mobilised big numbers. People say "Yes, I want to go" according to our stats. But if you look at the conversion rate it is very low. One of the reasons why people don't end up being snipped is because the guys will go and when they get to the facility most of them become impatient to wait for it – they discover that they are waiting too long and they become very frustrated and they leave. This is going to influence the others as well.

The clients become very confused. They don't know which side to go for their folder and so on. People become frustrated and they leave.

An employee for one of the implementing partners who is tasked exclusively with social mobilisation of clients agrees that the long waiting times are a factor in deterring potential clients for circumcision services.

I think also being in a hospital or being in a clinic, sitting and waiting. That environment could deter clients whereas if they were going to be circumcised using one of our mobile clinics in a remote area that would play a huge role.

<u>*Follow-ups*</u>

Males who have been circumcised need to return to the clinics after 48 hours, 7 days and 21 days in order to undergo want is known as a "follow-up". During these follow-ups the clients are examined by nurses and their wounds are cared for. These experience of these follow-ups can be very negative.

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An employee for one of the implementing partners who is tasked exclusively with social mobilisation of clients explains it in the following way:

I do hear reports that –as far as follow ups are concerned – that's the biggest deterrent because if clients don't take care of themselves and they come into the facility sometimes they have to wait long hours because I mean the facility is busy and their primary focus is not follow ups unless they have a dedicated nurse that is dealing with follow ups. Then they are seen instantly. So for the most part it is clients complaining that it is after the procedure that they experience discomfort and they experience a bit of pain.

The negative experiences of the follow-ups were also mentioned by two participants in the focus group discussion with circumcised males.

C FGD P7: *Yes a follow up yes and she presses like this and I said no, you don't feel the pain. She don't do it gently. She just take it and work with it. I thought to myself this is my most precious part and look at the way she work with it.*

C FGD P1*:* *They tell you, you must squeeze it to reduce the swelling, but I didn't and when I went for my second follow up, it was swollen. She took the bandage off and it was still a bit painful and she grabbed it, her whole hand and she was squeezing and I was laughing. I asked her are you finished hurting me, so she said yes I am. I said to her, "Look here thank you man, the pain is joyful". I don't actually have fear, so I laughed. I am laughing so I don't feel any pain.*

Role of staff

As illustrated by the previous extract, the problems with follow ups are, to a degree, linked to the role of the staff. This is illustrated by a participant in a focus group for circumcised males who recounted how he felt somewhat mistreated during a follow up.

> *I had a fear. While she was busy with it, she treated it like it was an instrument. I thought it would be better for a man, knowing, he knows you must be careful because it is the only thing that we have, but the lady was just treating it like a piece of meat.*

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Another issue with regard to health staff can include the impact, as illustrated in the extract from a key informant from an NGO involved in mobilisation, of doctors who are not as skilled as they could be. This reputational problem can impact on the uptake of clients who are unable to access services elsewhere.

> *The other thing is when the procedure was not done correctly because sometimes there is mistakes – to such an extent that there are patients that say no because if I am going to that facility – (pause). This is because they know mostly the Doctor that is working here. I am not going there because Dr X is doing MMC there. Therefore I would rather prefer to go somewhere else. (So) because people don't want to go to Heideveldt, for example, they would rather go to Grassy Park but because they don't*

have the means they say that they rather just don't go. This is because of the Doctor and the clinic staff.

4.4.3. The Six Week Healing Period Post Circumcision

All men who undergo circumcision are instructed not have sex for a least six weeks after the circumcision to allow for the complete healing of the penis. If there are adverse events then this period may be extended. This six week healing period post circumcision looms large in the minds of the uncircumcised and the circumcised

In fact when the issue of the six week healing period was raised in a focus group for circumcised males, a general discussion took place.

C FGD P3: *My friend was worried about that six weeks about not being intimate with his wife. He was worried she was going to go off with someone else.*

C FGD P8: *I thought about that, but I am a very sexually active person. I think about sex all the time. Without sex for six weeks was hard.*

C FGD P5: *In my situation, I had to resort to other things to satisfy us, so it wasn't a problem. But during that period, when you are with her, if it comes awake down there it hurts.*

A senior manager of one of the implementing partners conducting circumcision feels that the period of sexual activity is an issue.

The period of 6 weeks without sexual activity is a big barrier. So somebody was saying why we are not mobilising in maternity wards because a women who gives birth will be out of action for six weeks (laughs).

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4.4.4. Comfortable with body as is

One of the barriers to the uptake of circumcision is the strongly held belief of many of the uncircumcised men that they are happy with their bodies and penises as they are. For some people this has a religious element as well – the belief that God made males with foreskins and that is the way it should be. This is illustrated by a participant in a focus group for circumcised males who recounted a conversation that he had with friend who was uncircumcised.

> *I was speaking to a friend who hasn't been circumcised and he asked me why must I remove it if I was born like this. Then I just walked away, because I can't debate with that, because even though you removing it, what he is trying to tell me why do you think God is seeing imperfection with it, He made it like that.*

A key informant who is uncircumcised summarises these beliefs in a coherent way.

> *No, with me it's not religious, it's not cultural, I just feel that you know, even with the foreskin on I can keep it clean., if I'm washing I can retract my foreskin and then keep it clean there, and ja, in fact I like the foreskin. I wouldn't like to change the appearance of my penis. There's this thing that people say, you already have so little, so why take more away, so I'd leave what I have.*

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4.4.5. Partners and Family

In the section on enablers, one of the findings of this study was that partners and family members can be an important motivator for male to be circumcised. But it is also clear that they can also influence their partners and male family members not to undergo circumcision.

<u>Partners</u>

A key informant from an NGO involved in mobilisation explains why female partners are sometimes strongly against the idea of their male partners being circumcised:

> *In some instances the clients also get demotivated by their partners as well. Because I have seen they say "Jy gaan jou piel afsny" (You are going to cut your penis off). So*

they will say to us my wife does not want it. Number one, they feel that there will be sexual changes because they don't really know what to expect. Number two, I think that they don't really want to support the whole process because they think their husband or partner maybe wants to sleep around. I think that they have not been educated enough to see how they benefit as well.

A participant in a focus group for circumcised males indicates that his partner was very much against his decision to get the circumcision. He had it done anyway.

No my girl was otherwise. She said you really mad, why do you want to do that and I said no I went. Every time when she phoned, then I put the phone off and I thought no, she is making me nervous now. But afterwards, she is quite fine with it.

An employee of one of the implementing partners conducting circumcision indicated that the six week period can be problem for partners as well.

The six weeks for some guys to wait for sex is quite an issue. I know that when we mobilise they go "Six weeks!" but it is only a month and two weeks. This can also be a problem for the partners.

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Family

Family members can also be important in putting pressure on males not to be circumcised. This seems to be very dependent on the personal beliefs of the different family members.

A participant in a focus group for uncircumcised males indicates how his mother has played a role in ensuring that he and his brother have remained uncircumcised even though it is common practice in the extended family for males to be circumcised.

It's been discussed on a regular basis in our family because most of the guys are circumcised and it's just myself and my brother because my mom doesn't, so she and my dad always had an argument, ja, and he's got a beautiful penis.

4.4.6. Gang violence

Depending on the area and the position of the circumcision sites, gang violence, and the clearly defined areas that each gang controls, can have an impact on inhibiting males from going to a particular site to access a male medical circumcision. This issue was raised by two of the key informants.

The first, an employee for one of the implementing partners who is tasked exclusively with social mobilisation of clients, sees it as being a particular problem in parts of Delft.

> *I will refer to Delft south as an example – some clients will not want to go into that area. Like they want to undergo the procedure but only if we can offer that they get circumcised elsewhere then they will gladly undergo the procedure. What we have done now is with Blikkiesdorp which is in that area…we will take our mobile theatre and we will circumcise them there. Because it is turf wars – it's turf wars.*

Another key informant from an NGO involved in mobilisation agrees that these turf wars can be significant.

> *Another possible barrier is gangsterism. Because now if you mobilise in this area here for example and the clinic is over the road there. Then the guys on this side cannot go to that side. Therefore they can't access the service. Therefore that is one of the reasons why we will pick people up and take them to another site. To avoid the conflict between this gang and that gang. This is a lot of the Coloured townships.*

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4.4.7. Substance Abuse

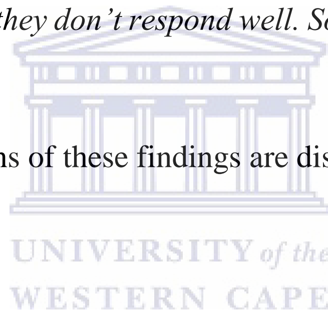
A barrier of a different sort is substance abuse. This has an impact in two ways. Firstly, people who have volunteered to be circumcised do not arrive because they would rather be drinking or taking drugs than presenting for circumcision. Secondly, if people do arrive under the influence of drugs or alcohol they cannot be circumcised.

A Department of Health nurse working in circumcision stated:

Alcohol consumption and all sorts of drugs are a problem. If (circumcisions are) scheduled for a particular day like at the end of the month there is a huge possibility that the clients will not show up because they would rather go and buy alcohol than to go come to the clinic to undergo a procedure that they consider to be very painful. Also if they arrive under the influence we can't do anything with them – can't circumcise them. And that has happened often.

A senior manager of one of the implementing partners conducting circumcision explains what the impact is of the drugs and alcohol and why it is not possible to circumcise males who are under the influence.

We had few cases that were deferring because they as said would scream they would give maximum dosage (of anaesthetic) but because of the tolerance due to whatever they are using on the side they don't respond well. So the screams would put people off.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In the next chapter the implications of these findings are discussed.

CHAPTER 5: DISCUSSION

5.1. Introduction

The nature of the procedure makes it a challenging intervention to deliver as it involves healthy men, who generally have low health seeking behaviours, undergoing an elective surgical procedure with cultural, ethnic, political, and religious dimensions (Ledikwe et al., 2014: 144)

In a recent study that looked at the behaviour of men and their partners after voluntary medical male circumcision, Toefy et al. (2015) indicated that the motivations for the "Coloured" male participants from the Cape Town Metropolitan Municipality to volunteer for circumcision were primarily hygiene, religious injunction and the desire to reduce the risk of contracting STIs other than HIV. These factors were also identified as enablers in this study as well although the role of religious injunction was not as significant as in the study by Toefy et al (2015). This was as a result of the fact that the proportion of Moslem men in their study was significantly higher than the proportion of Moslem men in this study.

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Enablers that were identified in this study which were not identified in Toefy et al. (2015) included the role of partners and family members as motivators, the influence of the perceived improvement in sexual experience and performance as well as the belief that the appearance of a circumcised penis is better than an uncircumcised one.

While there are as yet no studies which look at the barriers to uptake of VMMC among "Coloured" males in the Cape Town Metropolitan Municipality, it is clear that many of the barriers that exist elsewhere in the country and the region are the same as among this group in the Western Cape. The main barriers that have been identified include the fear of pain, concern about possible complications, concern over sexual performance as well as the unwillingness to go without sex for 6 weeks. These have been identified in a number of studies (George et al., 2014; Hatzold et al., 2014; Scott et al., 2005).

In addition to these barriers factors which emerged as additional barriers in this study included the impact of the experiences of the health services, the role of partners and family as well as the impact of substance abuse and gang violence.

5.2. Enablers

The drive to circumcise males across South Africa is clearly a bio-medical HIV prevention methodology as numerous studies have shown its effectiveness as a means to reduce the transmission of HIV from females to males (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007).

Acceptability studies from elsewhere in the country indicate that the desire to reduce HIV risk is the primary motivator for boys and men who are presenting for circumcision (Peltzer et al., 2014; George et al., 2014). However, the findings of this study show that this is not the case among "Coloured" males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality. While the reduction of the risk of contracting HIV is still one of the factors it is not the dominant enabler. The findings of this study indicate that hygiene is the most significant factor. It would be fair to say that this is followed by the desire to reduce the risk of contracting other STIs and then by the desire to reduce the risk of contracting HIV.

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Hygiene is a factor in most of the acceptability studies and other studies that focus on the enablers or facilitators for VMMC in South and Southern Africa (Lagarde et al., 2005; Hatzold et al., 2014; George et al., 2015). However, it tends to be one of the less important motivators especially in areas where HIV prevalence is high.

In a recent study conducted by Toefy et al. (2015) which looks at the behaviour of "Coloured" men and their partners after voluntary medical male circumcision the male participants were asked to give an indication as to the motivation for their uptake of circumcision. The researchers found that one of the primary motivations was the desire to get it done for hygiene reasons. This was borne out in both the focus group discussions as well as the key informant interviews in this study.

However there were some contrary views, which, while acknowledging that hygiene was an issue for uncircumcised men, did not see it as a big enough issue to drive one to be circumcised.

Therefore while hygiene is clearly a proven and acknowledged enabler it is not a powerful enough motivator to convince many men to undergo this surgery.

For many of the men who volunteered for circumcision this motivator was the desire to reduce the risk of contracting STIs including HIV. The moisture beneath the foreskin provides an excellent niche for STI pathogens and cuts, abrasions and tears of the foreskin put uncircumcised men at increased risk of acquiring STIs and HIV (Jayathunge et al., 2014).

Most of the acceptability studies and the studies that focussed on the motivating factors that led to men presenting for circumcision came to the conclusion that the reduction of the risk of contracting HIV was the most important motivator of all. These include the studies by Lagard et al. (2003), Scott et al. (2005), George et al. (2014) and Hatzold et al. (2014). It is worth noting that these studies were all conducted in areas where the HIV incidence was high.

Among “Coloured” males in the Western Cape the situation is more complex and the role of other STIs is more significant as an enabler although HIV remains a factor.

In many respect these sentiment reflect those of participants in other studies from other parts of Africa where older married men also do not consider themselves to be at risk of acquiring HIV (Sgaier et al., 2014; Macintyre et al., 2014).

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In fact even older married men who recognise the protective benefits of circumcision and acknowledge that they may be unfaithful do not see the threat of acquiring HIV or other STIs a being strong enough to warrant presenting for circumcision.

Partners and significant influential family members can also provide motivation for the males to present for circumcision. They can be key enablers. This is not unique to Coloured males in the Cape Town Metropolitan Municipality but was also noted in the study by George et al. (2014) which looked at the facilitators and barriers among adolescent boys in KwaZulu-Natal. In the study by George et al. (2014) it was the mothers who played a key role.

As a result of the fact that the majority of the participants in this study were not adolescents the influence of wives and girlfriends was undoubtedly stronger.

Among the circumcised men there is a genuine belief that their sexual performance improved after circumcision and that the sexual experience was better after the circumcision than before. This finding is similar to those of Hatzold et al. (2014) who studied the facilitators and barriers to circumcision in Zimbabwe.

These findings are supported by the findings of George et al. (2014: 184) in their study referenced earlier where they noted that “The perceived increase in sexual pleasure for boys having undergone circumcision also mustered support for the procedure”.

It is very hard to judge whether or not there is an increase in sexual pleasure and performance for circumcised males. There are no definitive studies that conform this and it seems to be a very subjective matter. However, what was clear from the focus group discussions is that this is a very strongly held belief among those that were circumcised and even among those who were not. Thus one can confidently say that it is an enabling factor whether it is verifiable fact or not.

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In a similarly subjective vein, many of the participants of this study indicated that they preferred the appearance of the circumcised penis. As illustrated in the results section, this was the case in both of the circumcised and uncircumcised groups and it was also noted in some of the key informant interviews. In other studies looking at enablers and barriers to circumcision in Southern Africa, there is no indication that appearance was a factor. It would be interesting to take this forward with a targeted study that focuses in more depth on this issue with a focus on both the relevant men and their partners.

The significance of the role of culture and religious injunction must not be underestimated as an enablers. Culture is a key element on many of the accessibility studies such as those by Lagarde et al. (2003), Scott et al. (2005) and many more. In fact there is strong feeling that

"cultural consideration should be a key consideration when developing demand creation strategies to encourage and, indeed, maximise uptake of VMMC" (Ledikwe et al., 2014: 142).

However, most of this focus on culture looks at traditional cultural beliefs and actions around reaching manhood. In the case of "Coloured" males it is different. The cultural aspect here is primarily a matter of religious injunction. As noted by Toefy et al. (2015) men who convert to Islam or wish to marry Islamic women have to be circumcised. Prior to the national circumcision drive, these circumcisions were done privately and often at a prohibitively high cost for many.

Apart from the religious injunction, which cannot be ignored, culture has an influence in other ways. This is through a form of peer pressure or, more accurately, the desire to conform to the norms of the groups with which one associates. Peer pressure is also seen as a key factor in the study by George et al. (2014) among adolescent boys in KwaZulu-Natal.

5.3. Barriers

On the whole the barriers that prevent “Coloured” males from presenting for circumcision in the Cape Town Metropolitan Municipality are similar to those among other groups in South Africa who do not practice cultural circumcision. These are the fear of pain, concern about possible complications, concern over sexual performance as well as the unwillingness to go without sex for 6 weeks.

In addition to these barriers, other issues were identified by participants in this study. These additional barriers included the impact of the experiences of the health services, the unwillingness to change the body that they were born with, the role of partners and family as well as the impact of substance abuse and gangsterism.

Fear is undoubtedly the key barrier inhibiting the uptake of VMMC services. The fear of pain is without a doubt the most powerful fear and therefore the most powerful barrier identified in this study.

It is clear from the results that the fear of pain was identified by all the participants in the focus groups discussions as well as the key informants. These findings are supported by all the literature that looks at barriers to circumcision throughout South Africa and Africa. In a recent study by George et al. (2014) looking at the barriers to uptake among adolescent boys in KwaZulu-Natal, fear of pain during or post the procedure was the most significant barrier of all. These findings are supported by Scott et al. (2005) and Lagarde et al. (2003) in their studies looking at acceptability in higher HIV transmission areas as well as the study by Hatzold et al. (2014) looking at the barriers and facilitators to uptake in Zimbabwe.

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To a certain degree the fear of complications and adverse events is not unfounded. While this this fear is more general in nature, there are a number of adverse events that do occur. These range are mild, moderate and severe and even on very rare occasions ultra-severe. The norm is an adverse event rate of 4% which includes 1% severe adverse events and 3% moderate adverse events (WHO, 2011).

These fears are not uncommon. In fact similar fears were identified in the study by George et al. (2014) referenced earlier and well as by Hatzold (2014) among men in Zimbabwe. Obviously when these adverse events do occur they have a negative impact on perceptions of circumcision among those who know the client who was circumcised. If one is living in a part of South Africa when the prevalence of HIV is very high then males are more likely to accept the risks associated with the procedure than in

Another fear that has been identified in most of the other studies that look at acceptability and barriers and facilitators to the uptake of VMMC is the fear of having to undergo an HIV test (George et al., 2014; Hatzold et al., 2014; Lagarde et al., 2003; Scott et al., 2005).

However, none of the other key informants or any of the focus group participants identified this as an issue. This is most likely the case because of the fact that the recent HSRC survey indicates that HIV prevalence among "Coloureds" between the ages of 15 and 49 years is 4.6% (Shisana et al., 2014: 44). As a result there is less fear associated with HIV tests as the likelihood of being positive is so low. In the focus group discussions there was no mention of the fear of an HIV test.

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The health services and the patient's experiences of the health services can also be a powerful barrier. This is also noted by Ledikwe et al. (2014) in their study where they note that the treatment of clients in the health services is one of the keys to a successful VMMC programme.

A number of the participants in this study made mention of the way that patients are treated.

After circumcision males are prohibited from having sex for six weeks in order to allow for the complete healing of the wound. For many of the prospective males and there partners this can be a significant barrier. It is also noted in a barrier in almost all of the relevant literature, including in the studies by Lagarde et al. (2003), Scott et al. (2005) and Ledikwe et al. (2004).

This concern about partners looking for sex elsewhere also arose in the study by George et al. (2014) among adolescent boys in KwaZulu-Natal and the study by Macintyre et al. (2014) which focused on the barriers to circumcision among older men in Kenya.

This unwillingness to undergo the procedure because of the six week healing period appears to be even more prevalent at the end of the year during the traditional South African holiday period.

One of the key elements that was spoken about in the focus groups was the unwillingness of some uncircumcised men to alter their bodies by removing a part of it. This belief in the unwillingness to remove a part of the body that they were born with does not arise in other studies.

However, the role of partners and family member has been mentioned in other studies. Just as partners and family member can be important motivators for the uptake of VMMC services, they can also be powerful agents advising against the decision to be circumcised. This appears to be the case in two situations. The wives and partners of older men see it as being unnecessary.

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Mackintyre et al. (2014) also note in their study of older men in Kenya that wives and partners could influence the decision negatively as they believe that older men are less likely to have multiple partners. In fact in the responses of older men from the focus groups it appeared that the wives and partners were somewhat suspicious of the desire to be circumcised.

Other barriers that were identified in this study were substance abuse and gangsterism. Substance abuse has an impact in two ways. Firstly, if males have made a decision to go for circumcision they may change their minds under the influence of drugs and alcohol. Secondly, if they arrive at the site under the influence of drugs and alcohol they will be deferred as there are good medical reasons as to why males should not undergo VMMC if they are under the influence.

The other issue of gangsterism was raised by two key informants only. Males are unwilling to attend a clinic in an area that is on a different gang’s turf. They will actively seek out a site that is outside of the area and that is not situated in a specific gang’s area.

Limitations

The sample size (23) may be considered to be too small to achieve the aim. However the richness and complexity of the data is sufficient for what is describes. Another limitation relates to the saturation of data (Pope & Mays, 2000) and adequate coverage. However, the researcher is limited by time, budgetary constraints as well as the guidelines of the MPH programme.

There is a potential risk for a 'selection bias' as the interviewees were not recruited in person by the researcher and even though the recruiters were briefed there is a chance that some participants were favoured. There was also a risk of 'interviewer bias' however the researched endeavoured to be neutral and avoid any use of leading questions.

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CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

It is clear from this research as well as the other studies such as the HSRC survey (2014) that currently among the "Coloured" community, the powerful barriers to circumcision largely outweigh the enablers.

The most powerful of these barriers that emerged out of this study was undoubtedly fear. This fear was dominated by the fear of pain which was mentioned by the vast majority of the respondents in the focus group discussions as well as by all the key informants. It is clear that this was also the case in other acceptability studies which have been discussed at length previously. In addition to the fear of pain the other powerful fears that were noted included, in the order of importance, the very real fear of complications and adverse events which remain a real concern for those who are uncircumcised. In addition, there is the fear that the circumcision could impact on sexual performance and finally the fear of embarrassment and discomfort the whole process would potentially bring.

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These fears are very real and cannot be underestimated especially when combined with the next most significant barrier which is the health services. The circumcision site and the experiences of the males at the site is one of the most important factors here. Badly organised sites where, for whatever reason, other males are making noises indicating that pain or discomfort are part of the procedure, have a negative impact on potential clients. In addition, the males' treatment at the required follow ups is key to creating a good reputation for the circumcision programme. Poor and disrespectful treatment of males by health staff is another factor as this can have a negative impact as males are much less likely to recommend the circumcision services.

The third most significant barrier is the six-week long healing period. For many males and their partners this period of healing is considered to be too long to be without sex. This is especially the case when the six-week period would fall over the annual holiday over December and January.

The next most significant barrier to emerge was expressed and explained as an unwillingness to change one's body. This is an interesting idea which essentially revolves around the idea

that it is largely unnecessary unless faced with imminent medical reasons. Factors such as hygiene and the risk of contracting STI's and HIV can be managed by adjusting one's behaviour and do not necessitate the removal of a part of one's body to which one is and has become attached.

In addition to the barriers listed above in certain circumstances, partners and family members (especially mothers) can be powerful forces which discourage males from accessing circumcisions and many also noted the role of substance abuse and gangsterism as well.

A key factor here is the fact HIV is not considered to be a significant threat among the "Coloured" populations. In the recent household survey conducted in 2012 they found that the prevalence among "Coloureds" between the ages of 15 and 49 years was 4.6% and that the overall prevalence in this age group in the Western Cape was 7.8% (Shisana et al., 2014: 44).

When compared with the prevalence for instance in KwaZulu-Natal of 16.1% (Shisana et al., 2014: xxvi) it is clear that the fact that circumcision partially protects from HIV is far less of a motivator for "Coloured" males than for males in KwaZulu-Natal, for instance. Especially when one considers that the HSRC survey shows that that black Africans have a "HIV prevalence 7.6 times higher than that of Coloureds" (Shisana et al., 2014: 40). In order to undergo an invasive and fear inducing operation a strong motivating factor like a real fear of contracting HIV would be a genuine enabler.

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The most powerful enabler identified in this study, and the study of Toefy et al. (2015), is hygiene. This was clearly a key motivator and facilitator among "Coloured" males. This is followed in importance by the protective value of VMMC, firstly, against the transmission of other STIs and, secondly, against the transmission of HIV. It is interest to note that in the formative research done by McCann referenced earlier in this study the researchers felt that the order of importance of the enablers in the Western Cape was HIV prevention, followed by other STI prevention and then only Hygiene (McCann, 2015). This is most likely because this research was not limited to "Coloured" males but included all the demographic groups in the Western Cape.

Just as the role of family and partners can be a barrier, they can also be enablers for some males. This depends largely on the particular views of the family and partners. Those in favour of VMMC certainly do exert pressure on their partners and male family members. However, it is worth noting that a number of the males who took part in the focus groups in this study had

steadfastly ignored their partners and family members who were trying to influence them either to have or not to have a circumcision.

What did come through strongly in the focus groups was the perception that circumcision brings about significant improvements in the sexual experience for circumcised men. This was due to the perception of improved sexual performance and also fact that the perception was that partners preferred circumcised penises and, in some cases, there was a strong belief that this made partners more sexually adventurous and, in particular, much more likely to engage in oral sex.

The role culture is also significant enabler. Non-Moslem men who convert to Islam or marry Moslem women are obliged to be circumcised. This is a cultural factor to a degree although it is a clear religious injunction that has to be obeyed in these circumstances. While it is a strong enabler to those for whom it is relevant, it does not apply to the majority of the population of "Coloured" males between the ages of 15 and 49 years.

The final enabler was the fact that there was consensus that the appearance of the circumcised penis was better than that of the uncircumcised penis, this was not necessarily a strong enough enabler to influence males to undertake circumcision.

As a result of the conclusions outlined above there are a number of recommendations that can be made to increase to uptake of VMMC among Coloured males between the ages of 15 and 49 years in the Cape Metropolitan Municipality. These recommendations essentially involve the need to break down the barriers and to accentuate the enablers.

6.2 Recommendations

The recommendations in this study focus largely on the need to expand the coverage of VMMC in the Cape Town Metropolitan Municipality and to increase the uptake among "Coloured" males between the ages of 15 and 49 years. To this end these recommendations address ways in which the enablers can be enhanced and accentuated. Obviously, these recommendations also focus on the way in which the barriers can be engaged with and their power and impact diminished.

This need to focus on the enablers and barriers is common to many of the provinces of South Africa, and, indeed, to many of the countries where VMMC is being advocated and implemented. As Ledikwe et al. (2014: 144) put it in their review:

> Currently, the main barrier to the rapid scale-up of VMMC in the majority of the priority countries is demand creation.

In fact the authors go further and, in some respects, endorse the need for the studies such as this one when they say:

> Understanding the contextual barriers and facilitators of VMMC for the …target population in each priority country is important in generating demand
>
> (Ledikwe et al., 2014: 144).

Recommendations of ways in which to enhance the enablers

With regard to accentuating and enhancing the enablers, the first recommendation would focus on the ways in which any social mobilisation campaigns are designed. Clearly the findings from this study indicate that the focus of these campaigns should not be solely on HIV prevention which has been the norm in the majority national and local campaigns that have been conducted on a national and more local level.

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There would be greater benefits, if one is trying to encourage Coloured males between the ages of 15 and 49 years to volunteer for VMMC, in focussing on other aspects. Hygiene is clearly a factor that has to be accentuated in any campaigns or other efforts to mobilise among this group. Other more innovative and unorthodox campaigns could focus on the perceived improved sexual experience and the perceived improved appearance to the penis. These elements could be foregrounded and the benefits related to HIV prevention could be held up as additional benefits. There is no doubt would bring re-energise and re-invigorate mobilisation activities in the Cape Town Metropolitan Municipality among "Coloured" males between the ages of 15 and 49 years.

The second recommendation as to how to accentuate the enablers of uptake for VMMC would be to focus on the cultural and religious aspect. As indicated previously Ledikwe et al. in their article on how to scale up demand creation for VMMC indicate that cultural considerations are essential:

> In fact there is strong feeling that cultural consideration should be a key consideration when developing demand creation strategies to encourage and, indeed, maximise uptake of VMMC (2014: 142).

This was also apparent in the study by Toefy et al. (2014) and indeed in this one. As a result it is a recommendation that any campaign attempting to mobilise men for VMMC actively focus on the Islamic community. Campaigns would need to make it clear that there was easy availability of free and safe circumcision services for Islamic men who have yet to be circumcised, for those who have converted to Islam and for men who are not Islamic but wish to marry Islamic women. In this way one could make sure that this cultural group is well served.

This strategy would be in line with the findings of Ledikwe et al. (2014) who emphasise the importance of targeting demand creation activities to specific segments of the population.

Recommendations of ways in which to break down the barriers to the uptake of circumcision

It is very clear that any recommendations that relate to the barriers to circumcision need to engage with fear – in particular, the fear of pain that is associated with a surgical intervention. To this end the first recommendation in this regard revolves are the introduction of the PrePex™ device, which is ne potential method of dealing with the barrier of fear, especially the fear of pain and possible complication.

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This PrePex™ device is a non-surgical method of circumcision which involves the placement of a device which cuts off the blood flow to the foreskin. The necrotic foreskin and the device are removed after 7 days. There is some mild pain on the removal of the device and many find that having the device attached for 7 days is uncomfortable (Lebina et al.: 2014).

This device will come into use in the Cape Town Metropolitan Municipality from the 1st November 2015 and it will be interesting to see if this has an impact on the uptake of VMMC. It is recommended that when advocating for its use, mobilisers focus on the fact the both pain and the potential for complications is significantly reduced.

The second recommendation in this regard is that there be further research done on the acceptability of the device among Coloured males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality. This will enable informed choices to be made about the roll out of the device.

General Recommendations

The final recommendation of this study is a more general one that relates to both the enablers of and to the barriers to the uptake of VMMC. This recommendation is that the author will convene a meeting to which he will invite the relevant representatives of the Provincial Department of Health, the implementing partner NGOs as well as the partners tasked with social mobilisation for VMMC in the province. The intention behind this meeting will be to share the insights gained from this study as well as the recommendations that have been made above.

The intended outcome of the meeting will be that these role-players will then be able to adapt their approaches, where and if necessary. Ultimately, it is anticipated that this would lead to greater demand and an increase in the numbers of circumcisions in the Western Cape.

To this end it is also the intention of the researcher to produce a policy brief summarising the findings, conclusions and recommendations of this study. This policy brief will be disseminated at the meeting of the role-players, as well as uploaded on the Community Media Trust website and the Circumcision Clearing House website, which is dedicated to providing a forum for sharing information, policies and research that relates to VMMC.

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Appendix 1

Attached below is the interview guide for the focus group of circumcised males.

Focus Group Discussion Guide – Circumcised Males

Introduction - interviewer and participants

Informed Consent

Ground rules

1. How did you hear about circumcision?

   Prompts:

   From whom?

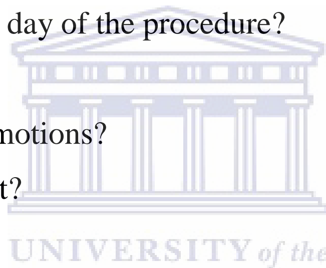
   What did they say?

2. What did you feel like on the day of the procedure?

   Prompts:

   What were your strongest emotions?

   How did the other guys react?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3. What did your family think of your decision to circumcise?

   Prompts:

   Were there any people who were strongly against it?

   Were there people in your family who encouraged you to do it?

4. What did you friends think of your decision to circumcise?

5. What about your partner?

   Prompts:

   Was she/he in favour?

   Did she/he influence you?

6. How was the whole experience for you?

Prompts:

How were you treated?

How did you feel?

Did you have to wait long?

What was your experience of the follow ups?

7. What are the benefits of circumcision?

Prompts:

Did you know these benefits when you decided to circumcise?

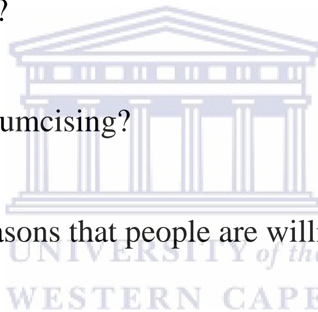
8. What were the reasons behind your decision to circumcise?

Prompts:

Where did you hear about it?

What did you hear about it?

What are the benefits of circumcising?



9. What do you think are the reasons that people are willing to come forward for circumcisions?

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Possible Prompts:

Is HIV prevention a factor?

What about STI's?

Is hygiene a factor?

Appearance?

Sexual Performance?

10. What do you think the things are that are stopping people from volunteering for circumcisions?

Possible Prompts:

Is pain a factor?

What about blood/injections?

What about the way people are treated?

Role of family and partners?

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Appendix 2

Attached below is the interview guide for the focus group of uncircumcised males.

Focus Group Discussion Guide – Uncircumcised Males

Introduction - interviewer and participants

Brief discussion of purpose of research

Informed Consent

Ground rules

1. What have you heard about Medical Male Circumcision?

   Prompts:

   From whom?

   What did they say?

2. What are the benefits of circumcision?

   Prompts:

   Are there other benefits?

3. Considering these benefits, why have you decided not to be circumcised?

   Prompts:

   Let’s discuss:

   Pain?

   Other fears?

4. What do your family think of your decision not to circumcise?

   Prompts:

   Were there any people who were strongly against it?

   Were there people in your family who encouraged you to do it?

5. Have any of your friends been circumcised?

   Prompts:

   If so what are they saying about it?

6. What do you friends think of your decision not to circumcise?

7. Has your partner tried to influence you to get a circumcision?

   Prompts:

   What did she/ he say?

8. What do you think are the reasons that people are willing to come forward for circumcisions?

   Possible Prompts:

   Is HIV prevention a factor?

   What about STI's?

   Is hygiene a factor?

   Appearance?

   Sexual Performance?

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9. What would have to change for you to want to get a circumcision?

   Prompts:

   Higher risk of contracting HIV?

   Other medical reasons?

10. What could people do to convince uncircumcised people like yourselves to get circumcised?

   Possible Prompts:

   Is pain a factor?

   What about blood/injections?

   What about the way people are treated?

   Any other factors?

Appendix 3

Attached below is the interview guide for the key informants

Interview Guide – Key Informants

Introduction – brief discussion of purpose of research

Informed Consent

1. Who do you work for and what is your job title?

   Prompts:

   How does your job relate to MMC?

2. What does your job entail?

   Possible prompts:

   What are you day to day tasks?

   How do

3. How does your job relate to Medical Male Circumcision?

   Possible prompts:

   How long have you been involved with MMC?

4. What are some of the challenges that you face in your job?

   Possible prompts:

   How is the MMC program different from other ones?

5.

6. What did your partner think?

   Possible prompts:

   Did your partner encourage you to get a circumcision?

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Was your partner pleased or not pleased with the results?

7. How was the whole experience for you?

Possible prompts:

Would you recommend the experience to friends and family? Can you explain why or why not?

Did you feel that you were treated with respect?

Was the procedure pain free?

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8. What do you think are the reasons that people are willing to come forward for circumcisions?

Possible Prompts:

Is HIV prevention a factor?

What about STI's?

Was hygiene a factor?

Appearance?

Sexual Performance?

9. What do you think the things are that are stopping people from volunteering for circumcisions?

Possible Prompts:

Are there any cultural reasons?

Would it be fair to say that fear is a real factor?

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School of Public Health

Private Bag X17, Bellville, 7535
South Africa
Tel: +27 (0) 21 959 2809/2166
Fax: +27 (0) 21 9592872
Email: soph-comm@uwc.ac.za
Website: http://www.uwc.ac.za/faculties/chs/soph

Appendix 4

PARTICIPANT INFORMATION SHEET

Project Title:

Barriers and enabling factors for the uptake of Voluntary Medical Male Circumcision among "Coloured" males between the ages of 15 and 49 years years in the Cape Town Metropolitan Municipality.

What is this study about?

This is a research project being conducted by Jonathan Cockburn at the University of the Western Cape. We are inviting you to participate in this research project because you are a "Coloured" male who has presented for or has not presented for Voluntary Medical Male Circumcision (VMMC) The purpose of this research project is to improve the understanding of why "Coloured" men are or are not volunteering for Medical Male Circumcision.

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What will I be asked to do if I agree to participate?

You will be asked to take part in a focus group discussion which will look at the reasons why "Coloured" male are willing to be medically circumcised or why they are not willing to be circumcised. You will be expected to take part in one focus group discussion at the offices of the SACTWU Worker Health Program in Salt River. After the focus group discussion you may be asked to take part in a more in depth interview.

Would my participation in this study be kept confidential?

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School of Public Health

Private Bag X17, Bellville, 7535
South Africa
Tel: +27 (0) 21 959 2809/2166
Fax: +27 (0) 21 9592872
Email: soph-comm@uwc.ac.za
Website: http://www.uwc.ac.za/faculties/chs/soph

Your personal information will be kept confidential. To help protect your confidentiality all study materials, including participant information forms, consent forms, tapes and transcribed materials will be kept in a secure environment that will only be accessed by the researcher. Transcribed material will not include your proper names but your chosen pseudonyms. All those involved in assisting the researcher with will be informed of the importance of ensuring privacy of personal information. At the end of the study, and after a reasonable period following the completion of the researcher's mini-thesis, the consent forms and tapes will be destroyed.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

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What are the risks of this research?

There may be some risks from participating in this research study.

During the focus group discussions or interviews, you will be asked to give your personal opinions about things that may make you feel uncomfortable or embarrassed. If this happens please feel free to ask me to stop questioning or probing at any time. If you have these feelings during an interview you may choose to pause the interview session for a while and

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South Africa
Tel: +27 (0) 21 959 2809/2166
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Email: soph-comm@uwc.ac.za
Website: http://www.uwc.ac.za/faculties/chs/soph

we will start again at your convenience. You can also choose not to respond to one or more of the questions.

I assure you that whatever you will say will be confidential. The records of all interviews will be kept safely and there will be no judgement passed based on your decision to be medically circumcised or not to be medically circumcised.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about why people are or are not volunteering for Medical Male Circumcision. This will help to inform the provincial Department of Health and its designated MMC partners to make decisions about ways in which to improve uptake of MMC. This can be done by identifying the barriers to uptake and also by identifying common reasons for men coming forward for the service. In this case it will be possible to tailor messaging and demand creation activities to best reflect the situation in the Western Cape. Currently mobilisation campaigns are national and are not targeted on any specific group. Information gathered through a study of this sort will enable role-players to take a more considered approach to resource allocation in different settings and among different groups.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

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South Africa
Tel: +27 (0) 21 959 2809/2166
Fax: +27 (0) 21 9592872
Email: soph-comm@uwc.ac.za
Website: http://www.uwc.ac.za/faculties/chs/soph

Is any assistance available if I am negatively affected by participating in this study?

Whilst no harmful impact is anticipated, any issues that emerge from the interview that require intervention will be referred to the bargaining council health care facilities which are also staffed by counsellors and by a social worker.

What if I have questions?

This research is being conducted by Jonathan Cockburn at the University of the Western Cape. If you have any questions about the research study itself, please contact Jonathan at: +2783 256 4052 jont5172@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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Director:
Prof Helene Schneider
School of Public Health
University of the Western Cape
Private Bag X17
Bellville 7535
hschneider@uwc.ac.za

Dean of the Faculty of Community and Health Sciences:
Prof Jose Frantz
University of the Western Cape

FACULTY OF COMMUNITY AND HEALTH SCIENCES

School of Public Health

Private Bag X17, Bellville, 7535
South Africa
Tel: +27 (0) 21 959 2809/2166
Fax: +27 (0) 21 9592872
Email: soph-comm@uwc.ac.za
Website: http://www.uwc.ac.za/faculties/chs/soph

Private Bag X17
Bellville 7535
jfrantz@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

Appendix 5

CONSENT FORM

Title of Research Project: Barriers and enabling factors for the uptake of Voluntary Medical Male Circumcision among "Coloured" males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate.

My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

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Participant's name ………………………...……..

Participant's signature ……………………………….

Witness ……………………………….

Date ………………………

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Fax: +27 (0) 21 9592872
Email: soph-comm@uwc.ac.za
Website: http://www.uwc.ac.za/faculties/chs/soph

Appendix 6

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: Barriers and enabling factors for the uptake of Voluntary Medical Male Circumcision among "Coloured" males between the ages of 15 and 49 years in the Cape Town Metropolitan Municipality.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study.

I also agree not to disclose any information that was discussed during the group discussion.

Participant's name ………………………………………..

Participant's signature ………………………………………..

Witness's name ………………………………………..

Witness's signature ………………………………………..

Date ………………………

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