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**Experiences of young Xhosa Men who undergone Medical Male Circumcision in the
Western Cape**

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DECLARATION

I, Zola Melody Silimfe declare that:

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DEDICATION

I dedicate this work my late aunt Onodwa Silimfe

“If tears could build a stairway and memories a lane

I would walk back to heaven to bring you back

No farewell words were spoken, no time to say goodbye.

You were gone before I knew it and only God knows why

My heart still aches in sadness and secret tears, No one knew what it meant to lose you but now I do. I know you want me to mourn for you no more but to remember all the happy memories” - Anonymous

Thank you for your contribution towards this piece of work. I remember we had even selected the perfect dress you will wear to my graduation but the Bible says “Many are the plans of man but only God’s plans prevail” - Proverbs 19:21

RIP Mamcethe 19-06-2017

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*“I know the plans I have for you. Plans to prosper you and not to harm you
Plans to give you an unexpected end” Jeremiah 29 verse 11.*

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
MC	Male Circumcision
MMC	Medical Male Circumcision
STIs	Sexually Transmitted Infections
TMC	Traditional Male circumcision
UNAIDS	United Nations HIV/AIDS Programme
WHO	World Health Organization

Glossary

Abakhwetha: Initiates

Ibhoma: Initiation

Ikhankatha: Traditional Nurse

Imbeleko: A castrated goat that is slaughtered for a baby boy to introduce him to ancestor

Ingcibi: Traditional surgeon

Isidoda: Bush language or bush code

Isichwe: A herb or leaf that is used to treat the operation of the initiate

Ityeba: A traditional bandage that is used to cover the operation of the initiate

Ixhwele: Traditional doctor

Ndiyindoda: I am a man

Ukudodisana: Talking in bush language

Ukojiswa: A ritual whereby a goat or a sheep is slaughtered for the initiate to celebrate or confirm his healing process

Ukuphondla: The pulling down of the foreskin that is attached and covers the penis

Ukuyalwa: A practice when elders of the community advise ikwrala about accepted ways of life and how a Xhosa man should conduct himself

Umkhwetha: An initiate

Usothu: Custodian of initiation school

ABSTRACT

The provision of medical male circumcision (MMC) in public health facilities was introduced as a strategy to curb the high rate of new HIV infections in South Africa. However, in the South African context, traditional male circumcision (TMC) is practiced across different tribes as a rite of passage from boyhood to manhood. Unfortunately, TMC has been associated with high numbers of deaths among young men attending local initiation schools.

While TMC and MMC differ in terms of surgical procedures, both procedures are for the removal of the foreskin. A significant difference between the two procedures is the fact that TMC is linked to an age old cultural practice that serves as a rite of passage to manhood, while MMC is mainly meant to decrease the risk of HIV infection in heterosexual men.

This research study investigates Xhosa men who opt for MMC instead of TMC. It aims to understand their knowledge of MMC and factors that influenced their decisions to opt for MMC and its related social and masculinity negotiations. This study will elucidate the complexities within which these men view MMC and ‘[negotiate their masculine and cultural identities.

The methodology adopted is qualitative, to provide a rich, in-depth understanding of the phenomenon being studied. A total of 9 Xhosa men who have undergone MMC in the past two years were recruited to participate. The men were 20-29 years old at the time of the study, and resident in Cape Town. Semi-structured individual interviews were used to explore the men’s understandings of their masculine and cultural identities in relation to their decision to opt for MMC.

The participants reported that health benefits and access to health care systems were among the main influences that prompted them to opt for MMC. Social media played a huge role in providing information on MMC and influencing young men to opt for MMC. The Brothers for Life campaign was one of the most effective campaigns that assisted to reach out to men and encourage them to get circumcised. The use of public figures leading the campaigns did have a positive impact on people. The challenge that the young men experienced was that within the Xhosa culture circumcision is a rite of passage from boyhood to manhood. Participants described the reactions of family and friends to their decision as varied. Some participants experienced discrimination from their family members based on their decision to opt for MMC.

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CHAPTER 1

1.1 Introduction

The aim of this study is to investigate the experiences of Xhosa men who have undergone MMC. This is important, because to them it is not just about the cutting of the foreskin, but a passage to manhood which includes important socialisation on being a man (Mavundla et al, 2009). The surgical procedure is also different, as no stitching is involved. A community in which TMC is the norm, men who opt for MMC are ridiculed, and are not referred to as real men. It is therefore vital to examine how traditionally circumcising communities embrace medical male circumcision. This research seeks to understand what influences these men to opt for medical male circumcision.

1.2 Background of the study

According to UNAIDS/CAPRISA (2007, 01) “male circumcision (MC) is regarded as one of the oldest surgical procedures in the world, and has been practiced by communities in different parts of the world for reasons such as cultural and religious identity”. Traditional male circumcision is the most common in Sub Saharan Africa, North Africa, Middle East, the Jewish Diaspora and elsewhere in the country.(Ntombana,2012).In South Africa traditional male circumcision is practised among various ethnic groups such as Bapedi, Basotho , Amazulu , AmaSwati , Vendas’s and AmaXhosa . According to the World Health Organization (WHO), 30% of men worldwide have been circumcised. In developing countries where MC takes place for religious or cultural reasons (WHO: 2007a).

However the Xhosa ethnic group takes pride in the ritual and it is practiced as a representation of the rite of passage from boyhood to manhood (Anike et al, 2013). Although it is commonly practiced among the Xhosa culture literature suggests that they are challenges that plague the ritual of TMC.

The procedure of TMC involves using an unsterilized blade on one or more initiates to remove the foreskin (Ntombana, 2012). In Africa traditional circumcision is mainly performed by unqualified traditional surgeons. This lead to complications such as such as sepsis, genital mutilation, gangrenous penis, excessive bleeding, death, septicaemia, gangrene, permanent disability from complete or partial amputation of the glans or shaft, the formation of a skin-bridge between the penile shaft and the glans, urinary retention, meatal ulcers, meatal stenosis, fistulae, loss of penile sensitivity, dehydration (Anike et al 2013). Despite the challenge of the

risk of life that is associated with the practiced. The Xhosa population persisted in practising the ritual, the ritual did not lose popularity .Ntombana (2012, 23) states that even when the “amaXhosa who moved to urban areas still contextualised the traditional practice of initiation to the conditions of urban life style”. The main challenge was the existence of HIV/AIDS posed a threat to TMC as the transmission of HIV/AIDS is through body fluids and traditional surgeons (ingcibi) would use one instrument on more than initiate and that would put the initiates at risk of contracting HIV and other sexually transmitted diseases .Mavundla, et al (2009,09) states that the “country has experienced serious problems associated with the practice of this rite ranging from dehydration to death in the traditional “bush” circumcision schools.” Although South Africa has a high number of deaths associated with traditional male circumcision, young men still go to initiation school. (Kepe, 2010, Vincent, 2008a) state that “due to the complications in TMC the government introduced regulations that will govern the practice and these regulations received mixed views from traditional leaders, and the public in general”.

However, South Africa has the highest Human Immunodeficiency Virus (HIV) prevalence in the world, and statistics on deaths related to this disease bear testimony to this sad fact. According to PEPFAR (2017,05) “In 2016, the HIV disease burden is estimated to have increased, with an estimated 7,104,706 PLHIV. The majority (55-60%) of HIV-infected adults are women. Black women aged 25-34 years have the highest prevalence, at 31.6%, and highest incidence, at 4.54 percent”. In South Africa, HIV infection is driven mainly by heterosexual relationships. Medical male circumcision (MMC) became one of the key components of prevention strategies adopted for countries with heterosexually driven epidemics (Avert: 2017). As a result, men were encouraged to take up MMC as a precautionary measure to decrease their chances of contracting HIV by 60 per cent (WHO: 2017). While MMC guarantees that the procedure will be undertaken by appropriately trained and skilled medical personnel, and promises a decreased risk of HIV infection, TMC continues to offer men an opportunity to attain a well-respected masculine identity within Xhosa society and an opportunity to be schooled by the elders on traditional norms.

In 2002, three randomized controlled trials (RCTs) were directed in Africa to survey the viability of MMC in the avoidance of HIV acquisition in men. The RCTs were in South Africa, Kenya, and Uganda in 2000 -2006,(Larke, 2010: 630). The results of the RCT were that MMC reduces the risk of male acquisition of HIV. (George, et al. 2012). When the results were reviewed, they revealed strong evidence that MMC reduces the acquisition of HIV among

heterosexual men by 38% and 66% over a period of 24 months, and this reiterated the fact that there is a correlation between MMC and the reduction of HIV (George, et al. 2012). The results of the RCT confirm that indeed MMC is an effective way to reduce the infection of HIV in heterosexual men.

George, et al (2012:921) state that “a current report has shown that five years after the first Ugandan trial, MC demonstrated a balanced viability of 67% in avoiding HIV acquisition”. This demonstrates MC is successful in counteracting HIV infection. In areas where HIV transmission is mainly heterosexual, the predominance of HIV and of male circumcision are associated. More than 30 cross-sectional investigations have observed the prevalence of HIV to be higher in uncircumcised men than in individuals who are circumcised. 9 and 14 studies demonstrate a defensive impact, extending from 48% to 88%.⁹ (Bailey et al 2007).

In South Africa, the RCT was undertaken in a peri-urban township called Orange Farm in Gauteng. As shown by the Nelson Mandela Foundation/HSRC investigation of HIV/AIDS, women between the ages of 15 and 49 in Gauteng had the highest HIV prevalence rate in the nation (HSRC, 2001). Research demonstrates that women are more in danger of HIV infection than men. Additionally, peak levels of vulnerability differed amongst men and women.

French specialists selected 1998 men between the ages of 15 and 49 years for a standard review. As indicated by Cater (2013, 01) in the RCT “the men were tested for HIV, their circumcision status was determined and demographic data were collected, and they were also asked about their sexual risk behaviour, including condom use and number of non-spousal partners.” Since 2007 UNAIDS and WHO have suggested that deliberate therapeutic male circumcision (VMMC) projects ought to be combined with prevention activities in settings with high rates of HIV infection (Cook, 2013).

MMC is performed as part of the process of traditional initiation into manhood, and many acceptability problems have been reported, notably those that relate to the visible difference between MMC and TMC. For example, Xhosa initiates report mixed attitudes to combining medical circumcision with traditional circumcision. The majority of initiates stated that there was a stigma associated with being medically circumcised (Peltzer, 2008).

1.3. Theoretical framework

This study was guided by the PEN 3 Model. Airhihenbuwa formulated the model in 1989 to guide a cultural approach to HIV/AIDS in Africa, and this model details the importance of culture in health promotion, as opposed to a narrow focus on individual behavioural approaches (Airhihenbuwa, 1989). The model contrasts the behaviour of the individual in relation to family

and the community as one of the major cultural factors that has implications for health problems (Airhihenbuwa & Webster, 2004). At times there is a focus on the negative aspects of culture and how it impacts health, and health strategies usually look at health issues from an individual point of view, instead of focusing on cultural aspects that include families and communities. For example, as much as circumcision is viewed as an individual choice, within the Xhosa culture it is a cultural norm that goes beyond the cutting of the foreskin. There are many cultural expectations and norms that influence a person's decision when choosing traditional circumcision, although it results in complications and loss of life in some cases.

The PEN 3 Model comprises three dimensions that are interrelated and interdependent. These dimensions are health education, educational diagnosis of health behaviour, and cultural appropriateness of health behaviour. (Airhihenbuwa, 1989: 60; Airhihenbuwa, 1995, 28; Airhihenbuwa, 2000: 12). These are discussed below.

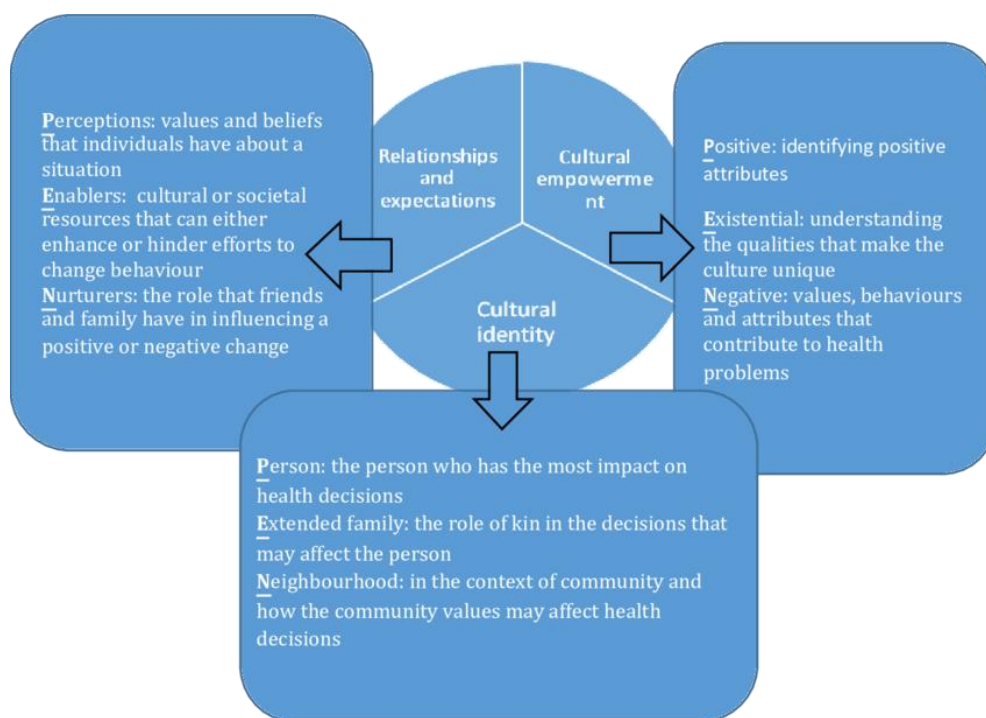


Figure 1 (Airhihenbuwa, 1989: 60; Airhihenbuwa, 1995: 28; Airhihenbuwa, 2000: 12)

“Airhihenbuwa (1989:61) states that the first dimension of the Pen-3 model is health education. The PEN acronym includes P for Person, to indicate that health education is committed to the health of every person. E stands for Extended Family. Health Education is concerned with both

the nuclear and the extended family. N is for Neighbourhoods. Health education is committed to promoting health and preventing disease in neighbourhoods and communities”

The second dimension of the PEN-3 model is educational diagnosis of health behaviour, which is used to identify which behaviour is most important and most changeable by examining the following factors:

P is for Predisposing. That is, knowledge, attitudes, values, and perceptions that may facilitate or hinder personal motivation to change.

E is for Enabling. This refers to societal, systematic, or structural influences or forces that may enhance or inhibit change, such as availability of resources, accessibility, referrals, and skills.

N stands for nurturing. Reinforcing factors that persons receive from significant others. These are attitudes and behaviour of health and other personnel, peers, and feedback from extended family, employers, and government officials (Airhihenbuwa: 1989).”

The third and most critical dimension is the cultural appropriateness of health behaviour. This dimension is important for developing culturally sensitive health education programmes for developing countries. The third dimension has the following aspects:

P stands for positive behaviour. These are behaviours that are known to be beneficial and should be encouraged

E refers to exotic behaviour. This refers to unfamiliar behaviours that have no harmful health consequences and therefore need not be changed (Airhihenbuwa 1989).

N is for negative behaviour, that is behaviours that are harmful to health and which health providers should attempt to help people change. (Airhihenbuwa: 1989).

The PEN-3 Model highlights the key aspects of health education, such as in most cases health educators focus more on the negatives of culture than the positive aspects. For example, in this case the emphasis is on how Xhosa initiates are hospitalised or die, and culture is viewed as a barrier to health. (Airhihenbuwa: 1989) observes that culture ought to be viewed as a partner and ought not to be singled out as the explanation for the failure of a health intervention. Culture is not often comprehended as something that impacts conduct. Instead strategists think of arrangements that emphasise on a person without considering the way that culture, family and group assume a bigger part contrasted with an individual. This model emphasises that there should be a focus on both negative and positive aspects of culture. The approach by the government that concentrates on the individual angle by presenting therapeutic male circumcision as restorative circumcision that decreases HIV/AIDS infection. This is acknowledged when people for whom a programme is proposed have the chance to participate in discussions around the issue (Airhihenbuwa, 1989).

1.4 Problem statement

Kepe (2010:730) states that “over the last two decades, the Eastern Cape Province has had the highest numbers of hospital admissions and deaths of initiates”. It is evident that there is a high number of young initiates that are being hospitalised which is an indication that the so called traditional circumcision is detrimental to the health of initiates if not done in a proper way. Circumcision is known as an initiation because it is seen as a transition from boyhood to manhood. Although there have been many deaths and hospitalized initiates, young initiates still go to initiation school.

The young boys go to what are called initiation schools where they are taught life lessons and about their culture and tradition. Boys are usually taught how to be heads of households and leaders in society. These things are what the medical circumcision procedure fails to address. Therefore traditional authorities feel that their culture and tradition is distorted because boys who go for medical circumcision do not fully go through the transition to becoming a man. It also shows form of masculinity when boys are in the initiation schools.

MMC was introduced not only as a means of eradicating deaths due to TMC, but to reduce HIV/STI infection among heterosexual men. The aim of this study is to investigate the challenges faced by these young men who opt for MMC as opposed to TMC.

1.5 Objectives

1. To describe the experiences of Xhosa men who opted for MMC.
2. To report on the perceived attitudes of others, such as extended family, and community members towards Xhosa men who opt for MMC.
3. To identifying factors such as knowledge, values, attitudes and perceptions that predispose them to opt for MMC.
4. To identify enabling factors for MMC among Xhosa men.

1.6 Research questions

To ensure that the objectives are met, the following overarching research questions are raised

1. What are the experiences of young Xhosa men who opt for MMC?
2. What is the attitude of extended family and community members towards those Xhosa men who opt for MMC?
3. What are the enabling factors that influenced Xhosa men to choose MMC?
4. What are the identifying values, attitudes, and perceptions that predisposed them to select MMC?

1.6 Structure of Dissertation

Chapter 2: Literature Review

In this chapter, we will outline published research on to male circumcision. We will also thoroughly explore traditional and medical male circumcision.

Chapter 3: Research Methodology

This chapter will focus on the research methodology. In this chapter we will present on the procedures that are followed to collect, code, analyse, and interpret the data. We will also include discussions of our research design, sampling methods, data analysis techniques and interpretation.

Chapter4: Data Analyses and Findings

In this chapter we will focus on the analysis and interpretation of the data that was collected. The findings of the study will be presented in a form of themes that emerge through investigation of the primary data that was collected. The analyses will be based on the data that will be provided by the participants of the research through research interviews.

Chapter 5: Discussion and Conclusion

This chapter will focus on discussion of the findings and in this chapter we will use the findings and conclude

Chapter 2

LITERATURE REVIEW

Introduction

This chapter will provide a brief background on TMC and MMC circumcision. It will first begin with elaborating on TMC as a rite of passage from boyhood to manhood. The literature will look at the procedures that within the Xhosa culture are followed in the transition to manhood. The literature reveals that those in the Xhosa culture are not the only ethnic group that practice TMC as a rite of passage in Africa. The literature reviews MMC in Eastern and Southern African countries and further explores MMC acceptability among communities. The literature also examines some of the factors that influence men to opt for MMC. The literature also deals with some of the underlying problems that are faced by initiates that choose MMC.

2.1 Traditional Male Circumcision

Globally there are 30% of men that are circumcised mostly for religious reasons and that in many African countries circumcision is carried out as an initiation ritual and rite of passage into manhood (Wilcken, et, 2010). Traditional male circumcision is usually performed in a non-medical setting and is conducted by a traditional surgeon who has no formal medical training. Govender (2013, 14) states that the national prevalence of circumcision was “approximately 38.5% of men in 2002, with most of the circumcisions taking place in non-medical settings, often after sexual debut”. There is a great variation of self-reported traditional circumcision among Eastern and Southern African countries, from 20% in Uganda to 80% in Kenya (Wilcken, 2010).

(Mavundla, et al., 2009) explained the traditional male circumcision in the Xhosa culture as follows: The procedure of circumcision within the Xhosa culture begins with the removal of the foreskin by the *Ingcibi* (Traditional surgeon). The young initiates go to live in the mountains or in the bush where they build houses called *ibhoma* where the initiates stay. During the initiate’s stay in the informal circumcision school (Mavundla et al., 2009), he is visited by the *ikhankatha* (traditional nurse) and elders. The *ikhankatha* cares for the wound by applying ointments made of herbs, and the elders teach the initiate about aspects of manhood according to the Xhosa tradition. The ritual can last for 3 to 4 weeks, during which time the initiate remains in a grass hut away from the settlement until he is healed. The elders also teach an *ukuthonta* (new language) which, on completion of the rite, the initiate may use to defend his manhood. As only circumcised men know the language, a man can therefore prove that he has

been initiated by speaking it. A man who goes through this traditional procedure of circumcision is respected in society and is accepted by society and family members and is allowed to participate in community decision making related to important affairs.

In the mountains the youthful initiates are guided by elders on cultural health, sex, and the dangers of promiscuity, and on how they should act. For many of the Xhosa it is vital that the system is extremely secretive and maintained. Inside the Xhosa culture it is unthinkable to make inquiries about what occurs during the ritual, and it is forbidden to share any information on what occurs during the initiation with women or uncircumcised men (Messner and Bulo, 2007)

Studies reveal that, despite the numerous cases of complications of TMC and deaths people continue with this Xhosa ritual. In his study Vincent (2008, 434) states that despite “the evident dangers of male circumcision the practice is by no means a dying relic, with approximately 10 000 Xhosa males circumcised yearly in the Eastern Cape”. Traditionalist continue to strongly believe in the procedure of TMC and believe that hospital admissions are a result of poorly managed procedures of TMC (Mavundla, et al., 2010).

TMC usually takes place from June to December, and during this period the morbidity and mortality rates increase complications that take place in the mountains. (Bottom et al, 2009). Circumcision is performed there was no anaesthetic, because the Xhosa culture dictates that in order for one to become a man one must endure and withstand pain which is seen as a sign of bravery (Bottom, et al., 2009). Lack of skills and knowledge by traditional surgeons is one of the reasons for complications such as dehydration or death. Traditional practitioners do not have the necessary skills and knowledge of health practices (Bottom, et al, 2009)

The Xhosa conventional circumcision has been challenged because it puts the initiates' lives in danger. However, Xhosa men still proceed with this transitional experience from boyhood to manhood (Messiner & Buso, 2007). They see the ritual as a vital part of the Xhosa culture that legitimizes a man as a man and a full individual separate from the group. One reason may be that it gives them power in society Messner & Buso (2007) state that "such power accompanies the status of masculinity which is accomplished after effectively after complying with all the requirements of the ritual. Generally, men must start to wed, to acquire property, and to take an interest in social exercises, for example, participating in cultural activities such as offering sacrificial animals and contributing to communal decisions. The privilege that is

agreed to ceremonially circumcised men is related with more prominent rights and obligations, and furthermore gives these men a higher social standing in society (Lee, 2006; Meissner & Buso, 2007)”.

It additionally gives men energy to mollify ancestral spirits because only men can address the ancestors (Meissner and Buso, 2007). Circumcision is viewed as open support for a culture's acknowledged standards of hetero masculinity (Vincent, 2008). Vincent, 2008 states that “accomplishing masculinity status offers energy to express or exercise manly characteristics. This is additionally connected with control over women. In the customary sense, as a result of sexual taboos and directions about sexual mores, men procure appropriate control and sexual articulation (Vincent: 2008).” In the Xhosa culture circumcision is a social phenomenon of building manly status and persons have to fit in to achieve manly attributes, which not available to those who do not follow the custom.

Traditional male circumcision is practiced by many among the Xhosa. Vincent (2008:05) states that despite the government administration’s attempts to screen conventional male circumcision in the Eastern Cape there is still a disturbing number of injuries and deaths among Xhosa initiates. Studies show that in 2006 there were 19 circumcision related deaths in the Eastern Cape in October alone (this excludes the December initiation season). In the same period, 63 Eastern Cape men underwent penis amputation and 562 were hospitalised (Vincent, 2008). In the Eastern Cape around 10 000 men undergo conventional male circumcision annually (Vincent: 2008).

In countries such as Tanzania traditional circumcision is practiced just like in the Xhosa community in South Africa, as in these countries TMC is also viewed as a rite of passage from boyhood to manhood. In Tanzania boys go to initiation school at between 10 to 18 years old (Wambur, 2016) The traditional procedure in Tanzania is similar to the Xhosa procedure as there is no anaesthetic nor suturing of the wound, as this is viewed as an opportunity to develop courage. The pain that is endured is seen as preparation for the outside world, where a man must be able to take on social responsibility. In Tanzania, there is also stigma against non-circumcised or medically circumcised men (Wambura, 2016). The clan leaders are the ones responsible for the implementation of the circumcision procedure to appease the ancestors

2.4. Medical Male Circumcision in Eastern and Southern Africa

Medical male circumcision is one of the oldest forms of surgical procedure in the world. According to George, et al. (2012, 921), “Medical male circumcision is the surgical removal of the foreskin (prepuce) to expose the glans penis. Depending on the country or region, MC may be a part of religious/cultural practices and rituals or a commonly practiced medical procedure.” The surgical procedure is different in medical circumcision and traditional removal of the foreskin. The reasons for the procedures also differ. TMC is seen as a passage from boyhood to manhood, whereas MMC is meant to decrease the risk of HIV infection in heterosexual men.

Sub-Saharan Africa has a high prevalence of HIV infection, and safe medical male circumcision is seen as an important strategy to prevent HIV (Wambura et al, 2011, 01). Tanzania is a country in which traditional circumcision has been practiced for centuries, MMC was introduced for this reason. There was concern around the issue of MMC acceptability in the country. Ecological studies have shown that the countries in sub-Saharan Africa with the highest HIV prevalence are those in which MC is not widely practiced (Halperin and Bailey, 1999).

On a continent whose population has been decimated by AIDS and other HIV related infections, the use of MMC for HIV/AIDS prevention has been of notable interest. The medical fraternity has been involved in research projects that focus on encouraging men to take up MMC. Research bodies and several stakeholders have been key drivers, government intervention has increased efforts and in most cases provided funds to support this cause. This procedure has been done on different scales and varying levels of intensity. An overview of MMC in Eastern and Southern Africa is therefore an important aspect of this research, to broaden the scope and have an overview of the subject.

In one study in Papua New Guinea, it was observed that circumcision does not only entail the removal of the foreskin but rather all forms of penile cuts are referred to as circumcision in this region (Kelly et al, 2012). It was found that the most common reasons for undergoing MMC is to lower the risk of HIV, and enhance sexual pleasure, as well as for reasons of personal hygiene. In Papua New Guinea many men have felt encouraged to undergo voluntary medical circumcision and they see this as a fight against HIV and some have highlighted that older women actually encourage them in their communities to go to clinics and be circumcised because it is the right thing to do for both parties if the men are sexually active (Kelly et al, 2012).

A study carried out in Zambia's Luanshya and Monze districts concluded that there were serious reservations in the community regarding MMC. Due to ignorance, many men and even women likened MMC to TMC and were therefore not fully aware of how MMC was done (Lukobo and Bailey, 2007). Efforts were made to raise awareness of the procedures involved in MMC, as well as its associated benefits. It was then that many began to see that the procedure lowered the risk of HIV and STIs and this was accepted provided the procedure was done or low cost.

2.5 Medical Circumcision and Acceptability

Research shows that in communities that practice TMC, men who are medically circumcised or non-circumcised are stigmatized. This is on the grounds that traditional circumcision epitomizes bravery, as sedatives are not used in the procedure (Mouton, 1996). This examination was directed to evaluate the acceptability of medical circumcision. Those circumcised in the formal health sector are vilified because traditional customs reward bravery. By contrast, medical male circumcision is given secretly, without pressure, and with advance advice (Lukobo and Bradley, 2012)

The differences between traditional and medical male circumcision techniques could influence the acceptability of medicinal male circumcision in traditional circumcising populaces. Statistics from the Demographic Health survey in Tanzania in 2003-2004 demonstrate that the average sexual presentation age was 18 years. These conditions gave the perfect chance to evaluate the acceptability of medical male circumcision performed before the start of sexual activity for HIV prevention in Tarime area, Northern Tanzania where the survey was conducted. In this areas, males are for the most part circumcised as young adults in the traditional settings. (Mouton, 1996) The same study demonstrates that prepubertal circumcision in medical setting was preferable in this populace. The preference of prepubertal circumcision in a medical settlings was due to the fact that the wound heals faster and there is less pain and bleeding and there is no loss of production time during the injury recuperating period (Mouton, 1996).

A study in Namibia revealed that MMC's proven ability to reduce HIV transmission by 60% is the primary reason why most men are willing to be circumcised. Other reasons include genital hygiene and correction of medical conditions related to the foreskin such as ulcers and lacerations. Men's knowledge and understanding of the relationship between MC and HIV prevention also plays a role in MMC acceptance. (Matseke et al: 2013). Studies conducted in

Nyanza Province in Kenya report that the primary reasons men chose circumcision were enhanced protection from HIV and STIs, improved hygiene, decreased risk of penile cancer, and improved sexual satisfaction for men and their sex partners. The primary reasons that men chose not to be circumcised were pain during/after the procedure, a long healing period, culture or religion, and time away from work (Matseke et al, 2013).

Although numerous studies have assessed willingness to be circumcise among non-circumcising communities, only one study has analysed willingness to receive medical circumcision in TPC communities. This study was undertaken among a population in Northern Tanzania in which 36 % had received MMC, there was nearly universal (96 %) support for providing sons with MMC. Yet a protracted struggle over circumcision practice between Xhosa leaders seeking to protect tradition and the South African government seeking to protect health of initiates indicates traditionally circumcising communities may not be unanimous in their readiness to alter circumcision practices (Chinake, 2007). One study found that traditional circumcision is preferred by BaPedi's more than other ethnic groups. Among the BaPedi ethnic group, traditional circumcision is considered the pride of the nation, meaning that the Pedi's grew up with this cultural practice and believe it must remain a part of their lives. For most of the participants, compared with MMC, traditional circumcision is not only about the removal of the foreskin, it is also a place where the initiate learns on how to conduct himself in a community and also a the rite of passage from boyhood to manhood (Setswe et al, 2015). In such communities where circumcision is embedded in cultural beliefs, acceptance of MMC option remains very low.

2.6. Stigmatization/ Pressure to go to the mountain

Research shows that in traditionally circumcising Xhosa communities there is a stigma among medically circumcised or non-circumcised men (Mentjies, 1998). Mentjies showed that men were excluded from social gatherings for choosing not to be circumcised. Another issue is that the uncircumcised need to keep on treating the customarily circumcised with a measure of regard paying little heed to their age (Mentjies: 1998). Mentjies (1998:12) stated that the "resilience of male circumcision among the Xhosa lies not in its perceived social value but rather in the social pressure on those who have not yet been to the mountain." In the Xhosa community a great deal of value is placed on traditional circumcision and uncircumcised men receive a lot of pressure to confirm from family, friends, partners and members of the community.

In the Xhosa community, only initiated men are eligible for marriage so this means that initiation is socially accepted adult status with marriageability (Messiner and Buso, 2007). A man that has gone through the initiation phase in the Xhosa culture will have a greater social standing and will be accepted by members of his family friends and the community. The process of initiation is the one that legitimises a man as a full member of the community and of his household and this is one of the important reasons that Xhosa men prefer to undergo traditional circumcision. That is, the initiation process gives them power in society as men. (Meissner & Buso 2007). Those who choose MMC experience discrimination from their family, friends and community. They are not considered as men because they opted for MMC. They are called names and are still referred as *inkwenkwe* (small boy). Although these young men opted for MMC their culture is still important in shaping who they are as young Xhosa men.

2.7. Reasons for Circumcision/ Factors that influence MMC decisions

Many factors impact young men's choice to decide on medicinal circumcision. The below are some of the contributing factors that have been found on various studies.

2.7.1 Exposure to Information about MMC

In a study conducted in Lusaka, Zambia, a large number of the males who opted for MMC mentioned that they found the information about the procedure via the media. One respondent said, "the way MMC is presented on television makes it very attractive and simplifies the procedure such that when I went for it I was not even scared, neither did I have any negative thoughts such as what if the process goes wrong" (Lukobo and Bailey, 2012) From this, one can gather that it is how the idea of MMC is presented that their choice of MMC instead of TMC.

2.7.2. Peer Influence

Considering the number of deaths recorded from TMC, and the trauma and pain involved, leads men to seriously consider if they want to go through that process. The influence of friends and peers cannot be ignored in this regard. Young men interviewed eluded to the fact that they heard about how simple MMC was as opposed to TMC. Peers play a large part in the decision-making process leading to choosing MMC (Setwake et al, 2007).

2.7.3 Spousal/Partner Influence/Sexual Pleasure

The role played by the spouse/ partner in MMC decisions is very important. One man stated: “I started to see it wasn't dangerous because my best friend from the Copperbelt did it. He even showed me. I then decided to talk to my wife about it (Wouabe and Brown, 2013).” Several studies have proved that current and future female partners, on the other hand, wielded quite a lot more influence over the men and in more diverse ways. Some have reported that their partners convinced them that MMC was safe, hygienic, and a way to make their love life more pleasurable (Wouabe and Brown, 2013).

2.7.4 Impact of Parents and other relatives

Family is a child's first socialization. Guardians fill in examples to youngsters, particularly fathers who themselves are circumcised. This helps them to urge their young men to recognize where MMC is accessible, make arrangements, and meet the expenses of circumcision (Muhangi: 2010). Although circumcision is an individual decision there are numerous different elements that impact on the choice. Muhangi (2010:06) finds that "In situations where grown-up children choose their own particular way to get circumcised, it was accounted for that they would at present look for the assessment of their folks and sometimes, other family".

2.7.5 Positive Societal Attitudes towards Circumcised Men

Men decide that they want to be circumcised at the intention stage of behaviour change. In one study carried out in Nigeria, many of the interviewed men describe explicit social pressure to become circumcised that pushed them to decide to undergo the procedure. One form of social pressure derived from individuals' perceptions that circumcision was the new norm. One participant stated: “This is an honest opinion; everyone around me has gone for it so I feel different. I was being neglected. Now I just feel like I'm doing what a man is supposed to do” (Wouabe and Brown, 2013). Society has in a way made circumcision the norm and those that do not want to be associated with the traditional route opt to undergo MMC which they see as a means to the end (Wouabe and Brown, 2013).

2.7.6 Availability and Quality of MMC Services

The Questions of availability and quality of services for male circumcision were also key in the decisions to seek medical male circumcision (Muhangi 2010). Parents of uncircumcised boys for instance reported that the key considerations they would consider before taking their sons for circumcision would include the assurance of good treatment and safety of the procedure.” It is essential to ensure that providers of MMC ensure a safe procedure and quality

service and thus that the procedure will not be detrimental to recipient's health. Access to MMC facilities plays a vital role in influencing young boys to opt for MMC. In South Africa there are a lot of NGO and government facilities that provide MMC services to the communities. MMC is free of charge in government facilities and NGO also provide the services at a no cost fee. It is cost effective and there are constant mobilisation programmes that occur in communities to encourage men to circumcise

2.7.7 Cultural Influences

TMC is an established cultural practice among traditionally circumcising groups, and therefore is usually not an optional procedure to be decided on an individual basis. The timing of traditional male circumcision, on the other hand, is a matter for individual decision. In some cases, regardless of whether the initiate feels ready to undergo male circumcision customs exist whereby sons are always circumcised at a certain age (Ahmed, 2007).

2.7.8 Role played by Religion

The biggest barriers to circumcision in certain areas of Zambia are religious. Due Some ethnic groups in specific areas, such as the Chawa and Muslim sects, view circumcision differently, and this greatly increases the number of men that take up voluntary MMC (Lukobo and Bailey, 2012) These religious groups have strong, otherwise divergent views on traditional circumcision. Many Christians have shared their views and made reference to the bible, stating that Jesus Christ was circumcised so they had to get circumcised too. (Wouabe and Brown, 2013).

2.7.9 Fear of Botched TMC

There have been several cases where TMC has gone wrong, casualties recorded, some young men have had their penises amputated, and some have had to be rushed to hospital. This has pushed a considerable number of males to opt for MMC which is considered safe and hygienic as the procedure is done by trained staff. (Muhangi, 2010).Media reported deaths and amputations of penises as a result of TMC gone wrong. In a study that was conducted in South Africa at the KT Motubatse clinic young men attested to the fact that they have heard negative reports of people being beaten and some dying by opting for MMC was a way of saving their own lives (Health E News,2014). The fear of what can go wrong during traditional initiations is a factor .In July 2014 the SA Press Association reported botched TMC that they were about 35 boys killed and another 180 that were hospitalised.

2.7.10 Fear of Promiscuity

In a research study that was conducted in Uganda by Muhangi (2010) that sought to find out the factors that influence men to opt for MMC. Among the one of the districts in Uganda in Palisa district they were fears that circumcised men and the women with whom they have their first sexual encounter after circumcision become hyper-sexually active. This myth is additionally identified with the belief that circumcised men are better at sex and therefore will be in high demand.

2.7.11. Health Benefits for MMC HIV Prevention

Medical Male circumcision according to the WHO it is an additional for the prevention of heterosexually acquired HIV infection in men (Chimuti,). The most salient reasons as to why do men undergo MMC is for health example, to reduce the risks of contracting HIV and STIs. In a research study that was conducted in Lesotho by Skolnik et al (2014) one of the participants motivated that “It is so one can live healthy even if one finds oneself in the way of diseases, they do not infect you with great intensity or create problems for you.” .Improving penile hygiene is among also one of the motivating factors among young men. According to some studies that have been conducted there is a belief that men believe that the foreskin harbours death and the removal of it the penis will be easier to bathe and dry (Bailey et al, 2007).

2.8. Traditional schools and initiation

Prior to a boy attending initiation school, there are other traditional customs that they need to participate in. An infant child needs to experience a service called *imbeleko*. This is a custom in which a goat is butchered to acquaint him with the ancestors of the clan. It is essential that this custom is fulfilled before initiation (No Author, 2014). The boy needs to likewise Undergo Ukuphondla and ukuqhawula whereby the foreskin is pulled down and the three arthesis that interface the leader of the penis to the pole are cut off. These procedures can take up to seven days to recuperate from. These procedures can be performed well before the young men go to school. Normally young men defer initiation until their late teens (No Author, 2014).

There are monetary considerations connected with the ritual, as the family needs to budget for the service depending on when the boy will attend initiation school. (No Author, 2014). Young men are told to abstain from sex for no less than seven days before initiation. The young men are not permitted to drink alcohol. It is believed that not following these guidelines may bring about negative outcomes during circumcision and recuperating.

2.9. Underlying problems faced in Initiation Schools

Problems related to initiation schools is the absence of skills, absence of supervision This is most detectable in Pondoland, where many young boys go to initiation schools and in like manner there are a greater number of reports of complexities (Dingeman et al ,2013). In any case, the whole of Eastern Cape is affected by challenges related to TMC. Lack of proper medical care post-circumcision is one explanation for casualties. Most initiation attendees have not been trained and do not have the necessary capacity to manage the initiates

Another problem is that relatives and other support groups and traditional leaders do not supervise initiation schools. This type of supervision would meant that even if complications do develop they can be recognized and tended to with the objective that no further issues arise.

Traditionally initiation schools are built far away in mountains or bushes in isolation with the general public. This makes it difficult for government officials to be accessed in terms of monitoring and when complications arise, because the construction of initiation schools. (Dingeman et al, 2013). The material that is used to build initiation schools is large plastics sheets and there is a fire that is continuously burning, the initiates lose fluids due to sweating and the water restrictions lead to them being dehydrated (Dingeman et al, 2013).

Dingeman et al (2013,04) states that “poor aseptic techniques lead to transmission of diseases such as HIV and Hepatitis B ,one single spear is used to commonly circumcise all initiates without intermediate sterilization”. Government stakeholders, such as provincial and local district authorities, often have poor planning and monitoring skills. It has been noticed that while traditional leaders do not accept liability for failed circumcisions, they guarantee that they are effectively associated with the protection of TMC (Dingeman et al, 2013).

2.10. Masculinity Concerns

Masculinity or the definition of what it means to be a man differs among individuals, and the development of this identity is dependent on family and culture, in addition to personality (Purusha:2007). Masculinity is not static, rather it changes over time. Society plays an important role in socialization notions of an ideal man. As Gennrich (2013, 06) states, in his essays **Understanding Men and Masculinities in South Africa**, “Masculinity is the dominant form of masculinity in a society....and this dominant form of masculinity is aggressive, competitive, and powerful and may even be violent compared to other forms of masculinity, because it subordinates women and other men.”. This type of masculinity we see manifest itself in traditionally circumcised males in the Xhosa community the Xhosa culture an ideal men in

the Xhosa culture. What this community recognizes as an ideal man is a man that has undergone TMC, and this society disregards and refuses to accept those who opt for MMC. Men who choose MMC are subject to rejection in society because these men do not live up to the community's notion of the ideal Xhosa man. Men who do not conform to the ideal hegemonic masculinity fall under the subordinate masculinity because, according to Gennrich (2013) these men do not live up to the community's standards of an ideal man. Real man'. Gwarta (2009) cites Vincent (2008) in his research, noting that for the Xhosa, 'becoming a man signifies that one is now eligible to marry, to inherit land and to participate in a family court'. . When a man graduates from boyhood to manhood it means that he can now participate in the family and community responsibility. The teachings that the young men are taught in the mountains equip them with leadership skills and to equip them with the necessary wisdom on how to conduct themselves as a man. Men who select MMC, according to Xhosa traditions, have not therefore fully transitioned from that rite of passage

2.11. Summary

This chapter focused on the different methods of circumcision. The literature review has tried to explain traditional circumcision and to investigate why people still undergo TMC despite the risks that they take with their lives. The literature covers perceptions and values and sacredness that is attached to the practice. The literature shows that the main reason that they undergo TMC, despite the escalating numbers of deaths and complications of initiates in initiation schools is the value and meaning attached to practice. It is not just an individual choice but it is a man's entrance into society and social acceptance.

Medical circumcision as an alternative to traditional male circumcision. In many African countries medical male circumcision has been accepted if communities do not subscribe to any type of traditional circumcision. Medical male circumcision is carried out in South Africa for health related reasons, as according to the RCT that have been conducted in Africa indeed evidence show that MMC reduces the risk of infection of HIV/AIDS among heterosexual men. The practice is viewed as being cheaper and safer compared than TMC.



CHAPTER 3

Methodological Approach

3.1 Introduction

The aim of this study was to explore and to understand the experiences of young Xhosa men in the Western Cape who opt for MMC. The focus of this chapter is to outline the methodology that is used to answer the research questions that were posed in this research study. This chapter will also outline the research tools that are used to collect data in this research study. The methodology that is used is a qualitative approach, and semi structured interviews were used to collect data. In this chapter, we will further describe the location of the study and will use maps to illustrate the study areas. This chapter also covers the limitations of the study and the ethical procedures that were undertaken in this research study.

The researcher adopted a qualitative interpretive methodology for this research. Qualitative research is designed to help researchers understand people, and the social and cultural contexts within which they live (Baxter and Jack, 2008). Such studies allow the complexities and differences of worlds-under-study to be explored and represented". Qualitative research allows the researcher to understand how the subjects perceive their own situation and their role within a certain context. Qualitative data is rich in detail and the role of the researcher is to actively engage in the making of meaning from the text or with the subject under study (Berg, 1995; Henning, et al.; 2004; Gergen, 1982).

The advantages of using a qualitative research method is that it provides rich detail and detailed descriptions of the participants feelings, opinions, and experiences, and also interprets the meaning of these actions.(Rahman,2016). In qualitative research, the researcher is able to discover participants' inner experiences and the interpretation of that particular experience. Malisha (2005, 31) states that "qualitative research expands the range of knowledge and understanding of the world beyond the researchers themselves". This often assists the researcher to gain an insight into why some things are the way they are. Lastly, qualitative research (an interpretive approach) can be constructed and reconstructed, and this makes it flexible. This approach gives participants a platform to construct their own experiences.

3.2. Constructivism/Interpretive Paradigm

This research study was guided by the constructivism / interpretive paradigm. According Piaget (1973, 05) "Constructivism is a theory of knowledge that argues that humans generate knowledge and meaning from their interaction between their experiences". The constructivist paradigm is not concerned with the objective and quantifiable. Rather it is subjective and contextualized and esteems sentiment. Kelly has said we are different because we perceive external events through our constructs (Kelly, 1999) .People may experience the same thing but the way in which they interpret it and what each experience means for them is unique. Constructivism is built upon the premise of a social construction of reality (Searle, 1995). Each person's constructs will be different (Glaserfeld, 1990)

The researcher choses the constructivism/interpretive paradigm because this theory is most suitable for the research topic. It allows each of the participants to synthesize their own perceptions of their reality based on their experiences. Glaserfeld (1990) states that, when it comes to the constructivism paradigm, no one individual can ever know how many possible constructs can exist. The researcher also uses the constructivist paradigm in this research because each experience of the participant is unique and their construction of it will also be unique. Learning or significance develops through cooperation amongst people and is depicted as co-built; it cannot be watched specifically yet should be translated (Kelly,1999). The constructivist worldview is therefore subjective because it depends on the researcher's understanding

The interpretive approach seeks to give meaning and understanding to the world. The purpose of interpretive analysis is to ensure that a rich description is provided characteristics, processes,

transactions, and contexts of the phenomenon that is being studied (Geertz, 1973). One of the advantages of this approach is that it allows the participants to detail their experiences. Constructs, may be conflictable and incompatible, meaning that people may experience the same thing but they will not interpret it the same way. This does not mean that their interpretation or construction of their experiences is wrong or right. Another critique of the constructivist paradigm is that the constructivist approach is subjective. A person's experience is interpreted according to their individual understanding.

3.3. Location of the Study

The study was conducted in the Western Cape in the City of Cape Town. The researcher worked with an organization called CareWorks to recruit the relevant participants. CareWorks is an organization that provides HIV/AIDS treatment and workplace programmes in South Africa, and has a programme for MMC. The researcher chose Cape Town as young Xhosa men, originally from the Eastern Cape, commonly choose to work or to study in Cape Town. Bekker (2001-2002,01) states that, in South Africa "circulatory migration is a norm practised as regarding the city of Cape Town receiving rural migrants from Eastern Cape in seek for greener pastures". In the research study conducted by Bekker states that most of Xhosa speaking people in the Western Cape involved their origins of their roots in the Eastern Cape.

3.4 Delineation

The participants in this research come from areas in Cape Town Metropolitan Municipality. They are from Gugulethu , Khayelitsha ,Langa and Observatory .The selection criteria for participants is young Xhosa men between the ages 18-35 who have been medically circumcised in the past two years . The findings of this research are based on the interpreted experiences of the young Xhosa men that have undergone MMC in the Western Cape and have been selected for the study.

Figure 3.1 Regional map illustrating the study area within the Western Cape.

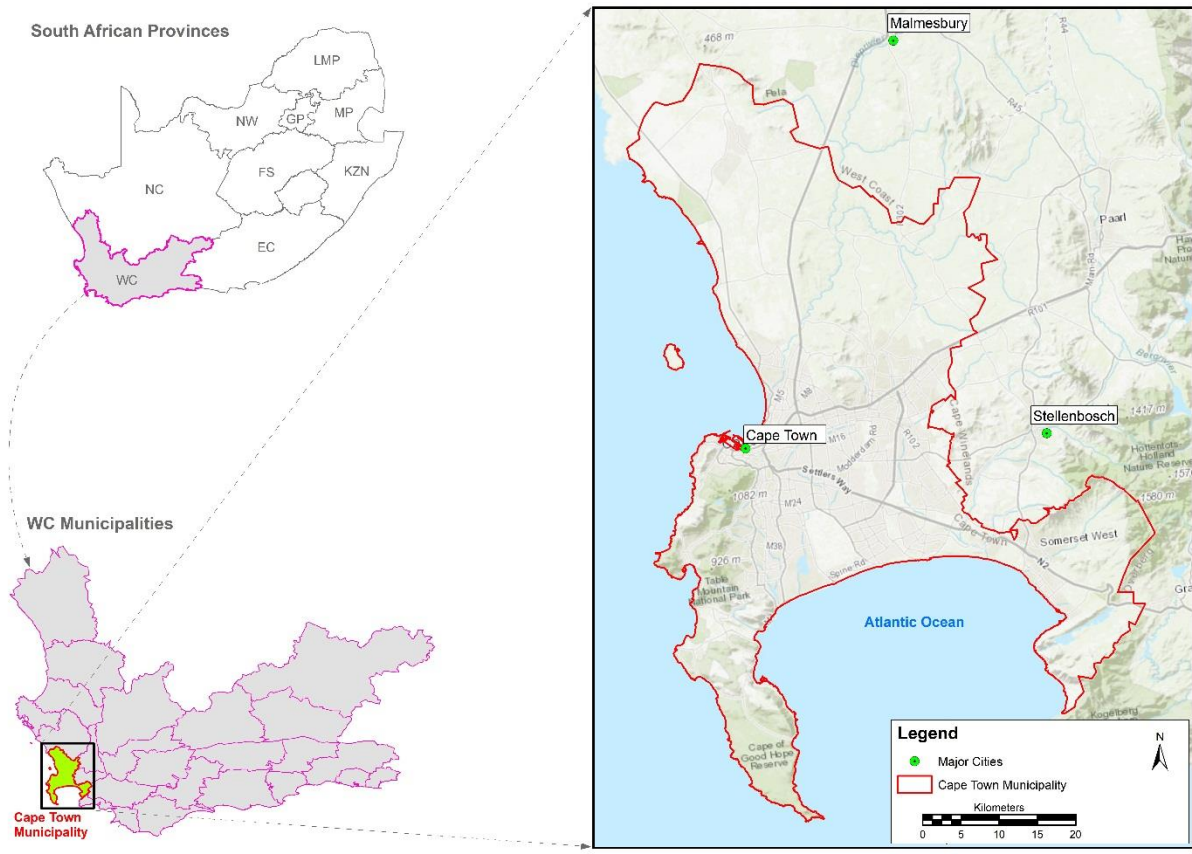


Figure 3.1 shows a map of South Africa on the left-hand side. It also shows where the province of Western Cape is situated in South Africa. As revealed here, the Eastern Cape is close to the Western Cape and this could explain the migration from the Eastern Cape to the Western Cape. The map on the right, which is the locality map, shows the city of Cape Town in the Western Cape.

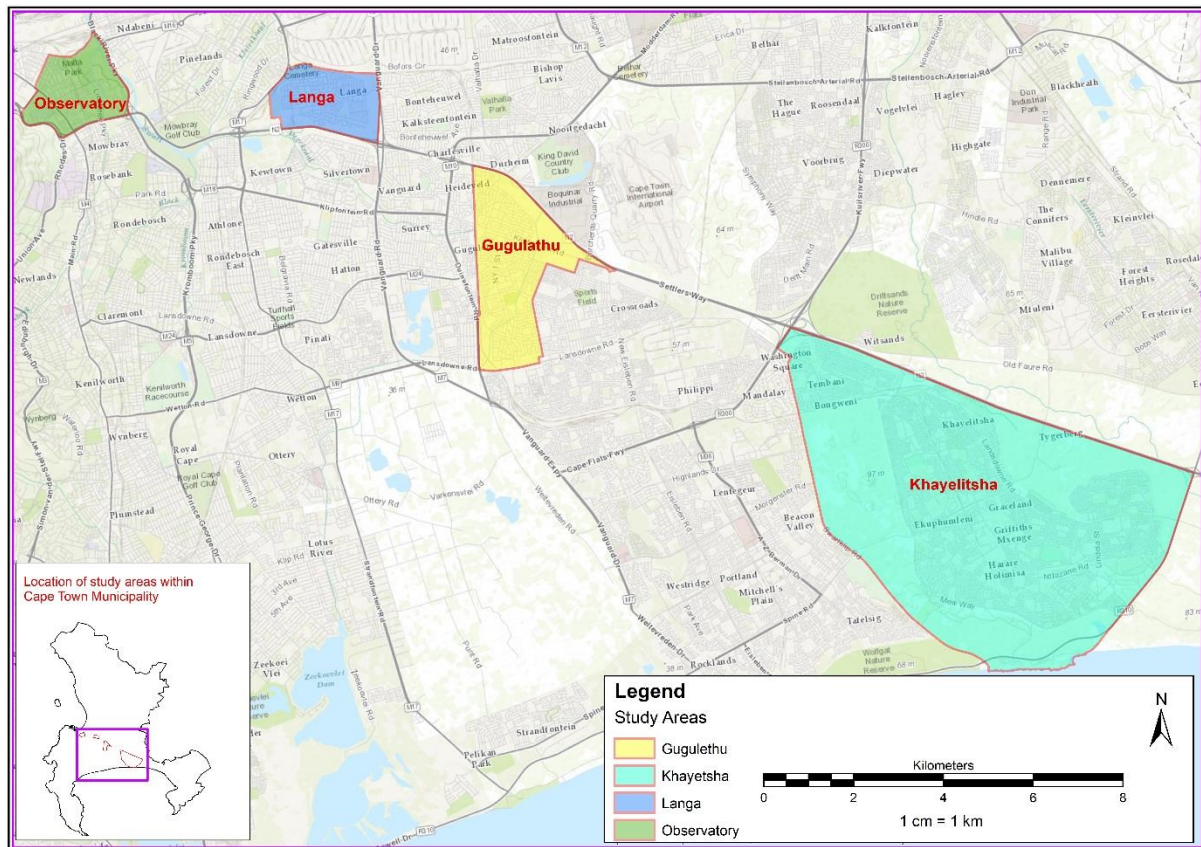


Figure 3.1.2 shows the specific areas in Cape Town in which the participants come from.

3.5. Sampling

According to Creswell (1998:110), sampling is the process of finding people or places to study, to gain access to study, and to establish a rapport so that participants provide relevant data.

3.6. Purposive Sampling

Purposive sampling, which is also known as judgmental sampling, is a method whereby the researcher uses his/her own discretion to select the participants to take part in a study. This method does not rely on any probability but rather the interviewer carefully selects respondents. (Saunders et al, 2012). In this research the researcher made use of purposive sampling and selected Xhosa men between the ages of 18 and 35 years who had undergone MMC. For the purposes of this discourse, these research participants were chosen because they are a perfect fit with what the researcher sought to find out, which is the experiences of Xhosa men who have opted for MMC, as opposed to the more culturally accepted TMC. Purposive sampling is an effective method when there are a limited number of participants who can serve as primary data sources, due to the nature of the research and its objectives. Purposive sampling is reliant on personal judgment and careful selection.

It is worth mentioning some of the advantages and disadvantages of purposive sampling. It is cost effective and saves time. Purposive sampling may be the only suitable method in instances where there is a limited number of participants who can serve as primary data sources because of the nature of the research. One of the disadvantages of purposive sampling generalization. Since there is a limited number of a participant, these will serve as a representation, yet this does not do justice to the topic, because every case is unique (Saunders et al, 2012).

The sample criterion will be based on young Xhosa men who have undergone MMC in the past two years. These young men were introduced to the researcher by the organization. The organization has various programmes including a male circumcision programme that falls under the HIV/AIDS programme (Purusha, 2017). The researcher interviewed participants referred to her by CareWorks. The participants were selected via the database of CareWorks that were representative of the characteristics that the researcher was looking for young men that have been medically circumcised in the past two years. The participants were first approached by the CareWorks coordinator who asked them if they were interested in the researcher study. Only when they have consented have an interest in the study that is when they were introduced to researcher.

3.6. Interviews as a tool for data collection

Interviews are data collection methods that involve oral questioning of respondents, either individually or as a group. We used semi structured interviews as a technique to collect data from respondents. Although the questions were standardised, we had some discretion concerning the order in which questions are asked, and used probes to follow up on ideas introduced by the respondent and to gain clarity. Semi-structured interviews are often used when the researcher wants to delve deeply into a topic and to understand thoroughly the answers provided (Harrel and Bradely, 2009). Qualitative methods are particularly suited to examining individuals within their cultural frameworks (Morrow et al, 2001). However, this attention to culture does not happen automatically and must be clearly defined as a primary lens through which the researcher conducts their investigation. It is therefore important for the researcher to always be aware of culture, context, and rapport.

3.7. Data collection

Interviews as data collection tool

The interviews were conducted in Cape Town at the CareWorks offices by the researcher. The fieldworker of CareWorks recruited the willing participants to be part of the study. The sample

criterion was to include young Xhosa men between the ages 18-35 years Xhosa men who have undergone MMC in the past two years. Participant gave consent before starting the interviews, the researcher went through the procedure of telling and allowing the participants to sign consent form that were available in both IsiXhosa and English. The language used in the interviews was isiXhosa because it was useful in gaining insight into participants' perceptions and values. Conducting the interviews in their home language gave the participants a chance to express their experiences without a language barrier. The young men predominantly come from townships around Cape Town and these areas are living spaces plagued with high unemployment and crime. The initial sample size was 10 participants but one participants participant dropped out and only 9 participants participated in the research study. The reason that the researcher chose the initial sample size was because of the nature research. MMC is a sensitive topic and few Xhosa men choose MMC. There were therefore not many participants available. Participants received reimbursements to cover their transport costs.

After all the interviews the researcher transcribed all interviews verbatim and used notes that were taken during the interviews.

3.8. Data Analysis

Thematic analysis was used to analyse the data. Thematic Analysis is an approach to dealing with data that involves the creation and application of 'codes' to similar responses (Gibson, 2006). Although thematic analysis is critiqued for its lack of scientific rigour and credibility, the method was best suited for this research, as it provided a means by which common themes from men's experiences and understandings of how their options of MMC influenced their socio-cultural experiences (Horsburg, 2002). The transcripts semi structured interviews were transcribed and then translated precisely from audio recordings. The researcher went through all the semi structured interviews and was able to identify recurring themes and look for similarities, differences and meanings among themes to group them together. By doing so the researcher was able to identify themes and this assisted in describing the data in rich detail. The researcher ensured that they read the transcripts more than once of each interview to ensure that they covered all points of interest.

The researcher then noted down all the themes that emerged from the data. The data was first reviewed without coding and this assisted the researcher to identify emerging themes without losing the connections between the concepts and their context (Bradley, Curry & Devers, 2007). The researcher then coded the participant's responses according to the themes that were

identified. Coding is a method used to develop a theoretical conceptualization from the data (Brod, Tesler, and Christensen, 2009). The researcher went through each interview repeatedly with open coding until nothing new came up, and this assisted for some codes to stand out.

3.9. Ethical considerations/Confidentiality

This study was approved by the University of KwaZulu Natal Humanities Ethics Committee and follows their codes of conduct and ethics requirements. Kvale (1996, 115) states that “confidentiality in research implies that private data identifying the subjects will not be reported.” In this study the consent form clearly states that the information shared will be published but that the researcher will ensure that the identity of the participants is protected. The researcher received a gatekeeper’s letter from CareWorks that permitted the researcher to recruit participants from those that work with their organisation. Thereafter, the participants were contacted by the coordinator and told about the study and those who agreed to participate were referred to the researcher. Goodwin (2014) emphasises that “confidentiality is the major safeguard against the invasion of privacy through research”. To keep things confidential means not to disclose the identity of participants. It is the role of the researcher to ensure that they make it clear from the beginning of the research what confidentiality means in qualitative research. The researcher used pseudonyms as a way of protecting participants’ identities. The researcher ensured that during the interview process the real names of the participants were replaced with pseudonyms. The first step was to replace names with pseudonyms. The researcher provided the participants her contact details in case they required feedback. The researcher abided by ethics principles of integrity and honesty and ensured that the identity of the participants is protected.

3.9.1 Informed Consent

The participants were given consent letters containing the relevant details of the research in IsiXhosa. The consent form highlighted that the information collected will only be used for research purposes. The participants were given an opportunity to ask any questions if they needed clarity on anything pertaining the research. The letter informed them that they had the right to withdraw from the study at any time. The informed consent letter provided details of the UKZN Ethics Board, the researcher, and her supervisor. The letter informed them that they had the right to contact The UKZN Ethics Board if they had any concerns about the study or the researcher. Each participant signed two copies of the consent form, one for the researcher and the second one for them to keep.

3.10. Trustworthiness

There have been many critiques are reluctant to accept trustworthiness of qualitative research (Shenton, 2004). To allow transferability of the research the researcher ensured that they provided sufficient detail of the context of the fieldwork so that the reader can be replicated or if the findings can be justifiably can be applied to other settings.

Ensuring the reliability means that if the work was replicated in the same context with the same methods and the same participants the results would be the same. The nature of qualitative research is not concerned with using fixed instruments. In qualitative research we are more concerned with reaching authenticity than realizing a single version of the truth. In this research the researcher will analyse the responses about the respondents' perceptions. However, for this study the researcher also ensured that she provided a detailed description of the research design and its implementation. This will give enough information to anyone who wishes to replicate the study.

The researcher ensured that any changes or developments that arise along the journey of this research would be communicated with the participants and her supervisor. The researcher ensured that the correct information was circulated and known to the relevant parties

3.11. Summary

The researcher used the qualitative method because it provided for an in-depth understanding of the phenomenon being studied. A total of 9 Xhosa men between the ages 20-29 who had who had undergone MMC within the past two years were recruited to participate. Semi-structured individual interviews were used to explore men's understandings of their masculine and cultural identities in relation to their decision to choose MMC. Thematic analysis was deemed the most suitable tool of analysis in this research study The ethical considerations were explained in detail to ensure participants' understood about confidentiality and consent, the nature of the research and the importance of their participation in the study.

CHAPTER 4 - FINDINGS

4.1 Introduction.

The purpose of this chapter is to summarise and present results derived from the data collection, as well as discuss the relevance of said data within the context of my guiding research questions. As mentioned earlier, in this research the thematic approach was used. Therefore, in this chapter, we discuss how we categorise our findings into themes that were identified throughout the interviews.

Participants attested to living in what could be defined as developed urban or suburban areas. All the participants live in locations dotted around Cape Town despite South Africa being an Upper-Middle Income Country, the economic and geographic landscape of the nation is characterized by “sharp dualisms.(Carter & May,1997:1).Evidence of this economic dichotomy was present in my sample, eight had stated their residences were in established townships, otherwise known as ‘locations’. South Africa’s townships, or ‘locations’, can be defined as “areas that were designated under apartheid legislation for exclusive occupation by people classified as Africans, Coloureds and Indians (Lester et al. 2009: 6).” Research shows that forty percent of all South African households are in townships, and conditions within these underdeveloped urban areas have “remained uncomfortable” despite the advent of democracy and end of apartheid in 1994 (Bond, 2008: 406; Lester, et al. 2009).This is evident in this research where most participants live in locations such as Langa, Gugulethu, and Khayelitsha which are known as high density areas.

In this section, each theme shall be extrapolated upon by referencing key excerpts and findings, and by exploring participant’s knowledge within the theoretical framework. An examination of these characteristics aims to help contribute toward a more holistic framework of data representation.

4.2 Demographic Variables

In addition determining the participants’ age, and level of education, questions also aimed to shed light on the physical conditions that men live under, as well as each individual’s access to health care facilities. The young men were aged 20- 29. These young men have been circumcised in the past two years. They come from townships around Cape Town in the Western Cape. Most of these men are employed, apart from one participant who is still a student.

Demographic Variables of Participants

Participant	Age	Education	Employment status	Marital status	Location
Zack	20	Undergraduate	Unemployed	Steady relationship	UCT residence
Gerard	22	Matric	Employed	Single	Langa Township
Siphamandla	22	Matric	Employed	Single	Gugulethu Township
Mayihlome	23	Grade 10	Employed	Single	Langa Township
Zamani	23	Matric	Employed	Single	Khayelitha Township
Siya	23	Matric	Employed	Single	Khayelitha Township
Mike	24		Employed	Single	Langa Township
Themviso	26	Post school completed	Employed	Single	Langa Township
Mike	29	Post school completed	Employed	Single	Gugulethu Township

4.4. Access to Health Care

Looking closer at the aspect of health education brings to light another important physical feature, namely, access to health care facilities. Ease of access to clinics and hospitals can influence the extent to which individuals come into contact with health-related information on MMC as well as other issues. The key driver explored within this theme related to individuals' access to healthcare in their residential environments. The respondents mentioned they did not have any trouble accessing a hospital or clinic where MMC was done. Gerald said he heard of

MMC from Groote Schuur hospital. None of the respondents said that they had problems accessing health care facilities.

4.5. Health Benefits of MMC

There are many underlining factors that influence a young man's decision to opt for medical circumcision. Male circumcision provides a degree of protection against acquiring HIV infection (Auvert et al, 2005). Research studies reveal that MMC reduces HIV transmission by approximately 60% among heterosexual men in Sub Saharan Africa. (Auvert et al, 2005). The findings reveal that one of the main factors that encouraged the young Xhosa men to opt for MMC are the health benefits that are associated with MMC .The young men were well aware of the health benefits and attest to the fact that that is why they chose MMC. In addition, studies have shown VMMC to be protective against some other sexually transmitted infections (STIs) in both men and women. VMMC has been found to reduce the risk of herpes simplex virus-2 in men (Tobian et al, 2009). The three randomized trial studies that were conducted in Sub Saharan Africa show that MMC reduces HIV infection by 60%.

“For me personally it was for hygiene purposes and the health benefits, it reduces chances of getting HIV/STI's by 60%. Knowing that the procedure is done by a professional medical practitioner. Having to do the procedure at a hospital with trained professionals is amongst the reasons that influenced my decision to opt for MMC.”(Sipho)

“The benefit is to live a healthy life, to prevent ourselves from diseases like HIV/AIDS and STI's and so forth” (Siya)

“You are protected from STIs and limited chances of being infected with HIV.”(Thembisolo)

Considering how dominant traditional circumcision is, each of the participants interviewed highlighted that the health benefits of male circumcision in reducing HIV and STI risk was the strongest motivator of their decision to undergo the procedure.

4.6. Media as tool to Information on MMC

In the face-to-face interviews, the young men admitted to getting information about MMC from the media. Some got the information from television adverts, and from social networks such as Facebook and Twitter. The Brothers for Life campaign was shown to be one of the most influential campaigns that encouraged men to opt for MMC by presenting the health benefits associated with MMC. This shows that being exposed to the correct information about MMC

benefits is a leading factor that influences young men to opt for medical circumcision over TMC.

The respondents interviewed in this research were quick to mention the major reason they opted for MMC was it was safe, because it was done in a hygienic setup, executed by professionals, and thus the chance of errors is very slim in comparison to TMC. One respondent said

“I used to watch TV, especially the season from November until January and heard that there are many initiates that die in certain rural areas, and I processed this thing because it would be me one day who dies there. So my mother didn’t mind that I chose MMC to protect my life because deaths occur there, it’s a matter of life and death. I chose MMC because it’s safe and safety is important.” (Zack)

4.7 Meaning of Traditional Circumcision

This theme talks about what it signifies to be a Xhosa man in the Xhosa culture as it has been stated earlier in the research study. The only route through obtaining manhood in the Xhosa culture is through the rite of passage . In Mavundla et al 2009 states that only when a man has gone through the rite of passage only then he is legitimized as an active member of the community or household, they are able to inherit and also to get married and be head of household.

4.7.1. Initiation School meaning of being a man

All participants agree that traditional schools are a source of knowledge and build certain characteristics in young boys.

Siya said that in initiation schools “boys are taught manhood, how to behave in community and what is expected from him as a man, when he leave the initiation school he need to know and understand what is expected from him as a man”.

The respondents expressed concern that through their choice of MMC they miss out on getting important teachings about manhood and responsibility, which are only taught in initiation schools. One respondent noted that there is a certain language that young men are taught in the initiation school and this language is taught nowhere else. Those who underwent MMC are ignorant of the language and feel like they do not have the right stature in society since this language and these lessons about manhood are only acquired through initiation schools.

“The difference between the man who went to medical circumcision and the one who went to traditional circumcision is the language they speak, there’s a men’s language that you speak

from the mountain, whereas if you are from the medical circumcision, you do not know the language. The man from the mountain receives teachings. If you did a medical circumcision, you do not get the teachings from elderly people. So, you miss out on important teachings that can help you to be a better man.” (Mayihlome)

There are teachings that the young Xhosa men who go to the mountain. They have a certain language that they speak it called *isidoda* (man language). Young men who are not traditionally circumcised would sometimes be asked to pay a fine.

“To me it means if I have things that I am supposed to get, I do not get, like when there is a boy who did traditional circumcision and we meet, he will ask if I am a man, and I would say yes, and he would ask how it is that I am a man is. It is where then that I need to explain but I would not know because I was not taught in medical circumcision. If I don’t know how to explain, I would get fined by him, a beer or I give him my blazer jacket.” (Gerald)

4.7.2. Importance of TMC

All the participants in the study were Xhosa medically circumcised men and even though traditional male circumcision is part of their culture they opted for MMC because for them it presented better options, as outlined in section on the Health benefits of MMC.

The respondents mentioned that for them it is not only about manhood, but rather the way TMC is carried out that pushed them to go for MMC.

Siya mentioned that “TMC makes us (Xhosa speaking people) who we are, and if you are not circumcised you will never be accepted as a man and it will always follow you up until you die, it does not matter where you stay”. He went on to state “whether you stay in the location or in the rural areas culture is culture, it will not change. People think that if you are coming or staying in a more urban setting there is no pressure to be traditionally circumcised, but they are wrong because your family values and traditions do not change, and our roots are still in the Eastern Cape. Our customs and way of life is deeply enrooted within our families.”

All respondents noted that those who were traditionally circumcised are the ones who are recognized as men and can take their rightful role and responsibilities within the communities and their homes.

“A real man within the Xhosa is the one that is traditionally circumcised in the Xhosa culture.” (Mike)

“Your family and the whole community at large do not recognise you as a man if you are medically circumcised you are not treated with respect. You are not recognised as a man if you do not follow the prescribed procedure of how to go through the rite of passage from boyhood to manhood.” (Zamani)

“A man in Xhosa culture is a person that went to the mountains or bushes to get circumcised anyone who does not do that is not considered as a man.” (Mayihlome)

4.7.3. Ancestors - more than the cutting of the foreskin

Another theme that emerged is that in traditional circumcision practice there is a link between the initiates, his family and the ancestors. Thembisio said that when a young man leaves for Initiation School they first have to go to the kraal and communicate with the ancestors. He also stated that throughout the whole procedure there is constant communication with ancestors he saw when his older brother after 7 days in initiation there was a ceremony called *sinojisa* (a ceremony done after seven days at the initiation school, in which initiates are given water). He furthermore stated that in MMC you do not connect with your ancestors in any level you just go to the healthcare facility. There is no ritual that is conducted to ask ancestors to protect your safety during the medical procedure.

This is meant to keep the ancestors informed and to ask them for guidance and protection of the initiates. Communication with ancestors plays an integral part in circumcision from the beginning until the last step of the initiation, for guidance and protection through the whole process. One can clearly see that to the Xhosa people, TMC is not just about cutting of the foreskin but has a broader cultural meaning. The respondents in this research pointed out that even though they feel they have not been accepted by the ancestors and society, they feel this does not bring any bad omen to them and strongly believe they can equally make it in life.

“Traditional male circumcision is not just about cutting of the foreskin, but it is also about connecting with your ancestors as being the only one in the family that opted for MMC I feel like I have broken a connection with my ancestors my father questioned me if is this what I will teach my children by throwing away our culture or is it just my decision” (Mayihlome)

“Unfortunately in a sad way to say that the traditional circumcision comes from our ancestors it a chain or a cycle that is forbidden for somebody to break or do otherwise. So I would say partly yes you are not considered as a man.” (Zamani)

“MMC is safe, but you lose your ancestral connection because you don’t do things the correct way.”(Thembiso)

Mbithi sees the method of conventional circumcision as emblematic of disposing of adolescence and preparing oneself for adulthood (Mbithi 1986) .Mbithi (1986: 10) states that "the starts is viably entering a concurrence with his kin once he has shed his blood, he joins the flood of his kin and surely turns out to be genuinely one with them". This is the tribal association that is a close need to interface with their ancestors. He goes on to state that start goes about as an extension between a prior phase of life and the profitable grown-up phase of life, and that ancestors on the grounds that their authorize of the procedure are effectively looked for as a feature of its execution (Mbithi, 1986). The slaughter of a sacrificial animal such as the goat or cow sties the individual to the land and subsequently to the ancestors (Momoti, 2002)

4.10 Societal Ridiculing

Considering the fact that TMC is has still is strongly preferred method of MC circumcision among the Xhosa men. The participants discussed at length the discrimination uninitiated (i.e., uncircumcised/medically circumcised men) males receive from the community. All the participants stated that they have received orchastrazation from family members and community at large .The participants mentioned name calling, social exclusion and loss of friends as some of the ways in which they received societal ridiculing.

4.10.1. Name-calling

The exclusion of medically circumcised or uncircumcised males is constantly reinforced through name calling in its constant repetition takes on the mantle of ritual. According to WHO (2008,47) states that “the image evokes the idea that the uncircumcised male is not yet fully human and cannot be regarded as capable of moral behaviour or moral responsibility. Such a person has limited rights because they are not yet a fully functioning member of human society.” The participants expressed how they were called derogative words based on their manhood. Gerald said he is called *ilulwane* (bat) this is a derogative term that implies that they are half man.

“They say that I am ilulwane (bat) because I am half man not a full man.” Gerald

The most common name calling is being called *inkwenkwe* (small boy). Before a young Xhosa man undergoes TMC he is called *inkwenkwe*, and when he comes back from the mountain he

is referred to as *indoda* (man). The change in the name is an indication that they have graduated from boyhood into manhood. The discrimination and name calling has led to initiates sometimes regretting the decision that they took to opt for MMC. The emotional impact of name calling on these young men is detrimental, although they view themselves as men.

“My sister, I went, but I did not hear a thing, but I went my sister because I wanted to be circumcised. Sometimes my sister I regret because I don’t rest thinking about it. In reality my friends are silly but myself I feel that I am a man just like them. My father insults me because I did MMC, it is not nice to be insulted.” (Gerald)

*“They have a really bad attitude. They exhaust me because there is this name they call me they say I am **notyofela** (weak).” (Thembiso)*

*“This is a hard one it usually like a private thing so even if you go back to your community how will they know, no one really knows, the hardship is being treated like a boy even if you won’t show it to the world that you have medically circumcised so like you taken as a boy they say **uyinkwenkwe** (small boy) if you didn’t go to the mountains.” (Zamani)*

Name calling reinforces the social exclusion that medically circumcised men experience. The names that they are called belittle them and threaten their masculinity. According to the Head of the Congress of Traditional Leaders in the Eastern Cape, Mwelo Nonkonyana men who opt for MMC are called *abadlezane*, which translates to (a woman who gives birth in a hospital ward (Cape Argus, 10 December 2003). These men are not considered as men they are deemed to be equivalent to being women.

4.10.2 Social Exclusion

Young boys face enormous pressure to go to the mountains. Peer pressure, avoiding being called cowards, avoiding being ridiculed and harassed, pressure from women and older people to maintain tradition, and the desire to gain respect feature strongly in the self-reported motivations of Xhosa males to be circumcised (WHO, 2008).

Uncircumcised or medically circumcised men experience ostracism by traditionally circumcised men and also their families and community members. The participants reported that they were excluded from traditional family gatherings. The social shunning of medically circumcised males reiterates the difference. For example, the participants mentioned that they are excluded from traditional rituals (*iteko*) as they are not allowed to sit in the same area as

men who are traditionally circumcised. Traditionally circumcised and non-traditionally or uncircumcised men are not even allowed to interact with each other. Bottoman and Tenge, 2006) find that uncircumcised males are psychologically traumatized as a result of the ridicule and harassment they experience at the hands of peers and elders.

“No ways, you are excluded even in cultural gathering or community gatherings they pick on. You just have to keep quiet that’s all. You are just excluded like that, it’s like being gay as there’s nothing for you, no one cares and you mistreated.” Siphamandla

**tears roll down* “They discriminate me during occasions, and isolate me, and I feel small about that when they chase me away, because I am like them.” (Mayihlome)*

[I was worried, feeling guilty about what I have done. Some ended up accepting it, but I get treated badly during occasions that separate men and boys. That is where my problem is. (Zack)

There is a norm of secrecy associated with the ritual of TMC in the Xhosa culture. Traditionally circumcised men will chase away uncircumcised or medically circumcised men because they say they want to speak *izinto zamadoda* (things concerning men). Siphho mentioned that *“When there are ceremonies I am chased away or they say I must not sit with amadoda (men)” (Siphho).*

The secrecy surrounding Xhosa traditional circumcision means that it is taboo to discuss any details related with TMC with outsider’s wives, uncircumcised men, or medically circumcised men. Anything that happens in the mountains is a secret and should not be discussed. Thus this notion of always separating traditionally circumcised men from others, which reinforces the social exclusion of non-traditionally circumcised men.

4.10.3 Loss of friends

Stringent age-amass progressive systems are seen in Xhosa society. Young men tend to stay within their age groupings, and frame kinship bonds inside those groups. Attitudes to circumcision are disruptive of these bonds, since an uncircumcised male will no longer be accepted in a group of circumcised males even though they may be of similar age and were once friends (WHO, 2008). Vincent (2008:439) states that “there are reports from the field of public health documenting the trauma experienced by uncircumcised or medically circumcised males who are harassed by their peers. In the research findings the participants expressed that they have lost friends based on them opting for MMC. Within the Xhosa culture when a boy goes through initiation, he has to leave behind all things from his boyhood.

“It is being mistreated, because you are not what they call themselves and that they are real man and all that. I had to make new friends and not entertain all that they were saying.” Siya

“It was difficult, I had to understand because opting for MMC that was part of the sacrifice. So I knew that things would be different because we were all circumcised in the same year. I am just the only one that opted for MMC. When we came back I knew things will never be the same. I had to understand because opting for MMC was part of the sacrifice. So I had to know that it will be different”. (Siphamandla)

These are some of the responses that participant gave when they were asked about the attitudes of their friends to MMC. The participants expressed how they had lost friends due to their decision to choose MMC. In the Xhosa culture it is believed that a man and a boy cannot be friends. This is because boys who are traditionally circumcised hold some sort of higher social status. Even the language that they speak when they come back from the mountains is different. They therefore feel that they can no longer be friends with those who chose MMC. This is a way of maintaining the traditional customs of the Xhosa culture (Mavundla, 2009)

“Too personal. You can no longer stay with them. There are these conversations they have when they come from the mountain, so you cannot get involved in those conversations.” Zack

“They said they will never do MMC but TMC. So I lost my friends, it’s just greetings. We fight because we took different ways of circumcision. Like they say I’m not a man, I am still a boy because I did MMC. ” (Mike)

4.11 Views about TMC

Although the participants have undergone MMC as opposed to MMC. The findings show that at least all the participants known or have heard of incidences whereby there have been young boys that have experienced botched penises and the treatment of initiates in initiation schools. All participants cited media as a source of reporting complications with TMC.

4.11.1 Treatment of Initiates in Initiation Schools

The participants showed concern about the treatment that traditionally circumcised men receive. The treatment of initiates was one of the underlying issues that lead to the deaths in initiation schools. The procedures that a young man who opted for TMC has to go through, include going without water for the first few weeks of the surgical procedure and this leads to dehydration. The strict dietary rules include that they should not drink water or eat salty foods. This is an attempt to limit urination as it will be painful after the cutting

of the foreskin. The beating of initiates as a way of disciplining them may cause complications should they sustain injuries, with beating resulting in death in some cases. The treatment of initiates in initiation schools contributes to why the young men chose MMC, because it guarantees their safety and wellbeing.

“ The problem, my sister, people die on the mountain because they are beaten and also get dehydrated. In MMC you do not get beaten, you drink water; you are allowed to drink water” (Zack)

“My sister, I can say it is right to do MMC because you do not get beaten up. My friends spoke about being teased and beaten, while in hospital you do not get beaten” (Gerald)

4.11.2. Complications and Concerns about TMC

All participants in the initial stages of the interviews stated that the reason they chose MMC is because they know and have heard several cases where some young men have experienced complications which resulted in them being hospitalized and their penises amputated that results to deaths due to botched traditional circumcision procedures. The respondents alluded to the fact that since TMC is done by older Xhosa men who have not acquired any formal education but only rely on experience, the probability of casualties is high. The procedure does not involve any suturing, thus healing takes long. Dehydration is a common occurrence during the procedure of TMC.

The respondents believed that in areas where death has occurred because of traditional circumcision, it is because traditional surgeons are doing circumcision without the involvement of elders and community leaders. They also placed the blame at the door of parents who do not take interest in their children's health.

Sipho said “what we normally find is that initiates die in areas where parents do not take interest in their child circumcision and send just anyone”. All respondents noted that they have heard of several complications in traditional circumcision schools and noted that some were very serious.

“The TMC that year, I heard that in Eastern Cape there a lots of deaths because of TMC. It like this, my parents are from Eastern Cape but I grew up here in Cape Town, I heard that there are deaths that time I was young so I didn't go to Eastern Cape for TMC. It is one of the reasons I opted for MMC.” (Thembiso)

“Yes because there in the mountain you can get diseases because when you get circumcised with other people, some people have diseases and you are not aware.”(Gerald)

“Owokay uhmmm the traditional circumcision is a high risk if I should say because over the years, many people have lost their lives or came out with botched penises so I just thought that I should go for a more healthy and convenient procedure.”(Siya)

“Based on the information that we have been receiving and hearing over the year’s via media the number of deaths of initiates is increasing over the years.”(Mike)

4.11.3. Masculinity- Not considered as a man

Within the traditional Xhosa culture, an ideal man is a man who went through the process of traditional male circumcision. What this society sees and recognizes an ideal man is a man that has undergone TMC and therefore many in this society refuse to accept those who choose MMC. Irrespective of age or social status if you did not go through the rite of passage from boyhood (*ubukwenkwe*) to manhood (*ubudoda*) through TMC, as the norm in the Xhosa culture, you are not recognized as a man.

“They swear me and they do not give me a chance at all. They do not want to accept me as a full man I am considered as half a man”. (Sipho)

”Unfortunately in a sad way to say that the traditional circumcision comes from our ancestors it a chain or a cycle that is forbidden for somebody to break or do otherwise. So I would say partly yes you are not considered as a man.” (Zamani)

“Yes (grins) I can say yes because won’t be considered as a man because there is always that thing of people discriminating you ‘you didn’t do this so you are not man enough ‘they are things and principles they are taught that you don’t understand so like yeah you not considered as a man where I am from. ” (Zack)

*“In the Xhosa culture you are not considered as a man they say **uyinkwenkwe** (small boy).A man in Xhosa culture is a person that went to the mountains or bushes to get circumcised anyone who does not do that is not considered as a man.”(Siya)*

4.12. Family Influence

Family is the primary source of socialization in a person life. Although circumcision is an individual choice to opt for MMC. Participants that came from backgrounds that were religiously stated

4.12.1 Family Influences

Family responsibility plays a vital role in the social construction of a man's identity in the Xhosa culture. The way the family treats and perceives the young men impacts on this. The young men had different experiences when it came to family responsibilities. Some were not given any family responsibilities because they were the youngest in their families, and having opted for MMC, they were not deemed as man enough to handle responsibilities. Others were given only minor roles, they were not allowed to contribute to important family decisions in any way. Not all families subscribed to the Xhosa norm of doing things, especially those who are religious.

“My family is a religious family so I am still treated the same and my family responsibility and my place within my family has not changed” (Thembiso)

“I feel that it has a form of limitation, yes, I will throw suggestions but the final decision will be made by the alpha male of the family, family wise in my own home they accepted me as I am so I do have limited authority” (Gerald)

“Luckily I am the youngest [there are others older than me] so I just watch from a distance on how things are done. I have never been in position forcing me to be responsible for issues at home, it's always taken by my brothers” (Mayihlome)

4.12.2 Acceptance of MMC

In the interviews, family members were the most frequently cited social actors involved in MMC decision making. The participants revealed the sentiments echoed by family members when they told them of their decision to defy culture and undergo MMC. Some family members were very supportive of the idea, but to other family members this decision was a disgrace. Even though some family members accepted their decision, they were not treated by their families as true Xhosa men worthy of being involved in decision making within the family. One participant was very clear on this, stating that, since his decision to defy culture, his own father openly told him that he does not recognize him as a man within the family and he will never be called to sit with the men of the family during family meetings.

4.13. Women's Opinions

In the Xhosa culture the exclusion of woman in the procedure of TMC carries a cultural significance, they are denied access to initiation schools or to any knowledge of any central aspects concerning the ritual, and they are like uncircumcised boys (Gwata, 2009). The restriction of women in the Xhosa ritual does not only affirm the inferior position that woman

in the Xhosa culture. It gives a clear distinction within the two sexes and reinforces gender disparities. Traditional circumcision therefore illuminates the qualities that separate boys from men and males from females (Schneider & Schneider, 1991).

When asked how young Xhosa women viewed them, Mike gave the above response. Throughout the interviews, this was an area of notable interest, as the respondents had different experiences of and opinions about how women treated them after they had taken up the option of MMC.

“If they know some of them call you names like uyinkwenkwe...but it differs from individual mostly woman are not aware of men decision not to opt for TMC. The only way they can find out is if you live in a rural area or a close community township area. If your community does not know that you went to the mountain. You are then considered less of a man. With the deaths of initiates and circumcisions going botched.” (Gerald)

“The attitudes are the same they can be also very mean also. It also depends some love their culture and go to an extent of not wanting to date an uncircumcised or medically circumcised man. It just differs from individual within the Xhosa culture. In the Xhosa culture woman are usually also excluded hence circumcision ceremony or details about circumcision are not discussed with women. They don’t really act nice towards you but it depends on how you handle it and some woman are more knowledgeable about MMC they will not judge.” Siya

“Woman opinion does not really matter because in the Xhosa culture woman should not be discussing things concerning circumcision” (Mayihlome)

The Xhosa culture is still rooted in patriarchy. As Siya stated, *“in the Xhosa culture women are usually also excluded, hence circumcision ceremony or details about circumcision are not discussed with women.”* Women are still excluded from having a say regarding circumcision. Xhosa norms state that women are not allowed to be part of circumcision ceremonies, or details pertaining circumcision. There is a lot of secrecy around circumcision. Mayihlome also stated that women’s opinions do not matter, and also believes that women should not discuss circumcision.

From this, one can gather that it is not only men who strongly believe being a Xhosa man involves TMC. As per Xhosa custom a male is never a complete man until they “go to the mountain”. Zamani stated that Xhosa women call him weak because he is not traditionally circumcised. Men that are medically circumcised are not recognised or respected by women,

and they are not given honour like a traditionally circumcised male. The general outcome is within the Xhosa culture is recognised as having undergone TMC.

4.14 Self-perception despite what others think

In his work Jenkins (1996) defines social identity as “our understanding of who we are and who other people are. It is similar as the gender construction whereby society or a group of people define what is a woman and a man. In the instance of the Xhosa culture a man is defined as a boy that underwent the rite of passage from boyhood to manhood. Becoming a man signifies that one is now eligible to marry, to inherit land and to participate in family court (Vincent, 2008). This theme reveals the participants’ self-perception of what it means to be a man to them outside what their cultures subscribes too.

4.14.1. INdiyindoda (I AM A MAN) Participants’ Perspectives

It was, however, interesting to see that the way that participants defined what a real man is not attached to traditional norm of what a Xhosa man is defined by their culture. The young men referred to themselves as man although they did not meet the requirements of what it is to be a man in their culture. To them manhood goes beyond the traditional rituals of their culture. A man to them is a person who is a protector, a provider, a person who is a good role model in society. Their definition of a man went beyond the cutting of the foreskin. In fact, when describing what it means to be a Xhosa man to them “*cutting of foreskin was not included*”. Being a protector and a provider were among the main characteristics that were used to describe the meaning of what a man is. The notion of protector and provider comes from patriarchal construction of the ideal man. There was a participant that said:

“A man must show his manhood through his actions,” (Mayihlome)

“For me a man in general is a person who is responsible, a person that takes care of important things and prioritise. People who respect themselves and want to lead by example, people who protect their families, not to abuse woman and substance abuse. You can use substances but not to abuse them. A man is a responsible person who can prioritise. It is not a person who went to the mountain and had their foreskin cut off.” Zack

4.15. Attitudes of Xhosa men toward men that opted for MMC

In the Xhosa culture circumcision is a sacred ritual. It is respected and the older, traditionally circumcised men ensure that they preserve their culture. Their ritual is sacred and highly secretive and that is why even when they attend traditional ceremonies such as Umgidi which is a welcome ceremony for the initiate and other traditional Xhosa ceremonies they insist that

the boys need to be separated from the men. The older Xhosa men are the custodians of this ritual. They therefore ensure that MMC is not accepted because it poses as a threat to their authority. The participants reported that older traditionally circumcised men were not accepting of their decision to opt for MMC. They were treated as delinquents who defied their own culture and opted for western ways of doing things.

Mayihlome stated that the attitude of older Xhosa men was, if you opt for MMC it meant “*awukwazi ukunyamezela nkwenkwe ndini kungakho nibalekela esibhedlela*” meaning “you fail to endure pain small boy that is why you run to the hospital.” It is not easy for them to understand or accept men that are medically circumcised. If you are medically circumcised you are referred to as *inkwenkwe* no matter your social status or age. You are not regarded as a man in their eyes.

Zamani stated that he experienced discrimination from his own father who belittles him and says *awuyondoda* (you are not a man) and he said when things would go wrong in his life his father would say “*kalokhu izinyanya zikuflatele wakhetha esibhedlela*” (ancestors have turned their back on you because you chose to go to the hospital)

“Yes I know their attitudes and actions they can be so cruel. They will go out of their way to exclude. For example, when there are traditional families all the men that were traditionally circumcised will sit together and if you are found within their mist they will chase you away. That usually does not affect me because I distance myself from something.” (Thembisio)

“Many of them disagree or disapprove because they feel I bridged or made a gap in something that supposed to synchronize, go from generation to generation, there are challenges here and there, like in ceremonies for instance you are not allowed to dwell where the men are.” (Mike)

4.16. Integration back into the community

The challenges that the young men experience after their decision to opt for MMC include discrimination from Xhosa people outside the family, even though these young men are based in the townships of Cape Town. One participant stated that some of his neighbours refused to assist him when he asked for help, because they said he was not a real man. People in their communities still maintain their cultural beliefs, although they had moved from rural Eastern Cape into the cities.

The participants found it difficult to integrate back into their communities. Thembisio stated that even if you do not make a public announcement, somehow the news will spread via close

friends or family members that “*umntana waka bani uye walukele esibhedlela*” (so and so child got circumcised at the hospital). He went on to explain to the researcher that the way circumcision is set up it is private but public. He gave as an example the celebratory ceremony that is done for initiates called *Umgidi* who then graduate from being *umkhwetha* (initiate) to *ikrwala* (man). Even if the ceremony was done in the Eastern Cape, he comes back to Cape Town wearing the new clothes of amakrwala, and everywhere he goes he is recognized and accepted as a man. If he opted for MMC, on the other hand, he comes back and carries on with his normal life, no ceremony is done. People in the community might find out via friends that you were left out when your friends went to the mountains. Being uncircumcised or medically circumcised, they are discriminated against as not a man

“My community people do not accept me, because there in Langa they know I didn’t go for TMC but in other places they accept me because they don’t know me. For instance, when I ask help from Langa people, they don’t assist because they know about my circumcision.”
(Mayihlome)

“Being a person that I am, we all come across different experiences I don’t focus on what other people say when people know they will always have negative things to say but I did not let that get to me. Major challenge is acceptance in your community, once they know that you medically circumcised, they don’t accept, they see you as a delinquent, someone who went against their culture, and you are not viewed or taken as a man. To them you are not a man. They use the word inkwenkwe (small boy) to belittle you. It like being gay if you opted for MMC and they know. Even if they don’t know you went for MMC, they assume you have not went to mountain yet so you are still a small boy.” (Mike)

4.18. Integrating TMC and MMC practices

Because of deaths due to TMC the participants opted for MMC for safety reasons and health benefits. The research revealed that they valued the teachings in the mountains that they do not get at the hospitals. In most cases, they would be excluded in gatherings because that they did not get the teachings. They are not familiar with the language used in the mountains, called *isidoda*. When they were asked if there was a way to integrate TMC and MMC practices, some participants thought that it would be impossible. They raised the same issues raised in the Application Health Standards Act. The participants stated that it cannot be integrated because in MMC health practitioners can be women, some are uncircumcised men, or health practitioners from others races. Traditionally, in the Xhosa culture these people are not allowed

anywhere near initiation schools. In Xhosa culture women are not allowed to be in the mountains or bush during the surgical procedure. The ritual of Traditional Circumcision is sacred to the custodians of the culture, who will ensure that they preserve this aspect of their culture.

One participant said that the older Xhosa men will say that their culture is being diluted; they are very protective of their traditions. Unlike during MMC, TMC initiates are not given anaesthetics. The belief in the Xhosa culture is that a man has to endure the pain of the initiation as rite of passage.

“No ways, the thing is that they are so secretive about the topic, they would not even allow you to interview them, it narrow minded people. They are proud of their culture and will protect it at all costs. There is nothing anyone can do. The government has tried I have seen they have tried to take boys from the bush and put them on medical circumcision or medical treatment because of the failed procedure of traditional circumcision but it never works because when they come back they are not man enough for them.” (Sipho)

“I don’t think they would agree, this tradition is performed by old men whom I don’t think they would agree to mix these two methods of circumcision. Women maybe can agree, problem women don’t have a say in circumcision. They will never agree because it will seem as if the tradition is being undermined and they know nothing.” (Mayihlome)

“That I doubt so much the medical procedure has females involved, other cultures other races such as white people involved. The traditional way forbids woman, other cultures and other races being part of the surgical procedure of cutting foreskin”. (Thembisio)

Some of the participants felt that integrating TMC and MMC was a good idea. They saw this as a way to curb injuries and deaths among young men undergoing TMC. The suggestion is that the surgical procedure of the cutting of the foreskin should be done at the hospital and then same day the initiates can go to the mountains to gain the teachings. As within the Xhosa culture the ritual of circumcision is intended to teach and prepare young boys into manhood (Dingeman et al, 2013). Having the surgical procedure would there is one instrument per person. Some participants thought that merging the two could work, although they were aware of the challenges faced with TMC being sacred and how outside people were not allowed into the ritual. One of the participants said that the two could be merged by the government training the **Ingcibi** (traditional surgeon) and they could be given medical circumcision tools like sterilized instruments to use on each initiate. He went on to say training the traditional leaders would

then not feel like they are allowing intruders into their culture, but just equipping them with relevant knowledge to perform the surgical procedure in a safe way. The training could include dietary information and the emphasis on the importance of allowing initiates to drink so that they do not become dehydrated. This will make the traditional leaders feel that they are still in control.

“I would be glad if there can be people who are well educated in hospitals because there are many initiates that die in the mountain. Let’s say they start with MMC and go to the mountain for teachings” (Gerald)

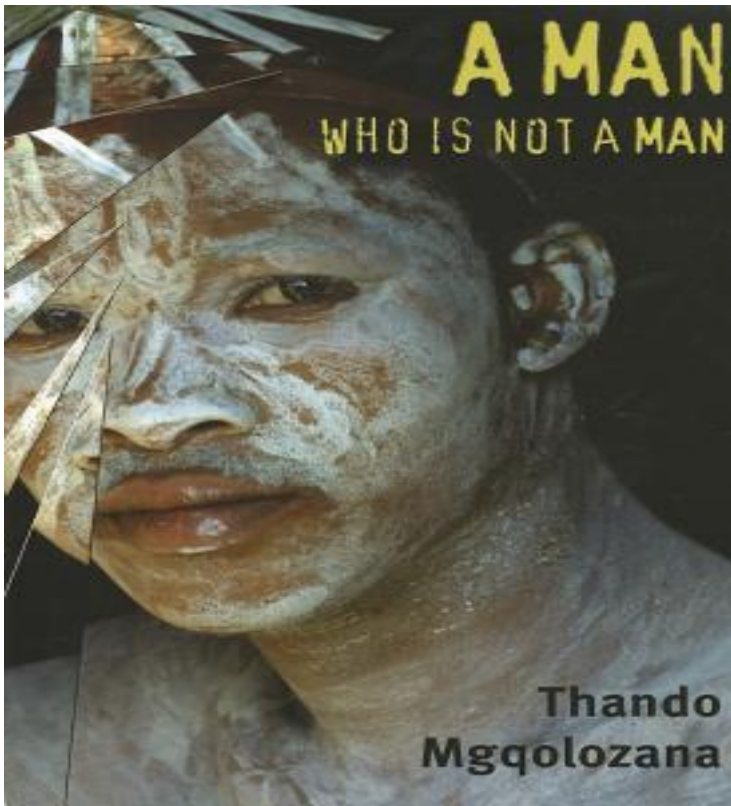
“I think that it can be the best option to reduce the rate of dying young man due to unsuccessful TMC procedures. They should first go to the hospital for the medical procedure and then go to the mountains to receive the teachings and get healed. The only challenge would that people have stereotypes and they feel like MMC diluting their culture. If they feel like MMC is changing their culture.” (Zama)

4.19 Summary

Health and safety benefits were the main reasons that prompted the young men to opt for MMC, including that MMC reduces the chances of contracting HIV/AIDS and STI’s. The young men seemed to be informed about the health benefits and have access to information on MMC. Social media plays a huge role in providing information on MMC and influencing young men to opt for MMC. The Brothers for Life campaign was amongst one of the most effective campaigns that assisted to reach out to men and encourage them to get medically circumcised. The use of public figures leading the campaign also had a positive impact and influenced people’s MMC choice. The challenge that the young men experienced was that within the Xhosa culture circumcision is seen as a rite of passage from boyhood to manhood. In the Xhosa culture it is viewed as impossible to obtain manhood without going through the prescribed rite of passage. Having opted for MMC, as opposed to TMC, the young men were ostracised by family members, friends and community at large. This included name calling to reinforce that a medically circumcised man is not yet fully human and cannot be regarded as a man. They have limited rights because they are not considered a fully functioning member of society. The young men would always be separated when it came to family gatherings from *amadoda* (traditionally circumcised men). The *amakwenkwe*, meaning small boys, but in this context referring to uncircumcised or medically circumcised men, would be seated in different places. Loss of friends was also experienced by those who opted for MMC. They could no longer be

friends with those who underwent TMC because in the Xhosa culture men and boys cannot be friends. This was another form of social exclusion. Some family members were accepting of their decision, however, the general reaction was non- acceptance. In the eyes of family, friends and other community members they were not treated as real men because they did not follow the prescribed rite of passage according to the Xhosa culture. The research findings thus revealed that they experienced discrimination in their own culture. In the Xhosa culture the traditional belief is that circumcision is not just about the cutting of the foreskin, but it is a covenant with the ancestors and that covenant protects you from evil spirits. The initiates felt as if they broke a covenant with their ancestors and that they were not therefore accepted by their ancestors.





Chapter 5

Discussion and Recommendations

5.1 INTRODUCTION

The aim of this research was to explore why young Xhosa men opted for MMC, and how they cope with the consequences of breaking with tradition. Men might have opted for MMC for health reasons, but their choice becomes a barrier to attaining public acceptance of masculinity within their culture. This research aimed to understand how these Xhosa men cope with being men who are unable to attain a cultural masculinity because of their preferred method of circumcision. The research findings were guided by the research objectives of this research. The first one was to describe the experiences of Xhosa men who opted for MMC. The second one is to report on the perceived attitudes of others - extended family, neighbourhood, community - to Xhosa men who opt for MMC. The third was to identify the factors (knowledge, values, attitudes, perceptions) that caused them to opt for MMC. The fourth one is to identify enabling factors for MMC among Xhosa men.

The data was collected from 9 young Xhosa men who had been medically circumcised in the past 2 years. A purposive sampling method was adopted in this research. The young men were from townships in Cape Town. This research was guided by the PEN 3 model.

The data will be clustered into five main themes for analysis and interpretation. These four main themes will cover all the themes that were discussed in the previous chapter.

1. Factors influencing MMC: Health benefits and Social Media
2. Acceptance and Integration into Society
3. Medical male circumcision in a traditional context
4. Complications, Concerns, Initiation School (What it means to be a Xhosa man)
5. Masculinity

5.2. Factors influencing MMC: Health benefits and Social Media

The most important factor that lead the young men to opt for MMC is the health benefits. Research shows that MMC reduces the chances of contracting HIV/AIDS by 60 percent (WHO, 2008). The participants were well informed on the health benefits that MMC provides. They stated that one of the benefits was that it also reduces their chances of contracting STI's. The young men stated that to them their health was more important than their culture. The alarming rate of deaths of initiates due to TMC complications is what made them to opt for the safer method. The participants stated that MMC procedure is done by trained health professionals using sterile instruments for the cutting of the foreskin. The theoretical framework that was adopted the Pen 3 model the P stands for P - Predisposing. Knowledge, attitudes, values and perceptions that may facilitate or hinder personal motivation to change, and in this instance the knowledge that they acquired about MMC is what motivated the young men to opt for MMC. The information that they were exposed to on MMC reducing HIV/AIDS among heterosexual men assisted their decision. Having access to health care facilities is another motivating factor to opt for MMC. None of the participants had problems with accessing health care facilities. MMC information campaigns by CareWorks in the township communities were effective. The participants stated that CareWorks booked and scheduled the procedure so it was easy, as they were booked to their nearest facilities. CareWorks also has a call centre that provided support for example, to remind them about the appointments and also to check up on them after the procedure.

Most of the participants first heard about MMC from social media platforms such as Facebook, and Twitter, and some used google to access information. The well-known Brothers for Life campaign also played an important role in influencing the young men's MMC decision. They stated that seeing it on television adverts and on billboards on highways influenced them. Having prominent actors that young males look up to head the Brothers for Life campaign brought fruitful outcomes.

5.3. Acceptance and Integration into Society

This theme will address the perceived attitudes of Xhosa men and women and the experiences of the men when they had to integrate back into society. Vincent, in his research on circumcision, states that traditional circumcision is not just about the cutting of the foreskin. During initiation, men are taught how to be a man and what it means to be a Xhosa man. When

they are integrated back into society they are eligible to marry, to inherit wealth, and to be heads of households. The teachings are that man has to be a provider and protector of his family. They now become eligible to represent their families in community gatherings and to participate in decision making in the community and within their families (Vincent, 2008). The reason that the young men are not recognized as real man is that they did not go through the whole initiation phase. The participants experienced social exclusion based on their decision to opt for MMC as opposed to TMC. In the Xhosa culture traditional circumcision is seen as a sacred procedure, apart from the teachings gained in the mountains. It is a covenant that is created between the initiates and their ancestors. Dingindlela (2014: 58) states that “ancestors are an integral part of the practice and the rituals that are performed are a way of communicating with ancestors and asking them to open a clear path and to protect the initiate.” In this research, the men show that they see themselves as not obligated to follow their culture, but it is for this reason that they are excluded from traditional family gatherings and important meetings because it is believed they have lost touch with their culture, and are therefore should not be accepted as proper Xhosa men.

In their narratives about their experiences, the participants stated that traditionally circumcised men did not accept them at all, whether those men were their fathers, brothers or friends. The bond that traditionally circumcised men have is tight and overrides one of blood, and they will protect their culture at all costs.

Medical circumcision breaks traditional taboos of TMC. These include the use of anaesthetics, contact with women and other races, and individualisation. Firstly, anaesthetic disregards the traditional notion that pain and suffering play a key role in the ritual as part of the process of demonstrating manhood and fitness for the respect and communal privileges that go along with manhood. The period whereby a man has to endure pain is an integral part of the transitions and withstanding dietary taboos such as not drinking water for the first week is part of this. Within the Xhosa culture the young initiates are not supposed to come into contact with women throughout the entire period of initiation. In a hospital setting it is impossible to prevent contact with women because some of the doctors and the nurses will be women. “The individualised nature of hospital circumcision removes from the practice its necessarily public dimension in which the community bears witness to the individual’s changed social and legal standing (WHO, 2008).” Because they made an individualised choice, the young men were not accepted by their family members or members of the community. They were treated like outcasts.

The participants stated that they would be given menial tasks to perform during family gatherings, because they were not considered to be men. They were not allowed to enter the kraal because only traditionally circumcised men were legitimized to enter and slaughter cows. Younger women were reported to discriminate if a man did not “go to the mountains”. The social exclusion could reach a point where the men separate fully. One participant stated that he no longer goes back home to the Eastern Cape because there the discrimination is worse than in Cape Town.

5.4. Medical male circumcision in a traditional context

In the Xhosa culture traditionally circumcised men are against MMC. One of the respondents suggested that there could be a way to merge the two but this should be done by consulting traditional leaders in the communities. Training of traditional surgeons would seem as one of the most feasible ways that could allow the two types of MMC to be merged. Traditionally circumcised men are conservative, but there perhaps could be an alternative method of circumcision that will protect their ritual and also the health of initiates if some traditional elements of the ritual could be included. They need to be consulted and included in the decision making on how we can preserve the culture of Ulwaluko but avoid complications and deaths. The government must not impose their resolutions in TMC but must be considerate of the ensuring that whatever recommendations they come up with are integrated with aspects of the ritual that are not dangerous to initiates' health. Chigono et al (2013) cited in Dingindlela (2014:66) “Concluded that the best way to implement medical male circumcision is to create synergy between traditional and medical male circumcision and this synergy can be created by designing programs that first interact with local knowledge systems which are also culturally responsive and acceptable, these programs will talk to perceptions and value systems that communities attach to circumcision and their health”. A recommendation would be to create a synergy between the two that could help to curb the deaths and it could be a way to help assist that medically circumcised males are not discriminated against within their communities.

Dingindlela (2014) state that MMC will not be accepted in the Xhosa culture in its own form. He further states that “as it is practiced in its current form, it will take away key elements of the practice and it does not appreciate the traditional practices associated with the tradition and meaning of these practices to traditional circumcised Xhosa men (Dingindlela, 2014, 40).” MMC in the Xhosa culture has led to cultural clashes and the way that is practiced it has no traditional elements attached to it. For instance, MMC surgical procedure can be performed by women, non-traditionally circumcised men, an uncircumcised doctor/male nurse and people

from other races or ethnic groups. This came as a cultural shock, and clashed with the Xhosa traditional circumcision procedures requirements. The research findings revealed that there is a need to have safe circumcision while also ensuring that they preserve non-health damaging elements of the Xhosa tradition.

5.5. Complications, Concerns, Initiation Schools

The health complications and deaths in the mountains are known to the participants, and are why they opted for MMC. They are aware of the deaths that occur in initiation schools and the ill treatment of initiates and believe that this is caused by the absence of parental or guardian supervision when they are in initiation school. Respondents said that guardians are leaving the sole duty to the customary practitioners who have not received any formal health training but rather depend on their experience.

5.6. Initiation School – What it means to be a Xhosa man

Initiation schools are a critical piece of the training, where young men are shown useful life lessons that will empower them to meet their obligations at home and in societies, and are instructed how to act in the public arena as men). None of the respondents could say exactly what is taught at the initiation schools because it is kept a secret among only those who go to the mountains. The respondents are ignorant of the new language that is taught during the initiation. Vincent, in his research, stated that initiates are also taught in initiation school how to behave as man. There were instances that one respondent said that his father would always say to him “*kanene awolukanga so awazi ukuba indoda iziphatha njani*” (meaning u did not go through initiation hence you do not know how a man must behave)

5.7. Masculinity (social construction)

It is evident that from narratives of the participants that there is no complete agreement on what it means to be a man, as the concept of masculinity is not homogenous. The participants define themselves as men although they are aware that in their culture they are not recognized as men. One of the participants responded that “*ndiyindoda mna*” (I am a man) this was his affirmation that, despite what his community says, he still considers himself a man. In the eyes of family, friends and community members they are not seen as men because they do not prescribe to the hegemonic masculinity of an ideal Xhosa man.

“The most legitimate and respected conception of masculinity is the one of prescribing to a particular set of behaviours and traits that are socially accepted and desirable to men and to

women(Connell 1987 cited in Willer et al 2013).” Masculinity is shaped by culture and in the Xhosa culture a man who undergoes the rite of passage as prescribed through the whole process of TMC is the ideal man. The young men were discriminated against because they did not adhere to the prescribed cultural norm of what it means to be a Xhosa man. One respondent stated emotionally that every day he gets told by his father that he is not a man and that he sometimes questions if he made the right decision by opting for MMC.

Masculinity is not static it changes over time and can be redefined and constructed. Connell (2000) cited in Smith (2010:10) states that “there is no single set or prescribed script for masculinity; rather there are multiple discourses of masculinity that are constantly changing in relation to the context in which boys and men find themselves”. When the participants were asked what it means to be a Xhosa man they stated that a man is a man through his actions. Being a man to them meant being a provider for their family, being a protector, being a role model to other young men, being independent, not depending on your parents for everything. The underlying characteristic of a man to them was being a provider and a protector. Baker and Ricardo (2005, 2) also state that “the key requirement to attain manhood in Africa is achieving some level of financial independence, employment or income, and subsequently starting a family. Moreover, in some settings older men also have a role in holding power over younger men and thus in defining manhood in Africa”.

Their definition of a man was different to that of their culture. Although in their culture they were viewed as being less of a man, to them they did feel some sort of inadequacy, but believed that manhood cannot be solely defined through the rite of passage. In their culture, they were considered to embody a subordinate masculinity because they do not meet the requirements of the hegemonic ideal man. They do not meet society’s expectations of what defines an ideal Xhosa man.

5.8 Limitations of the study

The most obvious limitation of qualitative research is that it tends to focus more on meanings and experiences and sometimes leaves out contextual sensitivities. (Rahman, 2016). During the process of trying to recruit young Xhosa men the researcher experienced challenges. The recruitment process took longer than anticipated. One of the challenges that led to the young men being reluctant to participate in the study is because of the sacredness and secretive nature of circumcision in the Xhosa culture

The researcher had to be critical and also reflect on her role as a Xhosa woman. The research was aware of the challenges from the fact that within the Xhosa culture it is taboo to discuss matters of circumcision with women. Some of the study participants initially felt a bit of discomfort at the beginning of the interview, which is why the researcher gave the participants a brief background on herself. It was only at that time that some participants felt more comfortable because they were aware that the researcher was Xhosa and could relate to some of their experiences. It was a challenge for some of the participants to open up to the researcher as a woman their experience of orchastrazation one participant became emotional. The building of a rapport at the beginning of the interview assisted when discussing difficult aspects of their experience. The researcher tried her best not to be biased in this research study given its limitations. The shortfalls of the study or aspects that could not be addressed can be addressed by future studies

5.9. Conclusion

In concluding the research study the findings were rather interesting findings. The major finding in this research study where the main reasons that influenced the young men to undergo medical male circumcision was the health benefits the participants were well aware that MMC decreases the risk of contracting HIV and STI's. Access to healthcare services and Media influences and campagns played a major role in creating an awareness on MMC. The brothers for Life Campagn is most common among the participants. The challenges the participants experienced is that their Xhosa custom that crucified them for having chosen MMC as opposed to TMC. They were not accepted in the community and within their family as real man as they did not abide by the traditional rite of passage from boyhood to manhood. According to their culture they were seen as less of a man, as they did not fit the criteria of "what an ideal Xhosa man" however the interesting phenomenon is their own self-perception was the total opposite. Despite the name calling and the discrimination they experienced, the young men still viewed themselves as a man because what it means to be a man was different to their culture.

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Ethical Clearance Certificate



12 August 2016

Ms Zola M Silimfe 211516638
School of Built Environment and Development Studies
Howard College Campus

Dear Ms Silimfe

Protocol reference number: HSS/0712/016M

Project title: Experiences of young Xhosa men who have undergone medical male circumcision Western Cape South Africa.

Full Approval – Committee Reviewed Protocol

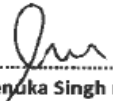
With regards to your response to queries received 01 August 2016 to our letter of 11 July 2016, the Humanities & Social Sciences Research Ethics Committee has considered the above mentioned application and the protocol has been granted Full Approval.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully


.....
Dr Shenuka Singh (Chair)

/px

cc Supervisor: Dr Kerry Vermaak
cc Academic Leader Research: Professor Oliver Mtapuri
cc School Administrator: Ms Nolundi Mzolo

Humanities & Social Sciences Research Ethics Committee

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Call Centre: 0860 10 11 10 - Switchboard: 021 - 673 5300 - Fax: 021 - 413 1064
PO Box 23460 Claremont 7735 - info@careworks.co.za - www.careworks.co.za

05 August 2016

Dear Dr Singh

Re: Experiences of young Xhosa men who have undergone medical male circumcision study

This serves to confirm that CareWorks has agreed to assist Zola Melody Silimfe to recruit participants from our medical male circumcision programme for the purposes of the above study. The student has agreed to furnish us with a copy of her dissertation on its completion.

Should you require any further information, please do not hesitate to contact me.

Kind Regards

A handwritten signature in black ink, appearing to read 'Rachael Rawlinson', is written over a light grey rectangular background.

Rachael Rawlinson
Programme Manager

Directors: - HJ Lake - Dr K Teversham - GPH Walton

ENGLISH CONSENT FORM

Ihave been informed about the study entitled (provide details) by (provide name of researcher/fieldworker).

I understand the purpose and procedures of the study/

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact

Zola Melody Silimfe

Contact number: 076 367 7828

email address melodysilimfe@gmail.com or 211516638@stu.ukzn.ac.za

OR

Dr Kerry Vermaak

Contact number: 031 – 260 2285

Email address: Vermaak@ukzn.ac.za

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Signature of Participant

Date

Signature of Witness
(Where applicable)

Date

Signature of Translator
(Where applicable)

Date

I hereby provide consent to:

Audio-record my interview YES / NO

Signature of Participant

Date

Signature of Witness
(Where applicable)

Date

Signature of Translator
(Where applicable)

Date

ISIXHOSA CONSENT FORM

Isivumelwano

Mna.....ndazisiwe ngoluphando lunzulu luthi (faka inkcukacha) ngu (igama lomphandi).

Ndiyayiqonda injongo nendlela oluzakuqhutywa ngalo oluphando nzulu. Ndilnikiwe ithuba lokuphendula imibuzo malunga nophandoolu kwaye ndaphendula ngokwaneliseka.

Ndiyaqinisekisa uba inxaxheba endiyithathe apha koluphando bendizityumbile kwaye ke ndingarhoxa na nini na, kungazochaphazela inzuzo ebekumele ndiyayifumana.

Xa ndithe ndaneminye imibuzo okanye ukungaqondi okuthile, ndiyayazi ukuba ndinga nxubelelana naye u

Zola Melody Silimfe

Kwezi nombolo : 076 367 7828

Ubhalelwano: melodysilimfe@gmail.com okanye 211516638@stu.ukzn.ac.za

OKANYE

Gqr. Kerry Vermaak

Nombolo: 031 260 7828

Ubhalelwano: vermaak@ukzn.ac.za

Ukuba ndinemibuzo okanye ndixhalabile ngama lungelo wam njengomntu othatha inxaxheba okanye ndixhalabile ngalo lona olu phando okanye ngomphandi, ndingakwazi unxibelelana ne,

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Ubhalelwano: hssrec@ukzn.ac.za

Isityikityo somthathi-nxaxheba

umhla

Isityikityo sengqina

umhla

Ndenza isivumelwano sokuba

Lushicilelwe udliwano-ndlebe

EWE / HAYI

Isityikityo somthathi-nxaxheba

umhla

Isityikityo sengqina

umhla

English/ISIXHOSA QUESTIONNAIRE

Questionnaire [Iphepha lemibuzo]

Please put a cross X next to the chosen answer [Beka u X ecaleni kwempendula oyikhethayo]

1.1.How old are you [Uneminyaka emingaphi?]	
--	--

2	What is the highest educational level that you obtained? [Leliphi ibanga eliphezulu oliphumeleleyo?]	
	Pre-school/ Gr R [Ibanga R]	
	Grade 1/Sub a/Class 1 [Ibanga A/1]	
	Grade 2/Sub b/Class 2 [Ibanga B/2]	
	Grade 3/Standard 1/Abet 1 [Ibanga 1/3]	
	Grade 4 /Standard 2/Abet 2 [Ibanga 2/4]	
	Grade 5 /Standard 3/Abet 2 [Ibanga 3/5]	
	Grade 6 /Standard 4/Abet 3 [Ibanga 4/6] / [izifundo zabadala 3]	
	Grade 7/Standard 5/Abet 3 [Ibanga 5/7]/ [izifundo zabadala 3]	
	Grade 8 /Standard 6/Abet 3 [Ibanga 6/8] / [izifundo zabadala 3]	
	Grade 9 /Standard 7/Abet 3 [Ibanga 7/9] / [izifundo zabadala 3]	
	Grade 10/Standard 8/Ntc 1 [Ibanga 8/10]	
	Grade 11/Standard 9/Ntc 2 [Ibanga 9/11]	
	Grade 12/Standard 10/Ntc 3 [Ibanga 10/12]	

Further studies incomplete [Izifundo eziphambili ezingagqitywanga]	
Diploma/undergraduate degree/other post school completed [Idiploma/ isidanga/ enye imfundo ephakamileyo]	
Further degree completed [Enye imfundo yesidanga egqityiweyo]	
Don't know [Awazi]	

3	What is your current marital status? / sesiphi isimo okuso ngokomtshato?
Married [Utshatile]	
Single [awutshatanga]	
Divorced / separated [Wohlukana nomlingane]	
Widower / Widow [Ungumhlolo/ umhlolokazi]	
In a steady relationship [Ukubudlelwane obuqinileyo]	
In a casual relationship [Ukubudlelwane obungacacanga]	

4	How would you describe your present employment situation? [Ungasichaza njani isimo sengqesho?]
Unemployed [Awuqeshwanga]	

Sick/disabled and unable to work [uyagula/ ukhubazekile awukwazi kusebenza]	
Student/pupil/learner [ungumfundi]	
Employed/Self employed [Uqeshiwe/uziqeshile]	
Other [okunye]	

<p>What year did you go for MMC [Uye ngowuphi unyaka kulwaluko esibhedlele]</p>	
--	--

<p>Are you originally from Cape Town? [Ngokokuzalwa usuka e Mpuma Koloni?]</p>	<p>YES [Ewe]</p>	<p>NO [Hayi]</p>
---	-------------------------	-------------------------

<p>Where are you originally from? [Usuka phi?]</p>	
---	--

<p>Where do you live in Capetown? [Uhlala ndawoni eKapa]</p>	
---	--

ENGLISH INTERVIEW SCHEDULE

Theme 1: Knowledge about MMC

1. How did you know about MMC?

Probe: Was it through social media, peers, campaigns,

2. What do you know about MMC?

3. According to your knowledge what are the benefits of MMC?

Theme 2 Decision to undergo MMC

4. What made you decided to opt for MMC as opposed to TMC?

Probes: What are the advantages of MMC?

Did you opt for MMC because you believed it was safer?

Did you opt for MMC because you believed it was less painful?

Did you opt for MMC because you believed it was quick to heal?

Did you opt for MMC for HIV prevention?

5. What influenced your decision to opt for MMC?

Probes

Were you influenced by media?

Were you influenced by friends?

Were you influenced by sexual partner(s)?

Were you influenced by media?

6. Did you discuss your decision with anyone before you went for MMC?

Probes

1. If Yes,
 1. With whom?
 2. What was their response?
 2. If No, why not?
-
7. How did your family react towards your decision of opting for MMC?
 8. What was the reaction of your friends towards your decision for opting for MMC?
 9. What advice would you give to a young man who has to make a decision on whether to opt for MMC or TMC?

Theme 4: societal (men, women, girls, boys) attitudes towards MMC

10. What does it mean to be a Xhosa man to you?
11. What is the attitude of Xhosa Men towards your decision to opt for MMC?
12. What is the attitude of Xhosa woman towards circumcision?
13. What are the attitudes of Xhosa girls towards your decision to opt for MMC?
14. What are the attitudes of Xhosa boys towards your decision to opt for MMC?

15. What are some of the challenges that you experienced going back into your community after having gone through VMMC?

Probes: Did community people talk badly or bad things to you about undergoing MMC?

16. How do you negotiate cultural norms?

Family responsibility-

Community responsibility-

17. Do you know about the Applications Health Standards in Traditional Circumcision Act?

18 .Do you think that there could be a way that TMC and MMC can be merged

If No ..Why?

If Yes..Why? and How?

ISIXHOSA INTERVIEW SCHEDULE

Amava amadoda angamaXhosa akhethe ulwaluko lwezempilo eNtshona Koloni

Umbuzo oqaqambileyo: Ukuhlolisisa amava amadoda angamaXhosa akhethe ulwaluko lwasesibhedlele nonxulumaniso ngesintu.

Umxholo 1: Ulwazi ngolwaluko lwazempilo

1. wazi njani ngolwaluko lwasesibhedlela?

wave kunxibelelwano lwamakhasi onxibelelwano, iintshomi, imipapasho?

2. Yintoni oyaziyo ngolwaluko lwasesibhedlela

3. Ngolwazi lwakho zeziphi iziphumo ezintle ngolwaluko lwasesibhedlela ?

Umxholo 2: Isigqibo sokwaluka esibhedlela

4. Yintoni eyakwenza ukhethe ulwaluko lwasesibhedlela ngaphezu kolwaluko lwesintu

Zeziphi iziphumo ezihle zolwaluko lwasesibhedlela

wakhetha ukwaluka esibhedlela kuba ukholelwa uba akuqaqambi kakhulu?

wakhetha ukwaluka esibhedlela kuba ukholelwa ukuba kuphola ngokukhawuleza?

wakhetha ukwaluka esibhedlela kuba uzikhusela kwisifo sengculaza?

5. Yintoni eyakwenza uthathe isigqibo sokwaluka esibhedlele ?

Probes

kukho indima eyadlalwa ngamakhasi onxibelelwano?

kukho indima eyadlalwa ziiintshomi?

kukho indima eyadlalwa ngabo udibaniselana nabo ngesondo?

6. Ukhona na umntu owaqale wathetha naye ngaphambi kokuba uthathe isigqibo sokuba wenze ulwaluko lwasesibhedlela?]

Probes

- a. ukuba ukhona
i. Ngubani?
ii. Waphendula wathini?
b. ukuba akekho, kwakutheni?

7. Basithatha njani abazali bakho isigqibo sakho sokuyokoluka esibhedlele

8. Iitshomi zakho zayithatha njani lento yolwaluko lwakho lwasesibhedlela

9. Yeyiphi iadvice ongayinika ikwenkwenza encini efuna ukukhetha phakathi kolwaluko lwasesibhedlela okanye lase ntabeni]

Umxholo 4: (amadoda, abafazi, intombi, amakwenkwe) imibono yabo ngolwaluko lwasesibhedlela

kuthetha ukuthini ukuba yindoda yomXhosa kuwe

10. Bakuthatha kanjani amanye amadoda amadala ngesigqibo sakho sokukhetha ulwaluko lwase sibhedlela

Bakuthatha kanjani abantu abadala abango mama ngesigqibo sakho solwaluko lwasesibhedlela

11. Akuthatha kanjani amantombazane amancinane amaXhosa ngesigqibo sakho solwaluko lwasesibhedlela?

12. Akuthatha kanjani amakhwenkwana amancinci ngesigqibo sakho solwaluko lwasesibedlela

13. Zeziphi iinkathazo othe wajongana nazo xa ubuyela ekuhlaleni emva kokuba wolukele esibhedlele?

Baye bathetha kakubi okanye izinto ezimbi abantu ekuhlaleni ngokwaluka esibhedlele?

14. Uzixoxa njani izinto zesintu

Ezifana neemfuneko zekhaya

Ezifana neemfuneko zasekuhlaleni?