

**THE MOTIVES BEHIND SWAZI MEN'S INCREASING
INTEREST IN CIRCUMCISION**

by

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ABSTRACT

The demand for circumcision in Swaziland has dramatically increased since it was reported that circumcision ensures 60% protection against HIV infection. The aim of this study was to explore the reasons for, and the motives behind, this increasing interest in undergoing circumcision. A generic qualitative research design was used, in which 17 circumcised men selected by convenience sampling at FLAS Clinic, Mbabane, participated. In-depth unstructured face-to-face interviews were used to collect data. The results showed that the main reasons for circumcision are perceived health, hygiene and sexual benefits, community influences, as well as medical reasons. It was concluded that the major motives underlying circumcision are personal and partner safety and satisfaction during sex. These motives were found to be both promotive and threatening to the interests of public health. After evaluating the risks and benefits, it was recommended that mass circumcision be promoted alongside reinforced and accurate health education on circumcision.

KEYWORDS

Circumcision; motive; HIV; AIDS; HIV transmission; public health, Swaziland; qualitative design.

Student number: 4547-115-0

DECLARATION

I declare that **THE MOTIVES BEHIND SWAZI MEN'S INCREASING INTEREST IN CIRCUMCISION** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



.....

CHARLES MAIBVISE

30 October 2012

.....

DATE

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Dedication

To my wife, Gracious, and kids, Ideal and Real.

*May the time we have lost in pursuit of this work bear lasting fruits in
our united future!*

Annexure A

Approval from the University of South Africa

Annexure B

Approval from the Ministry of Health, Swaziland

Annexure C

Approved letter seeking permission from the Family Life Association of Swaziland (FLAS)

Annexure D

Demographic data of participants, and grand tour question

Annexure E

Lwati ngenzawo yekutalwa kanye nembuto loyingcayizivele (Demographic data of participants, and grand tour question)

Annexure F

Consent form

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LIST OF ABBREVIATIONS

ABC	Abstinence, Being faithful to one partner, and use of a Condom
AIDS	Acquired Immune Deficiency Syndrome
ATR	African traditional religion
BSSMRP	Behavioural Sentinel Surveillance for Most-at-Risk Populations
CDC	Center for Disease Control
CSO	Central Statistical Office
FLAS	Family Life Association of Swaziland
GDP	Gross domestic product
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MC	Male circumcision
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-governmental organisation
OVC	Orphans and vulnerable children
PSI	Population Service International
SDHS	Swaziland Demographic and Health Survey
STI	Sexually transmitted infection
SWAGAA	Swaziland Action Group Against Abuse
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
UNISWA	University of Swaziland
USAID	US Agency for International Development
WHO	World Health Organization

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, a wide range of literature relating to this study is reviewed. The main concepts in which this study is rooted are also discussed. A framework illustrating the interrelationships between these concepts is presented. Issues of HIV in Swaziland are discussed, with particular focus on trends in HIV prevalence, as well as circumcision as an HIV preventive measure. Empirical and theoretical literature on the effect of circumcision on HIV transmission and the related public health implications is reviewed. The apparent impact and public perceptions of the ongoing massive circumcision campaigns are explored. Misunderstandings and misconceptions about HIV and circumcision are also discussed. This review of the literature is designed to serve a specific purpose, as explained below.

2.2 PURPOSE OF THE LITERATURE REVIEW

According to Babbie and Mouton (2001:565) in Tshibumbu (2006), every research report should be contextualised within the existing body of knowledge. As such, the general purpose of reviewing literature is to gain an understanding of the current state of knowledge about the research topic of interest. In this study, the literature review assisted the researcher to identify the gaps in the body of knowledge about the motives behind circumcision. The research topic was then refined based on this knowledge. An understanding of the relationship between the main concepts in the research topic was also obtained from the literature review. In addition, the ideal methodology to address the research objectives was identified through the literature review. This guided the structuring of the grand tour question, as well as the preconceived scope of the probing questions. In order to ensure that the above purposes were successfully accomplished, the reviewed literature was of a significantly wide scope, as elaborated in the following section.

2.3 SCOPE OF THE LITERATURE REVIEW

Theoretical, empirical, legal and media sources of literature were consulted, available in both physical and electronic form. The bulk of the literature was obtained electronically from web-based sources, owing to their ready and convenient availability. A variety of information was, however, acquired from these sources. Hard-copy sources comprising textbooks, journals, government policy documents, and newspapers, among others, were also consulted, mainly from the University of Swaziland (UNISWA) library.

Media sources from local and regional press releases were useful in providing views and opinions of the public about circumcision and HIV. Current updates and public statements about HIV and/or circumcision programmes from involved governmental and non-governmental organisations were also occasionally obtained from media reports. Empirical sources consulted were mainly research reports and statistical databases of various organisations. Recommendations by the Government and public health authorities, as well as national policies on HIV and circumcision, constitute some of the legal sources that were consulted. Theoretical sources, mainly web-based, were also consulted. The methodology adopted in this study was based on findings from these reviewed theoretical sources. More crucial is the fact that these sources were also used to shed light on the main concepts used in the research topic, as explained in the next section. This guided the structuring of the theoretical framework for this study.

2.4 CONCEPTUAL FRAMEWORK

A conceptual framework refers to a network, or “a plane”, of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena. These concepts support each other and are linked in a way that gives rise to a unique and specific phenomenon (Jabareen 2009). A conceptual framework serves to guide the researcher’s thinking in designing and structuring a research study around the main concept, a function referred to as the heuristic function (Mouton 1996:198). This study is centred on the concept “motive”, which was defined in Chapter 1 of this dissertation. A person with a motive is said to be motivated, and a state or act of being motivated is referred to as motivation (Farlex 2012a). Concepts constituting the conceptual framework of this study were derived from various theories that explain behaviour and decision making from a psychological perspective. Central among these theories are

theories of motivation. Closely related to these theories are theories of emotion, as well as cognitive theories. Below follows a definition of motivation and an explanation of its influence on behaviour and decision making, based on the interrelated views of certain theorists.

2.4.1 Motivation

Motivation is the force that initiates, guides, and maintains goal-oriented behaviours, or causes us to take action (Cherry 2012a). There are several theories that explain the nature and origin of motivation. These include instinct theories, incentive theories, arousal theories, humanistic theories, drive theories, self-determination theories, as well as Maslow's Hierarchy of Needs theory (Haynes 2011; Cherry 2012a; Self-Determination Theory [Sa]a). Common among these theories is that motivation can be either intrinsic or extrinsic. Intrinsic motivation involves engaging in behaviour because the behaviour itself is enjoyable, thus the motive is from within the individual. An example is sexual desire. In extrinsic motivation, the motive is from outside the individual. For example, one does something in order to achieve some other outcome, either after being influenced by someone or with the intention to ultimately engage in an intrinsically motivated behaviour, such as being circumcised in order to enjoy better sexual pleasure (Haynes 2011). Another common understanding among these theorists is that motivation can be biological or psychosocial (social, emotional, or cognitive) in nature (Haynes 2011; Cherry 2012a; Self-Determination Theory [Sa]b).

2.4.1.1 Biological motives

Biological motives form the basis of the drive theories and also constitute the basic physiological needs in Maslow's Hierarchy of Needs theory. According to the drive theories, organisms act to survive and reproduce, and they are guided or driven towards those ends by their needs or drives, namely hunger, thirst, the avoidance of pain, and sex. Thus, these drives are intrinsic motives that are triggered by unmet homeostatic needs or imbalances in the body. They can be categorised as primary or secondary motives. Primary motives are the direct unlearned biological pushes, such as hunger. Secondary drives are those drives that are learned to be associated with a primary drive, for example circumcision is associated with an increase in sexual satisfaction

(George Boeree 2009; Haynes 2011; Cherry 2012a). Innate biological motives are often reinforced by psychosocial motives.

2.4.1.2 Psychosocial motives

Psychosocial motives include those motives that have an underlying acquired deep feeling or reasoning. The basis of these motives is one's knowledge, which Oyewale (2008) defines as a recall of factual information, which is a prerequisite for appropriate behaviour. According to Oxford Dictionaries Online (2012b), knowledge refers to facts, information, and skills acquired through experience or education. This explains the importance of socialisation into, or experience of, societal norms and value in influencing sexual, sociocultural and other forms of behaviour. Similarly, formal education and health promotion campaigns are based on the same understanding. While knowledge is a necessary cause for any particular behaviour, it is not a sufficient cause to produce that behaviour (Glanz & Rimer 1995; Joubert 2007). The ability of knowledge in conjunction with other associated causes to provoke specific feelings or affect (emotions) accounts for its influence on decision making and actions. Emotional motives are looked at in more detail below.

Emotional motives: These are drives with an underlying emotion. According to Oxford Dictionaries Online (2012c), an emotion is a strong feeling deriving from one's circumstances, mood, or relationships with others. Various theories of emotions agree that these feelings involve thoughts, physiological changes, and an outward expression or behaviour. The relationship between these aspects is, however, still debatable. According to the James-Lange Theory, it is a thoughtful interpretation of a stimulus or arousal that leads to an emotion (Baron, Kalsher & Henry 2008:316). Interpretations of any given situation are generally based on one's knowledge and understanding of the situation. For instance, knowledge of the sexual transmission of HIV would make one interpret unprotected sex as a risky behaviour, which, in turn, would lead to the emotion of fear of infection. One would therefore look for a possible solution to reduce the risk, in this case circumcision. An even more direct link between knowledge and behaviour is the ability of knowledge to influence thinking and reasoning, thus constituting cognitive motives.

Cognitive motives: Cognition, the basis of cognitive motives, refers to the mental processes involved in gaining knowledge and comprehension, including thinking, knowing, remembering, perceiving, imagining, judging, and problem solving (Cherry 2012b; Farlex 2012). Several theories, collectively known as cognitive theories, have been postulated to relate cognition to behaviour. These theories are concerned with the development of one's thought processes and how these influence one's understanding of, and interaction with, the world. The assumption of these theories is that human beings are logical beings that make choices that make the most sense to them (Cherry 2012b; Baron, Kalsher & Henry 2008:252). What makes sense regarding any situation is individualised, depending on one's knowledge, thinking, and reasoning. This is a function of age and level of cognitive development. According to the foremost cognitive theorist, Jean Piaget, children think differently from adults, quantitatively and qualitatively. They are active thinkers, constantly trying to accurately understand the world around them (Baron, Kalsher & Henry 2008:253). Thus, as people age and mature, they gain a better understanding of the world, which, in turn, influences them to make new decisions which they think would make more sense. Cognitive motives, therefore, complement social motives, based on the following understanding of social motives.

Social motives: These are drives that result from people's attempts to conform to what is expected of them according to societal norms and values. The ultimate aim is to strengthen or create good social relationships with parents, friends, and relatives. According to Erikson's theory of psychosocial development, every person must pass through a series of eight interrelated stages over the entire life cycle. At each stage, individuals' perceptions of what is expected of them vary. In adolescence, at the stage of identity versus role confusion, individuals seek to establish a clear self-identity through assuming various roles, and if they fail to assume a particular role, they become confused (Baron, Kalsher & Henry 2008:278). In this context, men may opt to be circumcised in order to identify themselves with a certain culture. In some societies, circumcision denotes true manhood (Plotkin, Mziray, Küver, Prince, Curran & Mahler 2011). At the stage of intimacy versus isolation, young adults seek to form intimate relationships with lovers, as well as enhancing their work and social lives. Thus, their sexual life also becomes a centre of focus, and efforts are made to try and attract peers of the opposite sex or please a sexual partner. Failure to achieve this, according to Erikson, would lead to maladaptive behaviours, such as isolation and prostitution

(Baron, Kalsher & Henry 2008:278). A study conducted by Plotkin et al (2011) shows that women in Tanzania prefer circumcised men to uncircumcised men. Based on this, the motive behind circumcision may be the need to attract, please, and/or satisfy female partners, or to promote the maladaptive behaviour of prostitution or sexual promiscuity, with the risk of HIV infection (Auvert et al 2005). As mentioned earlier in this section, one's cultural experience and socialisation greatly influence one's knowledge, and hence perception, of societal values and beliefs.

Following this discussion, it is apparent that a number of factors interrelate to collectively motivate one to take a certain action, in this case circumcision. Such an interrelationship of concepts can best be illustrated by making use of a conceptual model, as follows.

2.4.2 The conceptual model used in this research

Mouton (1996:198) describes a conceptual model as an attempt to represent the dynamic aspects of a phenomenon by illustrating the relationships between its elements in a simplified form. According to Earp and Ennett (1991), a conceptual model is a diagram of proposed causal linkages among a set of concepts believed to be related. Similarly, Dictionary.com (2012b) defines a conceptual model as a type of diagram which shows a set of relationships between factors that are believed to impact or lead to a target condition. Below is a conceptual model illustrating relationships of various factors that may influence the decision to be circumcised. The model was designed by the researcher under the collective inspiration of the various theories described above.

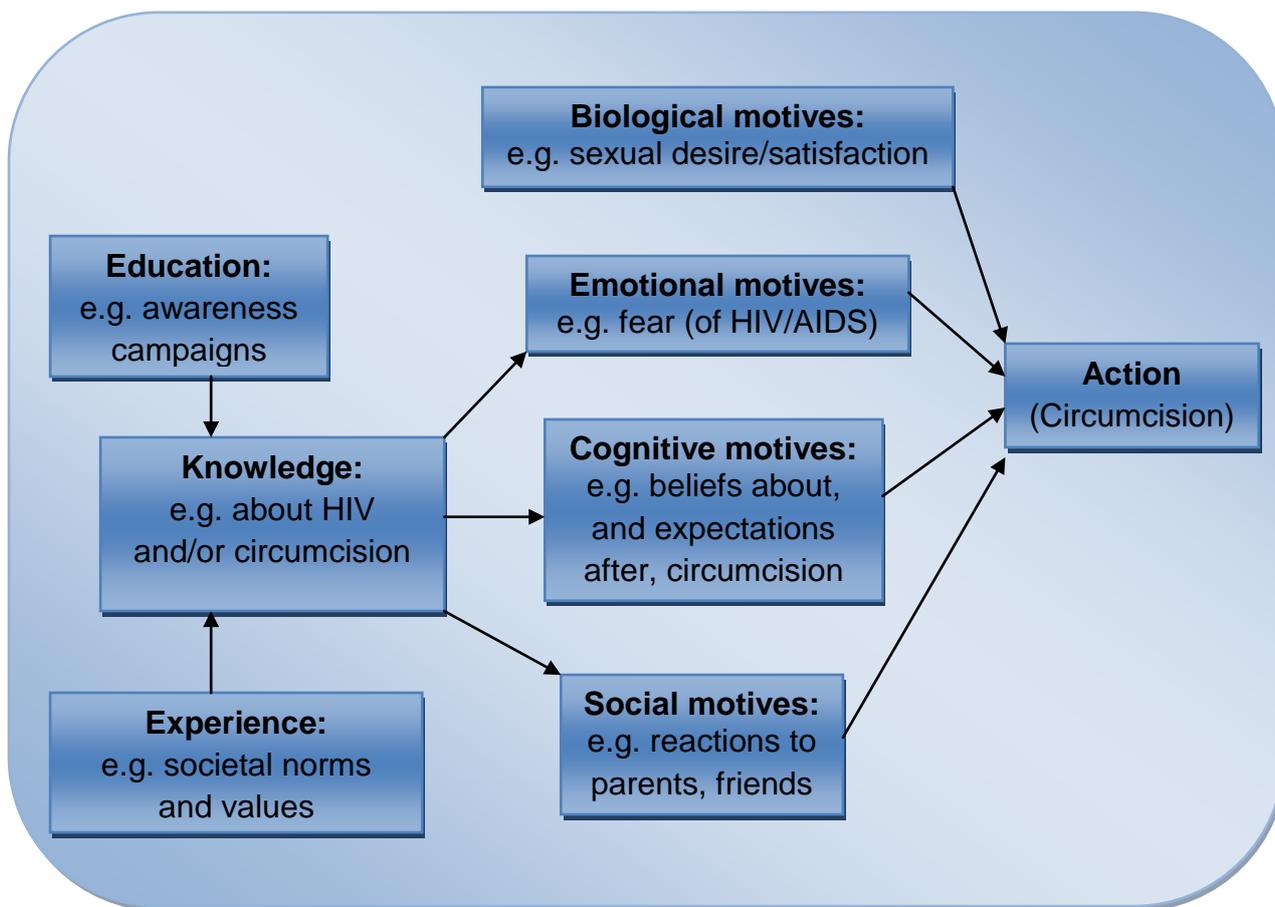


Figure 2.1 The conceptual model used in this research

Under the guidance of this conceptual framework, a detailed literature search about the main concepts in the study was conducted, so as to shed more light on the context of the study. It is worth noting that the conceptual framework was not forced on the study, but the findings were reflected within its categories. Basically, this study is about HIV and circumcision, and it is worth first exploring the status quo about these phenomena, nationally and globally.

2.5 HIV AND CIRCUMCISION

HIV and circumcision are concepts that have existed side by side for decades. The history of each of these concepts has unfolded and impacted on mankind independent of each other. As the devastating impact of HIV and AIDS continues, scientists and health personnel have sought wider solutions to the problem. This has led to the discovery of a hidden beneficial relationship between HIV transmission and circumcision. The following section describes the trend and impact of HIV and AIDS,

which led researchers to the discovery of the relationship between HIV transmission and circumcision.

2.5.1 The HIV and AIDS pandemic

HIV/AIDS is currently the world's greatest threat to public health. It has drawn a lot of attention globally owing to its unique trends and prevalence, as well as its massive negative impact that cuts across almost all sectors of society, as explained below.

2.5.1.1 The history, trends, and prevalence of HIV and AIDS

The earliest fully documented case of HIV and AIDS dates back to 1959, an adult male living in what is now the Democratic Republic of the Congo. Thereafter several cases were noted, presenting with similar signs and symptoms of immunosuppression, commonly pneumocystis pneumonia and Kaposi's sarcoma, among other opportunistic infections. It was not until 5 June 1981 that the first cases of HIV and AIDS were reported in the Mortality and Morbidity Weekly Report (MMWR) of the United States of America (The rise of HIV/AIDS 2002; AVERT 2011c).

Since then, HIV has spread dramatically throughout the world, with an estimated 2.7 million people being newly infected every year (Bongaarts, Pelletier & Gerland 2011). Currently, approximately 33.3 million people are living with HIV/AIDS, up from about 7.5 million in 1990 and 28.6 million in 2001 (AVERT 2011c; UNAIDS 2010). The prevalence, and hence impact, of HIV/AIDS varies from region to region, from less than 0.2% in East Asia to 5% in sub-Saharan Africa, according to 2009 statistics (AVERT 2011d; Global Health Council 2011a). Although sub-Saharan Africa accounts for only about 10% of the world's population, approximately two-thirds of the world's HIV-infected population lives in this region (CDC 2006; Global Health Council 2011c; World Vision 2002). Figure 2.2 below illustrates HIV prevalence by region.

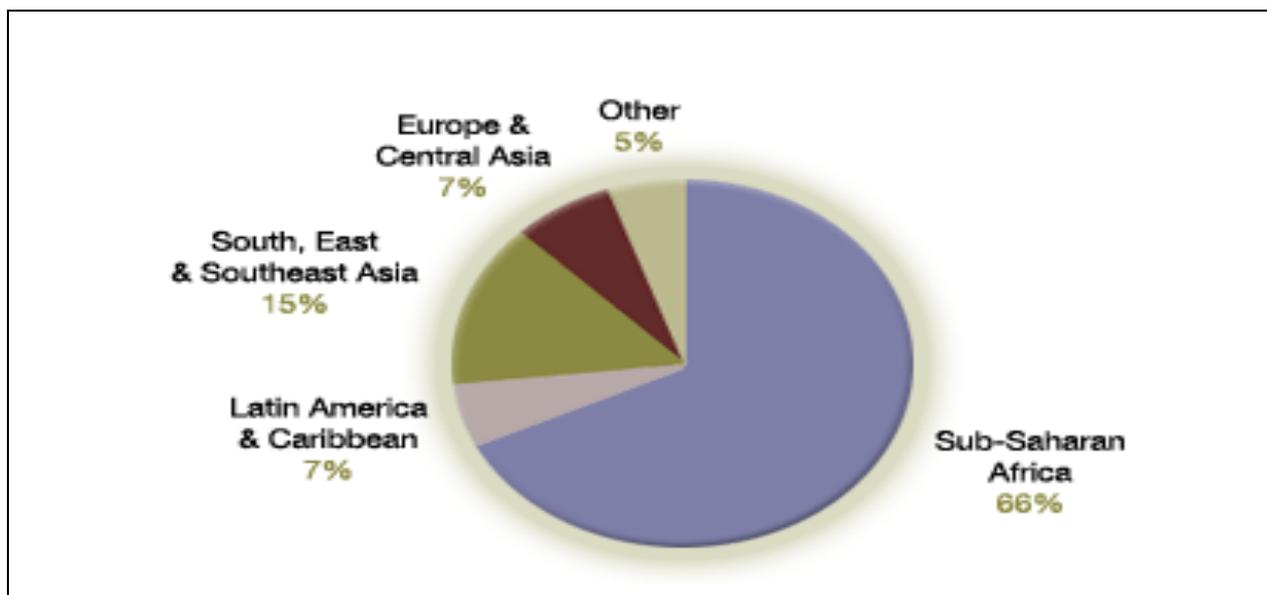


Figure 2.2 Adults and children living with HIV/AIDS by region, 2008
(Global Health Council 2011a)

With such an alarming prevalence, the impact of HIV cannot go unnoticed or be taken for granted.

2.5.1.2 The impact of HIV and AIDS

Globally, about 1.8 million people die annually from HIV/AIDS (UNAIDS 2010). A cumulative total of 24 million people have died from the disease between 1980 and 2007, and by 2030 this total is projected to reach 75 million (Bongaarts, Pelletier & Gerland 2011). In fact, HIV/AIDS is the third leading cause of death after respiratory infections and diarrhoea in low-income countries, accounting for 7.8% of all deaths (WHO 2011). Figure 2.3 below illustrates HIV-related deaths as a proportion of the total number of deaths by region.

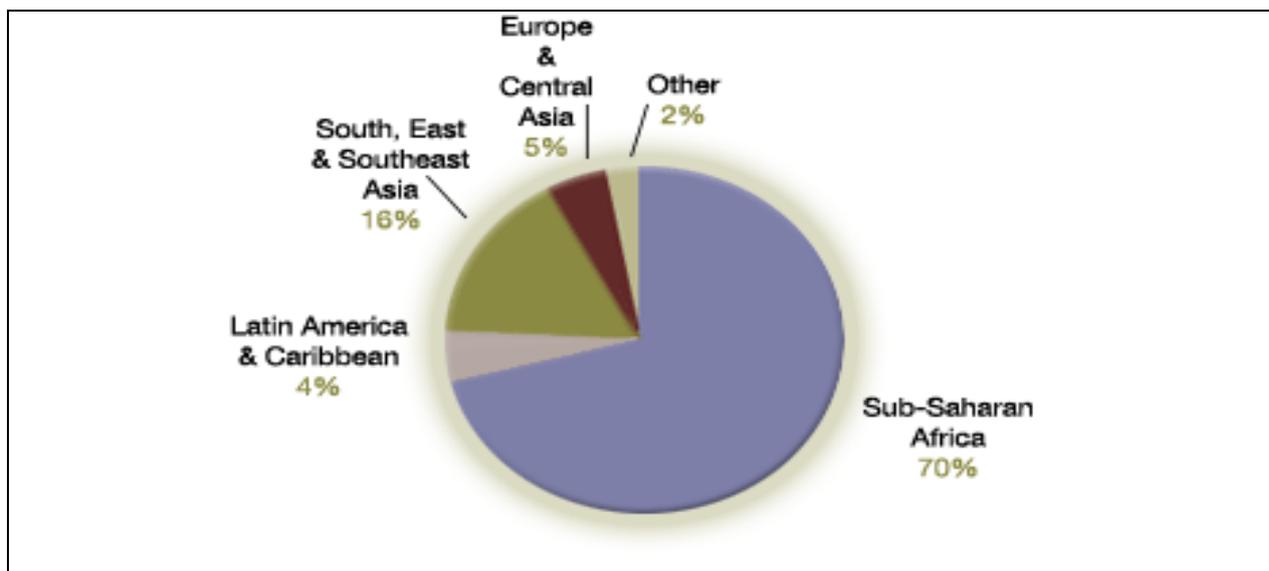


Figure 2.3 Estimated deaths due to AIDS by region, 2008

(Global Health Council 2011a)

The ravaging effects of HIV/AIDS are not only confined to the obvious illnesses and deaths, but extend to almost all sectors, most crucially the economic sector. It is worth noting that the economically active population, that is, people of 15 to 49 years, is the sector of the population that is worst affected. This group now accounts for 60% of all deaths in sub-Saharan Africa, compared to 20% between 1985 and 1990, when the epidemic was in its early stages (AVERT 2011a). In addition to the deaths of skilled labourers in workplaces, there is also much absenteeism as workers fall sick or attend to sick friends and relatives or attend their burials (CCA [Sa]). Because of such factors, it is thought that the gross domestic product (GDP) of the worst affected countries is losing around 1.5% per annum, implying that after 25 years the economy will be 31% smaller than it would otherwise have been in the absence of HIV/AIDS (AVERT 2011a).

The impact of reduced productivity is compounded by increased expenditure to mitigate the impact of HIV/AIDS. Combating HIV/AIDS, malaria, and other diseases is one of the eight Millennium Development Goals (MDGs) adopted by the United Nations in the year 2000 (UNDP [Sa]). One of the targets of this Millennium Development Goal was to achieve universal access to prevention, treatment, care, and support by the year 2010. In pursuit of this objective, global spending on HIV/AIDS activities in 2006 totalled \$8.9 billion. By 2008 this figure had increased to \$13.7 billion. UNAIDS estimated that the global funding need in 2010 would be \$25.1 billion, and it projects that by 2015 the

annual resource need will reach \$54 billion (Global Health Council 2011b). Thus, global funding is increasing, but the global need is growing even faster, widening the funding gap. Figure 2.4 below shows trends in the United States (US) and global spending on HIV/AIDS and the global need for universal access to HIV/AIDS care.

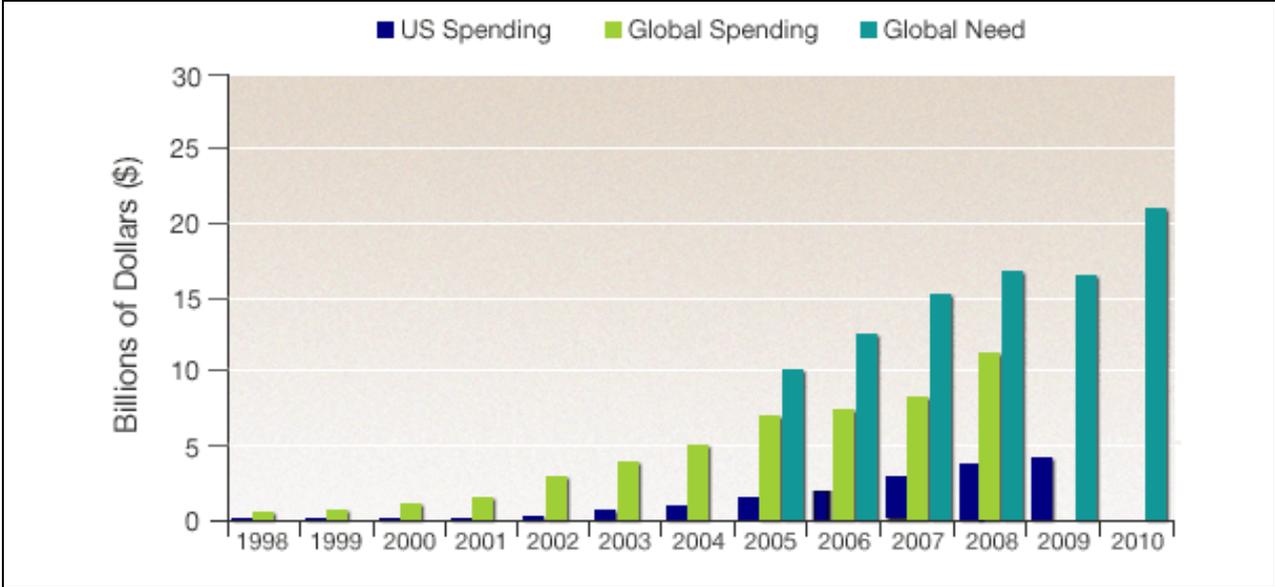


Figure 2.4 Estimated United States (US) and global spending on HIV/AIDS, and the global need for universal access to HIV/AIDS care by 2010

(Global Health Council 2011b)

This situation is a direct result of the high HIV-related mortality rate. As millions of adults lose their lives to HIV/AIDS, millions of children are orphaned, adding more financial burden to their respective governments and the global community at large (World Vision 2002). About 12% of all children in Botswana, for example, are orphans, and 72% of them are AIDS orphans (AVERT 2011e).

As noted earlier, the impact of HIV and AIDS is worse in Southern Africa, particularly in Swaziland. This country, with an adult HIV prevalence of 26.3%, and 19% for the general population, is ranked the country most affected by HIV/AIDS worldwide (AVERT 2011d; USAID 2010; AVERT 2011b). It is estimated that 15% of the population is made up of HIV- and AIDS-related orphaned and vulnerable children (OVC) (UNDP 2009b). As such, much attention and scarce human and material resources are being channelled towards the fight against HIV/AIDS and the alleviation of its impact. In the

2008/2009 financial year, the Government set aside E130 million¹ (the equivalent of R130 million), up from E16 million (the equivalent of R16 million) in 2002, to benefit over 100,000 OVCs (Swaziland 2010). About 63% of the population lives below the international poverty line (UNICEF 2010; UNICEF & WHO 2008).

While the national and global HIV and AIDS situation continues to worsen, tireless efforts have been made, and are still being made, to try and combat the epidemic. The following discussion covers some of the measures that have been taken.

2.5.1.3 HIV preventive measures

The fight against HIV and AIDS is as old as the disease itself. However, with so many years having passed since the first cases of the disease were reported, there is still no cure for the disease. As such, the prevailing interventions as of now focus primarily on prevention of further spread of the disease, as well as alleviating or mitigating the impact on those who are already infected or affected. Traditional preventive approaches have included HIV/AIDS awareness campaigns, the promotion of condom use, managing the spread of sexually transmitted infections, and screening of all donated blood (AVERT 2011b). Lately, greater emphasis has been placed on behaviour change and risk-reduction strategies. These include an emphasis on abstinence, faithfulness to one partner, delaying of the onset of sexual activities, and empowering women in matters relating to sex. This follows the realisation that heterosexual transmission accounts for over 90% of all new infections (USAID 2010; Global Health Council 2011a). It is with this added focus on heterosexual-related HIV transmission that the protective effect of male circumcision was discovered. A study conducted by Auvert et al (2005) at Orange Farm in South Africa revealed that circumcision reduces by 60% the chances of a man contracting HIV infection from a woman through an act of unprotected sex (USAID 2010; AVERT 2011a).

Following these reports about the benefits of circumcision, the demand for safe and affordable circumcision services has been growing fast, particularly in Southern African countries that are the worst affected by HIV/AIDS. At the University Teaching Hospital in Zambia, demand has grown from one circumcision to 15 circumcisions a month, with a

¹ "E" stands for "emalangeni", the currency of Swaziland.

three-month waiting list, while an increase of from less than one circumcision per month to 40 circumcisions a month has been reported at one Swaziland hospital. The formal announcement in 2007 by the WHO and UNAIDS of recommendations by experts to include male circumcision as an HIV prevention strategy has further motivated circumcision activities. Governments of various sub-Saharan African countries have established policies to scale up circumcision (WHO 2006; WHO 2007a; AVERT 2011f). It is worth noting that circumcision has been in existence for years in different parts of the world, as explained in Chapter 1. Various purposes and motives have been identified as being behind these traditional circumcisions. Thus, prevention of HIV transmission as an emerging motive for circumcision has blended these traditional motives. The next section consists of a further discussion of circumcision, with a particular focus on the motives behind it, its history, prevalence, and trends, as influenced by the various motives.

2.5.2 Circumcision: its history, prevalence, and trends

Male circumcision is one of the oldest and most common surgical procedures in the world. The practice can be traced back to as early as 2300 BC among the ancient Egyptians. Despite this fact, data on the prevalence of traditional male circumcision are currently inadequate (Ahmed 2012; WHO 2009b; WHO & UNAIDS 2007a). This is partly attributed to the fact that most of these circumcisions are carried out by unqualified people under informal traditional settings, where no documentation of the procedure and its statistics is done. Researchers' efforts to collect this information are hindered by a number of factors. In some communities, there is secrecy associated with circumcision status, such that most men are reluctant to disclose their status. Furthermore, some men are not clear when describing their status. In some places where circumcision is widely practised, the local languages do not have a specific word that precisely conveys the meaning of "male circumcision" as the surgical procedure of removal of the foreskin. The practice is often an indistinct element of the rite of passage referred to as "initiation", "being a man", or "islamisation" (WHO 2009b; WHO & UNAIDS 2007a). The limitation posed by the lack of specific vocabulary pertaining to male circumcision in certain languages prevents researchers from eliciting accurate information about circumcision. Many countries, however, have progressively incorporated more and more questions on male circumcision in their demographic health surveys, thereby ensuring better estimates of the situation.

According to World Health Organization statistics, approximately 30% of males worldwide are estimated to be circumcised, about two-thirds of them being Muslims (WHO 2009b; WHO & UNAIDS 2007a). Figure 2.5 below shows the global distribution of male circumcision as of the year 2006.

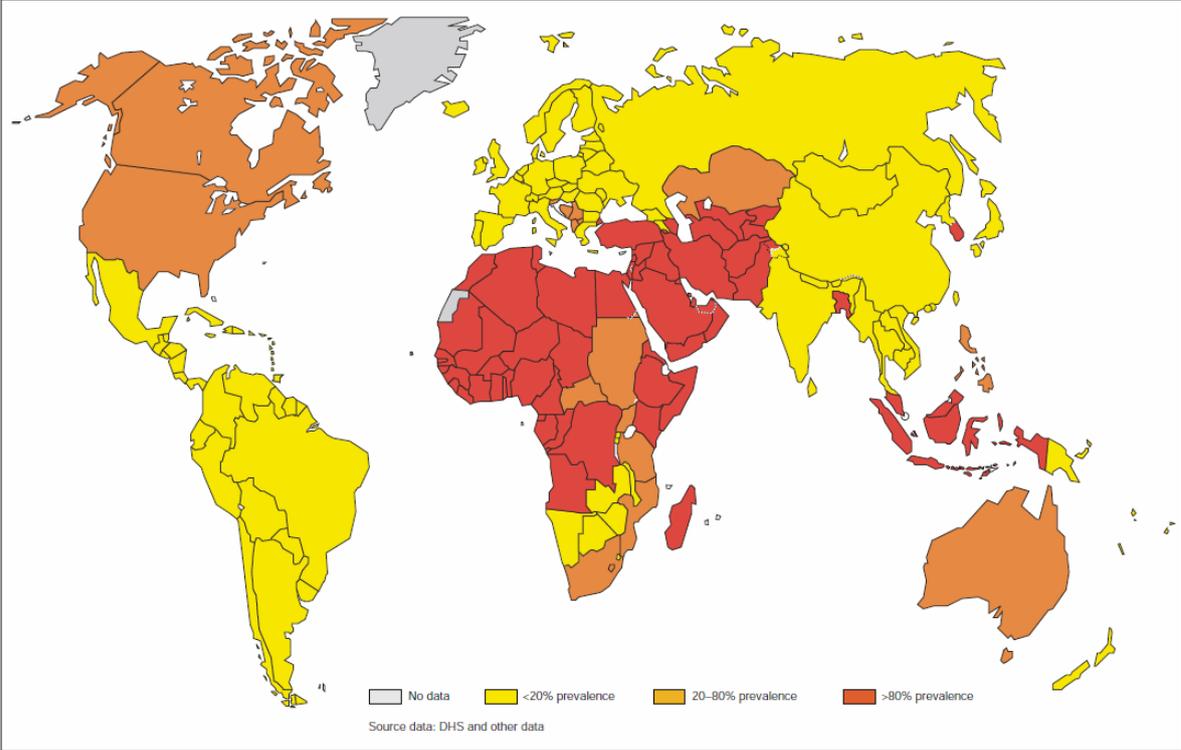


Figure 2.5 Prevalence of male circumcision at country level, as of December 2006
(WHO 2009b; WHO & UNAIDS 2007a)

This distribution is influenced by a number of factors that motivate men to undergo the procedure of circumcision. An investigation of the determinants for circumcision is provided in the following section.

2.5.3 Motives for circumcision

As mentioned in section 1.1, there is a wide range of motives for which men undergo circumcision. These include religious, cultural, social, medical, and other motives (Wambura, Mwanga, Mosha, Mshana, Mosha & Chagalucha 2009; WHO & UNAIDS 2007a).

2.5.3.1 Religious motives

Religious motives are drives that are based on one's religion. Religion can be defined as a belief in, the worship of, or obedience to, a supernatural power or powers considered to be divine or to have control over human destiny (Farlex 2012; Oxford Dictionaries Online 2012d). The main religions in the world include Judaism, Islam, Christianity, African traditional religion, Hinduism, and Buddhism, among others (Haselhurst & Howie 2011; Cengage Learning [Sa]). Figure 2.6 below shows the global distribution of these religions.

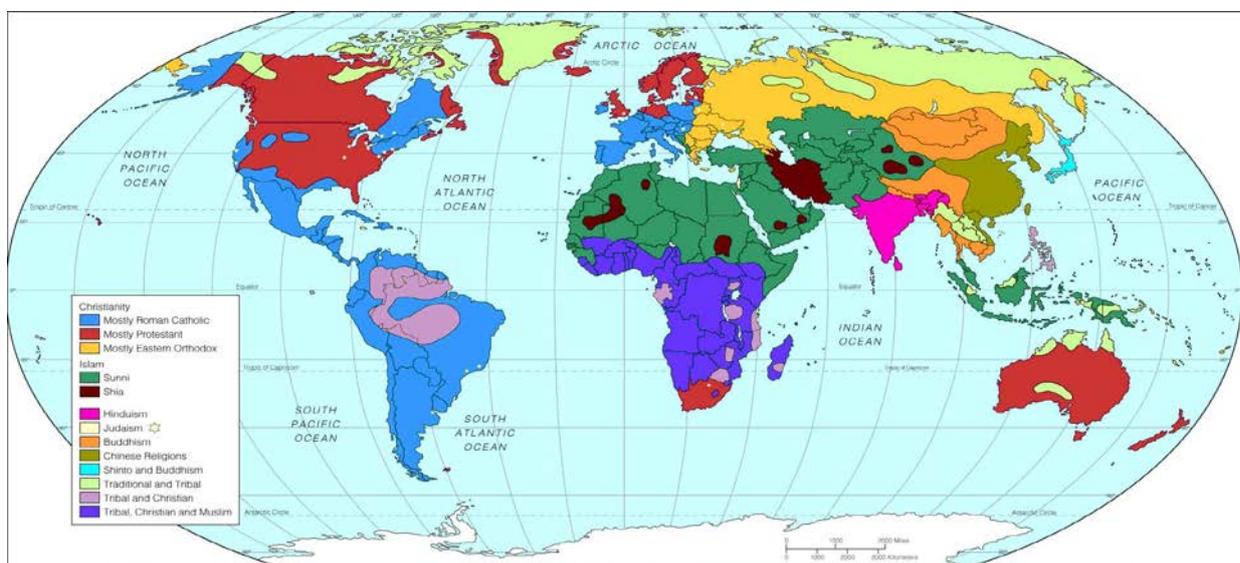


Figure 2.6 Dominant religions at country level
(Cengage Learning [Sa])

Followers of these different religions have different beliefs about circumcision, which, in turn, influence the practice and the prevalence of circumcision among followers of these religions. This section provides a discussion of how some of these religions perceive circumcision and how followers of these religions associate themselves with the practice.

Judaism: This refers to the monotheistic religion of the Jews, tracing its origins to Abraham and having its spiritual and ethical principles embodied chiefly in the Hebrew Scriptures and the Talmud (Farlex 2012). The majority of Jews reside in North America,

Israel, and Europe, although they are scattered throughout the world (LeElef [Sa]; Nationmaster.com 2012). According to the Jewish religion, every male infant should be traditionally circumcised on his eighth day of life, provided there are no medical contraindications to the procedure. This is based on the injunction in Genesis 17:10 in the Jewish holy book, the Torah. According to this scripture, circumcision signifies a covenant with God, and every male should undergo it, as was done by their father, Abraham (WHO & UNAIDS 2007a). In obedience to this scripture, nearly all Jews throughout the world are circumcised (Dave, Johnson, Fenton, Mercer, Erens & Wellings 2003; Laumann, Masi & Zuckerman 1997; WHO 2009b; WHO & UNAIDS 2007a).

Islam: Farlex (2012) defines Islam as a monotheistic religion of Muslims characterised by the acceptance of the doctrine of submission to God, known as Allah in Arabic, and to Muhammad, as the chief and last prophet of God. This religion is mainly practised in North Africa, Arab countries, and part of Asia (Cengage Learning [Sa]). Like Jews, Muslims believe in circumcision as a confirmation of their relationship with God. Although this practice, known as *tahera*, meaning “purification”, is not documented anywhere in the religious book of Islam, the Qur’an, it is nevertheless widely practised. It is even mandatory in one of the six Islamic schools of law, known as the Shafi’ite school. The other schools consider the practice as traditional, known as *sunnah*, and it is strongly encouraged. In fact, it is unlawful for men to perform certain religious rituals without having been circumcised. Such rituals include making the *hajj*, or pilgrimage, to Mecca, which is one of the Five Pillars of Islam (Tierney 1908; Ahmed 2012; Rizvi, Naqvi, Hussain & Hasan 1999). Thus, in a way, all Muslims are compelled to be circumcised, and they are the largest religious group to practise male circumcision. While there is no stipulated age for undergoing circumcision, and people can be circumcised at any age, it is recommended that the procedure be done at an early stage. Most Muslims circumcise their sons on the seventh day of life, in accordance with what the Prophet Mohammed himself did with his sons (Rizvi et al 1999). Some Muslims do it differently, but within the period from birth to puberty. For example, in Turkey circumcision is performed between the eighth day of life and puberty (Ozdemir 1997), and in Indonesia it is performed between 5 and 18 years of age (Hull & Budiharsana 2001). In Pakistan it is performed between 3 and 7 years of age for those born outside of a hospital, or otherwise a few days before being discharged from hospital after birth (Rizvi et al 1999).

With the global spread of Islam from the 7th century AD, male circumcision spread widely and was adopted by many previously non-circumcising societies. In Malawi, for example, due to Muslim influence male circumcision is concentrated in the Southern Region, mostly among the Yao (in the lakeshore area), the Mang'anja, and the Lhomwe. The practice is otherwise rare in other parts of the country (Nkhata 2009). In some places, the presence of Muslims in large numbers has influenced the prevalence of circumcision in that particular area. For example, in the Rakai District of Uganda, 99% of Muslim men are circumcised, compared with just 4% of non-Muslim men. Similarly, the prevalence of circumcision is estimated at 74% among the Sukuma ethnic group of the Mwanza region of north-west Tanzania as a result of Muslim influence (Nnko, Washija, Urassa & Boerma 2001; Kelly, Kiwanuka, Wawer, Serwadda, Sewankambo, Wabwire-Mangen, Li, Konde-Lule, Lutalo, Makumbi & Gray 1999; WHO & UNAIDS 2007a). Likewise, about 96% of Muslims in Ethiopia are circumcised (Central Statistical Agency [Ethiopia] & ICF International 2012).

Christianity: This is a religion based on the life and teachings of Jesus Christ. Followers of this religion, known as Christians, believe that Jesus Christ is the Messiah, sent by God to redeem them (Christianity 2005). As shown in Figure 2.6 above, Christianity dominates the greater part of the world (Cengage Learning [Sa]). While Judaism and Islam are the main influencing religions with regard to circumcision, Christianity also plays a significant role, with the influence varying from place to place. There is a mixture of views and practices concerning circumcision among Christians. Some Christians do not undergo circumcision, based on St Paul's letter to the Galatians, which states that in Christ Jesus neither circumcision nor uncircumcision counts for anything (Galatians 5:6; Galatians 6:15; Corinthians 7:19.). Catholics do not practise circumcision, based on the papal bull issued by Pope Eugenius IV during the Ecumenical Council of Florence in February 1442. Catholics believe that circumcision is a feature of the Mosaic Law and the Old Testament, which, according to the New Testament, are no longer necessary for personal salvation (Circumcision Reference Library 2004). Similarly, some Christian churches in South Africa reject the practice, viewing it as a pagan ritual (Rain-Taljaard, Lagarde, Taljaard, Campbell, MacPhail, Williams & Auvert 2003). On a similar note, the advent of Christianity and colonial administration in Tanzania influenced some Yao ethnic groups to stop the practice of male circumcision (Nkhata 2010).

Contrary to this view, Coptic Christians throughout the world, for example in Egypt and Ethiopia, still retain some of the early Christian practices, including circumcision (Circumcision Reference Library 2004; WHO & USAID 2007). According to the 2011 Ethiopian Demographic and Health Survey, 96% of men among Coptic Orthodox Christians are circumcised (Central Statistical Agency [Ethiopia] & ICF International 2012). Studies in Malawi and Zambia have also revealed that some Christians in these countries feel that Christians should be circumcised, since Jesus Christ himself was circumcised (Lukobo & Bailey 2007; Ngalande, Levy, Kapondo & Bailey 2006). In the Nomiya Church in Kenya, circumcision is a prerequisite for membership of the church (Mattson, Bailey, Muga, Poulussen & Onyango 2005).

African traditional religion (ATR), and other religions. ATR is a religion found in Africa and practised by Africans, which is based on their culture and lifestyle. It is universally characterised by the worship of forefathers or ancestors, who are believed to be the mediators between living people and God. The word “traditional” implies that the religion is passed on from one generation to the other orally by word of mouth. Unlike the other religions described above, ATR cannot be traced back to any one founder, but rather to the various ethnic groups that make up the totality of the African community. As such, this religion is not practised uniformly throughout Africa. Instead, there are some variations from one ethnic group to another. Male circumcision is one of the practices that appear to be a feature of specific ethnic groups, and not ATR in general. Thus, ATR per se seems to be silent about circumcision. The same applies to Hinduism, Buddhism, and other religions that have not been discussed. They all appear to be neutral as far as male circumcision is concerned. Of interest, however, is the distribution of circumcised people among believers of these religions, particularly ATR, where the pattern appears to follow specific ethnic groups (Modiboa [Sa]; National Open University of Nigeria [Sa]; WHO & UNAIDS 2007a). In the following section, an explanation of the influence of ethnicity on circumcision is given.

2.5.3.2 Ethnicity

According to Oxford Dictionaries Online (2012e), ethnicity refers to a state of belonging to a social group that has a common cultural tradition. The African continent consists of a multitude of ethnic groups with varying cultural practices. In Ethiopia alone, for example, there are more than 80 ethnic groups (Central Statistical Agency [Ethiopia] &

ICF International 2012). Male circumcision is one of the cultural practices that is viewed and practised differently from one ethnic group to another. Prevalence of male circumcision may vary greatly from one ethnic group to another within the same country. For example, in Tanzania, prevalence varies from above 80% in traditionally circumcising regions to between 26% and 69% in the traditionally non-circumcising populations. In Kenya, with a national prevalence of about 84%, prevalence is only 17% and 40% among the Luo and Turkana ethnic groups, respectively (Wambura et al 2009; WHO & UNAIDS 2007a). In Malawi, the prevalence is about 33% in the Southern Region where the Yao and Lhomwe people reside, compared to 12.2% and 5% in the Central Region generally and the Northern Region, respectively. Among the Yao and Lhomwe alone, it is 82.3% and 29.8%, respectively, compared to 2.0% and 4.0% among the Tumbuka and Tonga ethnic groups, respectively (Nkhata 2010; National Statistical Office (NSO) [Malawi] & ORC Macro 2005).

The majority of African ethnic groups practise male circumcision mandatorily as a rite of passage of adolescents into manhood (Mavundla, Netswera, Bottoman & Toth 2009; Wambura et al 2009). Failure to do so is unacceptable and attracts stigmatisation to the man. Examples of such groups are the Gogo in Dodoma Region and the Kurya in Mara Region, both in Tanzania (Wambura et al 2009). Explanations to justify this practice vary. Some believe that it indicates masculinity, bravery, and endurance, typical of a real man, as well as a sign of self-identity (Doyle 2005; WHO & UNAIDS 2007a; Wambura et al 2009). Some groups, including the Dogon and Dowayo of West Africa and the amaXhosa of South Africa, view the foreskin as the feminine element of the penis, the removal of which (along with passing certain tests) makes a man of a boy (Silverman 2004; Crowley & Kesner 1990; WHO & UNAIDS 2007a). As such, the majority of males in East and Southern Africa are circumcised between the ages of 12 and 22 years, whereas those in West Africa are generally circumcised much earlier (WHO 2009b). With its widespread practice, male circumcision has acquired a socially desirable status, motivating boys to undergo the procedure.

2.5.3.3 Social desirability

Without necessarily being compelled by religion, ethnicity, or tradition, as described above, many boys are being circumcised with the desire to conform to their peers from circumcising areas. As an example, the city of Mwanza in Tanzania, which is in a

traditionally non-circumcising area, now has an estimated circumcision prevalence of 17-21% under the influence of this motive. As boys mix with circumcising ethnic groups at school, the practice of circumcision is becoming more acceptable and more common (Wambura et al 2009; Weiss, Plummer, Chagalucha, Mshana, Shigongo, Todd, Wight, Hayes & Ross 2008). According to Wambura et al (2009), peer pressure as a reason for circumcision accounts for 6.5% of all cases of circumcision. Not only boys succumb to peer pressure, but also older men (Plotkin et al 2011). Similarly, in a study by Kim, Oh and Choi (2002) conducted in Korea, 61% of respondents believed that they would be ridiculed by their peer group if they were not circumcised. Furthermore, in a survey conducted in the Philippines, where circumcision is almost universal for boys aged 10-14 years, about two-thirds of the boys that participated in the survey reported that they chose to be circumcised simply “to avoid being uncircumcised” (Lee 2005). According to the WHO (2007b), Israel, with a circumcision prevalence of 99.9% and the custom of circumcising at infancy, had a unique experience for over 15 years of having to manage massive numbers of adult male circumcisions in medical settings. The majority of these circumcisions were performed on immigrants from non-circumcising countries, predominantly the former Soviet Union. It is believed that the desire to “belong” is likely to be the main factor behind the high numbers of circumcisions among these immigrants (WHO 2007b; WHO & UNAIDS 2007a). Circumcision is not only associated with specific social groups, but also with a certain economic status, as described below.

2.5.3.4 Socio-economic status

In addition to the aforementioned factors, circumcision has also been found to be associated with economic status. Circumcision prevalence is higher among wealthy and more educated people. This is reflected in, among other things, the emergence of the practice in the United Kingdom in the 19th and 20th century, where it was practised mainly by upper-class people. Likewise, a study conducted in the United States shows that the proportion of circumcised men is higher among those who use the more expensive private surgeries and those with private medical insurance, as well as the more educated (Nelson, Dunn, Wan & Wei 2005; WHO & UNAIDS 2007a; Wambura et al 2009). Worth noting, however, is the fact that this trend is not so consistent in Southern Africa. The trend in Tanzania seems to be consistent with these observations, with 90.8% of the male urban population circumcised compared to 60.6% in the rural areas. In Malawi there is no distinct association between wealth and circumcision.

Figure 2.7 illustrates these trends in selected African countries (Statistical Office (NSO) [Malawi] & ORC Macro 2005; WHO & UNAIDS 2007a; Wambura et al 2009).

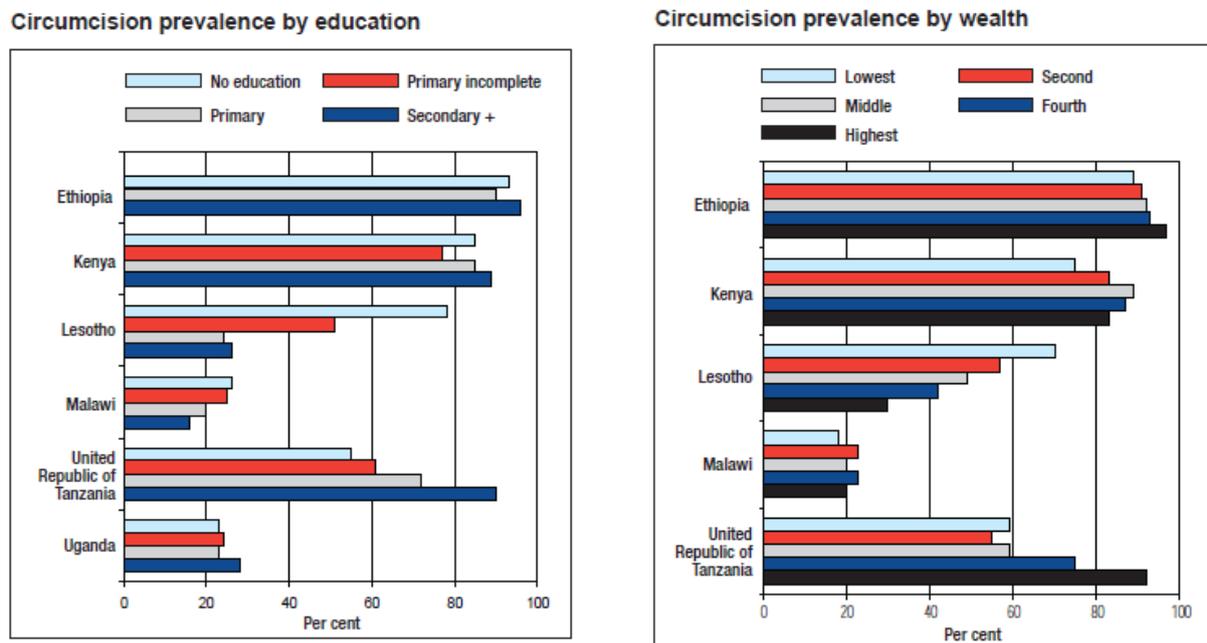


Figure 2.7 Circumcision prevalence by education and wealth quintile
(Wambura et al 2009)

A higher educational level usually serves to ensure enlightenment as to the perceived benefits of circumcision, while greater wealth provides the means to implement the decision to be circumcised, so as to enjoy the benefits of circumcision. The literature has revealed some perceived health and sexual benefits associated with circumcision, thereby motivating people to be circumcised. The following section sheds more light on this aspect.

2.5.3.5 Perceived sexual and health benefits

While the effect of circumcision on sexual pleasure continues to be debatable, biological analysis and most randomised research studies show that circumcision increases sexual satisfaction in both sexual partners. The inner foreskin is the source of most genital sensation and pleasure, and its removal will contribute to reduced sensitivity thereby delaying orgasm in men (The Art of Manliness 2010). In addition, the continuous exposure and tactile stimulation of the glans penis after circumcision is

believed to reduce its sensitivity, resulting in delayed orgasm in men as well. In support of this, Senol, Sen, Karademir, Sen and Saracoglu (2008) reported that circumcision increases pudendal evoked potentials, leading to a significantly higher ejaculatory latency time. An earlier study by Senkul, Iseri, Sen, Karademir, Saracoglu and Erden (2004) also reported an increase in the time required to orgasm following circumcision, while, by contrast, Laumann, Masi and Zuckerman (1997) found that uncircumcised men were more likely to experience premature ejaculation. As far as women's experiences of sexual intercourse with circumcised men are concerned, a study by Kigozi, Lukabwe, Kagaayi, Wawer, Nantume, Kigozi, Nalugoda, Kiwanuka, Wabwire-Mangen, Serwadda, Ridzon, Buwembo, Nabukenya, Watya, Lutalo, Nkale and Gray (2009) showed that only 2.9% of women reported less sexual satisfaction after their husbands had been circumcised. The rest reported increased satisfaction, or otherwise no change. According to Plotkin et al (2011), women in Tanzania have expressed a preference for having sex with circumcised men to having sex with uncircumcised men. This has placed pressure on men to be circumcised, so as to please their wives.

In addition to increased sexual pleasure, circumcision has also been associated with increased penile hygiene and protection from sexually transmitted infections (STIs). This perception has existed for years and accounts for the vast majority of circumcisions in several countries or social groups. In the United States, where 75% of the population is circumcised for non-religious reasons, mothers have cited hygiene as the most important determinant in choosing to circumcise their sons (WHO 2009b; WHO & USAID 2007). Likewise, two studies conducted in Korea revealed that 71% and 78% of respondents, respectively, cited improvement of penile hygiene as the principal reason for undergoing circumcision among those who thought it was necessary (WHO & USAID 2007). Improved hygiene is perceived to go along with a reduced risk of contracting STIs. Indigenous African healers have promoted male circumcision as a protection against disease for centuries (WHO 2009b). In a situational analysis conducted in Tanzania, 25.4% of all circumcised men cited prevention of STIs as a reason for undergoing circumcision, while 17.2% cited increased penile hygiene (Wambura et al 2009). In fact, being uncircumcised is associated with the stigma of being more prone to sexually transmitted infections, such as HIV (Plotkin et al 2011). With the growing impact of HIV and AIDS, as suggested in section 2.5.1.3 of this chapter, the protective effect of circumcision against HIV infection has generated much

interest in public health practice. The following section elaborates on the relationship between HIV transmission and circumcision.

2.5.4 HIV transmission and circumcision

Research publications suggesting a protective effect of male circumcision against HIV infection can be traced back to as early as 1986 (Fink 1986). Up to now, the mechanism by which this protective effect occurs is still debatable. Initially it was postulated that the glans penis mucosa becomes more keratinised after circumcision, thereby reducing its permeability to HIV (Waskett 2011; McCoombe & Short [Sa]). Studies have shown, however, that this mucosa is equally keratinised in both circumcised and non-circumcised men (Szabo & Short 2000). The other possible explanation, given by McCoombe and Short [Sa], as well as Szabo and Short (2000), is that HIV manages to penetrate the mucosa through CD4 and CCR5 receptors found on the Langerhans cells. These cells are found superficially on the frenulum and the inner aspect of the foreskin more than anywhere else on the penis. In addition, the epithelium lining of these sites is thinner and has little protective keratin (Qin, Zheng, Wang, Shen, Sun & Ding 2009). Circumcision will, therefore, constitute a significant reduction in the surface area for HIV transmission.

As research on the protective mechanism of male circumcision continues, several observational studies have been conducted since Fink's (1986) publication, which have all converged on the same conclusion, namely that male circumcision is protective against HIV (Bongaarts, Reining, Way & Conant 1989; Moses, Bradley, Nagelkerke, Ronald, Ndinya-Achola & Plummer 1990; Halperin, Weiss, Hayes, Auvert, Bailey, Caldwell, Coates, Padian, Potts, Ronald, Short, Williams & Klausner 2002). More recently, a randomised, controlled intervention trial by Auvert et al (2005) confirmed that circumcision reduces the chances of heterosexual female-to-male transmission of HIV by 60%. These findings were further confirmed by two similar studies: one conducted in Kenya, by Bailey, Moses, Parker, Agot, Maclean, Krieger, Williams, Campbell and Ndinya-Achola (2007), and the other conducted in Uganda, by Gray, Kigozi, Serwadda, Makumbi, Watya, Nalugoda, Kiwanuka, Moulton, Chaudhary, Chen, Sewankambo, Wabwire-Mangen, Bacon, Williams, Opendi, Reynolds, Laeyendecker, Quinn and Wawer (2007) (WHO 2008a; WHO, UNFPA, UNICEF, World Bank & UNAIDS 2006). In support of these findings, epidemiological data from different countries and among

different ethnic groups has shown a slight negative correlation between HIV prevalence and circumcision prevalence. Figure 2.8 below illustrates this relationship in selected African countries (Grund 2010; WHO & UNAIDS 2009).

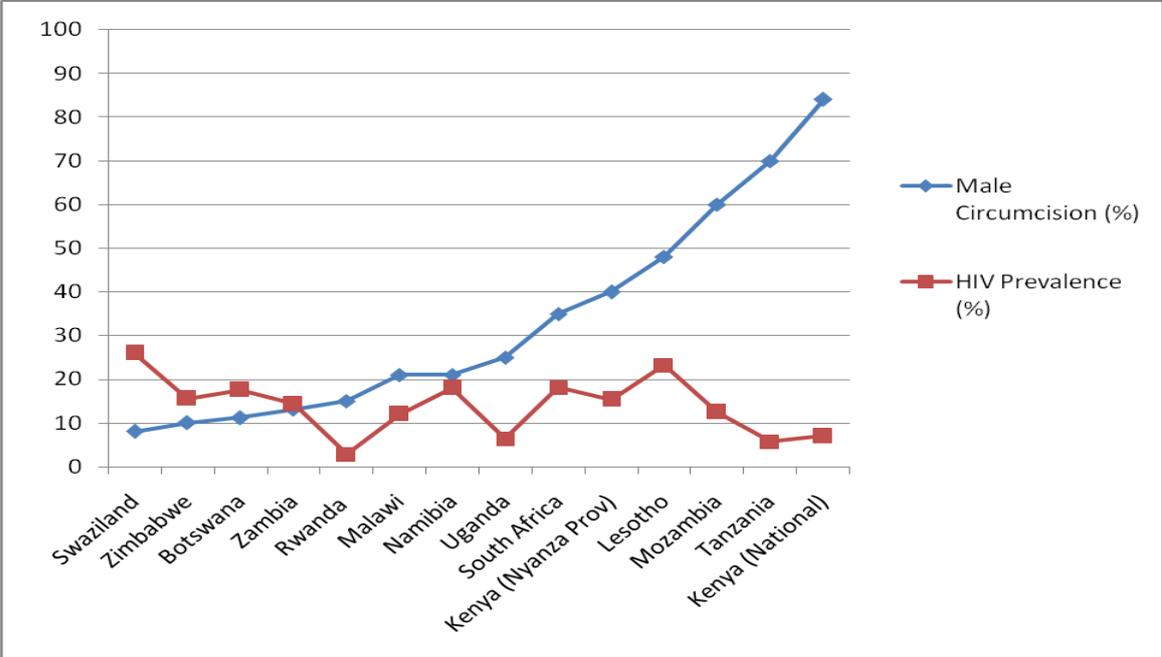


Figure 2.8 The relationship between HIV prevalence and circumcision prevalence in selected African countries

(Grund 2010; WHO & UNAIDS 2009)

A mathematical modelling of the Auvert et al (2005) study shows that male circumcision could avert about 2 million new HIV infections and 0.3 million deaths over the next 10 years in sub-Saharan Africa. In the 10 years after that, it could avert a further 3.7 million new HIV infections and 2.7 million deaths. It has also been shown that male circumcision is equivalent to an intervention such as a vaccine or increased condom use, which reduces transmission in both directions, to the male and to the female, by 37% (Williams, Lloyd-Smith, Gouws, Hankins, Getz, Hargrove, Zoysa, Dye & Auvert 2006). Many similar calculations have been done for different localities, showing similar significant long-term benefits of male circumcision in controlling HIV transmission, particularly in the worst affected countries (USAID 2011; Grund 2010; Rogowska-Szadkowska 2010).

Based on these findings and observations, in 2007, the WHO and UNAIDS formally announced the recommendation that male circumcision be added to the comprehensive HIV prevention package. This package includes the provision of HIV testing and counselling services, treatment for sexually transmitted infections, the promotion of risk reduction and safer sexual practices, as well as the provision of male and female condoms and the promotion of their correct and consistent use (Rogowska-Szadkowska 2010; WHO 2007a, 2009b). In addition to these preventive strategies, the minimum package for male circumcision services, according to the WHO (2007b), should include the male circumcision surgical procedure as described in the WHO, UNAIDS and JHPIEGO (2008) Technical Manual for Male Circumcision under Local Anaesthesia. This is meant to maximise the public health benefits of circumcision and minimise complications associated with the circumcision procedure.

From a situational analysis that was conducted, it was noted that the procedure of circumcision will be beneficial mainly in those areas with low circumcision prevalence and high HIV prevalence, and specifically among high-risk groups (WHO 2007b). Based on this information, priority was given to Southern and East Africa, and 13 countries considered to be the worst affected were selected, Swaziland being one of them (WHO & UNAIDS 2009; Grund 2010) (see Figure 2.8). As a roll-out strategy, it was agreed that a campaign approach be used and that plans be put in place to respond to the expected inevitable increase in demand for circumcision services. To this end, new centres of excellence in circumcision will be established, in addition to integrating circumcision services into already existing health care delivery structures (WHO 2007b). From 2007, certain countries started to gain momentum in performing circumcisions as an HIV prevention strategy, integrating the various different elements of the strategic roll-out plan. The following section focuses on the situation in Swaziland with regard to HIV transmission and circumcision.

2.6 THE SITUATION OF HIV TRANSMISSION AND CIRCUMCISION IN SWAZILAND

The dynamics of HIV transmission and circumcision have been one of the top stories in public health practice in Swaziland over the past five years. This has been prompted by the continuous and rapid spread of HIV/AIDS, which provides no hope of a solution in the near future using the current prevention strategies. The following section elaborates on the situation with regard to HIV prevalence and transmission in Swaziland.

2.6.1 HIV prevalence and transmission in Swaziland

As mentioned in section 2.5.1.2, Swaziland is rated the worst country affected by HIV worldwide, with a prevalence of 19% (22% among females, and 15% among males) among the general population (≥ 2 years), and 26% (31% among women, and 20% among men) for the reproductive population aged 15-49 years. Life expectancy was reduced by half between 1997 and 2007 to about 31 years, accompanied by various socio-economic challenges (News24 2008; News24 2010; USAID, 2010). However, trends in prevalence and incidence have started showing signs of stabilising, with life expectancy standing at 37 years as of 2009 (NERCHA 2009). Annual HIV incidence peaked around 1999 at almost 6%, and since then it has been gradually decreasing, to about 2.9% in 2009 (NERCHA 2009, 2012). A further decline to about 2.4% by 2015 is projected. Similarly, antenatal prevalence has also stabilised, between the peak of about 42% in 2004 and 41% as of 2010 (NERCHA 2009, 2012). Figure 2.9 shows the trends in prevalence and incidence of HIV.

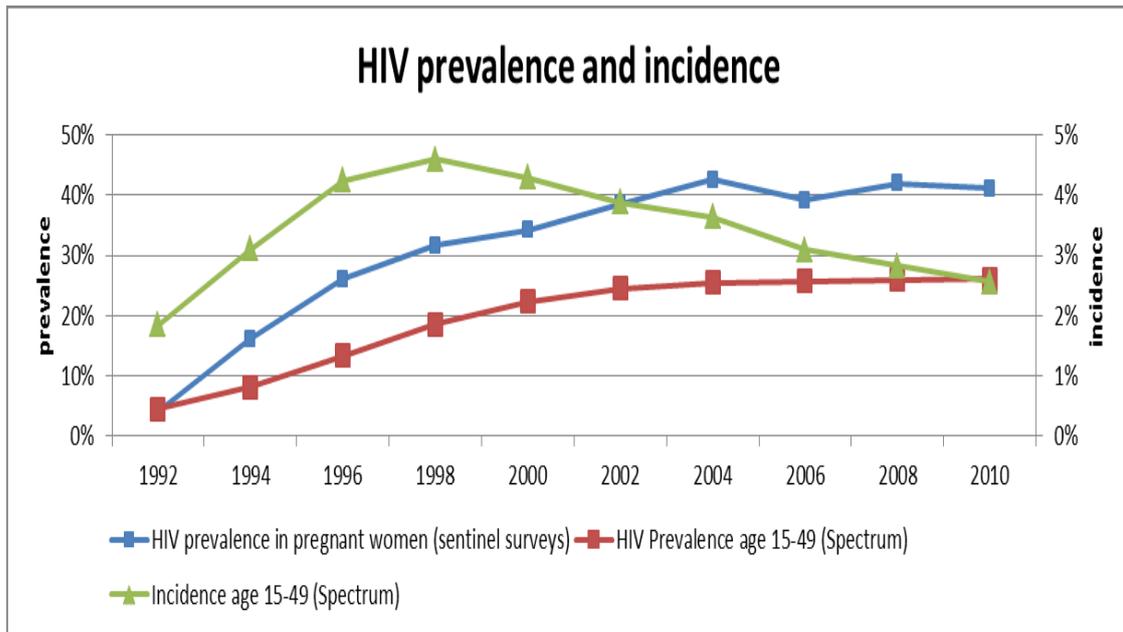


Figure 2.9 Trends in HIV prevalence and incidence
(NERCHA 2012)

Despite the positive trends in HIV incidence and antenatal prevalence, the number of new infections is still unacceptably high. The following figure (Figure 2.10) illustrates the projected number of new infections among the economically and sexually active age group (15-49 years), assuming a continuation of the current trends in HIV incidence.

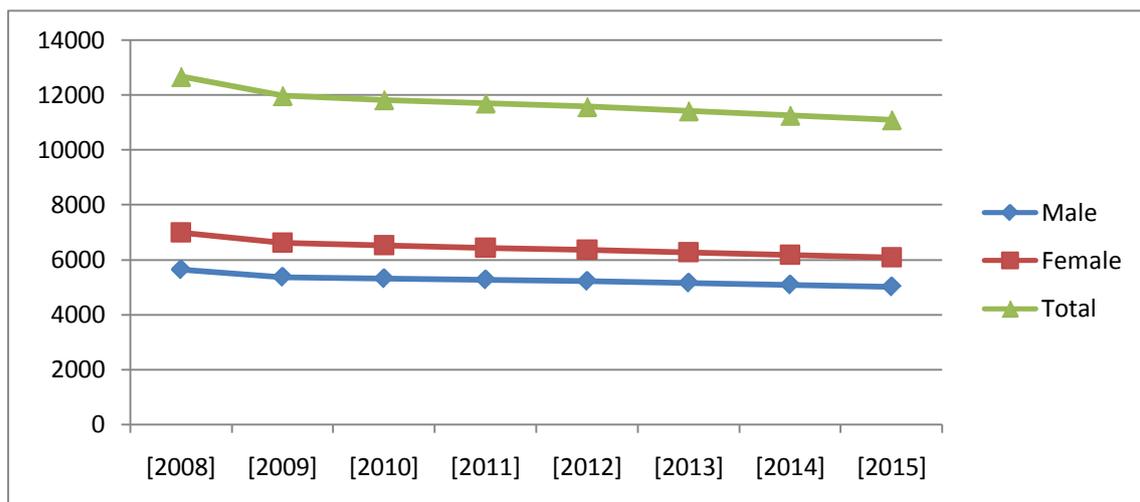


Figure 2.10 Projected number of new infections among 15 to 49-year-olds
(NERCHA & UNAIDS 2010)

As mentioned in section 1.2.2, about 94% of new infections are through heterosexual transmission (USAID 2010). Risky sexual behaviour is still a common scenario in the country. According to the 2010 Multiple Indicator Cluster Survey (MICS) report, among women who have had sexual intercourse in the past 12 months, 2.7% have had more than one sexual partner, up from 2.3%, as reported in the SDHS 2006-07 (Central Statistical Office [Swaziland] 2008; Central Statistical Office [Swaziland] & UNICEF 2011). On average, each of these women would have 2.4 lifetime sexual partners. Up to 43.9% of those with multiple sexual partners engage in high-risk sexual intercourse, and only 73.1% use condoms, up from 54.6% in 2007. The situation is even worse among men, where 15.7% of men who have had sexual intercourse in the past 12 months have had more than one partner. On average, each of them would have about 6.6 sexual partners during their lifetime. Of those who have had sex, 58.2% engaged in high-risk sexual intercourse, and of these, only 71.0% used condoms, up from 68.0% in 2007. To make matters worse, only 40.1% (47.3% of women, and 31.3% of men) of the sexually active group (15-49 years) had undergone an HIV test in the preceding 12 months and knew their HIV status, according to the 2010 MICS report (Central Statistical Office [Swaziland] 2008; Central Statistical Office [Swaziland] & UNICEF 2011; NERCHA 2012).

The continual practice of risky sexual behaviour can be attributed to many factors, among them a lack of knowledge. Only 51.9% of women and 51.4% of men have accurate and comprehensive knowledge about HIV transmission, according to the SDHS 2006-07. As of 2010, some slight improvement has been noted, though, according to the 2010 MICS report, where the level of comprehensive knowledge stood at 58.2% for women and 53.6% for men. More specifically, among other facts, only 63% of women and 59% of men rejected the two main misconceptions that HIV can be transmitted by witchcraft, mosquitoes, and other insects, and through sharing food, and know that a healthy-looking person can be infectious (Central Statistical Office [Swaziland] 2008; Central Statistical Office [Swaziland] & UNICEF 2011; NERCHA 2012).

However, HIV prevalence trends contradict statistics relating to knowledge of HIV transmission. For instance, despite being more knowledgeable about HIV, more women than men are infected. This is partly attributed to economic hardships, to which women are more vulnerable than men. A significant number of women resort to commercial sex

in order to earn a living, regardless of their awareness of HIV. Up to 81% of the 323 commercial sex worker respondents in the Behavioural Sentinel Surveillance for Most-at-Risk Populations (BSSMARP 2011) study reported that they had received information on HIV in the 12 months preceding the study. According to the report, 82.3% of these female sex workers reported to have used a condom at their last sexual encounter with a regular client, and 87.7% reported to have used a condom at their last sexual encounter with a new client. Prevalence of HIV among these women was reportedly 69.7% (NERCHA 2012).

Other major drivers to the spread of HIV include early sexual debut. According to the 2010 MICS report, 3.8% of women and 2.6% of men aged 15-24 reported to have had sexual intercourse before age 15. This is compounded by intergenerational sexual practices, which are also common. Cultural practices such as the custom of inheriting the wife of a deceased brother and polygamy are also playing a significant role.

From the above discussion, it is apparent that the conventional “ABC” strategy for prevention of HIV is far from being successful. A strategy with minimum interference in sexual activities would be preferable, and circumcision could be one such strategy. The following section explains the current situation regarding circumcision in Swaziland.

2.6.2 Circumcision in Swaziland

Swaziland consists of a homogeneous population that practised male circumcision widely in the past, but the practice has declined with urbanisation and westernisation (WHO 2006). According to the SDHS 2006-07, only 8.2% of men aged 15-49 years were circumcised in the country in 2007. Slightly less than two-thirds of these men claimed that they were circumcised at an age younger than 13 years, and only 20% claimed to have been circumcised at the age of 20 or older. Of those who were not circumcised, 43.1% expressed the desire to be circumcised in future, while 54% said that they didn't want to be circumcised, and 2.9% had not decided. Seventy-four percent of those who were already circumcised cited health/hygiene as the principal reason for their decision to be circumcised. The same reason was also cited by 96% of those who had not yet been circumcised but expressed a desire to have the procedure performed (Central Statistical Office [Swaziland] 2008).

The findings of the Auvert et al (2005) study and the subsequent recommendation of circumcision as an additional HIV preventive measure brought a sharp turnaround in circumcision trends in Swaziland. As from around 2006, a marked acceptance of, and positive attitude towards, circumcision started to show among the general public, to the extent where the demand for the procedure by far surpassed its supply. In a household survey of Swazi men in both urban and rural areas in that year, 87% indicated that they would want to undergo the procedure if it helped reduce the risk of HIV infection. In January of the same year, the media reported on a “circumcision riot”, when over 100 men in the capital city were turned away because not enough physicians were available at a “free circumcision Saturday” event (Klausner, Wamai, Bowa, Agot, Kagimba & Halperin 2008). By December, the Mbabane Government Hospital, Swaziland’s main referral hospital, had a nine-month-long waiting list for men wishing to undergo circumcision. The Mbabane Clinic, a private hospital, performed approximately 40 circumcisions per month. Before the Orange Farm study, the clinic was performing one procedure per month, on average. As of 4 May 2007, the FLAS had performed a total of 432 procedures, and was performing an average of 15 circumcision procedures per month (WHO 2006, 2008b).

In an effort to complement this perceived health incentive, the government took an initiative to scale up male circumcision. A male circumcision policy was introduced, with the target of circumcising up to 80% of all men aged 15-49 over a five-year period (Grund 2010; Nqeketo 2010). In order to achieve this, the government in partnership with the private sector had to increase the capacity of the public and the private sectors in providing male circumcision services. In terms of human resources, the Ministry of Health hosted a workshop in January 2006 to train 60 doctors and nurses on how to perform circumcisions (WHO 2006). A male circumcision (MC) task force was also set up, members of which attended a series of workshops in 2010 in Johannesburg on the scale-up of MC (Nqeketo 2010). In terms of infrastructure, MC was integrated into the existing structures of the health care delivery system comprising the public and the private sectors. These include the Mbabane Government Hospital, the Mankayane Government Hospital, the Mbabane Private Clinic, as well as the Family Life Association of Swaziland (FLAS) clinics. One private clinic operated by the FLAS began offering male circumcision in January 2006 (WHO 2008b). In addition, numerous new sites were also established, fixed and mobile, as well as outreach events (Mazzotta 2011; Nqeketo 2010).

In addition to the making available of circumcision services, further efforts have been made to continue sensitising and mobilising men to utilise the services. Promotion of male circumcision for HIV prevention in the local press and on radio stations started in early 2006 (WHO 2006, 2008b). These promotion efforts culminated in full-force campaigns backed by the Government in partnership with a number of non-governmental organisations under the name “Soka Uncobe” (Mazzotta 2011; WHO 2009a). Even more ambitious targets were set. At the beginning of 2011, an initiative was launched to circumcise between 125,000 and 175,000 HIV-negative males from 15 to 49 years of age in a 12-month period (AVERT 2011b; Jackson 2011).

Even though the set targets have not been met (Nqeketo 2010), much improvement has been noted in terms of the prevalence of and interest in circumcision since the 2005 Orange Farm study. Recent statistics, according to the Swaziland Multiple Indicator Cluster Survey (MICS) 2010, show that 19.1% of all men aged 15 to 59 are now circumcised, with the least prevalence having been found among the 50-59 year age group. Compared to the 8.2% for the 15-49 year age group reported in the SDHS 2006-07, this corresponds to an approximately 133% increase in circumcision prevalence over these few years. In the same MICS report, 81% of men who were questioned reported that they would want their sons to be circumcised (Central Statistical Office [Swaziland] & UNICEF 2011).

It is assumed that those men who are seeking circumcision services or showing an interest in circumcision are doing so with the same understanding as the public health authorities who are providing the service. The following section clarifies the perspective of the public health authorities concerning HIV transmission and circumcision.

2.6.3 The perspective of the public health authorities

As mentioned in section 1.2.2, 94% of all transmissions in Swaziland are through heterosexual contact. Between 50% and 65% of new infections occur among steady long-term partners, owing to the fact that one in six heterosexual couples in the country is serodiscordant (USAID 2010; CSO [Swaziland] 2008). This scenario, in the context of high HIV prevalence and low circumcision prevalence, means that the country will potentially benefit a lot from massive circumcision, hence the inclusion of the country

among the chosen 13 countries (see Figure 2.8). Mathematical models have shown that if Swaziland can circumcise 50% of males aged 15-49 by the end of 2020, one HIV infection could be averted for every four circumcisions performed (Grund 2010). Similar mathematical modelling studies have also suggested that such an exercise could reduce annual HIV incidence in Swaziland by 75% by 2025 (AVERT 2011b). The success of this strategy, however, lies in the strict observation of the terms and conditions that were clearly laid down by the WHO/UNAIDS Technical Consultation on Male Circumcision and HIV Prevention held in 2007 (WHO & UNAIDS 2007b).

In this consultation, public health authorities did spell out in their second conclusion that male circumcision does not provide complete protection against HIV. As such, it should never be used as a stand-alone strategy or substitute to the other known methods of HIV prevention. Instead, it should always be considered as part of a comprehensive HIV prevention package, including the strategies of promoting a delay in the onset of sexual relations, abstinence from penetrative sex and a reduction in the number of sexual partners, the provision of male and female condoms and the promotion of their correct and consistent use, the provision of HIV testing and counselling services; and the provision of services for the treatment of sexually transmitted infections (WHO 2007a; WHO & UNAIDS 2007b). The male circumcision procedure itself should be performed as described in the WHO/UNAIDS/JHPIEGO Technical Manual for Male Circumcision under Local Anaesthesia (WHO 2007a; WHO, UNAIDS & JHPIEGO 2008).

The WHO and UNAIDS (2007b) also acknowledged and emphasised in their third conclusion that the communication of correct information about this strategy is critical for its success. Clear, correct and consistent messages should be produced at global, regional, national and community level and be disseminated to the consumers of circumcision services. The messages should communicate, among other things, the need to continue with safe sexual practices as well as the need to abstain from penetrative sex for about six weeks post-operatively to allow complete healing. Known and unknown facts about HIV transmission and/or circumcision should also be communicated. It was also stressed that these messages and counselling sessions should be extended not only to circumcision candidates, but also to their sexual partners, in order to win their cooperation (WHO & UNAIDS 2007b).

In the context of Swaziland, male circumcision service providers are doing their best to disseminate correct information about male circumcision and to align their practice as much as possible with the above described recommendations, so as to ensure a common understanding with their clients (News24 2008; Jackson 2011). It cannot be ascertained, however, that this ultimate goal of reaching a common understanding and a viewing of the circumcision strategy from the same perspective is being attained. A review of the literature suggests that there is a mixture of feelings and understandings, as well as some misconceptions about HIV transmission and/or circumcision among the general public, as explained in the following section.

2.6.4 Perspectives and misconceptions of the general public

As the demand for male circumcision sharply rises following the campaigns described above, one would assume that the main reason for men seeking circumcision services would be to protect themselves from acquiring HIV. According to the 2010 MICS, however, the reality would seem to be different. Of the 19.1% of men in the country who are now circumcised and the 81% who have reported that they would want their sons to be circumcised, only 22% cited prevention of HIV and AIDS as the reason for undergoing circumcision. The majority (52%) reported health or hygiene as the reason, while 18% cited tradition or religion. This clearly shows that Swazis view circumcision from a variety of perspectives. Cultural, traditional and religious perspectives are some of the perspectives, which seem to have a dual influence on the decision to be circumcised.

From the above statistic that 18% of respondents in a study cited tradition or religion as the reason for being circumcised, it follows that traditional or religious influences promote circumcision to some extent in Swaziland. Although this perception cannot be ascertained in the case of Swaziland, in some cultures circumcision is perceived as an indication of bravery and manhood, as explained in section 2.4.1.2 of this chapter (Plotkin et al 2011; Doyle 2005; WHO & UNAIDS 2007a; Wambura et al 2009). Based on this perception, women would also then prefer circumcised husbands, thus in a way compelling their husbands to undergo the procedure (Plotkin et al 2011). In addition, while the effect of circumcision on sexual pleasure and satisfaction is still debatable, some articles have convinced a significant number of men and women that circumcision

enhances sexual pleasure and satisfaction (Kigozi et al 2009; Senol et al 2008; Senkul et al 2004; Laumann et al 1997).

In contrast, cultural and religious influences seem to discourage circumcision among some Swazis. Of the 19% of male respondents in the 2010 MICS who reported that they would not want their sons to be circumcised, 37% cited tradition or religion as the reason (CSO [Swaziland] & UNICEF 2011). Mncedisi Dlamini of Population Services International (PSI), a non-profit organisation helping with the circumcision campaign, was quoted in a media report as saying “Swazis feel it is not the custom of their forefathers, they have biblical concerns and they want to know what we do with their foreskins”. According to the same report, a joke was made on a local television channel the previous year, which led to the widespread belief that foreskins were being sold on the streets and being used to make a herbal spice mixture (Jackson 2011). These are misconceptions that are causing men not to seek circumcision services.

Of greatest concern to the objective of preventing HIV transmission is the misconceptions among those who have been circumcised or have been convinced to be circumcised. Chief among these misconceptions is the one summarised in this quotation from a media report: “But there are rumbling fears that the ‘kindest cut’ may actually be a double-edged sword, if men fool themselves that circumcision gives them immunity and indulge in risky sexual behaviour” (News24 2008). Another media quotation based on the same misconception states: “One man boasts that he got circumcised because it is ‘nice to have sex without condoms’.” The man quoted was living in White City, a sprawling shantytown outside Swaziland’s second largest city, Manzini. There are many similar press reports showing evidence of this misconception, as explained in Chapter 1 of this dissertation (Circumcision campaign an admission of failure 2011; Circumcision campaign clouding HIV issues 2011; Stop this circumcision advert, please! 2011).

Based on this discussion, it is apparent that there is a mixture of views and understandings among the Swazi community about the ongoing circumcision campaigns for HIV prevention in the country. This is negatively affecting the success of these campaigns and requires prompt attention. The success of these campaigns requires a comprehensive understanding of the situation of HIV transmission and

circumcision in Swaziland, as discussed in this entire chapter, and as summarised in the following conclusion.

2.7 CONCLUSION

This chapter opened by explaining the conceptual framework which is guiding this study, where the concept of “motive” was discussed. The various types of motives were also discussed, relating them to their possible influence on one’s decision to be circumcised. The concept of circumcision was also discussed, with particular focus on its distribution and prevalence, as well as the factors that influence its practice in different geographical areas, including Swaziland. The recently discovered relationship between HIV transmission and circumcision was also explained. The prospect of mass male circumcision for the prevention of HIV transmission in Swaziland based on the discovered relationship between HIV transmission and circumcision was also explored. The chapter ended by exploring the differences in views and understandings between circumcision service providers and the general public regarding the ongoing circumcision campaigns. These differences, if not addressed, are bound to undermine the successes of the campaigns and the public health benefit of the entire mass circumcision exercise. The greatest threat identified was the misconception that circumcision offers total protection from HIV infection. A remedy to the situation should start from a comprehensive knowledge of the motive behind the current uptake of the procedure by those who are doing so. It is the need to discover this knowledge which has prompted this study. The following chapter describes the method by which this knowledge was discovered.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter presents a discussion of the research design followed in this study, as well as the methods by which the researcher managed to accomplish the research objectives and answer the research question. These include the research population, sampling, data collection, analysis, and measures for ensuring the trustworthiness of the study, as well as ethical considerations observed in the study. All these are guided by the research design, as explained below.

3.2 RESEARCH DESIGN

This refers to the overall plan for obtaining answers to the research questions or meeting the research objectives. Control measures that were used to minimise bias were also specified. The research design was guided by the researcher's overall world view, or paradigm, as described by Polit and Beck (2004:13, 726).

3.2.1 Research paradigm

This study is a qualitative research study. This approach allowed the researcher to systematically interact with the participants in order to discover their subjective and unique experiences, understandings, and perceptions about circumcision. The approach allowed the researcher to view the findings in the sociocultural and historical context of Swaziland. The concept of circumcision was studied in the natural setting in which it is occurring, that is, in health care centres in Swaziland and in the community at large.

The paradigm of qualitative research uses unstructured methods of enquiry which allow the informants to provide in-depth and comprehensive subjective accounts of their beliefs about the phenomenon under investigation without any limitations. It allows the

researcher to be closer to the informants and their personal experiences and understandings, hence enabling the elicitation of in-depth information. In the case of this study, the paradigm of qualitative research allowed circumcision to be viewed from a holistic perspective, thus considering the multiple interdependent factors that influence its practice. These include the public health benefits of circumcision, sociocultural norms, values, as well as personal behavioural factors (Brink 2006:113; Imel, Kerka & Wonacott 2002; Polit & Beck 2004; UNISA 2010).

3.2.2 Research design

A generic qualitative research design was adopted. This design is rooted in a paradigm of personal knowledge and subjectivity, and emphasises the importance of personal perspective and interpretation. This makes this design powerful in understanding subjective experience, gaining insights into people's motivations and actions, as well as cutting through taken-for-granted assumptions and conventional wisdom. In this method, bracketing is a requirement on the part of the researcher, that is, the researcher should suspend his or her own prior assumptions or understandings or preconceptions to be open to the informants' views of the phenomenon under investigation as it appears in the chosen context. Thus, the approach solely depends on the informants' actual words (Cohen & Daniels 2003; Finlay 2008; Lester 1999). Conclusions are then drawn from these words through abstract thinking, among other ways. According to Burns and Grove (2005:6), there are three major abstract thought processes: introspection, intuition, and reasoning. In this study, reasoning, and specifically logical reasoning, was used to draw conclusions (Polit & Beck 2004:12; Burns & Grove 2005:7). The following section describes reasoning and the reasoning strategies that were used in this study.

3.2.3 Reasoning and its strategies

Reasoning refers to the processing and organising of ideas in order to reach a conclusion (Burns & Grove 2005:7). Similarly, Farlex (2012) defines reasoning as an act or process of drawing conclusions from facts, evidence, or any other information that is assumed to be true. Depending on the nature of the facts or evidence from which conclusions are drawn, reasoning can be categorised into various strategies or patterns

(McSwain 2009; Lizier 2009). The reasoning strategies that were used in this study are bracketing, intuition, induction, deduction, analysis, and synthesis.

3.2.3.1 Bracketing

Burns and Grove (2005:728) define bracketing as a qualitative research technique of suspending or laying aside what is known about an experience being studied. Similarly, Polit and Beck (2004:712) describe this strategy as the process of identifying and holding in abeyance any preconceived beliefs and opinions about the phenomenon under study. Although bracketing can never be achieved totally, according to Polit and Beck (2004:253), in this study the researcher tried by all means and as much as possible to “bracket” out the world and any preconceived ideas in order to obtain the pure, uninfluenced perspectives of clients about their motives for circumcision. To accomplish this, the researcher’s senses of self-awareness and self-control were strictly applied.

Bracketing created a favourable climate for intuition, which is another technique that was applied by the researcher.

3.2.3.2 Intuition

Intuition refers to an insight or understanding of a situation or an event as a whole that usually cannot be logically explained (Burns & Grove 2005:740). According to Polit and Beck (2004:254), it occurs when the researcher remains open to the meanings attributed to the phenomenon under study by those who have experienced it. This allows the researcher to be immersed in the participants’ descriptions of their own lived experiences, and thus be able to acquire a comprehensive and accurate interpretation of the descriptions (Fain 2004:222).

In order to achieve this, the researcher avoided judging, criticising, or evaluating participants’ points of view based on his own preconceived ideas. This was augmented by the researcher initially establishing good rapport with the participants, thereby enabling them to freely, openly, and truthfully share their life experiences with the researcher. In addition, the researcher was extra alert and noted any insights that he received, because it is quite common for some feelings or intuitions to be suppressed,

ignored, or dismissed as silly (Burns & Grove 2005:6). Use of intuition ensured the successful accomplishment of inductive reasoning.

3.2.3.3 Inductive reasoning

Inductive reasoning refers to the process of logically drawing general conclusions from a set of observed data, that is, reasoning from specific observations to more general rules (Burns & Grove 2005:739; Polit & Beck 2004:12). This means that the researcher has to evaluate several specific events, situations, or observations and come up with broad generalisations or theories based on the observed trends, patterns, and regularities (Aqil Burney 2008; Trochim 2006; The Naked Science Society [Sa]). Because it is based on experience or observations, inductive reasoning is more open-ended and exploratory in nature. The resultant knowledge is therefore usually subjective, with some degree of uncertainty. As such, the observations, trends, or patterns which a researcher records should be strong and/or accurate to ensure that it is unlikely that the conclusion that is drawn from them will be false, hence the measures of trustworthiness described in section 3.4 of this chapter (IEP 2003; Trochim 2006; Aqil Burney 2008).

In this research inductive reasoning was used to generate knowledge about the main motive behind circumcision, based on the various reasons given by the participants. The researcher explored in depth each participant's life experience and how circumcision featured.

Not only inductive reasoning was used in this study, but also deductive reasoning, since both methods of reasoning play an important role in research, according to Polit and Beck (2004:12).

3.2.3.4 Deductive reasoning

Deductive reasoning refers to the process of drawing specific conclusions from known generalisations (Burns & Grove 2005:8; Polit & Beck 2004:12). The initial generalisations, called "premises", are assumed to be true and thus provide a guarantee of the truth of the conclusion. It would therefore be impossible for the conclusion to be false if the premises are true (Godorn [Sa]; IEP 2003; Cline 2012).

Although the premises themselves remain unproven and unprovable, they must be acceptable at face value, or by faith, or for the purpose of the exploration (Godorn [Sa]). Deductive reasoning is therefore used for those arguments or conclusions that are based on laws, rules, or other widely accepted principles. As such, this reasoning strategy can be described as reasoning of the form “If A, then B”, thus direct application of knowledge in the production of new knowledge (Aqil Burney 2008; The Naked Science Society [Sa]).

In this study, the researcher uses deductive reasoning to draw conclusions from the literature during the literature control of the findings, in his use of the literature to motivate for this research, and, lastly, in the development of evidence-based strategies and recommendations to maximise the public health benefits of circumcision.

In addition to the strategies described above, analytical reasoning was another technique used.

3.2.3.5 Analysis

Analysis is a systematic examination and evaluation of data or information, by breaking it into its component parts to uncover their interrelationships (WebFinance 2011). It involves going into depth, studying the different parts of something, or dissecting something, in order to reason out and understand the whole (McSwain 2009; Walker & Avant 1995:28).

In this study, analytical reasoning was performed during the literature control to understand key concepts of this study by relating the different factors that influence them. It was also used during data analysis to relate different segments of each participant’s narrative, so as to construct knowledge of the true motive for circumcision. This process also assisted in the identification and categorisation of themes. Analysis was followed by synthesis.

3.2.3.6 Synthesis

Synthesis is a reasoning strategy in which knowledge and understanding from different sources is integrated. It involves putting together parts or ideas from diverse sources to

form a coherent whole, with the focus on creating a new meaning or knowledge structure (McSwain 2009; Lizier 2009). LoBiondo-Wood and Haber (2002:42) similarly define it as a combination, or putting together and combining, of parts into a whole to make sense of it, and to explain relationships. Ultimately, synthesis enables the formulation of general statements about the phenomenon under study (Polit & Beck 2004:572).

In this study, the reasoning strategy of synthesis was used during the literature control to formulate the conceptual framework for the research by integrating various factors into a solid model. The strategy was also used during data analysis to put together information from different participants into single coherent facts. In addition, different segments of each participant's narrative were synthesised into solid facts. Lastly, synthesis was used in the drawing of conclusions and the making of recommendations from the various findings.

The information from the participants to which the researcher applied the above reasoning strategies had been obtained by means of the following research methods.

3.3 RESEARCH METHODS

Research methods are the steps, procedures, and strategies for gathering and analysing data in a research investigation. These are often determined by the nature of the research question or the research objectives that are to be addressed. Research methods specify the research population, the data collection methods, and the method of data analysis (Creswell 2003:17; Polit & Beck 2004:49, 723). The following sections explore each of these aspects as applied to this study.

3.3.1 Research population

The research population refers to the set of individuals that have the characteristics or variables of interest to the researcher. Within the broad sense of research population, the specifications of population (universum), target population, and accessible population can be singled out (Polit & Beck 2004:289-290). Below are these specifications, as applied to this study.

3.3.1.1 Population (universum)

The terms “population” and “universum” are often used interchangeably by many authors (Brink & Wood 2001:131; Landman 2005; MUBS [Sa]). According to Bless and Higson-Smith (1995:85), these terms synonymously refer to the entire set of objects and events or group of people which is the object of research and about which the researcher wants to determine certain characteristics. Similarly, Polit and Beck (2004:289) define population as the entire aggregation of cases in which a researcher is interested. In this study, all Swazi men constituted the population (universum), since they are the individuals who are increasingly showing an interest in undergoing circumcision.

3.3.1.2 Target population

Target population refers to the aggregate of cases or group of individuals about which the researcher would like to make generalisations. This population usually has varying characteristics, and it is also known as the theoretical population (Brink & Wood 2001:132; Castillo 2009; Polit & Beck 2004:290). In this study, the target population consisted of the Swazi men who had recently been motivated and convinced to be circumcised and had agreed to undergo the procedure, thereby contributing to the noted dramatic increase in circumcision prevalence as from 2006. The inclusion criteria were as follows:

- Men who were circumcised in or after 2006, because that is when the increase in demand for the procedure was first noted (Canada.com 2006; WHO 2006). This period also followed the initial promotion of circumcision as a potential preventive measure for HIV transmission (Auvert et al 2005).
- Men who were not circumcised but had demonstrated a willingness or an intention to be circumcised.
- Men who were aged 18 years or more at the time of circumcision, since they are the targets for the ongoing circumcision campaigns (AVERT 2011a; Canada.com 2006; Grund 2010; Mazzotta 2011).

3.3.1.3 Accessible population

The accessible population is the population in a research study to which the researcher can apply his or her conclusions. This population is a subset of the target population. It is the population that is available to the researcher, from which the researcher can draw his or her sample (Castillo 2009; Polit & Beck 2004:218, 290). Since the aim of qualitative research is to discover meaning and uncover multiple realities, the accessible population should be as information-rich as the target population regarding the phenomenon of interest (Polit & Beck 2004:305). This study was conducted at the Family Life Association of Swaziland (FLAS) in Mbabane. As such, the accessible population for this study consisted of those men who met the inclusion criteria, as described earlier, who visited the FLAS, Mbabane, during the period 28 June to 11 July 2012, when data collection was performed. This period coincided with school holidays in South Africa. The participants came either for circumcision or for a review two days or more after the circumcision procedure, or they just accompanied their colleagues to the procedure after they had undergone it some time back.

3.3.2 Sampling

Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit & Beck 2004:291). In order to obtain the best portion of the population to get the richest data to fulfil the research objectives, there is a need for careful consideration of the sample size, the sampling method, and the sampling technique. The following sections provide more information about these considerations, as applied to this study.

3.3.2.1 Sample size

A sample refers to a subset of a population selected to participate in a study, and sample size refers to the number of subjects or participants in the sample (Answers.com 2011b; Polit & Beck 2004:731). While a number of issues can affect sample size in qualitative research, the guiding principle should be the concept of saturation, that is, sampling to the point at which no new information is obtained (Mason 2010; Polit & Beck 2004:308). The same principle was applied in this study, thus there was no predetermined sample size. Pure qualitative research studies, however, are

conducted on small sample sizes, typically 10 or fewer subjects (Polit & Beck 2004:308, 309; Smith & Osborn 2007). According to Boyd (2001) in Groenewald (2004), two to 10 participants, or research subjects, are sufficient to reach saturation. Of importance is qualitative and not statistical validity (Lester 1999). In this study, 17 participants were interviewed, including one who was used for a pilot interview of the methodology. Equally important is the method by which participants are obtained, known as the sampling method.

3.3.2.2 *Sampling methods/approach*

Sampling methods, or sampling approach, refers to the overall plan of how the sample will be obtained. It is broadly categorised into two approaches: probability sampling, and non-probability sampling. Qualitative studies almost always use a non-probability sampling approach (Ploeg 1999; Polit & Beck 2004:305). The same approach was used in this study by virtue of its suitability for the nature of the research. This approach is characterised by non-random selection of participants, where the probability of each participant being included in the study is unique and unknown (Brink & Wood 2001:134). While probability sampling in quantitative research seeks to demonstrate the representativeness of findings through random selection of subjects, non-probability sampling techniques in qualitative research are concerned with seeking information from specific groups and subgroups in the population (Hancock 2002). Similarly, this study sought to elicit motives for circumcision, specifically from those who had been recently circumcised among the 18-49 year age group. Within each chosen sampling approach there are specific sampling techniques that can be adopted. In this study, the following sampling technique was adopted.

3.3.2.3 *Sampling technique*

Sampling technique refers to the specific process by which the entities of the sample are selected (OECD 2004). In this study, convenience sampling was used. The use of this method is common in qualitative studies (Coulmas 2006:44; White 2007:109; Rootman, Tait & Sharp 2010). This technique, also known as accidental sampling, involves using the most conveniently available participants (Polit & Beck 2004:292). In this study, participants were selected continuously as they came. Each client who came seeking services and met the selection criteria, at each instance of identifying

participants, was selected. All clients who agreed to participate also agreed to be interviewed instantly. As such, each selected participant was interviewed before the next participant was selected, thus sampling and data collection occurred simultaneously and continued until data saturation had been reached. More information about the data-collection process is given in the following section.

3.3.3 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives or questions of a study (Burns & Grove 2005:733). Data collection can be done in several ways. In this research project, the researcher used two methods to collect data, namely: (1) in-depth individual unstructured interviews, and (2) observations in the form of field notes.

3.3.3.1 In-depth individual unstructured interviews

In-depth unstructured face-to-face interviews were used to collect data, as was done by Ruffin (2007:66) and recommended by Ploeg (1999) in similar qualitative studies. Interviews involve verbal questioning of the participants by the data collector. This can be done over the telephone or face to face (Lobiondo-Wood & Haber 2006:356). The latter approach was adopted in this research. Participants had the option of being asked questions in English or siSwati. All of the participants opted to be interviewed in English. Face-to-face interviews are characterised by synchronous communication in time and place. This allows the interviewer to obtain additional information communicated by the interviewee non-verbally through social cues, such as intonation and body language (Brink 2006:147; Opdenakker 2006). Some motives for circumcision are not socially acceptable, and participants were not comfortable to verbally disclose such, hence the need to capture the non-verbal communication as well. In addition, face-to-face interviews provide the interviewer with an opportunity to clarify questions and concepts to the interviewee, where need be, as explained by Brink (2006:147).

With the assistance and mediation of the nurse in charge of the Family Life Association of Swaziland (FLAS) Mbabane Clinic on each day of data collection, participants were identified as they came to book for the procedure of circumcision, or to undergo the procedure at the FLAS Mbabane Clinic. Research participants were given an informed

consent form containing information about the entire research process, including the following: the purpose and benefits of the research, the data-collection process, the risks and benefits of participating in the study, and the participant's right to choose to participate or not to participate and/or to discontinue participation at any time without incurring any penalty or prejudiced treatment. The consent form also requested permission for the researcher to audiotape the interview. Those who agreed to participate in the research were requested to sign the consent form (see Annexure F for the consent form that was signed by the research participants).

- ***Interview process***

Although participants had the option to schedule the interview to a later time, all of them preferred to be interviewed instantly. The interviews were conducted in a selected private room negotiated for at the FLAS, Mbabane.

A grand tour question approach was followed. This involves starting by asking one broad open-ended question in order to gain a general overview of the phenomenon, on the basis of which more focused questions would be subsequently asked. The grand tour question in this study was "*What made you decide to be circumcised?*" This helped to elicit participants' initial impressions about their motives behind wanting to be circumcised. Subsequent questions enabled a deeper and wider exploration of, and probing into, participants' feelings, opinions, and perspectives, so as to come up with rich data, which was required to unearth participants' hidden motives for circumcision, if any. The duration of the interview sessions varied from one participant to another, ranging from about 6 minutes to about 27 minutes, with an average of 16 minutes and a standard deviation of about 5 minutes. The length of the interview was dependent on the amount of information which the participant was able to share. Further individualized probing questions were asked as the interviews unfolded, depending on the participant's response (Polit & Beck 2004:340, 719). The researcher used various communication techniques to encourage participants to express themselves.

- ***Communication techniques applied during the interviews***

The communication techniques applied by the researcher to encourage participants to express themselves included both verbal and non-verbal techniques. The verbal

communication techniques included probing, clarification, paraphrasing/reflective commenting, silence, empathy, summarising, and short verbal response.

- **Probing:** Polit and Beck (2004:728) define probing as the elicitation of more useful or detailed information from a respondent in an interview than was volunteered on the first reply. According to Salazar et al (2006:184) in Matshediso (2008), probing triggers additional thoughts, thereby yielding detailed information necessary for a qualitative study. Probing in this study took the form of asking more specific and focused open-ended questions based on the participant's initial response, as directed by the research objectives.
- **Clarifying:** Clarifying means to make clear or easier to understand (Farlex 2012; Collins English Dictionary 2006:141). The researcher ensured that participants accurately understood questions by elaborating where participants seemed to have missed the point. Paraphrasing was used to ensure the accurate capturing of the participant's message.
- **Paraphrasing/Reflective commenting:** According to Oxford Dictionaries Online (2012f), to paraphrase is to express the meaning of something written or spoken using different words, especially to achieve greater clarity. It involves mirroring to the participant what he would have conveyed, which could be a specific message, an implication, or underlying feelings. The researcher did this each time during the interviews as the need for clarity arose.
- **Silence:** Oxford Dictionaries Online (2012g) defines silence as the fact or state of abstaining from speech, or complete absence of sound. In a trusting relationship where there is rapport, silence allows time for the participant to reflect and gather his or her thoughts and feelings. Similarly, in this study, silence was used to give participants the opportunity to recall remote memories of their past experience.
- **Empathy:** This refers to the ability to recognise and acknowledge feelings of someone without experiencing the same emotions (Merriam-Webster 2012; Health24 2003). This skill was used where participants expressed undesirable or painful past experiences or states that would have motivated them to be circumcised, such as past experiences of cancer.

- **Summarising:** According to Macmillan Dictionaries Online (2012), summarising refers to providing a short account of the most important facts or features of something. It involves giving an overview of a text or using one's own words to shorten a piece of text so that it includes only the essential information (University of New South Wales 2009; University of Newcastle 2008).

In this study, the researcher used the technique of summarising at the beginning of each interview session to give the participant direction. It was also used at any time when the need arise to focus or make the participant move on when he or she got stuck. Each session was also concluded with a summary.

- **Short verbal response:** The researcher used short responses, such as “um”, to encourage the participant to continue, or to show agreement. These responses were often used either to trigger further elaboration, or as interjections in a participant's continuous narration.

In addition to the information expressed verbally by the participants, non-verbal cues were noted, as recommended by Groenewald (2004). These were captured in the form of field notes, as described in the following section.

3.3.3.2 Observations, recorded as field notes

According to Schwandt (2007), there is no standard definition of field notes, or their form or content. The Oxford Dictionary of Archaeology in Answers.com (2012) defines them as records of observations or interpretations made during fieldwork. Similarly, Polit and Beck (2004:718) define them as the notes taken by the researcher describing the unstructured observations he or she has made in the field, and his or her interpretations of those observations. This was the conceptual definition adopted in this study, with a specific focus on those records in the form of written notes. These notes were in the form of jottings, as described by Russell Bernard (2011). These are scratch notes taken during the course of data collection to serve as a trigger to recall observations, thoughts, or realisations that occurred during the interview process (Polit & Beck 2004: 382-383; Wilson 1993:222-223; Moul & Goodman 2009:174; Russell Bernard 2011; Williams [Sa]). Field notes can be broadly categorised into two types: observational

(descriptive) notes, and reflective notes (Polit & Beck 2004:382; Williams [Sa]), both of which were collected in this study.

- ***Observational (descriptive) notes***

Observational (descriptive) notes are detailed and accurate descriptions of what the inquirer sees, hears, and experiences. They include a description of the participants themselves, their behaviours and reactions, as well as the physical setting and the environment itself. Accounts of particular events and actions in the setting are also given, including accounts by the parties involved. The researcher-participant relationship is also described. These types of notes constitute the bulk of all the field notes that are taken in a research study (Russell Bernard 2011; Williams [Sa]; Polit & Beck 2004:382-383; Wilson 1993:222-223).

- ***Reflective notes***

Reflective notes comprise comments about the researcher's own feelings and what the researcher is learning while collecting the data. They build on descriptive field notes, described above, and go beyond mere descriptions to include speculations, feelings, problems, ideas, hunches, impressions, prejudices, analyses, plans for future inquiry, clarifications, syntheses, connections, and other ideas about what the researcher is learning in the inquiry. In this way, they help to provide a contextual framework for the interpretation of the descriptive field notes, their analysis, and the conclusions of the study as a whole (Williams [Sa]; Russell Bernard 2011; Williams [Sa]; Polit & Beck 2004:382-383; Wilson 1993:222-223). Since in qualitative research, the researcher serves as the data-collection instrument, reflective notes also help to provide the basis for deducing possible influences of the researcher on the study findings (Williams [Sa]; McCaslin & Scott 2003). Reflective notes can be further categorised as follows, according to their content and the purpose which they serve (Williams [Sa]; Polit & Beck 2004:382-383).

- ***Methodological notes:*** These are reflections about strategies and methods used in the data collection. Based on a review conducted of these notes after each interview session, the researcher progressively refines his or her interviewing and observation skills. Any alterations to the originally planned

method are indicated (Russell Bernard 2011; Williams [Sa]; Polit & Beck 2004:382-383; Wilson 1993:222-223).

- ***Theoretical (analytical) notes:*** These are reflections on the researcher's efforts to attach meaning to observations, and serve as the starting point for data analysis (Polit & Beck 2004:383). In fact, they constitute the ongoing process of clarifying meaning and interpreting the information being gathered, in the light of the relationships being developed between the researcher and the participants, so that a better understanding of the phenomenon of interest is obtained (Williams [Sa]). A similar understanding may also be obtained from repeated reviewing of observational and methodological notes (Russell Bernard 2011).

- ***Personal notes:*** These are comments about the researcher's own feelings while in the field. They include comments about emotions resulting from, and challenges encountered during, the fieldwork, as well as ethical dilemmas and possible conflicts. These notes are crucial in determining the possible influence of the researcher on the study results (Polit & Beck 2004:383).

All the field notes described above, together with the audiotaped interviews, were integrated into the data analysis process, as described below.

3.3.4 Data analysis

Data analysis started at the moment data collection began, in the form of taking field notes, especially the analytical field notes, as described above. The search for themes and concepts started at this point. An editing analysis style was used, as described in Polit and Beck (2004:570-571). This is consistent with the generic process of qualitative data analysis, as described by Creswell (2003:191-195), which was followed in this study. The process comprises the following steps:

- Organising and preparing the data for analysis. This involved transcription of the interviews from the audiotapes and merging the transcripts of the interviews with field notes in a word-processing document.
- Reading through the transcript to get the general sense of the information.

- Coding, that is, breaking down the narrative data into more general and transferable parts or insights. The guiding steps for the coding process as described by Tesch (1990:142-145) in Creswell (2003:192) were followed. Similar data segments were categorised and labelled.
- Identifying main themes for analysis for each participant and across different participants. These are descriptions generated from the coding process about the phenomenon in question and/or its setting.
- A description of how the themes were presented in the dissertation. Narrative passages were used in this study, with each theme covered separately.
- Making an interpretation of, or attaching meaning to, the data. This involved formulation of an exhaustive description of the motive behind the decisions to be circumscribed based on the gained insights.

The above steps in the process of data analysis concluded the procedure (method) by which answers to the research question were obtained. The following section describes aspects of the research method which were applied to ensure trustworthiness of these answers.

3.4 TRUSTWORTHINESS

Trustworthiness refers to the degree of confidence qualitative researchers have in their data (Polit & Beck 2004:734). In this study, Guba's (1981) model for assessing trustworthiness was used, as described by Krefting (1991). Based on this model, trustworthiness has four aspects that contribute a measure of rigour to a piece of qualitative research. These are truth value, applicability, consistency, and neutrality. These aspects are assessed using the strategies, or criteria, of credibility, transferability, dependability, and confirmability, respectively (Krefting 1991; Lincoln & Guba 1985:290; Polit & Beck 2004:430-436; Imel, Kerka & Wonacott 2002). This section describes how each aspect of trustworthiness was ensured using the respective strategies, or criteria.

3.4.1 Truth value

Truth value establishes how confident the researcher is with the truth of the findings, based on the research design, the informants, and the context (Krefting 1991:215). This

aspect is assessed by the strategy of credibility, which Polit and Beck (2004:430) define as confidence in the truth of the data and their interpretation. Since qualitative research is rooted in a naturalistic paradigm, which assumes multiple and dynamic realities, Krefting (1991:215) asserts that truth value is usually obtained from the discovery of human experiences as they are lived and perceived by the participants. In this study, the motives behind circumcision, as lived and perceived by the participants, were discovered through a strict application of credibility through a number of strategies, as described by Krefting (1991:217-220). These strategies include the following:

3.4.1.1 Prolonged engagement

According to Lincoln and Guba (1985) in Krefting (1991:217), prolonged engagement entails spending an extended period of time with informants, so as to allow for the establishment of rapport and to enable informants to become accustomed to the researcher. Failure to allow for this relationship building will lead to bias, since participants will be likely to give socially acceptable responses, rather than their actual personal experiences.

In this study, this risk was averted by the fact that the researcher has been living among the Swazi community for the past couple of years. This allowed the researcher to develop social compatibility with this community, thus enabling the easy establishment of rapport with any member of this community. The researcher also took a few minutes to chat with each participant just to create rapport before starting the interview session. In addition, the researcher made an effort to prolong each interview session by making use of the various communication skills discussed in section 3.3.3.1. As the interview progressed, the participants became more accustomed to the researcher and became more open and willing to share information truthfully. Data was collected to the point of saturation, as described earlier (Imel, Kerka & Wonacott 2002; Polit & Beck 2004:57; UNISA 2010). Prolonged engagement goes hand in hand with persistent observation.

3.4.1.2 Persistent observation

According to Krefting (1991:218), persistent observation provides a measure of the extent to which the researcher has sampled all possible situations, including different social settings. This was ensured by choosing a study site located in the capital city,

which is the central and referral point for all activities. As a result, study participants had various demographic characteristics, as described in Chapter 4 of this dissertation. In addition, the data-collection period coincided with the time of school holidays in neighbouring South Africa, a factor that had a significant positive impact on the results, in the sense that it enabled the researcher to elicit the influence of neighbouring countries on circumcision in Swaziland, as described in Chapters 4 and 5 of this dissertation. According to Lincoln and Guba (1985:304), whereas prolonged engagement provides scope, persistent observation provides depth.

Prolonged engagement and persistent observation, however, when applied to an extreme degree, will compromise the quality of the data, warranting reflexivity.

3.4.1.3 Reflexivity

Ruby (1980) in Krefting (1991:218) defines reflexivity as an assessment of the influence of the investigator's own background, perceptions, and interests on the qualitative research process. To ensure reflexivity, the researcher jotted down personal field notes, described in section 3.3.3.2, and audiotaped the interviews (Polit & Beck 2004:383). In this way, possible researcher influences were captured and brought into account during the stage of data analysis. The above two methods, which were used to ensure reflexivity, also ensured triangulation, which was another strategy applied in this study.

3.4.1.4 Triangulation

Triangulation refers to the use of multiple methods to collect and interpret data, so as to converge on an accurate representation of reality (Polit & Beck 2004:734). Of the four types of triangulation identified by Denzin (1989) in Burns and Grove (2005:224), methodological triangulation was used in this study to enhance credibility. Methodological triangulation refers to the use of two or more research methods in a single study (Burns & Grove 2005:225). In addition to face-to-face interviews, observations were used, and in addition to audiotaping, field notes were taken. These additional methods allowed for repeated review of the original raw data by the researcher and other selected peers, as follows.

3.4.1.5 Peer examination

Peer examination involves the researcher discussing the research process and findings with impartial colleagues who have experience with qualitative methods (Krefting 1991:219). This strategy was also applied in this study, where methodological and analytical ideas were shared with workmates who were knowledgeable in that area of study, to complement the researcher's own credibility.

3.4.1.6 Researcher credibility

Researcher credibility refers to the faith that can be placed in the researcher based on his or her qualifications, experience, and reflexivity, among other aspects (Polit & Beck 2004:434). Polit and Beck (2004:434) see this as a crucial factor, since in qualitative research the researcher serves as the data-collection and analysis instrument.

In this study, the researcher was not completely new to the field of research. The researcher is conducting academic research for educational purposes for the third time for an undergraduate Honours programme and for a Master's programme in the field of biomedical sciences. The researcher has also been a coordinator of research activities at a college of nursing and has supervised research projects for diploma students before moving on to a university, where he is involved in the supervision of undergraduate research projects. Besides this experience, he has successfully completed the module "Principles and Methods of Health Research" offered by UNISA, which was a prerequisite for undertaking this research project. This expertise has been useful in ensuring the credibility of this study, including the structural coherence of the data.

3.4.1.7 Structural coherence

The criterion of structural coherence seeks to ensure that there are no unexplained inconsistencies between the data and their interpretation (Krefting 1991:220). To enhance this, the researcher strived to elicit detailed information from participants the various communication skills described earlier, chief among them being probing. The various reasoning strategies, also described earlier in this chapter, were also applied to try and explain every emerging significant finding.

Once truth value has been established, as described above, the researcher has to consider also applicability as another aspect of Guba's (1981) model. The following section covers this.

3.4.2 Applicability

The aspect of applicability, which is analogous to the property of external validity in quantitative research, refers to the extent to which the results of a qualitative inquiry are applicable to other situations or subjects (Lincoln & Guba 1985:290; Krefting 1991:216). According to Krefting (1991:216), applicability is assessed using the criterion of transferability, which is analogous to the property of generalisability in quantitative studies. The term "transferability" refers to the extent to which the findings of a qualitative study can be transferred to other settings or groups (Lincoln & Guba 1985:203). Qualitative research is conducted in a naturalistic setting, where there is no control of the setting. Naturally each setting is unique, thus contextualising the findings of a qualitative research study. This prevents generalisation, but allows transferability. As such, Streubert and Carpenter (2003:39) in Matshediso (2008) define transferability, or fittingness, as the likelihood that research results will have the same meaning in similar situations. The challenge, though, remains to objectively prove the similarities between any different settings (Polit & Beck 2004:436).

Therefore, the obligation of a researcher in enhancing transferability is to present sufficiently detailed descriptive data about the research setting or context, as well as about the transactions and processes observed during the inquiry (Polit & Beck 2004:436; Krefting 1991:216). This will enable comparison with the setting and the context to which the research findings are to be applied. Polit and Beck (2004:435) are of the view that transferability is, to some extent, an issue of sampling and design rather than the soundness of the data itself. In this study, the researcher used the following strategies to ensure transferability.

3.4.2.1 Dense descriptions

According to Polit and Beck (2004:41), a dense, or thick, description refers to a rich and thorough description of the research setting and of the transactions and processes

observed. By using dense descriptions, the researcher will ensure that anyone interested in transferring the research findings will have an adequate base of information data. This is in accordance with Elandson, Harris, Skipper and Allen's (1993:145) and Lincoln and Guba's (1985:278) view that to enable anyone to transfer research findings, evidence should be accumulated about contextual similarities. In this study, detailed descriptions of the study setting, the research design, and the results were given to create a clear image of the situation in the reader's mind. Data were also collected up to the point of saturation using open-ended questions with probes, so as to ensure that the information obtained was very rich. Sampling selection was also important in achieving this.

3.4.2.2 *Sampling*

Merriam (1988:174) and Polit and Beck (2004:435) regard sampling as another strategy that can be used to enhance transferability. In this study, the researcher carefully designed the inclusion criteria to ensure the inclusion of information-rich participants only. Burns and Grove (2005:342) define sampling criteria, also known as eligibility or inclusion criteria, as a list of characteristics essential for membership or eligibility in the target population (Polit & Beck 2004:290). The researcher ensured inclusion of participants who had personally experienced a motive for circumcision during the period of interest. The description of these participants was another strategy used.

3.4.2.3 *A demographic description of the participants*

A detailed description of the study participants is provided in section 4.2 of this dissertation to give the reader a full perspective of the situation, thereby also enhancing transferability.

By ensuring applicability, among other aspects, the researcher also worked to ensure neutrality.

3.4.3 *Neutrality*

The criterion of neutrality is a measure of the extent to which the findings of a study are free from bias (Lincoln & Guba 1985:290). It is measured by the strategy of

confirmability (Krefting 1991:220), which Polit and Beck (2004:435) define as the objectivity, or neutrality, of the data, that is, the potential for congruence between two or more independent people about the accuracy, relevance, or meaning of the data. According to Mavundla and Netswera (2006:10) in Matshediso (2008), neutrality can be achieved when truth value and applicability are established.

As such, in this study the researcher applied reflexivity, triangulation, peer examination, and bracketing, as described in sections 3.4.1.3, 3.4.1.4, 3.4.1.5 and 3.2.3.1, respectively, to ensure confirmability. In addition, an inquiry audit was also conducted.

3.4.3.1 Inquiry audit

An inquiry audit is a scrutiny of the data and relevant supporting documents by an external reviewer for verification (Polit & Beck 2004:435; UNISA 2010). This involves the external auditor going through an audit trail and being able to follow and understand the research process and progression (Krefting 1991:221). Polit and Beck (2004:435) define an audit trail as a systematic collection of materials and documentation necessary for an inquiry audit. In this study, the audit trail consisted of the field notes that had been collected, the audio tapes, and the drafts of the research proposal and write-up. Guba (1981) in Krefting (1991:221) considers an inquiry audit as the major technique for establishing confirmability.

The final criterion is that of consistency, described as follows.

3.4.4 Consistency

Krefting (1991:216) and Lincoln and Guba (1985:290) define consistency as the extent to which findings of an inquiry would be consistent if the inquiry were replicated with the same subjects or in a similar context. In a quantitative research study, this property would be termed “reliability”. Unlike the case in quantitative studies, where the setting is controlled, in the naturalistic settings of qualitative studies, variability is always expected, since the researcher and the participant are the main instruments that are assessed for consistency (Krefting 1991:216). Consistency in a qualitative research study is termed “dependability”, rather than “reliability”. The concept of dependability implies trackable variability, that is, variability that can be ascribed to identify sources

(Guba 1981 in Krefting 1991:216). One would therefore need a clear image of the contexts or settings that are being compared, to discern discrepancies to which variability can be attributed.

Streubert and Carpenter in Pooe-Monyemore (2007) believe that dependability is met once the researcher has determined the credibility of the findings. In this study, therefore, the strategies used to ensure credibility, as well as applicability, as described in sections 3.4.1 and 3.4.2 respectively, were also used to ensure the dependability of the study. These strategies include a dense description of the research participants, triangulation, and peer examination.

In pursuit of trustworthy answers to the research question, the researcher was, however, cautious not to compromise the rights, interests and/or integrity of the participants, the institutions involved, and the scientific community at large. The following section provides a discussion of how the rights, interests, and integrity of the above-mentioned parties were protected.

3.5 ETHICAL CONSIDERATIONS

Ethical considerations entail the extent to which research procedures adhere to professional, legal and social obligations towards the study participants. The following ethical considerations were observed in this study.

3.5.1 Protecting the rights of the participants

According to the Belmont Report of 1978, there are three basic ethical principles for protecting the rights of human participants in a research study. These are respect for human dignity, beneficence, and justice (Polit & Beck 2004:143; Burns & Grove 2005:735; UNISA 2010). In this study, these principles were observed as follows.

3.5.1.1 *Respect for human dignity*

Participants' right to self-determination was respected, and this was explained to the participants. Thus, the participants had the autonomous right to voluntarily choose to participate or not, or to terminate their participation at any time with the risk of incurring

any penalty or prejudiced treatment. The use of excessive and coercive stipends was avoided. Participants were also not coerced into sharing information which they felt was private. In view of participants' right to full disclosure, the entire research process was explained to the participants, including the purpose of the research, the data-collection process, and the risks and benefits of participating in the research. A verbal evaluation of the participants' understanding of the research process was made before they were requested to make a decision of whether they would participate or not in the study. Those who agreed to participate were requested to sign an informed consent form in acknowledgement of their voluntary acceptance (Polit & Beck 2004:147; Burns & Grove 2005:181, 193; UNISA 2010).

3.5.1.2 *Beneficence*

The principle of beneficence seeks to prevent harm to and exploitation of, and maximise benefits for, study participants (Polit & Beck 2004:712; Burns & Grove 2005:191-192). Good communication and interpersonal skills were required by the researcher. This ensured the establishment of rapport with the participants, so as to avoid psychological stress and fear in the participants. It was also ascertained that the choice of venue and time were comfortable and convenient for each participant. The researcher also emphasised to participants that they needed to disclose only the information they were comfortable disclosing, and that there would be no coercion. No costs were incurred by the participants in the entire process.

Potential benefits from participating in the research were explained to the participants. These included the possible gain of additional information about circumcision. Any misconceptions relating to the subject matter were also resolved for the benefit of the participants. The awareness of the misconceptions which the researcher gains, as well as the clarifications of these misconceptions, were also incorporated into the content of the routine health education on circumcision, which is currently being disseminated to all communities countrywide. It was explained to participants that at community and national level, the information provided by the participants, and the insight gained from this information by the researcher, would be useful in the formulation of policies relating to circumcision. It was explained that such policies would directly benefit the community, and the nation at large, of which the participants are part.

Against these benefits, potential losses or damage were also explained. These include loss of precious time, psychological distress from self-disclosure, and possible fatigue or boredom from prolonged interviews (Richards & Schwartz 2002; Burns & Grove 2005:192). Assurance was given, however, that efforts would be made to minimise such losses or damage.

3.5.1.3 Justice

The principle of justice is concerned with participants' right to fair treatment and their right to privacy (Polit & Beck 2004:149; Burns & Grove 2005:189). With regard to the right to fair treatment, all participants were treated equally. Selection to participate in the study was not governed by any discriminatory criteria. All willing participants who constituted the accessible population and met the inclusion criteria were selected to participate in the study. Participants were also given the researcher's telephone number and email address to enable them to contact him at any time for any clarification, if required. Privacy and confidentiality were enhanced by conducting the interviews in a private room at the FLAS, where no one could overhear the conversations. Participants were also labelled with numerical codes, rather than their real names, so as to ensure anonymity. Thus, the first three participants to be interviewed were labelled as "01", "02", and "03", respectively, and so on. In addition, the collected data were kept confidentially under lock and key, with the right to access reserved for the researcher (Polit & Beck 2004:149; Burns & Grove 2005:186, 188; UNISA 2010).

3.5.2 Protecting the rights of the institution

To ensure protection of the rights of the institution, the research proposal was submitted to the UNISA Health Studies Research and Ethics Committee for approval before the research was embarked on. A similar approval was sought from the Scientific and Ethics Committee of the Swaziland Ministry of Health and Social Welfare. In addition, prior permission to conduct the study was sought from the FLAS authorities. Refer to Appendices A, B and C for these approvals. Based on recommendations from the review boards of each of these institutions, the research protocol was modified accordingly to ensure that it was ethical, taking into consideration the ethical principles discussed above, among other factors (Polit & Beck 2004:156; Burns & Grove 2005:199; UNISA 2010).

3.5.3 The scientific integrity of the research

Respect for the scientific community must be maintained by protecting the integrity of scientific knowledge. The scientific integrity of this research was enhanced by avoiding fabrication, falsification, forging of information, and intentional manipulation of the research methodology to support preconceived views. All data and findings were presented the way they appeared. Plagiarism was also avoided. All sources referred to have been acknowledged, both in the text and in the bibliography (UNISA 2010).

These ethical considerations constitute the final aspect to be discussed in this methodology chapter, which is summarised in the following conclusion.

3.6 CONCLUSION

In summary, this chapter discussed the design and methodology of this study. It was explained that a generic qualitative design was used in which participants were selected by means of convenient sampling. Data was collected through unstructured interviews based on a grand tour question. The interviews were audiotaped, in addition to field notes being made. The process by which the data were analysed and the measures applied to ensure the trustworthiness of the data were discussed. The chapter ended with a discussion of the measures taken to ensure that the study was ethically sound.

In the following chapter, the results which were obtained from the methodological steps and procedures which were described in this chapter will be presented.

CHAPTER 4

DISCUSSION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter, the research findings obtained from the analysis of data collected from men in Swaziland are presented. The findings are discussed in the context of the existing corpus of knowledge on the phenomenon of circumcision. The main purpose of this research was to explore and describe the motives behind circumcision among Swazi men.

The findings are presented in narrative form, with periodic inclusion of direct verbal quotations from participants to emphasise some facts and to offer readers evidence of what transpired during data collection. In a few instances, data were summarised in the form of tables. The chapter starts with a description of the characteristics of the participants, before a comprehensive discussion is provided of the themes that were identified during data analysis.

4.2 CHARACTERISTICS OF THE PARTICIPANTS

A total of 17 subjects participated, including one subject who was used for the pilot interview. The sample size was determined by data saturation, which is characteristic of most qualitative studies (Mason 2010; Polit & Beck 2004:308). The sample comprised men who were waiting to undergo the procedure of circumcision, as well as those who had already been circumcised, a few minutes, days, months, or years ago, dating back to 2007. The age of the subjects ranged from 19 to 42 years. While some were employed, others were unemployed school leavers or students, studying either at high school or a tertiary institution, locally or abroad. All participants could effectively communicate in English, even though the least educated only went as far as Grade 7 at school.

Some participants were residing in the urban area of Mbabane, while others had come from distant semi-urban or rural areas. One participant was a Mozambican who had been residing and working in Swaziland for some years. He, however, often visited home. While all the other participants were native Swazis, some of them had spent much of their time in South Africa, either working, pursuing their high school or tertiary education, or just staying with relatives. All the participants were Christians, except for one, who was not affiliated to any specific religion. Table 4.1 below provides a summary of the characteristics of the participants.

Table 4.1 Characteristics of the participants

Client no.	Age (yrs)	Highest education <i>P = Primary</i> <i>S = Secondary</i> <i>T = Tertiary</i>	Marital status <i>M = Married</i> <i>S = Single</i>	Religion	Residence <i>U = Urban</i> <i>SU = Semi-urban</i> <i>R = Rural</i>	Employment status	Other information <i>Cd = Circumcised</i> <i>F = Form</i> <i>SA = South Africa</i>
1	42	S	M	Christian	U	Employed	From Mozambique
2	28	T	S	Christian	U	Employed	Based in Swaziland
3	24	S	S	None	U	Employed	Educated up to F3
4	19	S	S	Christian	U	Unemployed	Doing F5 in SA
5	40	T	M	Christian	U	Employed	Staying in SA; Cd early 2012
6	24	T	S	Christian	U	Unemployed	Student. Cd in 2007
7	19	S	S	Christian	SU	Unemployed	Staying in SA for the past 5 yrs
8	34	T	S	Christian	R	Employed	Cd a month ago
9	20	S	S	Christian	U	Unemployed	Finished school in 2010
10	30	T	S	Christian	U	Employed	Based in Swaziland
11	21	P	S	Christian	U	Unemployed	Educated up to Grade 7 (Std 5)
12	25	S	S	Christian	R	Unemployed	Doing matric; Swazi
13	21	S	S	Christian	U	Unemployed	Doing F3 in SA
14	21	T	S	Christian	U	Unemployed	Student - UNISWA
15	21	S	S	Christian	SU	Unemployed	Cd in July 2011
16	21	T	S	Christian	U	Unemployed	Student - UJ, SA
17	22	S	S	Christian	U	Unemployed	Doing F5 in Swaziland

A further reflection on these characteristics will be given in the following section. The researcher will now discuss each characteristic as it relates to the emerging themes under discussion.

4.3 THE MAIN THEMES

In this study, three main themes emerged reflecting the motives behind the increasing interest in being circumcised, from the client's perspective. These themes are: the perceived personal benefits of circumcision, community influences, and medical reasons. Each of these themes has been further divided into categories and subcategories, as illustrated in Table 4.2 below.

Table 4.2 Themes, categories, and subcategories

Themes	Categories	Subcategories
Perceived personal benefits	Protection from diseases	<ul style="list-style-type: none"> • Reduces risk of contracting HIV • Reduces risk of contracting STIs • Reduces risk of cervical cancer • Feelings of safety and security from these illnesses • The need to complement abstinence, faithfulness, and the use of condoms
	Hygiene and easy cleaning	<ul style="list-style-type: none"> • Easy to clean, and no accumulation of dirt under the foreskin • The foreskin itself is bacteria-infested, posing a danger to the man
	Sexual benefits	<ul style="list-style-type: none"> • Increased sexual satisfaction • Increased sexual vigour • Delayed orgasm
Community influences	Psychosocial motives	<ul style="list-style-type: none"> • Giving in to pressure from: <ul style="list-style-type: none"> ➢ Public health advocates ➢ Sexual partners • Peer pressure • To please one's girlfriend(s) • To demonstrate one's manhood • To utilise the free and readily available service
	Religious/cultural motives	<ul style="list-style-type: none"> • Biblical influences <ul style="list-style-type: none"> ➢ Jesus Himself was circumcised ➢ The ostensible belief that God helps those who help themselves • Ethnicity <ul style="list-style-type: none"> ➢ Originating from circumcising groups ➢ Mingling with circumcising groups
Medical reasons	Congenital malformations	<ul style="list-style-type: none"> • The foreskin is too big: <ul style="list-style-type: none"> ➢ Attracting teasing from peers ➢ Making it difficult to use a condom
	Delicacy of the foreskin	<ul style="list-style-type: none"> • The foreskin is prone to tearing, leading to: <ul style="list-style-type: none"> ➢ Pain ➢ Increased risk of infection

4.3.1 Perceived personal benefits

The perceived personal benefits of undergoing circumcision are one of the major themes which emerged, and they essentially reflect intrinsic motives. According to Haynes (2011), intrinsic motives are drives that originate from within the individual. To a great extent, these benefits reflect the positive effects of, or the extent to which the general public is accurately learning the benefits of, circumcision, as portrayed in the male circumcision campaigns discussed in Chapter 2 of this dissertation (Mazzotta 2011; WHO 2009a). This theme therefore expresses a cognitive motive behind circumcision, which is consistent with Cherry's (2012b) and Baron, Kalsher and Henry's (2008:252) view that human beings are logical beings that make choices that make the most sense to them based on their acquired knowledge and beliefs. This theme provides a range of perspectives from which circumcision is viewed positively. The commonly cited benefits of circumcision are as follows.

4.3.1.1 Protection from diseases

Almost all the participants acknowledged their understanding of the fact that circumcision in one way or other prevents the risk of acquiring certain diseases, as promoted in various media, thus constituting a major motive to be circumcised. A direct response by one participant to the grand tour question was:

You know, it's because every time I listen in the radio, or I see in the television [sic], you see, if you circumcise [get circumcised], there are many opportunities to be defended from now getting many sicknesses, so that's why I came here to be circumcised.

This was a view that was shared by most of the participants, suggesting that the main influence in the decision to undergo circumcision are the circumcision campaigns, as discussed in Chapter 2 (Mazzotta 2011; WHO 2009a). From the knowledge collected, the resulting cognitive motive, as described by Baron, Kalsher and Henry (2008:252), appears to be protection from diseases. However, there were some differences in opinion concerning the degree of protection offered, as well as the specific diseases

that circumcision can protect against. Specific diseases which were cited were sexually transmitted infections, in particular HIV and AIDS, but also cervical cancer.

- ***Sexually transmitted infections (STIs)***

It emerged that the core message by public health advocates through circumcision campaigns and various media promotions, as perceived by circumcision clients, is to prevent STIs. One of the participants expressed this as follows:

Their [the media's] main point is that it [circumcision] reduces the risks of one getting STIs, because they say in that part of the penis, when it is still covered, there will be a build-up of germs, and stuff like that. It's soft, and when you indulge in sexual intercourse, it's easy for that soft skin to get some cuts, and stuff like that. Then, there will be that exchange of blood, so if you circumcise [get circumcised], it [the penis] hardens up a bit, so it's not easy for it to be cut.

The teachings in the circumcision campaigns and media promotions seem to be complementing what the majority of the target population (young men) are learning in their various general education sessions in various learning institutions, thereby cognitively motivating them even more to be circumcised. As testimony to this, one participant said:

I studied Life Sciences [at high school level in South Africa] – Biology – in the past. So that subject inspired me that when you circumcise [get circumcised], you can get this [sic], you can prevent this. So, afterwards I discovered in televisions and radios [sic] that it was true.

In addition to the need to put into practice what had been learned, as the motive, another drive was also noted, namely a prior unpleasant experience of having an STI, or having witnessed an STI on another person, and so trying to avoid contracting an STI. This constitutes a biological motive to be circumcised, which forms the basis of the drive theory. According to this theory, human beings are forced to act by forces that drive them towards fulfilling their physiological needs, which include the avoidance of

painful sex (George Boeree 2009; Haynes 2011; Cherry 2012a). One participant who was influenced by this motive said:

[In] early January [2012], I had an STI. My penis was cracking. So, when he [a public health advocate] told me that it [circumcision] reduces the risk of getting STIs and HIV, I decided to circumcise [be circumcised].

Another participant with similar experiences said:

The problem is I was getting STIs from my girlfriend. That's why I decided to come here and be circumcised.

Some men seek circumcision services in response to frightening narratives by friends of experiences of having STIs, as exemplified in the following response:

Actually, we had a friend this past weekend who said he had an STI, and he is not circumcised, I doubt. And he was a bit complaining that it itches a lot.

As discussed in the literature review section, prevention of STIs is a widely documented motive for circumcision (Plotkin et al 2011; Wambura et al 2009). According to the WHO (2009b), indigenous African healers have promoted male circumcision as a protection against disease for centuries. Lately, of all STIs, HIV and AIDS have been singled out, because of their uniqueness and special consideration in relationship to circumcision. The following section discusses the findings concerning the prevention of HIV and AIDS as a motive for circumcision.

- **HIV and AIDS**

The results of this study show that all the participants have heard of the protective effect of circumcision against HIV, and the majority of them cited this as one of the motives for circumcision. This is consistent with the reports which were previously discussed in section 2.6.2 of this dissertation, that thousands of men have been circumcised, and many more are still being targeted, since the onset of mass circumcision for HIV prevention in Swaziland, based on the Auvert et al (2005) publication (Nqeketo 2010; WHO 2006, 2008a, b; AVERT 2011b; Jackson 2011).

While all have heard of the protective effect of circumcision, however, not all have been convinced. One participant, who commented on the reported lower chances of contracting HIV among circumcised men compared to uncircumcised men, said:

No, it's a rumour from people who are not properly informed about this circumcision procedure. Because I don't think... actually it's not true that when you are circumcised, you don't get HIV easily. It's just a rumour circulating.

Another participant with the same view confirmed this widely held view by saying:

I still don't believe [it]. I think it's the same.

Similarly, when another participant was asked whether HIV was among the sexually transmitted diseases that he intended to prevent by being circumcised, he replied:

No, not HIV. HIV is a fatal disease. You can get HIV even if you are circumcised.

Thus, according to him, other STIs can be prevented by circumcision, but not HIV. This explains why, according to the 2010 MICS report, only 22% of circumcised men cited prevention of HIV as the reason for their circumcision (CSO [Swaziland] & UNICEF 2011). This does not come as a surprise, since many misunderstandings and misconceptions concerning HIV and circumcision have been published, as discussed in Chapter 2 (News24 2008; Circumcision campaign an admission of failure 2011; Circumcision campaign clouding HIV issues 2011; Stop this circumcision advert, please! 2011; Jackson 2011).

Some respondents who believed and understand that circumcision, in principle, reduces the risk of acquiring HIV still felt that this benefit was not a sufficiently compelling motive to be circumcised, based on their knowledge of their own sexual behaviours. One participant remarked as follows:

OK, on the aspect of HIV, I am a Christian, as you know, and I am not somebody who sleeps around, so if we [my sexual partner and I] know our status and we remain faithful to each other, then I think it's the way to go. The issue of HIV is there, but I can't dwell much on it, because it's not a primary concern [for me], since I know how I conduct myself [I know my sexual behaviour].

This line of thinking is not in any way different from the public health philosophy underlying the strategy of circumcision, since circumcision is meant merely to be an adjunct to other prevention measures, as described by Rogowska-Szadkowska (2010) and the WHO (2007, 2009a, b). If followed properly, other prevention measures are sufficient to protect one from HIV, even without circumcision.

Some participants who had confidence in their own sexual behaviour nevertheless believed that there are some STIs which may not necessarily be caused by risky or negligent sexual behaviours, but which just occur naturally. As such, they felt that prevention of STIs was still a justifiable reason for undergoing circumcision. One such commonly cited STI was cervical cancer, which is caused by the human papillomavirus. This motive is explained in more depth in the following section.

- ***Cervical cancer***

Cervical cancer, or cancer of the cervix, is caused by the human papillomavirus, which is usually transmitted sexually from males to females. It emerged that some participants came for circumcision primarily to prevent this STI in their sexual partners. These were men who were either married or in a stable relationship and about to be married, and who had been influenced by their female partner. One participant who had been influenced in this way remarked:

OK, basically I am preparing to get married actually, so we were just discussing this with my girlfriend actually, that the most, most serious thing is, you know, looking at the health aspect of it, you know, she was more concerned about cervical cancer, because she heard that when one is circumcised, it reduces problems with women – cervical cancer, because really these days cancer is common all over the place.

For this participant, the underlying motive for undergoing circumcision, from a psychosocial perspective, may have been to please his sexual partner. As Baron, Kalsher and Henry (2008:278) assert, at the intimacy versus isolation stage of psychosocial development, young adults seek to form intimate relationships with lovers, and efforts are made to try and please a sexual partner.

To a greater extent, however, the participant seems to have been cognitively motivated by the understanding of the consequences of cancer, based on his previous personal experiences, as indicated in the following narrative by him:

I know what cancer can do, because I experienced some of it last year, and I just shared that with her. I had an operation. I had an adenocarcinoma last year, and I suffered a lot, so I know if they say it's a cancer [sic], so then why do you have to [expose someone]? You don't have to expose someone to such issues, so try and protect somebody, especially when you know that if something like this [circumcision] is possible, then why don't you try and do like that? So that's the thing that made me to say maybe somebody [my girlfriend], who is innocent, suffering from someone [me]. If there is a way of preventing that, then we can do it.

Participants' knowledge about the relationship between circumcision and cervical cancer is in line with published literature on the subject. A study by Castellsagué, Bosch, Muñoz, Meijer, Shah, De Sanjosé, Eluf-Neto, Ngelangel, Chichareon, Smith, Herrero, Moreno and Franceschi (2002) revealed that male circumcision reduces the risk of penile human papillomavirus (HPV) infection in men. In the aforementioned study, the virus was detected in approximately 19.6% of uncircumcised men, compared to a prevalence of only 5.5% in their circumcised counterparts. Penile HPV infection is associated with a fourfold increase in the risk of cervical HPV infection in the female partner, which, in turn, is associated with a 77-fold increase in the risk of cervical cancer. Further findings also indicate that women with multiple sexual partners are 58% less likely to develop cervical cancer if their partner has been circumcised (Young 2002; Castellsagué et al 2002).

Based on these findings, circumcision for the prevention of cervical cancer is encouraged in some countries (Young 2002). However, this benefit has been found to be significant mainly in developing countries, where there are no HPV vaccines (Van Howe & Storms 2009). In industrialised and other countries, where cervical cancer screening is routine, this relationship between cervical cancer and circumcision is not clear (Boyles 2011). As such, routine circumcision is neither recommended nor discouraged in the United States (Boyles 2011). At the same time, in developing countries, there is still not much activity on circumcision for cancer prevention. According to The Lancet Oncology (2009), this is simply because cancer prevention strategies, in general, in these countries are often limited and have to compete against HIV for funding.

The reduced risk of infection that goes with circumcision, as described above, gives people a sense of safety and security from these illnesses. This, on its own, has been a major motive behind circumcision, as described below.

- ***Feelings of safety and security from these illnesses***

The results of this study show that the misconception of total protection against STIs, including HIV, by circumcision, which threatens public health interests, does exist, as discussed in section 2.6.4 (News24 2008; Circumcision campaign an admission of failure 2011; Circumcision campaign clouding HIV issues 2011; Stop this circumcision advert, please! 2011). One participant who had witnessed signs of this misconception remarked as follows:

It's just that what maybe most people usually think is that when you are circumcised, you are immune to sexually transmitted disease, and even maybe AIDS. I have met some people who hold that view.

Another participant, who had been influenced to share the same line of thinking, responded to the grand tour question as follows:

Nowadays most of the people around my area are already circumcised, and they give me more advice about circumcision, about the STIs, HIV and AIDS. You are so safe when you are circumcised.

Because of these feelings of safety and security, risky sexual behaviour is no longer perceived to be as threatening as it used to be, as illustrated in the following response by one participant:

If I forget to use a condom, I know now I am safe.

Another respondent expressed the same sentiments, as follows:

They [friends] say you feel free, because sometimes you are drunk and forget to use a condom when you have sex with girls. You cannot get all the diseases that the girlfriend has.

With this feeling of freedom and safety, safe sexual practices may not be guaranteed, thereby confirming the researcher's hypothesis that circumcision may be fuelling risky sexual behaviour. The results of this study also show that a significant proportion of the men who come for circumcision primarily to prevent STIs, including HIV, often indulge in risky sexual behaviour. As an example, a participant who testified to having had four girlfriends in succession and to having had sex with each one of them said:

Sometimes I don't use a condom. When we are having sex, one, two, three rounds, so [in] the last one I don't use a condom, because the sperms are not strong, stronger than [not as strong as] the initial ones.

This participant had had episodes of STIs, and had been made to believe that a circumcised person cannot contract STIs. This was his main motive in coming for the procedure of circumcision. Again, this seems to support the notion expressed in some media reports, as discussed in section 2.6.4, that men are undergoing circumcision to enable them to continue their risky sexual behaviour, assuming total protection from HIV infection by virtue of having been circumcised (News24 2008; Circumcision campaign clouding HIV issues 2011; Stop this circumcision advert, please! 2011). Another participant, whose motive for undergoing circumcision was similar to the above-mentioned motive, and who also had multiple girlfriends, said:

You know, where I live [in South Africa], there are so many things happening, you know. People are so much active [sic]. There are so many parties, so many joys, and my friends are sometimes taking me to their parties. You find that it is hard to refuse. You meet many people. Sometimes there are girls, you see, and anything may happen. If you have a girl and a male, it is like a dog and meat, you see. A dog cannot leave meat like that and say “No, I am now OK [I’m not “hungry”]”.

The participant added that most of his peers felt that circumcision is a stupid thing, because having to abstain from sex for six weeks after the procedure is just too much for them. This communicates volumes on how frequently these unmarried young men indulge in sexual activities. It is undisputable that the motive for circumcision for such people is to promote their risky sexual behaviour, and also to substitute the “ABC” strategy of HIV prevention with circumcision. This conflicts with the previously discussed principle of the minimum package for circumcision, as outlined in the WHO (2007a) and UNAIDS (2007b).

On the other hand, it also emerged that some participants fully understood and appreciated the minimum package for circumcision and the need to complement the “ABC” strategy of HIV prevention with circumcision as an adjunct strategy.

- ***The need to complement abstinence, faithfulness, and the use of condoms***

The results of this study show that the participants were aware of the conventional methods of protecting themselves from sexually transmitted diseases, that is, abstinence (A), being faithful to one partner (B), and correct and consistent use of condoms (C) (Rogowska-Szadkowska 2010; WHO 2007a, b, 2009a, b). However, they acknowledged the fact that this “ABC” strategy may at times fail, or may not be feasible, thereby necessitating circumcision as an adjunct method. Regarding the “A” of this strategy, it emerged that abstinence is not easy, if at all possible, for someone who has had sex before, as expressed by one participant:

With the issue of abstaining, if you have tasted [sex], you will always want [it]. It’s kind of hard. They do it [abstinence] when you are under a situation [sic] like you are in jail, something like that. You can abstain, by force, ja. But

voluntarily it's not easy to abstain, once you have tasted [sex]. Maybe for the younger ones that haven't been exposed to it, [they] can abstain, but you, as an adult, since you have been exposed [to sex], you will want [it], again and again.

Similarly, to a married couple who wish to have a child, abstinence and the use of condoms are not feasible. In addition, it was felt that the possibility that one's partner could be HIV-positive could not be ruled out. Consistent with these sentiments, Swaziland's Central Statistical Office (2008) reported that one in six heterosexual couples in a steady long-term relationship countrywide is serodiscordant, and that between 50% and 65% of new HIV infections occur among such couples. Regarding faithfulness to one partner, one participant remarked as follows:

In terms of faithfulness, you can be faithful, but sometimes we are tempted. Everyone is tempted, even if you are a Christian. Even if you are what, we are tempted. We are in this planet [sic]. We are tested. Challenges are there, so I may not [cannot] guarantee myself to be faithful, because temptations are always there.

Other participants added that even if they are certain about their own faithfulness, the same may not be guaranteed about their partner, as one participant openly remarked:

I don't trust people. Girls cheat [have many sexual partners] so much.

This issue of multiple sexual partners and unfaithfulness to one partner from the participants' perspectives is consistent with the findings of the Central Statistical Office (CSO) [Swaziland] and UNICEF's (2011) report that, on average, each woman in the country who has had sex will have 2.4 sexual partners in a lifetime. The corresponding figure for men was 6.6 sexual partners. Of these women, 2.3% reported to have had sex with multiple sexual partners in the 12 months preceding the study. The corresponding figure for men was 15.7%.

In terms of correct and consistent use of condoms, most of the participants were of the view that condoms are not 100% protective against sexually transmitted infections, as one participant remarked:

Condoms are made by humans. Everyone makes mistakes. The one who makes condoms may make a mistake, and the condom may burst along the process [sic].

The above quotations illustrate a common understanding among public health advocates and their circumcision clients, that is, that circumcision should come to the rescue in cases where the “ABC” strategy accidentally or unavoidably fails (WHO 2007a, b, 2009a, b).

Alongside the benefit of protection from diseases, many participants cited improved hygiene as another benefit of circumcision.

4.3.1.2 Improved hygiene

The majority (52%) of the male participants in the study conducted by CSO [Swaziland] and UNICEF (2011) reported health or hygiene as the reason for undergoing circumcision. Similarly, a significant number of the participants in the current study cited hygiene as the most important reason for undergoing circumcision, followed by the prevention of STIs, and then other factors.

- ***Cleanliness of the genitals***

The fact that circumcision keeps the genitals clean appeared to be the most important reason for undergoing circumcision among the participants in the current study, particularly among the older participants, for whom sex was not a priority. The general understanding was that a circumcised penis is easy to clean, and there is no dirt that accumulates under the foreskin, as is the case with uncircumcised men. One participant expressed these sentiments as follows in his response to the grand tour question:

The cleanliness, my brother. Nothing can beat that feeling of feeling fresh. Ja, because even when you urinate, with the foreskin there is something [some urine] that will remain [and you will have to pull the foreskin back], and you will find the white stuff [smegma] around. Now [after being circumcised], nothing remains.

Some participants commented on the foul smell of this “white stuff”, known as smegma (Farlex 2012h), particularly in summer. Another participant, with similar feelings and understandings, had the following to say:

So I said, “Let me just do circumcision, just to keep myself clean and dry,” you know, because when it’s [the penis is] enclosed, it’s always a bit wet, so that’s why the building of fungi occur [sic], you know.

As discussed in Chapter 2 of this dissertation, circumcision primarily for the sake of penile hygiene is not a practice that is peculiar to Swazis alone, but is a worldwide practice. This has been proved by studies undertaken in the United States, Tanzania, and Korea, to name a few countries (Wambura et al 2009; WHO & USAID 2007). The unhygienic aspects of being uncircumcised are partly attributed to the biological nature of the foreskin itself, as explained below.

- ***The foreskin itself is bacteria-infested, posing a danger to the man***

Knowledge of biological sciences by participants proved to be the basis of some cognitive motives behind circumcision. Naturally, the foreskin contains various normal floral bacteria, like any other part of the body. The warm and moist conditions under the foreskin are so promotive to growth of these bacteria, that, if not properly checked, they can easily multiply into diseases. One participant expressed this danger as follows:

When I do my Life Sciences at school, I learn more about foreskin. The foreskin is a dangerous organ in the body, because they contain more bacteria, and it’s easy to multiply a disease, but if you are circumcised, diseases will not affect you easily.

Another participant expressed similar thoughts:

When you are not circumcised ... lijwabo [the foreskin] ... when you are not circumcised, sometimes it contains bacteria inside of it. These bacteria can harm you sometimes. That’s why I must keep it clean.

The above arguments about bacteria under the foreskin are consistent with a number of scientific publications, including those by Schoen (2007), Chung and Dale (2004), and Balat, Karakök, Güler, Uçaner and Ki̇bar (2008), among others.

In addition to the health and hygiene benefits of circumcision, which apply to all men, there are also sexual benefits to being circumcised, which were cited mainly by the sexually active subjects in the sample for this study. The following section provides details of this finding.

4.3.1.3 Sexual benefits

As noted in Table 4.1, the majority of participants were unmarried youths of less than 30 years of age. According to Sigmund Freud's theory of psychosexual development, these young men are in the genital stage, where sexual organs and adult love are the centre of attraction (Baron, Kalsher & Henry 2008). Furthermore, according to the drive theory, sexual desire is considered one of the primary drives that compel individuals to take action (George Boeree 2009; Haynes 2011; Cherry 2012a). In line with this understanding, it emerged that the need to increase sexual satisfaction, delay ejaculation, and increase sexual vigour are some of the motives behind circumcision.

- ***Increased sexual satisfaction***

Most of the young adult men in the study did mention the need to increase sexual satisfaction for themselves and their sexual partners. This appeared to be the general feeling, even in their discussions in social gatherings, as one participant related:

The most talked about [reason for circumcision] is the benefit when it comes to sexual intercourse with a woman. They say a woman prefers a circumcised man than [sic] an uncircumcised one, you see. So, amongst guys, that will be the reason that will draw interest more than the others, because the others are just health benefits. They are not, like, interesting reasons. You know, there is always interest when it comes to sex. It's basically that one that I hear most people taking about.

Another participant, who had just undergone the procedure of circumcision, confirmed these sentiments as follows:

From my point of view, it's something I wanted to do, but I was afraid of doing it. I don't know if it's true or not, but a lot of people say it makes a difference in a sexual relationship, and in intercourse it makes a bit of a difference, so I also wanted to try it out.

Yet another participant, who had been circumcised about a year before this study, testified to this benefit, speaking from his own personal experience:

It [circumcision] changed my life, you know. When I have sex, I feel like "eihhh, no!" [an expression of intense pleasure]. My girlfriend tells me "eishhh!" [an expression of intense pleasure].

Sexual satisfaction was also partly attributed to sexual vigour, as described below:

- ***Increased sexual vigour***

Increased sexual vigour is a significant motive among the sexually active. One of the participants, who had been circumcised about a year before this study, remarked:

Most of them [colleagues] they like to circumcise [to be circumcised] because they... in siSwati they want to be "xhonxonxo" [an informal word for expressing sexual vigour] [laughter]. When they have sex, "Uhhh! Uhhh!" [an expression of intense pleasure and laughter]. I play it [sex] long time.

This suggests that the duration of each sexual encounter matters as far as sexual satisfaction is concerned, as is elaborated on in the following section.

- ***Delayed orgasm***

It is believed that the foreskin is associated with premature ejaculation, which leaves the female partner unsatisfied during sexual encounters. This becomes a cause of concern

for young men, as one participant who had just been circumcised explained the motive for his circumcision:

The problem for myself, when I have sex with her [my girlfriend], this foreskin gives me a health problem. You can easily ejaculate. If you circumcise [are circumcised] you last, for just [sic] [at least], for five minutes. I see that she was affected. This girl is so open, and I know... I see that she loves me so much, because she can share with me. If there is something that she cannot feel well about me [doesn't like about me], she tells me.

This participant, who has had many sexual relationships before, went on to emphasise how significant this problem is among his peers:

I will advise other boys around my area to come and do this [be circumcised], because I see it's not my own problem [of early ejaculation], but I know others are... they have this problem. Girls just quit. They can't tell you. They quit or cheat [have sexual affairs] if you are not making them to be satisfied. People around use some tablets to last [delay orgasm]. I don't use that.

The issue of delayed orgasm and improved sexual satisfaction as a motive for undergoing circumcision has been proven in a number of studies, as discussed in Chapter 2 of this dissertation (The Art of Manliness 2010; Senol et al 2008; Laumann et al 1997; Plotkin et al 2011; Kigozi et al 2009; Senkul et al 2004). In terms of the drive theory of motivation, circumcision is therefore serving as a secondary drive, because it is associated with increased sexual satisfaction, which is a primary drive (George Boeree 2009; Haynes 2011; Cherry 2012a).

Apart from the intrinsic motives of the perceived personal benefits of circumcision that have been discussed so far, it has emerged that some of the motives behind circumcision are extrinsic in nature, as explained in section 2.4.1 of this dissertation (Haynes 2011; Cherry 2012a; Self-Determination Theory [Sa]a). Extrinsic motives are drives from outside the individual. The community at large is the major source of such extrinsic motives. The following section provides an elaboration of these findings.

4.3.2 Community influences

Typically, human beings do not live in isolation. Each individual lives in the company of others, as a family, on a smaller scale, and as a community, on a larger scale. Each individual strives to fit in in the community by adhering to what is expected of them by the community. The results of this study show that some men are coming for circumcision simply because the community, or part of it, expects or wants them to do so. These forces are in the form of psychosocial, religious or cultural expectations of the community.

4.3.2.1 Psychosocial motives

The majority of the participants in this study were between the ages of 18 and 30. From a psychosocial perspective, Eric Erikson, in his theory of psychosocial development, would classify these participants as young adults in the stage of intimacy versus isolation (Baron, Kalsher & Henry 2008:278). In this stage, individuals primarily focus on creating and/or strengthening good social relationships with parents, friends, relatives, and other members of the community.

- ***Giving in to pressure***

While the decision to be circumcised remains a voluntary choice for every man in Swaziland, apparently there has been so much pressure from some members of the community for men to undergo circumcision. According to participants' accounts, it has become difficult for them to resist, and it feels like they are compelled to get circumcised. Commonly cited sources of such pressure were public health advocates and sexual partners.

- **Public health advocates**

Since the introduction of the Swaziland Government's policy of male circumcision and the subsequent establishment of the Male Circumcision Task Force in 2010, much community mobilisation has been taking place (Grund 2010; Nqeketo 2010). Members of the various stakeholders involved, such as the FLAS, PSI, and JHPIEGO, under the name "Soka Uncobe" have been found almost everywhere in public places trying to

persuade men to be circumcised (AVERT 2011b; Mazzotta 2011; WHO 2009a). This created irresistible pressure, expressed by one participant as follows:

By the way, I was running away [avoiding being circumcised], but I then told myself that running won't help. OK, for the first time, really, really, there at Prince of Wales [a sports ground], members from here [the FLAS] were there, so the other one, another sister, called me and told me more about circumcision. I told her that I want to decide first, so she took my number and said she will call me. So I switched off my phone, saying "Aaa".

When asked why he was avoiding being circumcised, he said:

I was scared. Even now [when I was circumcised now], I was still scared.

Another participant who felt coerced by the excessive campaigns said:

As they were teaching, people from Soka Uncobe, they were all over Swaziland. They came to my area. We were sitting at the markets. Almost every day they were there, preaching us, preaching us [sic].

Apart from health care workers, another group of people that was shown to verbally create irresistible pressure for males to be circumcised were the sexual partners.

➤ Sexual partners:

As noted in section 2.4.1.2, women prefer circumcised men to uncircumcised men, for various reasons (Plotkin et al 2011). Because of these reasons, sexual partners, specifically girlfriends, seem to be pressurising their boyfriends to be circumcised. The following is a response from one participant that testifies to this effect:

At some point with my girlfriend, ja, she talked about it, that maybe one day I must consider getting circumcised. It took me a while though, because I didn't see a need or reason at that point. I then felt I was ready to come and do it, ja, after quite a while. It took me almost a year [to decide]. I would make excuses here and there – "No, I am busy", and stuff like that.

Another participant said:

Actually I will not have been here [being circumcised] if it was not for her [my girlfriend].

Even more directly, another participant expressed this pressure as follows:

I thought it [undergoing circumcision] was painful, but aah, I am a gentleman. I must try it, because my friends had circumcised too [have been circumcised], so I was the one left [the only one that was not circumcised], and my girlfriend forced me to circumcise [be circumcised].

While sexual partners and health care workers have been reported to influence men to be circumcised, this “coercive” nature of their influence has not been clearly documented. Chances are that it might have been featuring among the non-specified reasons, which accounted for 3% of all circumcisions in Swaziland by 2010 (CSO [Swaziland] & UNICEF 2011).

Apart from direct verbal coercion to undergo circumcision, it appeared that in some instances men are compelled by the situation to act, either to fit in with their peers or to please their girlfriend(s), as elaborated on below.

- **Peer pressure**

The influence of peer pressure has already been illustrated in the previous quotation. To add to that quotation, another participant said:

It's actually kind of embarrassing, if I may tell you, not to know your [HIV] status, and also to say you are not circumcised. It is now! Because most of my friends and stuff like that, OK, they are, but then, like, there you come. You are still not circumcised. And so, I decided to take the step to come and finally do it.

This finding is consistent with Plotkin et al's (2011) findings in Tanzania that being uncircumcised is associated with the stigma of being more prone to sexually transmitted infections such as HIV. Similarly, in a study by Kim, Oh and Choi (2002) in Korea, 61% of respondents believed that they would be ridiculed by their peer group if they were not circumcised. The influence of peer pressure on circumcision has been discussed in greater depth in Chapter 2.

- ***Pleasing one's girlfriend(s)***

Without necessarily being requested by their girlfriends to be circumcised, some men felt compelled to do so, based on their own knowledge of their partner's preferences. One participant expressed this feeling as follows:

Everyone knows about it [the benefits of circumcision]. Ladies, men – they know about it, and every lady will want her man to be circumcised at one point.

Another participant with similar sentiments from his girlfriend said:

So she [my girlfriend] also heard that from her friends – the enjoyment and everything. She also encouraged me, saying, "Maybe you can even do it."

The ultimate objective, therefore, will be to impress their partners and thus strengthen their sexual relationships, as asserted by Erikson in his psychosocial theory of development (Baron, Kalsher & Henry 2008:278). One participant directly confirmed this line of thinking by saying:

They [the people from Soka Uncobe] told us that when you are circumcised, you make your partner happy.

Another participant, who had just put that understanding into practice, remarked:

I actually wanted it to be a surprise to her [my girlfriend]. She has been saying, "You must get circumcised," but I told her I gonna do it December time, so now she's gonna be surprised.

Consistent with these findings, Plotkin et al (2011) reported that women in Tanzania have expressed a preference for having sex with circumcised men to having sex with uncircumcised men, and this has placed men under pressure to be circumcised, so as to please their wives. It was found that there was a need for men to prove their manhood not only to their girlfriends, but also to the community at large, as elaborated on below.

- ***Demonstration of one's manhood***

According to the expectations of the community, manhood is shown by being brave, among other characteristics. Circumcision is known to be painful and is undergone by brave men only. It has emerged that the need to demonstrate manhood accounts for some circumcisions among Swazi men. One participant, who had recently been circumcised for the purpose of demonstrating his manhood, said:

I just felt relaxed that I am circumcised. I felt a real man. I feel I am a real man, because I was brave enough to do that thing [circumcision].

Similarly, another participant, who was influenced by the same motive, said:

I thought it [undergoing circumcision] was painful, but aah, I am a gentleman. I must try it, because my friends had circumcised too, so I was the one left.

This finding is not surprising, considering the age range of the participants, as described in section 4.2. According to Erikson's theory of psychosocial development, some of these participants would be classified as adolescents in the stage of identity versus role confusion. In this stage, individuals seek to establish a clear identity for themselves through assuming various roles and activities. Failure of the individual to establish an identity for himself will lead to role confusion (Baron, Kalsher & Henry 2008:278). In some cultures, undergoing circumcision shows bravery and manhood, as described in section 2.4.1.2, thus giving a man a sense of identity (Plotkin et al 2011; Doyle 2005; WHO & UNAIDS 2007a; Wambura et al 2009).

Over and above all the motives discussed so far, the public health sector further promoted the practice by making the service free and readily available to the public, as explained below.

- ***Utilisation of the free and readily available service***

This study shows that the waiving of a fee for circumcision services has caused a significant change in circumcision trends in Swaziland, from a negligible demand for the procedure to an overwhelming demand, as described by the WHO (2006), among other sources. A participant, who had been circumcised in 2007, when asked whether the practice of circumcision is new in Swaziland, explained the increase in demand for the procedure as follows:

No, it's [the practice of circumcision is] not very new. Because I remember by then [2007], we were still even paying to circumcise [be circumcised], so there was a time where they said FLAS no longer require [sic] one to pay, so that's when there was an influx [of people coming for circumcision]. Ja, we had to pay, I think something like 450 [rand], if I am not mistaken.

Emphasising the need to utilise this freely available service, another participant commented as follows:

The fact that it is free, you cannot just stay behind, because we are not giving [paying] even a cent here. So, it's helpful for every male who make [sic] that decision to be circumcised.

Not only has the free-of-charge aspect of the service attracted men to undergo circumcision, but also the fact that the service is readily available any time and is provided efficiently, as expressed by the following participant:

Another thing is that these centres are all over Swaziland. They are many, such that you cannot even think of. The services are always there and available.

Another participant added:

So, when I heard that FLAS is doing [circumcision] and you don't have to wait for a long time to be circumcised, I went in [I decided to undergo the procedure].

This motive is a direct result of the circumcision scale-up efforts by the Government in partnership with the private sector, which date back to early 2006. This move has led to marked capacity building in terms of human and infrastructural resources for the delivery of circumcision services, as described in Chapter 2 (WHO 2006; Nqeketo 2010; Mazzotta 2011). Ultimately, the resulting commendable availability, accessibility, and affordability of the services constituted a sufficient cause for clients to avail themselves of these services.

Regarding community influences, the contribution of the religious and cultural aspects of the community are worth noting.

4.3.2.2 Religious/cultural motives

As shown in Table 4.1, almost all the participants indicated that they are Christians, who believe in the Bible. The following is a description of how this belief motivated men to come and be circumcised.

- **Biblical influences**

As discussed in Chapter 2, the influence of Christianity on circumcision varies from place to place and is bidirectional (Circumcision Reference Library 2004; Mattson et al 2005; WHO & USAID 2007; Rain-Taljaard et al 2003). Similarly, this study also shows that the religious motives for circumcision among participants were based on individual understandings of the Bible. One of the participants, who cited a Biblical motive for his circumcision, commented as follows:

As I read the Bible, I came across this verse which says also Jesus was circumcised, so I said, "Guys, they are busy saying, 'You are not a Jew. You are not a Jew'." I said, "There is no problem. I am not a Jew, but I am a son

of God.” So I said, “Whatever happens, I will pray first and go and do circumcision.”

Similarly, studies in Malawi and Zambia have shown that some Christians in these countries feel that Christians should be circumcised, since Jesus Christ Himself was circumcised (Lukobo & Bailey 2007; Ngalande et al 2006). In expressing another ostensibly Biblical motive, one participant said:

As far as I know, because I normally read the Bible, the Bible says “God helps those who help themselves”. So, if I don’t circumcise [get circumcised] and say God will help me, He won’t. I need to help myself in order for God to help me, because He sees that I am willing.

Although Swaziland is dominated by Christianity, it is a multicultural country, with traces of practices by certain ethnic groups (Answers Corporation 2011b; NationMaster.com 2011).

- ***Ethnicity***

Even though Swaziland is, by and large, a non-circumcising country, the results of this study show that the influence of neighbouring circumcising ethnic groups is being felt in the country. Some of the participants were motivated to be circumcised, either because they originated from circumcising countries, or because they often mingle with circumcising groups.

- **Originating from circumcising groups**

It appeared that some men currently residing in Swaziland and contributing to the high demand for circumcision are of foreign origin. One such participant from a circumcising ethnic group said:

And sometimes, you know, in our country [Mozambique], if you are born, after 10 years you must be cut [circumcised].

This illustrates the exact situation that was discussed in the literature review section, that the prevalence of circumcision in some places is influenced by the global spread of circumcising groups to these places. This has been exemplified by the infiltration of circumcising Muslims into certain ethnic groups in Uganda and Tanzania, leading to a higher prevalence of circumcision among these ethnic groups (Nnko et al 2001; Kelly et al 1999; WHO & UNAIDS 2007a). These circumcising groups end up influencing the native inhabitants to be circumcised, as has been observed in this study, as well as according to the following findings.

➤ Mingling with circumcising groups

The multicultural nature of Swaziland means that native Swazis mix with circumcising people, who end up influencing the Swazis to also undergo circumcision. One participant gave the following testimony:

I have even heard one who was circumcised from birth. So he was one other person who was, like, telling us to circumcise [be circumcised].

In addition, Swazis also often temporarily migrate to other countries for economic reasons, usually to go to school or to work. To illustrate this fact, Table 4.1 shows that a significant proportion of the participants in this study were either studying or working in South Africa, a country known to have some circumcising ethnic groups (Mavundla et al 2009; Crowley & Kesner 1990; WHO & UNAIDS 2007a). One participant expressed as follows how this influenced him to be circumcised:

I had a friend of mine who was studying in South Africa. He did circumcision, I think, some five or six years back. Even the campaigns were not that much that time, but he did it. He told me that, you know, when you are circumcised, you normally enjoy [having sex].

The motives for circumcision that have been discussed so far are essentially motives relating to avoidance or the enhancement or maximisation of social or psychological pleasure or satisfaction. However, at times circumcision is motivated by the need to restore or maintain optimum body function. Such reasons are regarded as medical reasons. They also emerged as part of the findings of this study, as described below.

4.3.3 Medical reasons

As explained in Chapter 1, medical reasons account for a certain percentage of circumcisions performed worldwide (Castro et al 2010; Ruan et al 2009; WHO 2009a). According to Spilsbury, Semmens, Holman and Wisniewski (2003), some of the medical conditions that warrant circumcision are phimosis, balanoposthitis, and balanitis xerotica obliterans. It emerged in this study that some men are coming for circumcision because of underlying medical conditions, specifically congenital malformations and delicacy of the foreskin.

4.3.3.1 Congenital malformations

Congenital malformations are abnormal body structures that one is born with. One participant with such a problem directly responded to the grand tour question as follows:

Basically I had a problem with my foreskin. It was, like, big, very big, such that it really affected me when I was using a condom, and for hygienic purposes, of course.

Thus, this participant wanted to restore optimum function with regard to condom use. In addition, the size of his foreskin always made him feel uncomfortable when he was with his peers, as he further explained:

I always wanted to circumcise [be circumcised], because, you know, when we were with a group of friends, like, I was in a hostel, so when we were going to take a shower, it was only my foreskin which was, like, longer than the others'.

Another reason which was cited as affecting optimum sexual functions in some individuals was the delicacy of the foreskin, as explained below.

4.3.3.2 Delicacy of the foreskin

While the inner foreskin is generally thin in all individuals and more susceptible to tearing, this characteristic seems to be worse in some individuals, to the extent of affecting their sexual function. One participant who decided to be circumcised partly because of this problem said:

Another thing that pushed me is sometimes when you are making love, the skin, the foreskin, it tears sometimes. You find that it gets cracks, so when I heard that FLAS is doing [circumcision] and you don't have to wait for a long time to be circumcised, I went in. Yes, [to avoid unnecessary] pain, and you have a 50% chance of not getting HIV.

As noted in section 4.3.1.1, the problem of the delicacy of the foreskin seems to compound, and at times be masked by, the problem of sexually transmitted disease. Some individuals perceive this problem as an STI on its own. It is possibly because of these factors that delicacy of the foreskin has not been documented as an independent reason for circumcision.

From the above presentation of results, it is evident that Swazis are being motivated to come for circumcision by a wide range of factors, ranging from personal factors to national and even international factors. The following section provides an overview of these findings.

4.4 OVERVIEW OF THE RESEARCH FINDINGS

The overall findings of this study are as follows:

- A wide range of reasons have been cited for the decision to undergo circumcision. The majority of these reasons are similar to those commonly cited by other authors, as discussed in the literature review. These are perceived health and sexual benefits, psychosocial and religious/cultural influences, and medical reasons.

- To some extent, the reasons were age-specific: younger men tended to be motivated mainly by sex-related benefits, while health-related benefits were of major concern for older men.
- Heterosexual partners were quite influential on men's decision to be circumcised, and these men cited mainly sexual and health benefits to being circumcised.
- Men that cited protection from STIs as the main motive for circumcision are those who often indulge in risky sexual behaviour.
- With or without circumcision, men are still indulging in risky sexual behaviour.
- Circumcision is creating a false sense of total safety and security from HIV and other STIs.
- Government's successful efforts in making circumcision services freely available and accessible have also motivated men to come for circumcision.
- Apparently, the approach by some public health advocates in promoting circumcision is to some extent coercive.
- The introduction of circumcision education in school curricula will assist future generations to better understand the science behind the HIV prevention strategy of circumcision. It seems that South Africa has done this, and the positive influence of this education is being felt in Swaziland as well.
- Christianity is the dominant religion in Swaziland, and its influence on circumcision is minimal and bidirectional.
- Through interaction in economic activities, neighbouring circumcising ethnic groups are to some extent influencing Swazis to be circumcised.
- Some other reasons why some men are not coming for circumcision also emerged, although that was not the primary focus of this study.

These findings would seem to provide a broad picture about the situation of circumcision in Swaziland. There is a need for further contextual interpretation of these findings to enhance their proper application in practice, as suggested in the following conclusion.

4.5 CONCLUSION

In summary, this chapter presented the results of this study. These were discussed in the context of Swaziland, and reference was made to the global situation, based on the existing literature. Generally, there is a wide range of reasons behind circumcision in Swaziland, which are not necessarily peculiar to this country alone, but are universal. An overview of the major findings was given in the previous section.

The following chapter provides an interpretation of these findings and the conclusions that were drawn. Recommendations for public health practice based on these findings will also be given.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter concluded with an outline of the overall findings of this study. This chapter presents the conclusions drawn from the interpretations of these findings. The ultimate goal is to give a comprehensive expression of the fulfilment of the initial research purpose and the set objectives. The limitations of the study are also discussed. Based on the findings, recommendations for policy formulation, health education, health care practice, and further research in the area of public health concerned with male circumcision are also presented.

5.2 CONCLUSIONS

This research was a generic qualitative study based on the naturalistic paradigm, where it is assumed that there are multiple realities. The choice of this research design was inspired by Burns and Grove's (2005:52) philosophy that qualitative research is a way of gaining insight through discovering meanings. This study aimed at assessing and analysing the reasons why large numbers of Swazi men are coming for circumcision. In so doing, the researcher was able to identify the meanings attached to circumcision from an emic perspective (Polit & Beck 2004:251), and hence the motive behind the increasing interest in circumcision.

While the qualitative design ultimately led to a satisfactory fulfilment of the research objectives, the process was not easy. The strategy of waiting for subjects to come for circumcision services at the health care centre ended up prolonging the data collection period, since the turnout of participants was not consistent. When the weather was bad, that is, overcast, rainy, and/or very cold, no one would come for the procedure. However, on other days, the turnout was so high that having only one data collector and using concurrent sampling and data-collection methods proved to be limiting factors. As such, the researcher ended up missing some potential candidates. In addition, the

minimum age limit of 18 years also led to the disqualification of a significant number of candidates who qualified in terms of having the variable of interest, but were outside the required age range, most of whom were between 15 and 17 years of age inclusive. In any case, the researcher eventually accumulated a sufficient and appropriate sample, since data collection was continued until saturation was reached.

The other challenge stemmed from the open-ended nature of the grand tour question and the subsequent probing questions, which resulted in abundant information being obtained, some of which was not entirely relevant to the purposes of this study. Furthermore, at times participants would digress from the topic, and the researcher had to use his communication skills to refocus them and probe for relevant information. This abundance of (at times irrelevant) data complicated the process of data analysis and the compilation of the results. However, the audiotaping of the interviews enabled the researcher to review the raw data several times in order to capture all the significant findings, as presented in the previous chapter.

The results, as presented in the previous chapter, show that there is a wide range of reasons, with various underlying motives, for why Swazis are coming for circumcision. The majority of these motives are not peculiar to Swazis alone, but are similar to those reported elsewhere in the world, as discussed in the reviewed literature. Worth noting is that some of the motives were promotive of, while others were a threat to, public health interests, as initially hypothesised by the researcher. Three main themes emerged relating to the motives behind circumcision. These are the perceived personal benefits of circumcision, community influences, and medical reasons.

From the various reasons given by the participants, it was inductively concluded that a significant proportion of Swazi men are motivated to come for circumcision because they know, understand, and appreciate that this course of action helps them as individuals. This decision by some individuals is primarily a product of their various learning experiences, in the form of social interactions, circumcision campaigns (Grund 2010; Nqeketo 2010; WHO 2009), and/or formal education at secondary or tertiary level, locally or in other countries. The major benefits of circumcision that are appreciated are those that relate to health and hygiene.

The protective effect of circumcision against sexually transmitted infections is a significant pull factor for men to solicit the procedure. Among these infections is the widely publicised HIV, which still has no known cure. Cervical cancer in sexual partners, which results from the infection of the penis by human papillomavirus, is another equally frightening disease which is motivating men to be circumcised, including men who trust themselves and their sexual partners to be faithful to one partner. It follows, therefore, that the motive for circumcision is to complement the “ABC” strategy of abstinence, being faithful to one partner, and the use of condoms in preventing STIs, including HIV.

It was also noted that participants who cited protection from STIs as the main motive for circumcision are those who often indulge in risky sexual behaviour. From this finding it can be deductively concluded that the motive behind circumcision is to provide protection from contracting STIs while these participants continue to engage in their usual risky sexual behaviour. This goes with the finding that circumcision is creating a false sense of total protection from HIV and other STIs, thereby promoting promiscuous sexual behaviour. Other sex-related motives were also noted.

Increased sexual pleasure is a common motive for circumcision among young men. It also emerged that once circumcised, these young men feel that their self-esteem, and their “market” in the sexual world, has been boosted, thereby promoting multiple sexual relationships. In addition, those men who would have just been circumcised for the sake of increasing sexual pleasure tend to crave for more for sex to compare the difference in pleasure before and after circumcision. These findings point to the conclusion that, to some extent, circumcision is promoting risky sexual behaviour, thereby exacerbating the spread of HIV. However, it also emerged that with or without circumcision, some Swazis are still engaging in risky sexual behaviour.

It was also noted that heterosexual partners had a significant influence on men’s decision to be circumcised. In this regard, the participants cited mainly the sexual and health benefits of circumcision, suggesting that the main motivating factor for men is to please and/or protect their spouses. This pressure is compounded by pressure from public health advocates and the need to please them. In addition, the Government and NGOs’ successful efforts in making circumcision services freely available and accessible, at times with incentives, have also motivated men to come for circumcision,

so as to utilise the free service, considering that previously the service was not free of charge.

Interactions in economic activities with neighbouring circumcising ethnic groups in South Africa and Mozambique are also to some extent influencing Swazis to be circumcised, with an underlying motive of social desirability, as discussed in the literature review section.

While every effort has been made to ensure the credibility of these findings, and the conclusions drawn from them, there were some limitations that are worth noting.

5.3 LIMITATIONS OF THE STUDY

Burns and Grove (2005:39) define limitations of a study as restrictions or problems in a study that may decrease the generalisability of the findings. In this study, the researcher identified the following limitations:

- Being a qualitative study, this research was conducted on only 17 participants, as determined by saturation. This limits the generalisability of the results among all Swazi men.
- In view of financial implications and complexity, and for the purposes of this study, convenience sampling was used, and sampling was done only on one site, namely the FLAS in Mbabane. This will also limit the generalisability of the results.
- Since face-to-face interviews were used, the researcher effect on the participants, which could have led to bias, cannot be ruled out.

Given that the study was designed with due consideration of these limitations, the researcher considers the finding to be sufficiently credible and worthy of utilisation in health care practice. The following section provides recommendations based on the findings.

5.4 RECOMMENDATIONS

The findings of this study show that the motives behind circumcision are both promotive of and a threat to public health. Based on an overall evaluation of these findings, the following recommendations are offered in terms of policy formulation, health education, health care practice, and further research, so as to maximise the public health benefit of mass circumcision.

5.4.1 Policy formulation

- Against the hypothesis that circumcision creates a false sense of total protection against HIV and other STIs, thereby promoting promiscuous sexual behaviour, it is recommended that national mass circumcision programmes under the national male circumcision policy of 2007, as described in sections 1.2.1.3 and 2.6.2, be supported and promoted. This is based on the finding that men are engaging in risky sexual behaviour with or without circumcision. Furthermore, those men who are likely to be more promiscuous after circumcision are those that are already promiscuous.
- In any case, it is recommended that emphasis be placed on the minimum package for circumcision, as stressed by the WHO (2007a) and the WHO and UNAIDS (2007b), from the formulation level to the operational level of the male circumcision policy of 2007 that the Swaziland Government will ultimately implement. Clear, correct, and consistent messages should be developed at global, regional, national and community level and be disseminated to the consumers of circumcision services.
- Apparently, the circumcision campaigns are targeting men aged 15-49 years (Grund 2010; Nqeketo 2010; WHO 2009). It is recommended that the target group be enlarged to include women of the same age group, since they have been shown to have an influence on their partner's decision, and they also benefit from the procedure, sexually and health-wise.

The eventual policy on circumcision that will be structured in accordance with the above recommendations needs to be communicated to all the stakeholders responsible for its

implementation. Similarly, the knowledge gained about circumcision in general needs to be communicated to the consumers of the knowledge. The policy and the knowledge gained from this research can be communicated through health education. In view of this, the researcher offers the following recommendations with regard to health education.

5.4.2 Health education

- It is recommended that instruction about issues relating to circumcision and the benefits of circumcision be incorporated into nursing curricula and general education curricula, so as to raise awareness about circumcision. The underlying scientific basis behind circumcision is better understood through formal education than through campaigns.
- In-service education for health workers is important in all centres where sexual and reproductive health services are offered.
- Currently, the benefit of circumcision that is emphasised the most is prevention of HIV, based on the Auvert et al (2005) publication. It is recommended that all the other benefits of circumcision be equally emphasised to enhance informed decision making, since different people value different things.

The knowledge acquired needs to be put into practice in the delivery of health care. The researcher has the following recommendations to offer concerning health care practice.

5.4.3 Health care practice

- As they are at the operational level of the entire circumcision strategy, it is recommended that health care providers be well versed and up to date concerning issues of mass circumcision and misconceptions surrounding circumcision. This can be achieved through in-service training, as mentioned above, as well as by individual searches for information in relevant sources.
- With this sufficient knowledge base, it is recommended that health care providers offer informative pre- and post-circumcision counselling to all their clients. Where

possible, it is recommended that the services of a professional counsellor be contracted.

- In the performance of their duties as health educators, the researcher recommends that health care providers present their information to clients as neutrally as possible. This gives clients freedom to make an informed decision on whether or not to be circumcised, without feeling coerced. Decisions made out of coercion are less likely to be accompanied by positively reinforcing behaviour.

Health care practice has to be evidence-based, suggesting that it should be rooted in up-to-date scientific research (Polit & Beck 2004:673; Burns & Grove 2005:640). On that note, the researcher recommends the following for further research.

5.4.4 Further research

- As hypothesised in this study, namely that male circumcision tends to promote risky sexual behaviour, it is recommended that an investigation be conducted to assess the post-circumcision behaviour of men who have been circumcised, and to compare this behaviour with their pre-circumcision behaviour. The degree of difference in behaviour prior to the procedure of circumcision and subsequent to it, qualitatively and quantitatively, will provide a better indication of the risk-benefit ratio of circumcision as a strategy for preventing the transmission of HIV and other STIs. This knowledge will be crucial in informing policy formulation with regard to circumcision.
- Based on the findings that women are pressurising men to be circumcised, or that they otherwise seek circumcised men, the researcher recommends that research be conducted to determine how male circumcision is influencing female sexual behaviours. A focus on women could be another way of addressing high-risk sexual behaviours by either partner resulting from the desire to enjoy the sexual benefits of circumcision.

With these recommendations, it is believed that the ultimate goal of this research study has been achieved.

5.5 CONCLUDING REMARKS

This chapter drew this dissertation to an end by presenting the conclusions drawn from the research findings. The purpose of the research would seem to have been achieved, and the objectives would seem to have been met. The research revealed that multitudes of Swazi men are coming for circumcision due to various compelling motives, chief among them being health, hygiene and sex-related motives. It emerged that some of these motives are geared towards prevention of transmission of HIV and other STIs, which is the objective of Swaziland's national policy on male circumcision. However, it was found that some motives are a threat to public health. Based on these findings, the researcher came up with recommendations to inform policy formulation, enhance health education and health care practice, and direct further research concerning the issue of male circumcision and HIV.

The researcher acknowledges that this research had some limitations, as was outlined in this chapter. Notwithstanding this fact, the researcher believes that implementation of the given recommendations will go a long way towards the success of male circumcision as a public health strategy in Swaziland.

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ETHICAL CLEARANCE CERTIFICATE**

HS HDC/35/2012

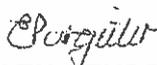
Date of meeting: 16 March 2012 Student No: 4547-115-0
Project Title: A critical analysis of the motive behind Swazi men's increasing
interest in being circumcised: A client's perspective.
Researcher: Charles Maibvise
Degree: Masters in Public Health Code: MPCHS94
Supervisor: Prof TR Mavundla
Qualification: D Cur
Joint Supervisor: -

DECISION OF COMMITTEE

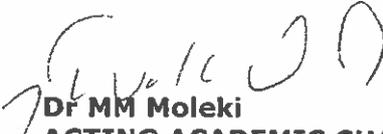
Approved

Conditionally Approved

Prof E Potgieter



CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE



Dr MM Moleki

ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

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



MINISTRY OF HEALTH
P.O. BOX 5
MBABANE
SWAZILAND

THE KINGDOM OF SWAZILAND

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

TO: C. Maibvise
UNISWA

DATE: 28th May 2012

REF: MH/599C

RE: A critical analysis of the motive behind Swazi Men's increasing interest in being circumcised: A Clients Perspective

The committee thanks you for your submission to the Scientific and Ethics Committee and the clarity on responses to the protocol amendment

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

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

Yours Sincerely,

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



UNISWA Faculty of Health Sciences
P. O. Box 369
Mbabane
Swaziland

04 April 2012

The Site Coordinator
Family Life Association of Swaziland
Mbabane Clinic
P.O. Box 1286
Mbabane
Swaziland

Dear Sir/Madam

RE: Request for permission to conduct a research study

I am writing to request for permission to conduct a research study at your clinic in partial fulfilment of the requirements of the degree of Master of Public Health which I am pursuing with the University of South Africa. The study is entitled: "A critical analysis of the motive behind Swazi men's increasing interest in being circumcised: a client's perspective"

If allowed, I wish to recruit and interview face-to-face a few participants from amongst your circumcision clients. The exact number required will be determined by data saturation. Participation will be absolutely voluntary and those who are willing will be requested to fill in a consent form (see attachment). Interviews will be held at any quiet and private venue within your institution or any other place agreed upon by the researcher and each participant. The interviews will be unstructured, with a grand tour question: "*What has made you to make up your mind and decide to be circumcised?*" followed by probing questions. The information collected will remain confidential and anonymous, and will be used only for the purpose of this study.

No costs will be incurred by your institution or the individual participants.

Should you need any further information or have any questions or concerns regarding the study, feel free to contact me on e-mail address cmaibvise@uniswa.sz or phone number +268-76386252.

If you agree, kindly sign below and I will come and collect as soon as you have finished. Alternatively, kindly write a signed letter of permission on your institution's letterhead acknowledging your consent and permission for me to conduct this study at your institution.

In addition, kindly endorse on the last page of the enclosed **Ministry of Health and Social Welfare Scientific and Ethics Committee application form**, where it reads: "Signature of Head of Department/Institution"

Thank you very much in anticipation.

Yours sincerely,



Mr Charles Maibvise
(University of South Africa)

Approved by:

Phelele Fakudze
Research + Evaluation Manager
Acting Director of Programmes

Print your name and title here

THE FAMILY LIFE ASSOCIATION
OF SWAZILAND

P.O.Box 1051, Manzini
Tel: 505-3082 / 505-5852



Signature

23/04/2012

Date and stamp

SITSASISELO G: LIFOMU LEKUVUMA

(Lakhiwe ngekutsi kucolwe lelo laTshibumbu 2006)

Uyacelwa kutsi uvume kungenela lolucwaningo loluhlose kutfola nekucwaninga sizatfu nembangela yekutsi ukhule umdlandla wekufuna kusoka emadvodzeni emaSwati. Lolucwaningo lwentiwa ngu Mnumzane Charles Maibvise, longumfundzi weNyuvesi yaseSouth Africa (UNISA).

Noma nje lusito lwemiphumela yalolucwaningo lungeke lucondzane nawe ngco , kepha lemiphumela itabasita kakhulu basebenti betemphilo ekutfoleni lwati lolufanele, futsi ibahlumise ekuchubeni umsebenti wabo wekufundzisa nekweluleka ngetindzaba letiphatselene nekusoka. Futsi lemiphumela itawusita kakhulu ekusunguleni nasekwakheni imigomo lemayelana nekusoka. Ukhululekile futsi kutsi utfole kucaciselwa kahle nangabe kukhona longakucondzisisi noma nangabe kukhona lwati lolutsite loludzingako mayelana nalolucwaningo. Loku ungakwenta ngekutsi ubute lomcwaningi ngekutsi umtsintse kulelikheli lakunike lona lapha ngenhla, noma umshayele kulenombolo letsi 76386252.

Kungenela kwakho lolucwaningo kuyawuya ngekutsandza kwakho, awukaphocelelwa. Futsi ungamonyula noma uyekele noma nini nawungasafuni, angeke ubekwe licala noma usolwe ngekwenta njalo. Lwati lesitalutfola kuwe kulolucwaningo lutawugcinwa ngetimphawu letivikelekile. Loku kwentelwa kutsi lolwati lungamataniswa nawe, futsi kungabikho lokukhombisa kutsi lutfolwe kuwe. Futsi lolwati lelutawutfolwa kuwe lutawuvikeleka, luyawutjentiswe kuphela kulolucwaningo.

Imininingwane yalolwati itawutfolwa kuwe ngekutsi ubutwe imibuto letsite, kepha loko kuyawenteka endzaweni lelungela wena nangetikhatsi letikulungela wena. Lokubutwa kutawutfwetjulwa ngemshini lotfwebula emavi.

Lesivumelwano sekuba yincenye yalolucwaningo ngifundzelwe ngachazelwa ngaso, futsi ngitivumele mine ngingakaphocelelwa kutsi ngilungenele lolucwaningo.

Sidladla salovuma kungenela lolucwaningo: _____ Lusuku: _____

Lona losayine lapha ngenhla ngimchazele konkhe ngalolucwaningo, futsi ngiyitfolile imvume yakhe yekulungenela lolucwaningo emva kwekutsi atenelise kutsi ulucondzisisa kahle lolucwaningo.

Sidladla semcwaningi: _____ Lusuku: _____

ANNEXURE D: BIOGRAPHICAL DATA, AND THE GRAND TOUR QUESTION

Biographical data

1. Participant code _____

2. Age _____

3. Occupation _____

4. Marital status (Tick whichever is applicable):

- Single []
- Married []
- Widowed []
- Divorced []

5. Place of residence (Tick whichever is applicable):

- Urban []
- Semi-Urban []
- Rural []

6. Religious affiliation (Tick whichever is applicable):

- Christianity []
- African traditional religion []
- Other [] Specify: _____

7. Highest education level attained (Tick whichever is applicable):

- Primary []
- Secondary []
- Tertiary []

The grand tour question

What made you decide to be circumcised?

ANNEXURE H: INTERVIEW TRANSCRIPT

Project: The Motives behind Swazi Men's Increasing Interest in Circumcision

Interviewer: Charles Maibvise

Interviewee: Participant No. 15

Date: 11 July 2012

Duration: 15 minutes 26 seconds

Place: Family Life Association of Swaziland (FLAS) Mbabane Clinic

Interviewer: Right, the recording process has already started now.

Interviewee: Ok.

Interviewer: That means everything that we are going to say will now be recorded.

Interviewee: Ok.

Interviewer: So I will start by this one where I said you are participant number 15, so I will put code 15 here.

Interviewee: Ok.

Interviewer: May I find out your age?

Interviewee: My age is 21.

Interviewer: Your occupation?

Interviewee: I am no longer working.

Interviewer: Are you married?

Interviewee: No.

Interviewer: Ok, single. Where are you staying?

Interviewee: Ubheni

Interviewer: Ubheni. Is that a rural, urban or semi-urban area?

Interviewee: Semi-urban area.

Interviewer: Semi-urban area?

Interviewee: Uh-huh.

Interviewer: Religion? We have Christianity, we have got African Traditional Religion, we have got other religions.

Interviewee: Christianity.

Interviewer: Highest level of education attained?

Interviewee: Secondary.

Interviewer: Then onto the main question that I wanted to find out, is to say what has made you to make up your mind to come and be circumcised? You said you got circumcised sometime last year, isn't it?

Interviewee: Yes.

Interviewee: That is 2011?

Interviewer: Uh-huh.

Interviewer: Around which time? Beginning of year, mid-year or end of year?

Interviewee: It's July.

Interviewer: Oh, July? Exactly a year ago?

Interviewee: Ja.

Interviewer: So I wish to find out what has made you to make up your mind to come and be circumcised at that time that you came?

Interviewee: There are these [circumcision campaign] members who want people to circumcise. They told me something, that circumcising reduces the risk of getting HIV. Early January I had STIs, like my penis was cracking. So when he told me that you reduce the risk of getting STIs and HIV I decided to circumcise.

Interviewer: Ok.

Interviewee: Yes, that is why I decided to circumcise.

Interviewer: Ok, issues of HIV and STIs?

Interviewee: Yes.

Interviewer: Ok, is there any other reason apart from that?

Interviewee: Uh-uh (shaking the head expressing a "no")

Interviewer: So, those were the main reasons?

Interviewee: Yes.

Interviewer: If I may try to find out on the STI that you had at that time, do you have any idea as to where you might have got it?

Interviewee: No.

Interviewee: No?

Interviewee: Ja.

Interviewer: Do you have a girl friend?

Interviewee: Ja, I have it [her].

Interviewer: Ok, but you had not yet slept [had sex] with her by then?

Interviewee: I slept [had sex] with her.

Interviewer: But, do you think ... [interjected].

Interviewee: I suspect her.

Interviewer: You suspect that? Ok.

Interviewee: Ja, I suspect her. That's why I decided to come and circumcise.

Interviewer: Ooh, Ok. And of course I know, people, men, if I may call them that, as they grow, at one point when the time for marrying comes they want to make sure that they make a careful choice of a lady not just to chose any lady. So, quiet often people have a number of ladies at a time. They date or fall in love with many girls to try and find out who is the best among these, and then at the end choose one. How many have you fallen in love with so far?

Interviewee: I have got 4.

Interviewer: You have 4 so far?

Interviewee: Uh-huh (nodding the head in agreement), 4 so far.

Interviewer: You have them all or you take one at a time and you seperate, bring another one, or you have them all at the same time?

Interviewee: I take 1 (pause; an expression of exchanging; laughter), 1 by 1.

Interviewer: Ok, ok. You realise that this one does not fit, and then you take another one?

Interviewee: Uh-uh (shaking the head in disagreement). All of them are fit.

Interviewer: All of them are fit? (laughter).

Interviewee: Ja (Laughter). I take 1, and sleep with.

Interviewer: And then?

Interviewee: And then I go and take another one.

Interviewer: So all these 4 you have slept [had sex] with them?

Interviewee: Uh-huh (nodding the head in agreement).

Interviewer: And once you sleep [have sex] with that you leave her to go?

Interviewee: Ja, I leave her to go (laughter). But I make sure that noone know each other.

Interviewer: Ooh, out of all these 4?

Interviewee: Ja, they didn't know each other.

Interviewer: Now, are you not afraid of these STIs and whatever, probably HIV and so forth, these things that are sexually transmitted?

Interviewee: Ja, I was not afraid. Now I am so afraid.

Interviewer: Oh, now, after you have had this one who gave you the STI?

Interviewee: Uh-huh.

Interviewer: Ok.

Interviewee: I picked 1, and now I stay with 1.

Interviewer: Oh, now you now have one?

Interviewee: Ja, so that I can know that if I get another STI I will know that its this one (demonstration of pointing at someone).

Interviewer: Oh!

Interviewee: So for all of the 4 I don't know who ... (laughter).

Interviewer: You are not even sure who gave you among all these 4?

Interviewee: Uh-huh (nodding of the head in agreement).

Interviewer: Ok, now at least you are now circumcised, and as you have said, this circumcision might at least prevent the chances of getting the diseases. Why are you now sticking to one this time? Do you think you are now safe and you can at least have a chance of getting more of these ladies?

Interviewee: Now I am safe.

Interviewer: You are now safe?

Interviewee: Ja, I am safe.

Interviewer: Now you can at least look for more? Or you still feel this circumcision is not enough.

Interviewee: Ja, its enough now.

Interviewer: Ok, ok.

Interviewee: Because, circumcising, *angithi* [isn't it that] we know that you have a chance of getting HIV, about 60% reducing HIV, 40% you can get HIV.

Interviewer: Oh, ok, ok. That is true. Now if I may I find out now. Precisely, from the moment you got circumcised, how did circumcison change your lifestyle? Do you have any description to say from the moment I was circumcised, maybe I used to be doing things in this way, now by the time I got circumcised I started doing it this way and so forth. How did circumcison change your life?

Interviewee: Yes, it changed my life.

Interviewer: It changed?

Interviewee: Ja, it changed. When I have sex I feel like, you know (laughter), hey ... no (expression of pleasure), because, you know, my girlfriend tells me, “eishhh” (expression of pleasure plus laughter).

Interviewer: The pleasure? She feels ... [Interjected].

Interviewee: Ja, I play it a long time, you know, a long time (expression of a very long time).

Interviewer: Ok, ok, ok.

Interviewee: Such that I told somebody that “eish, go and circumcise”.

Interviewer: Because of this pleasure that you would have after?

Interviewee Uh-huh, I explained to him *kutsi* [that] when you circumcise you get this and this and this and you feel better.

Interviewer: What benefits do you often tell those who you would want to convince to come and be circumcised? One of them, like you are saying, is sexual pleasure. What else do you often tell them? What advantages do you specify to say go and be circumcised because 1, 2, 3.

Interviewee: Because (1) You can't have STIs because when you..., you know the penis?

Interviewer: Yes.

Interviewee When you finish having sex, you want to go with your girlfriend to town, you never wash your body, no.

Interviewer: Aha, at that time?

Interviewee: At that time. You say, “ah ah, later”.

Interviewer: Ok, ok.

Interviewee: Uh-huh. But when you are circumcised you can go.

Interviewer: Ok, there is not much of that dirt which remains?

Interviewee: Uh-huh (nodding the head in agreement).

Interviewer: Ok, ok. Those are some of the advantages that you say to them?

Interviewee: Ja.

Interviewer: If I may find out, at the time that you finally made up your mind to be come and be circumcised, did your girlfriend know, or did you discuss that with your girlfriend or any of your girlfriends by then?

Interviewee: No.

Interviewer: You did not tell them?

Interviewee: No.

Interviewer: Oho. They only found you after being circumcised?

Interviewee: Yes. *Angitsi* [Isn't it that] I stay alone.

Interviewer: Ok.

Interviewee: When I want a girlfriend I go to her homestead and pick her, you know.

Interviewer: To your place?

Interviewee: To my place. And when I circumcised I will just stay, and when I go to her homestead I tell her, "No, I will see you later".

Interviewer: Ok. Is there any one of your girlfriends who you had sex with before circumcision and then had sex with her again after circumcision?

Interviewee: Uh-huh (nodding of head in agreement).

Interviewer: How many, or all the four that you talked about?

Interviewee: Uh-uh (nodding of head expressing a "no"). One.

Interviewer: Did she make any comment about it?

Interviewee: Ja.

Interviewer: What comment did she make?

Interviewee: That I told you (laughter).

Interviewer: Ok, ok. I get your point, and I think basically that's what I wanted to find out, really, to say what is it that has made you to make up your mind and what benefits are you seeing after being circumcised. If I may find out again, from your own discussion with your other colleagues who might be circumcised or who might not be circumcised, what are their views about circumcision? What have you heard them saying about circumcision, either those who have

been circummcised or those who have not? What are their comments?

Interviewee: They say ah, circumcision is not good because they make Ben's spices, you know, the ones who are not circumcised.

Interviewer: They make what?

Interviewee: They make Ben's spices, with their skins.

Interviewer: Ooh, ok, ok. That's the reason why they don't come?

Interviewee: Uh-huh. Now there are no people who are coming to circumcise, and there are no lots of Benies, Ben's spices.

Interviewer: Ok. Which ones are these Ben's spices?

Interviewee: You don't know Ben's spices?

Interviewer: In the streets? Or where? In shops?

Interviewee: In shops. Ben!

Interviewer: Oh, the actual Ben's spices that are sold in ... [interjected].

Interviewee: Ben's spices, there is a picture of a person wearing a cap.

Interviewer: Ooh! Why are people suspecting that? Where is the link there, those spices and... [interjected].

Interviewee: In Swaziland people said when you circumcise you get a packet of Ben's spices, that's why we suspect that Ben is made of the skins.

Interviewer: Ooh, each time you get circumcised you are given that packet?

Interviewee: Ja.

Interviewer: For free?

Interviewee: For free.

Interviewer: Ooh, that's around the time when you were circumcised?

Interviewee: Uh-huh, that's why we suspect that Ben is made of the skins (laughter).

Interviewer: What other things were you given by then apart from those Ben's spices? All people were just being given Ben's spices after circumcision?

Interviewee: Ja, but they didn't give anything to me.

Interviewer: Ok, but some were being given by then?

Interviewee: Ja. They told me that they were given Ben's spices, some were given some T-shirts, you know, bags.

Interviewer: Oh, different things?

Interviewee: Different things.

Interviewer: Ok. That's around 2011, is it? Last year?

Interviewee: Ja.

Interviewer: Oh, that's where the aspect of spices came from. Ok, fine, those were the comments of those who did not want to come and be circumcised. What about the comments of those who have agreed to come and be circumcised?

Interviewee: Most of them, they like to circumcise because they ... (stammering, in search of the proper expression). I don't know, man. I don't know how to express it (laughter).

Interviewer: Is it different from what you have explained earlier to say they come because they want to increase their sexual... [interjected].

Interviewee: Ja. It's not different.

Interviewer: It's basically that?

Interviewee: Uh-huh.

Interviewer: And issues of HIV also?

Interviewee: Uh-huh.

Interviewer: And STIs? Is basically the same?

Interviewee: Ja. In siSwati they want to be *xhonxonxo* [sexual vigour] (laughter).

Interviewer: They want to be what, *xhonxonxo*?

Interviewee: *Xhonxonxo* (laughter).

Interviewer: What's that?

Interviewee: When they have sex, uhhhh uhhh uhhhh [expression of intense pleasure plus laughter].

Interviewer: Ok, ok. I get your point. That's the explanation which they use.

Interviewee: Ja, "hey, *sa usoka, xhonxonxo*" [hey, if you undergo circumcision you will perform exceptionally good, sexually].

Interviewer: So mainly that's what you will hear people talking about, that after this thing you will be *Xhonxonxo* (laughter).
No, it's ok, I think basically that's what I wanted to find out.

Interviewee: Ok.

Interviewer: Yes, and I thank you very much for that contribution. Do you have any question that you might need to ask regarding whatever questioning we have been doing?

Interviewee: I don't have any question.

Interviewer: You don't have any question, anyway. So, on that note let me stop this thing [the recording] here and thank you very much for your participation.

Interviewee: Ok.

ANNEXURE F: INFORMED CONSENT

(Adapted with modifications from Tshibumbu 2006)

You are being requested to participate in a study to assess the motives behind the increasing interest by Swazi men in being circumcised. The study is conducted by Mr Charles Maibvise, a student at the University of South Africa.

Although the study may not benefit you directly, it will help elicit information necessary for health care personnel to enrich their health education and counselling related to male circumcision. It will also guide policy formulation in matters relating to male circumcision. You are free to ask for clarity or seek additional information regarding this research from the researcher at any time on cell number 76386252.

Your participation in the study is entirely voluntary, and you may withdraw at any time without incurring any penalty or prejudiced treatment. The information collected from you will be identified by codes, so that it will not be linked to your identity. In addition, the information will be kept confidential and be used only for the purposes of this research. Data will be collected by means of interviews at a time and place that is convenient for you. The interviews will be audiotaped.

This consent has been read and explained to me, and I voluntarily consent to participate in this study.

Participant's signature _____ Date _____

I have explained this study to the participant who has signed above, and I have sought his or her informed consent.

Interviewer's signature _____ Date _____

SITSASISELO E: LWATI NGENDZAWO YEKUTALWA KANYE NEMBUTO
LOYINGCAYIZIVELE

Umnininngwane ngendzawo yekutalwa

1. Umfanekiso/ luphawu lwalotinelako _____
2. Uminyaka _____
3. Umsebenti _____
4. Simo sekwendza _____
 - Akatsatsi/akatsatfwa []
 - Utsetse/utsetfwe []
 - Ngumfelokati []
 - Lowehlukene ngekwemtsetfo []
5. Indzawo yekuhlala (beka luphawu lolufanele)
 - Wasedolobheni []
 - Wamadvute nelidolobha []
 - Wasemaphandleni []
6. Inkholo yakho (beka luphawu lolufanele)
 - Ngumkhrestu []
 - Inkholo yelisiko lesiAfrika []
 - Noma lenye, cacisa la _____
7. Lizinga lekufundza lophetsele kilo
 - ePrimary []
 - eSecondary []
 - eNyuvesi/college []

Umbuto wetfu loyingcayizivele

Yini lokukwente wakhe lesincumo endvondvweni yakho sekusoka?