

**An Assessment of Students' Attitudes and Perceptions Towards Medical  
Male Circumcision on Howard College, Campus University of Kwa-Zulu  
Natal**

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## **Abstract**

In recent years, the positive correlation between male circumcision (MC) and reduced risks of sexually transmitted infections (STIs) have been increasingly recognised. Although MC has been practiced for centuries in traditional settings in South Africa, it is fraught with challenges including loss of penis, sepsis and deaths resulting from botched circumcisions. In recognition of the challenges associated with traditional male circumcision (TMC) and the need to increase VMMC as an STI prevention strategy, the South African Department of Health is promoting VMMC which targets males aged 15 years and above. Since 2014, the Department has been implementing the (VMMC) programme in higher education institutions (HEIs). This paper investigates implementation of the voluntary medical male circumcision (VMMC) campaign and programme on Howard College Campus, University of Kwa-Zulu Natal. We implemented a mixed research method with 88 purposively selected students. The study found that the VMMC programme was highly inclusive of relevant stakeholders resulting in 88% reported awareness of the programme among study participants. The study participants reported that VMMC is safe and reliable (85%), reduces the risks of STIs (78.8%), provides positive health benefits (85%), is safer compared to traditional male circumcision (85%), enhance sexual satisfactions (27.5%), and gives a boy a status of being man (33.8%). Despite these positive perceptions, there is a potential for risk compensation given that 33.8% of participants reported that a condom use was not required after undergoing VMMC. The need to adhere to traditional practices was found as a key barrier to the adoption of VMMC. The findings of the study show high positive attitude towards VMMC which calls for a concerted effort in the implementation of VMMC campaigns in HEIs. In addition, there is a need to work closely with traditional health workers to increase health and safety of MC in tradition settings since this is the preferred option for some people. Lastly, VMMC programmes need to be cognisant of the potential of risk compensation associated with VMMC and communicate these to target audience.

## Declaration

I, ....., declare that

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information unless specifically acknowledged as being sourced from other persons.
4. This thesis does not contain other persons' writing unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
  - a. Their words have been re-written but the general information attributed to them has been referenced
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5. This thesis does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the thesis and in the References sections.

Signed

.....

Student Signature:.....Date.....

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## **Dedication**

To my lovely Sisters, Buhle Khawula and Bavelile Hlongwa, my Uncle Mzwakhe Clemont Mbili, Sbahle Ma-Ngcobo, and Makanti Funani Mngadi who passed on during the course of this Dissertation.

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## **List of Acronyms and Abbreviations**

**CC** – Campus Clinic

**C/HIV/SU or CHASU** – Campus HIV/AIDS Support Unit

**DoH** – Department of Health

**HCT** – HIV Counselling and Testing

**HCC** – Howard College Campus

**HEAIDs** – Higher Education HIV/AIDS Programme

**KZN** – KwaZulu-Natal

**KZNDoH** - KwaZulu-Natal Department of Health

**MC** – Male Circumcision

**MMC** – Medical Male Circumcision

**SA** – South Africa

**SRC** – Student Representative Council

**STIs** – Sexually Transmitted Infections

**TMC** – Traditional Male Circumcision

**UKZN** – University of KwaZulu-Natal

**UNAIDS** – Joint United Nations Programme on HIV/AIDS

**VCT** – Voluntary Counselling and HIV Testing

**VMMC** – Voluntary Medical Male Circumcision

**WHO** – World Health Organization

# **CHAPTER ONE**

## **INTRODUCTION AND BACKGROUND OF RESEARCH TOPIC**

### **1.0 Introduction**

For the past three and half decades, there has been an ongoing struggle against the HIV/AIDS pandemic. Despite advances in the medical field, there is no known cure for the Virus. To combat the spread of HIV, efforts have focused on awareness and prevention campaigns. In recent years, there has been a growing attention given to the roles of Male Circumcision (MC) as an HIV/AIDS prevention strategy. In the South African context, the values of MC as an HIV/AIDS prevention strategy have been recognised. However, tensions continue to persist between Voluntary Medical Male Circumcision (VMMC) and Traditional Male Circumcision (TMC) approaches to undergoing MC. This thesis examines the implementation of VMMC campaigns on the Howard College Campus (HCC) of the University of Kwa-Zulu Natal (UKZN). This chapter provides the general background to the study. The chapter also presents the research questions, justification of the theoretical approaches adopted in the research as well as the structure of the thesis.

### **1.1 Background and Outline of Research Problem**

South Africa has one of the highest prevalence of HIV/AIDS epidemic in the world. The prevalence rate of HIV among adults aged between 15 and 49 is 18.9% compared to the global average of 0.8% (United Nations programme on the HIV/AIDS, 2014:1). Despite emphasis on condom usage and extensive public awareness programs, HIV/AIDS epidemic continues to present a health challenge to the country. Although the country has witnessed a decrease in the incidence of HIV/AIDS in recent years, new cases of HIV/AIDS infection is still unacceptably high. South Africa had a 12.2% HIV prevalence in 2014 compared to 10.6% in 2008. The prevalence varies across the nine provinces of South Africa. KwaZulu-Natal province leads in HIV/AIDS prevalence (16.9%) followed by Mpumalanga (14.1%), Orange Free State Province ( 14.0%), North West (13.3%), Gauteng (12.4%), Eastern Cape (11.6%), Limpopo (9.2%), Northern Cape (7.4%) (Human and Science Research Council, 2014). The Western Cape has the least prevalence of HIV/AIDS (5.0%). Generally, the prevalence is higher among young people in rural informal areas (Human and Science Research Council, 2014).

The development of Sexually Transmitted Infections (STIs) prevention strategies, particularly HIV, has become a core function of the health sector worldwide. In the past, condom usage,

abstinence and social education were key strategies used to combat the spread of STIs. Findings from extensive field studies have resulted in new STI prevention strategies including male circumcision (MC). “MC has been shown to provide men with lifelong partial protection against HIV infection, genital ulcers, syphilis and penile cancer” (United Nations Programme on HIV/AIDS, 2007:19; Science-Based Medicine Board, 2008). MC arguably widens the scope of HIV/AIDS prevention strategies.

An examination of existing research concerning health programmes shows that little attention has been paid to health prevention programmes in Higher Education Institutions (HEIs). Mathew (2012) argues that in HEIs, priority has been on identifying people living with HIV and commencing antiretroviral treatment (ARV) as well as trying to develop a cure for the HIV infection. In HEIs, HIV/AIDS Support Units are responsible for implementing MMC campaigns and programs aimed at creating awareness about VMMC as well as educating students about STIs. Very little has been explored and prioritised concerning prevention except for motivations and distribution of condoms.

The intention of this research was to critically examine the implementation process of the VMMC and ascertain attitudes and perception of students towards VMMC campaigns at UKZN, Howard College Campus. In order to better understand the dynamics of the VMMC program, it is of crucial importance to gain an understanding of influences and factors that impact attitudes and perceptions of the VMMC programme.

## **1.2 Key Research Questions**

The intention of this study was to investigate attitudes and perceptions of students towards VMMC at the HCC of UKZN. To this end, the study aimed to answer the following questions:

- How is the medical male circumcision programme being implemented?
- Are there any challenges associated with the implementation of the programme/campaign?
- What are students’ attitudes towards medical male circumcision?
- What are the effects of students’ attitudes on the implementation of the programme/campaign?
- Do attitudes of student affect the success of the programme/campaign?

### **1.3 Location of the Study**

This study took place on the HCC of UKZN. UKZN is a HEI consisting of five campuses: Pietermaritzburg campus, Westville campus, Nelson Mandela Medical School, Edgewood campus and HCC. HCC is situated in Durban and is one of the oldest institutions of higher learning in KZN. As an institution, UKZN is a fairly new university which emerged out of the merger between the former University of Durban Westville (UDW) and University of Natal. During the apartheid era, the University of Natal was exclusively for white students while UDW was mainly for non-white students, the majority of whom were Indians with a small black student population. The merger between the University of Natal and UDW came into effect in 2004 (Makgoba, 2007). The merge is the product of the ANC-led government strategy of transforming the landscape of HEIs in post-apartheid South Africa (Asmal, 2002). As a result of the merger as well as government emphasis on transforming the landscape of HEIs in South Africa, UKZN is now dominated by African students from previously disadvantaged marginalised communities.

At UKZN, a wide range of interventions, including the VMMC programme and campaigns, have been launched since the Department of Health (DoH) introduced the VMMC programme in 2012 (KZNDoH, 2013). Through its HIV/AIDS policy, the University of Kwa-Zulu Natal is committed to ensuring that its intervention of prevention, treatment as well as care addresses the ravages of the HIV/AIDS pandemic. UKZN seeks to develop a strategy that will enhance learners to graduate alive and free of STIs and HIV/AIDS (UKZN AIDS Policy, 2005). In the University of KwaZulu-Natal (UKZN) health interim document and policy statement including the strategic plan 2010 and 2020, the university committed itself to developing health prevention strategies including MMC as part of its STI prevention strategies rather than depending only on HIV/AIDS awareness and condom distribution. This study seeks to explore the implementation of the VMMC programme at the HCC of UKZN with a particular emphasis on students' perceptions and attitudes. To achieve this, the study is guided by a set of key research questions and objectives.

### **1.4 Theoretical Framework**

Commitment and prevention are fundamental to combating the HIV/AIDS pandemic. MMC is one of the HIV/AIDS prevention strategies that have been adopted in recent years in addition to the Abstain, Be Faithful, Condomise (ABC) method. The method is facing social, cultural and ethical challenges which make the implementation of VMMC programme fraught with

impediments. Therefore, understanding the difficulties and complexities that undermine successful implementation of the VMMC programme can be better improved by adopting models of public policy implementation.

To understand the formulation and implementation of health programs in HEIs, it is important to apply program analyses that will focus on the enactment, implementation challenges and impetus of the programmes. The advantage of analyzing policy/programme is to understand the 'process' of application, whether implementation did occur, and the prescribed steps were adopted, disregarded, ignored, or transformed. The most important element should be the various stakeholders' participation and communication as well as the opinions of people affected by the policy or programme. Makinde (2005: 63), describes "participation and communication as an essential ingredient for effective implementation of public policy/program". Public participation provides opportunities for the inclusion of their opinion on policy issues that affect them. This enhances public acceptance of the programme and minimises materialisation of unnecessary problems including public protests.

Different people have different attitudes, behaviour and even expectations of issues such as the VMMC. An influence or motivation behind an individual choosing to be circumcised or not, choosing to use a condom or not can be as a result of societal influence. In this instance, Fishbein (2000) argues that the inability to have voluntary control over lifestyle or culture in which people resides will have greater influence on their decisions as they are subject to that particular norm. Attitudes and perceptions of people towards the VMMC can be better understood by adopting relevant methods of evaluating and assessing different aspects of behaviour through the adoption of social science techniques adopted in psychological studies to better understand the outcomes. This study therefore adopted the theory of reasoned actions as the second theoretical framework for understanding the attitudes and perceptions towards VMMC at the HCC, UKZN.

### **1.5 Structure of Dissertation**

The study is divided into six chapters. The summary of the first chapter is covered within the introduction and background of research above. Below is a brief overview of chapter's two to six.

### *Chapter Two: Literature Review*

Chapter two reviews the literature on MC. Both the merits and demerits of MC, TMC and VMMC are explored and discussed. In doing this, the chapter provides critical insights into perspectives on MC, TMC, and VMMC and highlighted some of the important factors concerning MC both globally and in South Africa.

### *Chapter Three: Theoretical Framework*

This chapter provides the description of public policy implementation and the theory of reasoned action as the theoretical approaches that underpinned the study. The chapter provides an overview of public policy and critically discussed approaches to public policy implementation. The goal was to provide a theoretical foundation for understanding how VMMC is implemented in the chosen context. The chapter also presents an overview and relevance of the theory of reasoned actions to the study.

### *Chapter Four: Research Methodology and Methods*

Chapter four presents the methodology adopted for the study. The chapter provides detailed information on the research methods, design, sampling framework, study population and data collection. Justification and application of the chosen research method is also presented and discussed.

### *Chapter Five: Research Findings*

Chapter five presents the findings from the empirical component of the research about the VMMC programme at HCC, UKZN. Research findings were presented descriptively with the aid of tables, charts and graphs. Findings from interviews and focus group discussions are presented narratively.

### *Chapter Six: Discussion, Conclusion and Recommendations*

Chapter six provides an overall discussion of the study findings. These are linked back to the literature and the theoretical frameworks. The chapter also gives a detailed conclusion and recommendations on the overall findings of the study.

## **1.6 Conclusion**

This chapter provided an overview of the study. The chapter provided the background to the study, key research questions that the study seeks to answer as well as the structure of the dissertation. The next chapter presents a review of pertinent literature on the research area.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

The primary aim of this chapter is to present a detailed review of male circumcision (MC). The chapter is divided into five sections. The first section gives an overview of MC. This is followed by a review of the roles and significance of TMC in society as well as the risks and challenges associated with practices of TMC. Section three unpacks MMC and associated challenges as well as factors that influence the adoption of VMMC as one of the methods for reducing STIs. The fourth section examines attitudes and perceptions towards MMC. The last section outlines the VMMC campaigns in South Africa.

#### **2.1 Overview of MC**

Rain-jaard (2003) defines circumcision as the chopping of the fold of male sex organ loose skin (referred to as the prepuce or male foreskin) that covers entirely the tip-head also known as glans of the flaccid male penis. The exact origin of male circumcision is not known with certainty and no one seems to fathom why this is so. However, it is believed to have begun as a religious sacrifice performed in different cultures with a symbolic significance as a rite of passage marking a boy's entrance into adulthood. According to Auvert and Taljaard et al (2006: 54), "the oldest document that has evidence pertaining to male circumcision has derivation in Egypt between (2345-2181 BCE)". Circumcision was also common among the Semitic people. In the present day, several ethnic groups in sub-equatorial Africa, the Arabs in Asia and European countries like Greece still value and practice MC (Auvert and Taljaard et al., 2006).

Today MC is still prevalent and is practiced by different cultural and ethnic groups in South Africa. However, the techniques and practice vary across different groups of people. Maintaining cultural identity as well as the desire to continue ethnic traditions are some of the rationales for continuing MC (World Health Organisation, 2009). In the context of South Africa, MC is still regarded as a rite of passage. However, the acceptability of MC and the desire to continue the practice among community members in present day South Africa depends on a variety of factors including rural or urban setting and the nature of MC (TMC vs MMC), complications and costs (World Health Organisation, 2009).

### **2.1.1 Overview of Traditional Male Circumcision**

Traditionally, MC is done by trained traditional specialists in traditional settings. TMC in South Africa is mainly carried out in initiation schools. For Oomen (2002), male traditional initiation domains and schools remain and will continue being the strongest fields of cultural and traditional rule; young males in most communities feel compelled to attend to go to initiations as a symbol of respect for cultural as well as traditional authority. Traditional Male Circumcision is seen as a symbolic traditional practice to many ethnic groups in South Africa and the world at large including Egyptians and the greater Asian countries (Wilken, 2010). TMC plays a significant role in various aspects of social life. However, different culture or tradition may have different ways or preferences of implementing the practice. Despite these differences, the motive or belief is largely linked to socio-cultural factors. A socio-cultural aspect can be defined as “a social activity that can be understood by taking into account social, cultural and ethical context of a group of people” (Gipps, 1999: 21). This is a set of beliefs, customs, practices and behaviour of different people or groups of people.

In South Africa, TMC is largely practiced by the AmaBhaca, AmaXhosa and AmaHlubi tribes (Malisha, 2005). TMC has a symbolic and significant impact in the up-bring and shaping of young boys in societies that practice the custom. “Male circumcision forms a significant part of the initiation process and is strongly associated with the transition from childhood to manhood” (Oomen, 2002: 67). This means that it has an element of ethnic identity as well as cultural significance among young men.

In provinces such as the Eastern Cape, Limpopo and Mpumalanga, TMC takes place in different seasons. “In the Eastern Cape, it occurs mainly during the summer and winter season and involves traditional surgeons, traditional nurses, the parents of the initiates and the initiates themselves” (Meissner and Davis, 2007: 45). The initiation process is performed in a designated area at an initiation school in which experienced and in some cases inexperienced traditional doctors and nurses perform the initiations.

TMC practice in South Africa provides traditional upbringing, symbolism and the ritual of becoming a man. This means that in some ethnic groups, it is not an individual choice to undergo circumcision since circumcision forms part of their tradition which needs be followed. For instance, Rainjaard (2003: 56) argues that “most individuals who grow up in societies where MC is practiced are encouraged by their parents to be circumcised”. In most

communities that practice TMC, elderly members perceive male circumcision as a good practice for a male child.

A study by Westercamp and Bailey (2006) found that circumcision is not an exclusively male issue since as “mothers and wives/partners” influence the decision of males about undergoing circumcision. The study noted that without these influences, some male will be loathsome to undergo circumcision

One significant aspect of the socio-cultural influence is that the practice has been glorified extensively to encourage young boys to become circumcised. This gives them no room in choosing between VMMC and TMC but bound to undergo solely TMC as rite of passage to manhood. Members of the society who still prefer TMC practice believe that it has divine and cultural symbolism and is a bridge that takes young initiates from a sensual level of upbringing to real manhood (Wilken, 2010). This means that MC is connected to cultural symbols and needs to be done in a traditional way in order for a young adult to become a man. In the Xhosa culture, for instance, a man is not viewed as a 'man' without undergoing the ritual of circumcision (Nkosi, 2005). A similar view subsists amongst the Venda people where “initiation schools for young men are called *Murundu*<sup>1</sup> and male circumcision forms a significant part of the initiation process and is strongly associated with the transition from childhood to manhood” (Oomen, 2002: 8). From the above examples, it is obvious that young adults cannot call or perceive themselves as adults when they have not undergone TMC, neither can they choose to marry a wife since they are still perceived as young men.

The symbolic aspect and role of the TMC is the gathering of young males who are ready to become men. These young men are brought together and taught various traditional lessons and symbolic aspects of being a man within their particular clan (Rainjaard, 2003).

### **2.1.2. Challenges/Risks Associated with TMC**

Although research concerning TMC and MMC has “investigated culture and its link to the HIV/AIDs pandemic, they have generally explored the determinants of sexual behaviour or have analysed the broad cultural context surrounding HIV transmission and sexual behaviour” (Caldwell et al., 1989, McGrath et al., 1992; Oshi et al., 2005: 123). It should be borne in mind

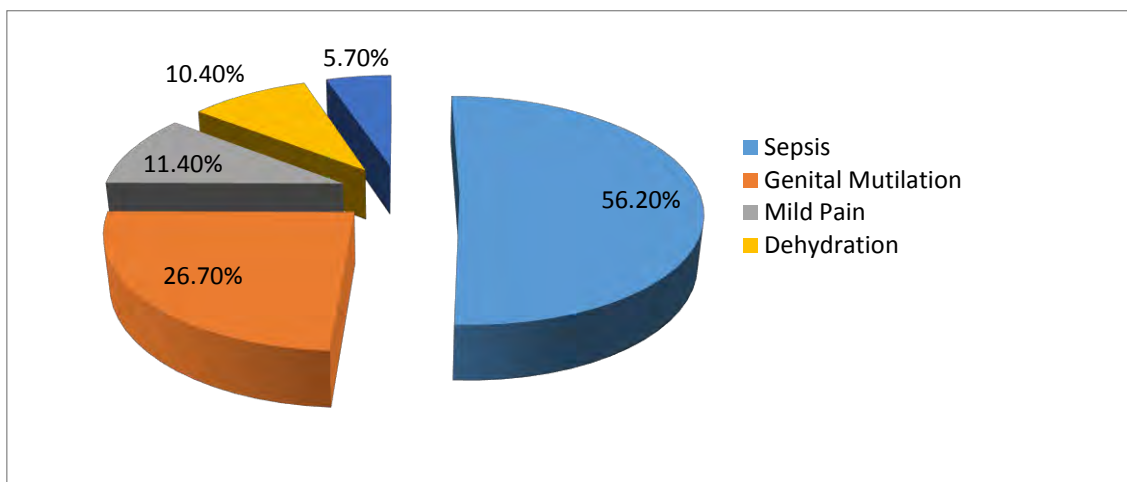
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<sup>1</sup> Initiation for boys in Venda

that, while the nature of sexual education in traditional initiation schools is relatively unknown, perceptions exist “that schools do not adequately educate participants about safe sex or the dangers of HIV/AIDS and may even encourage risky sexual behaviour” (Mturi and Hennink, 2005: 112). Against this backdrop, traditional schools have been condemned on issues of safety and health. Oomen (2002: 10) argues that “the roles of traditional institutions in socialising young people and improving their awareness of sexual health in the context of HIV/AIDS have been relatively thin”. Young people in traditional circumcision lack social education on basic sexual health and behavioural norms.

Peltzer (2008) argues that TMC is increasingly coming under criticisms as an unsafe practice. In recent years, there have been accounts of serious complications or adverse effects associated with TMC. These include advanced infection, severe loss of blood, and mutilation of the penis resulting in deaths of the circumcised. A study involving participants aged 15-35 in Eastern Cape and Limpopo provinces relating to the high prevalence of complications associated with TMC reported initiates suffering from sepsis (56.2%), genital mutilation (26.7%), dehydration (10.4%) and amputation of glands (5.7%) (Wilken, 2014).

*Figure 1: Complications of Traditional Circumcision in South Africa*



Source: (Wilken, 2014: 16)

It has also been reported that wounds in TMC took longer to heal. In addition, there have been reported cases of incomplete circumcision (Wilken, 2014). These findings were based on recall of participants, as well as observations in traditional initiation schools including data available at health clinics about initiates admitted for severe infection after TMC. The study noted that complications associated with TMC results from reduced intake of fluids, initiates kept in

outdoor camps, the use of unsterilized knives, and initiates being kept long in the forest before they are released (Wilken, 2014). Complications associated with TMC have been attributed to the lack of training on the part of some traditional practitioners (Oomen 2002). It also appeared that lack of skills among the traditional surgeons especially in illegal initiation schools has become a major problem among TMC (Anika 2013).

Illegal initiation schools in South Africa have been a controversial issue resulting in a high rate of death among initiates. Illegal initiation schools are operated by unprofessional practitioners (Mabe, 2013). Circumcision in these sites is usually carried using a razor blade or knife. After the foreskin has been removed the wound is covered with eucalyptus<sup>2</sup> leaf or maize leaves and left for weeks while the initiate is in seclusion (Anike et al, 2013). Complications among TMC sites were a result of tight dressing to allow haemostasis<sup>3</sup> which causes ischaemia<sup>4</sup> and loss of gland (Anika et al, 2013). According to Mabe(2013), the minister for health in the province of Eastern Cape has announced that the number of illegal initiation schools, death and serious injuries among initiates are very high.

According to the information compiled by the Limpopo Working Committee on Initiation Schools, there are 140 illegal initiation schools in the province (Makana, 2015). A vast number of initiates circumcised in TMC schools reveal being subjected to harsh and unforgettable experiences. This has been associated with the view that custom has been hijacked by criminals who have a total disregard for human life and only carried out the practices for commercial purposes. It has also been noted that some so-called “traditional surgeons” performed the procedure under the influence of alcohol” (National Department of Health, 2013: 12).

In most TMC initiation settings, health and safety measures are not prioritised. This has been a key concern in a country with a high prevalence of HIV/AIDs and other highly infectious diseases. Even though TMC practitioners are expected to abide by the Health Standards in Traditional Circumcision of 2001, Meissener and David (2007: 228) believe that “the problems with the Act are based on non-compliance by traditional surgeons and nurses, parents and the initiates themselves, leading to the above complications and fatalities”. In addition, there is

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<sup>2</sup> Diverse genus of flowering trees

<sup>3</sup> Human body response to blood vessel injury

<sup>4</sup> Restriction in blood supply

very little independent monitoring of initiation schools since the settings are often shrouded in mystery thus undermining independent verification of the implementation of the Act.

The shortage of resources and staff in the Eastern Cape (a province where the practice of TMC is prevalent) has placed a burden in TMC sites that are complying with the Health standards. This has led to increases in the number of people going to shady initiation schools (Eastern Cape Department of Health, 2013).

The nature and practice of traditional male circumcision, particularly among Xhosa culture in the Eastern Cape has been the talk of the country and has also received much adverse publicity in the national media in the past years. During June and July 2015, about 34 boys died resulting in a total of 153 fatalities of initiates since 2012. About 80% of these related deaths occurred in illegal initiation schools (Nicolson, 2015). The death toll of initiates for the current Eastern Cape initiation winter season closed at 29 (Wakefield, 2015), followed by Limpopo with three reported deaths and other remaining provinces (Mandiwana, 2015). Despite criticisms, most traditional leaders favour TMC as they believe it is a customary practice which has been part of their culture for centuries. Malibu (2000: 48) argues that “even though male initiation schools tend to be of a high profile, many criticisms of these schools have suggested that the initiation process socialises men to perceive women as sexual objects”. This phenomenon possesses a threat in a society that is highly devastated and affected by teenage pregnancy and STIs.

Many young men, after being circumcised, believe that they can practice unsafe sex because circumcision means that they are adults and they need to practice penetrative sex in order to prove themselves as men. This attitude has been attributed to the lack of social education pertaining to health issues in TMC setting (Peltzer et al., 2008). TMC schools do not want to work with departments of health, neither do the schools provide initiatives with programs that facilitate awareness and health standards. Even though positive values are being imparted on initiates regarding manhood and sex-related issues, these lessons are not fully manifested in the initiatives. Peltzer et al., (2008: 8) argues that empirical data from different academic research show that the main sources of condom information received by the initiates were from “local clinics, peers, schools and the mass media and none of the respondents in his study named traditional initiation schools as a source of information about condoms”.

Due to complications experienced in TMC initiation schools, TMC has lost some of its reputation and significance. Despite the problems and tensions associated with death and complications experienced by initiates as a result of un-trained facilitators, the traditional initiation process is still followed and remains an important rite of passage for many young people (Jeannerat, 1997). Criticism of the practice is yet to have any major impact on its popularity among young men. TMC continues to occupy an important position in the life of many South African ethnic groups such as Xhosa, Venda and Swati. Members of these ethnic groups argue that TMC has been practiced for many centuries for “non-religious reasons but as an integral part of a rite-of-passage to manhood, the oldest surgical procedure known traditionally and undertaken as a mark of cultural identity or religious importance” (UNAIDS, 2007: 17). Those that enforce TMC perceive themselves as custodians of that particular culture and strive to preserve the sociocultural importance of the TMC process. In recent years, however, there have been increasing calls for the implementation of medical male circumcision (MMC) in place of TMC.

### **2.1.3. Medical Male Circumcision**

MMC is done by professional practitioners in health institutions. MMC is a surgical practice of removing the foreskin of a male person. The potential of VMMC in the fight against HIV and other sexually transmitted infections (STIs) has been recognized internationally. According to UNAIDS (2007: 19), health scientists and organizations believe “that male circumcision should be introduced as an efficacious intervention for the prevention of heterosexually acquired HIV infection. The argument is that MC has been shown to provide men with life-long partial protection against HIV infection, genital ulcers, syphilis and penile cancer” (Science-Based Medicine Board, 2008: 1).

Even though health institutions have realised the potential of circumcision in reducing STIs, circumcision for medical or health reason is still a controversial issue. concerns about MMC relates to pain, the risk of bleeding, infection, irritation of the glands, increased risk of meatitis (also known as inflammation of the opening of the penis), the risk of injury to the penis and other socio-cultural related issues (UNAIDS, 2007). Another barrier to MMC is that the practice is expensive since it is done in a medical or clinical setting and requires professional medical practitioners (Tarimo et al., 2012). Despite the foregoing, circumcision in a medical setting is still regarded as the safest practice compared to TMC (WHO, 2014). In the South African context, the free VMMC was introduced to address cost issues associated with MMC.

#### **2.1.4. Overview of Voluntarily Medical Male Circumcision**

VMMC is carried out by professional doctors and nurses and is done in medical centres including clinics or hospitals. The potentials of VMMC Centres are being harnessed by governments to improve the quality of health governance and the fight against HIV/AIDS and other STIs. The health sector as well as other organisations at all levels have moved quickly to introduce safe VMMC in South Africa and the world at large. As a result, numerous public health advocacy organizations, including the World Health Organization, have argued for the inclusion of MMC programme as an integral part of any large scale HIV prevention strategy (UNAIDS/WHO 2007; Potts et al., 2008; White et al., 2008). National organisations such as ANOVA Health Institute played a significant role in the successful rollout of MMC in South Africa by funding the Centre for HIV/AIDS Prevention Studies. The mandate of this centre is to reduce HIV/AIDS in South Africa by providing innovative preventative health solutions through the implementation of evidence-based strategies. Furthermore, ANOVA assisted and supported the DoH with the development of national guidelines, setting up of provincial meetings and supporting the expansion of VMMC sites (ANOVA Health Institute, 2013).

#### **2.1.5. Conceptualising VMMC (MMC as Reliable Practice)**

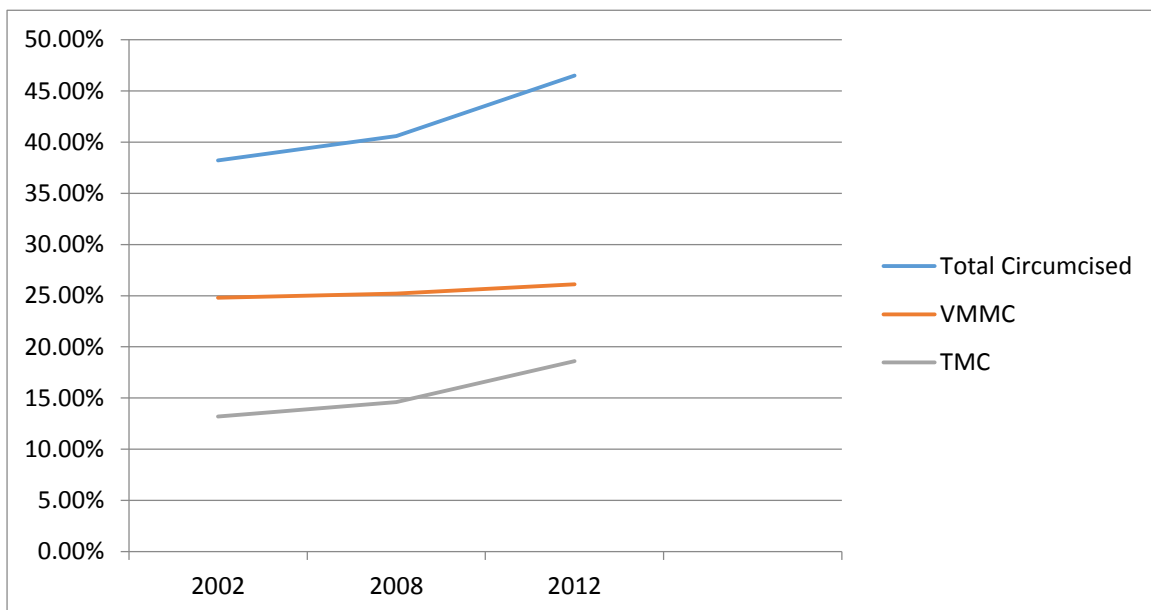
MC has long been a traditional or cultural practice for some people in Africa and the World. Ever since the World health Organisation and various government health departments realised the potential of MC to offer some protection against STIs, male circumcision has been endorsed and a large emphasis has been placed on VMMC in South Africa. Emphasis on VMMC is associated with safety and reliability compared to TMC.

Complications experienced in traditional initiation schools have placed a burden and concern about the health issues of young initiates. Due to the outcry of complications in TMC, the DoH saw the need to launch massive VMMC campaigns in both urban and rural areas including primary, and secondary schools, and HEIs around South Africa. VMMC is seen as a good process of transformation from the old process that is associated with much great negative health issues (Health-e, 2013).

In 2010, South Africa saw a global influx of thousands of international visitors for the soccer world cup. It was during this time that the National Department of Health initiated a massive

VMMC program targeting young and older males around the country. A major VMMC program was implemented in major townships in Gauteng including the famous Orange Farm situated South of Johannesburg. According to Lissouba (2010), the main intent of the program was to target under privileged or low income communities with minority or uncircumcised men exposed to high STIs and HIV. Young and old men aged 15 years and above were targeted for free VMMC. The VMMC project named *Bophela Pele*, a Sotho language meaning (Health First), reached at least more than fourteen thousand men within a few months of implementation (Lissouba et al., 2010: 1). At the commencement of the first major rollout in 2010, the Province of KwaZulu-Natal was among the first provinces to be targeted for VMMC (Meyer et al., 2011). VMMC is growing and being prioritised in most African countries. Recent statistics on self-reported MC in a study by Anike (2013) revealed that 52.5% participants reported that they had been circumcised in a traditional setting while about 40% were circumcised in a hospital or clinic. These findings show positive attribute given that TMC has been in practice for decades while VMMC has been advanced for less than a decade. In South Africa, the government introduced the VMMC policy and programme in 2010. The reported findings indicate a rapid uptake of the practice in a relatively short period and the potential for future growth.

*Figure 2: Trends in Adult Male Self-reported Circumcision by Type of Circumcision, South Africa 2002, 2008 and 2012*



Source: (Anike, 2014: 18)

In KwaZulu-Natal, VMMC took place in hospitals, medical clinics and mobile sites making use of community mobilization involving local stakeholders residing in areas where VMMC services were to be provided. The positive benefits that were included within these camps were that men undergoing VMMC were educated about post-procedural behaviours in order to ensure the correct understanding of all relevant issues regarding VMMC and to avoid risk compensation (Mathew, 2012).

Three years after the launch of VMMC, the campaign began targeting HEIs as well as some primary and secondary schools in townships and rural areas. At the University of KwaZulu-Natal, VMMC Campaign and the Men's Forum programme was launched on the Howard College Campus in April 2013 through the cooperative effort between UKZN, the DoH, the eThekweni Municipality and partner NGOs (Majola, 2013).

The launching of the campaign was informed by studies which showed that in the three universities in KwaZulu-Natal, the prevalence of HIV was at 4.1% of male students and 7.8% of female students. The study also found that females between 18 and 19 years constituted 1.5% of those that live with HIV (HEAIDS, 2010). The study further found that among these students, two-fifths had more than one sexual partner in their past sexual experiences. Among these, a quarter of students were noted to have not used condoms at last sex (HEAIDS, 2010).

In line with the UN's recommendation on the scaling up of MMC as part of a comprehensive HIV prevention package, it was recommended that South Africa circumcise at least 8 million males most of whom should be HIV negative. This will have a positive impact on reducing HIV/AIDS transmission. According to Meissner and David (2007), empirical data showed that the progress in implementing MMC in prioritised countries has been limited, with fewer than 25,000 MMCs performed in any one country (Meissner and David, 2007).

#### **2.1.6. Challenges Associated with VMMC**

Challenges with VMMC are connected with resources constraints such as inadequate infrastructure, health sites medicine, equipment and shortage of qualified staff. Infrastructure and staffing may refer to equipment, medical sites and other tangible things used to carry out the VMMC service. Most young men prefer to be circumcised in a hospital setting because of

safety and health standards as opposed to TMC (USAID, 2012). Good staffing may be required for the scale-up of VMMC. This needs to be a prerequisite for VMMC. However,

most programs in SADC countries lack adequate staffing, health facilities report that they would be able to increase the number of VMMCs performed if they had additional staff, equipment, and instruments such as surgical tables, protective gear, operating instruments, disposable equipment, sterilizers, reliable electrical power, adequate water supply, medicines, availability of the procedure room, and more staff trained on how to perform the surgery (USAID, 2012: 19).

According to the USAID (2012: 23), “a reliable and efficient system supply chain management is needed for the procurement and distribution of VMMC equipment and consumables, hence male circumcision should be offered with full adherence to medical ethics and human rights principles, including informed consent, confidentiality, and absence of coercion”. All VMMC sites are expected to meet the above principles to ensure a safe and conducive medical site for MMC. The above-mentioned hitches relate to considered challenges associated with VMMC.

VMMC is also affected by social perceptions and influence. For instance, most young people, who come from a rich cultural or traditional background where MC has been long practiced in traditional settings, see VMMC as bad practices that prevent them from practicing traditional customs. In most cases, they are influenced by their elders and other community members not to undergo VMMC thereby forbidding the positive health benefit of VMMC.

## **2.2 Arguments against MC**

The Science-Based Medicine (2008: 16) notes a number of arguments against MC including the general view held by people who believe that nature does not make mistakes. Against this backdrop, it is held that it cannot be put as a fact that removing the foreskin of a male reduces chances of contracting diseases. Secondly, some religious groups, academics and other members of the society argue that MC is a form of genital mutilation and a violation of human rights (Science Based Medicine, 2008:16). Relatedly, another strand of argument holds that once a male is circumcised early on in life, he suffers permanent physiologic consequences (e.g. that boys who were circumcised at birth are more sensitive to pain later in life). It has also been argued that the uncovered glands become less sensitive and some men mourn their lost

foreskin. According to this view, some circumcised males miss the lost foreskin so much that they try to reconstruct it (Science Based Medicine, 2008:16).

Circumcision is scientifically proven to lower risk of certain sexual transmitted disease concurrently associated with risk factors such as pain, bleeding, infection and irritation of gland and even loss of life (Science Based Medicine, 2008: 19). In addition to the foregoing, Westercamp and Bailey (2006) argue that some misconception and risk compensations remain about the preventative nature of circumcision for STIs transmission. It remains an argument that people might misunderstand the way in which circumcision reduces the risks of STI transmission. This misunderstanding results in risk compensation among circumcised males. Risk compensation alludes to a situation where an individual's perceived sense of security ushers in riskier sexual behaviour that exposes the individual to greater overall risks (Mathew, 2012). In terms of MC, a person could believe that circumcision gives protection against STI's and hence engage in unprotected sex.

### **2.2.1 Perceptions and attitudes towards MC**

In this section, I have presented an overview of different studies conducted in South Africa and Southern African development communities at large in order to present different perceptions and attitudes regarding MC in different settings. When assessing the literature used to shape this study, the result of many MC studies in South Africa were consistent with other acceptable studies from sub-Saharan Africa suggesting that MC may generally be more acceptable than believed.

The greatest tragedy of most MC social science research is that in all previous studies, the main reasons for favouring MC were prevention of STIs, including HIV, and beliefs surrounding the likelihood of pain and/or enhanced pleasure during intercourse and circumcision status (Bailey et al., 2002; Halperin et al., 2002; Kebaabetswe et al., 2003; Lagarde et al., 2003; Nanko et al., 2001; Rain-Taljaard et al., 2003). These are referred to as tragedies because of the negative impact of such views, (i.e. most people who adhere to these stories maintain the wrong perspective that undergoing MC will protect them against STIs and HIV/AIDs, that circumcision is painful and gives enhanced pleasure). As a consequence, some circumcised people engage in riskier behaviours such as choosing not to wear condoms. The perceptions also lead to uncircumcised not wanting to undergo circumcision and in a long run cause greater harm.

Values and attitudes towards MC differ across cultures. Within the Swazi culture, for example, a real man is defined as someone who has a wife and children, a man has to be sexually functional and in that regards the issue of MC does not introduce a threat to this cultural value or aspect because circumcision is not a pre-requisite for a traditional rite of passage. These people are not concerned with circumcision, nor do they want to become circumcised.

At the individual level, attitudes and perceptions towards MC also defer. In studies that focused on age, it is apparent that among older men, the only reason for choosing to circumcise was to give a woman more sexual pleasure. Unlike older men, “younger men cited cultural symbolism, protection from STIs, pain during sex, and sexual satisfaction as reasons for circumcision” (Scott and Weiss, 2010: 164), however, the overall determination placed culture to be the greater barrier for individual to undergo MC. In another study in South Africa, Westcamp and Bailey (2006) found that reported beliefs about circumcision mostly have positive connotations that circumcision will benefit a person in some way. Such benefits include improved health, enhanced sexual performance, greater respect and good fortune.

According to Rain-jaard (2003), it is believed in certain cultures that being uncircumcised brings bad luck. This means that males who are not circumcised will have a dark future or miserable life. Respondents in the study by Rain-jaard felt that men have more respect for other men who have been circumcised. In addition, women respect circumcised boys more than those that are uncircumcised. Furthermore, parents give more privileges to circumcised boys (e.g. a circumcised boy will be allowed to visit a girl alone in her room). This is an implicit permission to engage in sexual intercourse with women after undergoing MC (Rain-jaard, 2003).

These preferential treatments have been qualified further and are now used against MMC. For instance, boys who undergo TMC would label boys who undergo MMC as typical men rather than real men. They are perceived as traitors and cowards for ignoring their own traditional practices. These thoughts are pervasive as they turn to discredit MMC, discouraging individuals' choice to undergo MMC in fear of being insulted or neglected by peers. In 2012, for example, a provincial newspaper called *Dispatch Live* revealed a situation where high school learners who had undergone MMC were insulted by senior boys who underwent TMC accusing them of being cowards and not being men-enough to go to initiation school (*Dispatch Live*, 2013).

A study by Lagarde et al., (2003: 162) revealed that most young people and parent would want their children to undergo MC because it gives protection against STIs. Another factor that encouraged MC was the perceived level of pleasure and sexual satisfaction, followed by religious influences (Lagarde et al., 2003). Other prominent factors that influence MC include fear of death during MC and becoming infected with HIV during MC in traditional setting. A minority of participants in the study expressed a view that MMC is expensive (Lagarde et al., 2003).

Most people who have undergone MC either traditionally or medically have quite similar attitudes and perception of the benefits, especially protection against STIs. However some do not see the value of undergoing MC when continued condom use is still advised (Jan et al., 2011). This is to say that, they do not see a reasonable ground to get circumcised and to also use a condom. For these participations, undergoing circumcision and condom usage are mutually exclusive. Consequently, they found it unacceptable to be circumcised and still use a condom.

The issue around condom usage after circumcision has been a controversial one. In a study in Johannesburg involving 230 participants, condom avoidance is not perceived as a benefit of circumcision. The study findings suggest that concerns related to risk compensation via condom avoidance associated with male circumcision are exaggerated (Bridges, 2010). This implies that most men who are circumcised would prefer to use a condom as a first measure of protection. A study by Scott et al., (2005) revealed no association between willingness to be circumcised and perceived health benefits. Rather, sexual pleasure was the strongest predictor of being willing to undergo circumcision. Other important aspects that were found in the study was that some people believed that male circumcision potentially encouraged adultery as newly circumcised men were curious to test the new shape of the penis (Rain-Taljaard et al., 2003).

In the Johannesburg study comprising 93% uncircumcised primary partners, 66% said that they would prefer their primary partner to be circumcised. Besides their immediate partner, 72.3% of all women participant said they would circumcise their sons (Scott and Weiss, 2010). However, attitudes towards MC by both males and females were shaped by factors such as safety of the procedure as well as costs. The study also showed that women perceived the

benefits of MC as for their protection as well as for their children's sake in the fight against HIV and STIs.

In another study conducted at UKZN, participants expressed that MC would increase risky sexual behaviour and undermine existing preventative strategies (Panjasaram et al., 2012). According to Panjasaram et al, (2012: 123), "a moderate level of risk compensation could mitigate any benefit of circumcision in preventing HIV infections since some observational studies have found that circumcised men engage in higher risk behaviours than uncircumcised men". Therefore, if MC increases risky sexual behaviour among men, then risks of HIV and STIs infections have not been reduced and the resources that are used in MMC are a waste of tax payer's money.

What became significant in most studies was that most participants raised concerns about the age at circumcision and have expressed negative attitudes towards male circumcision after childhood (Tarimo et al., 2012). This is to say that they prefer to be circumcised in early childhood. This is due to the belief that circumcision in early childhood is better compared to being circumcised in adulthood. Another vital issue that was raised was that MMC is expensive. Therefore, many parents cannot afford to take their children to hospitals and other medical centres that perform MMC (Tarimo et al., 2012).

In most cases, attitudes were related to the level of knowledge of individual with regards to MMC. Again, in the study at UKZN, it became evident that an equally moderate score for attitudes could directly relate to the knowledge as suggested by a number of studies. Individual respondent's attitudes become positive especially after being educated on the topic (Panjasaram et al., 2012). These attitudes and perceptions call for considerable motivation and campaign for MMC to be successful. The aforementioned is the rationale for the DoH to engage in massive VMMC Campaigns since 2010.

Quite a number of researchers dealing with recent MC research have argued that in most Southern African countries including Swaziland, Botswana, Malawi and South Africa, MMC campaigns face cultural challenges. According to Gonzalez and Pebody (2013), implementers of VMMC had paid insufficient attention with regards to the social meaning of circumcision in different settings. This is to say that less consideration has been put in place as a contemplation of ethnic, religious differences as well as dominant aspects associated with a

particular form of masculinity (Gonzalez and Pebody, 2013). VMMC campaigns deal less with the social aspect and meaning despite prevailing predominant cultural challenges. The study at UKZN dealt in-depth with MC and did not focus much on individual perceptions and attitudes towards VMMC. The present study assesses attitudes and perceptions towards the VMMC campaign at UKZN, HCC.

Most of the arguments associated with MC practices are connected to social, cultural and medical consequences. However, this section dealt with the overview of MC and tried to explore some of the differences of opinions between TMC and VMMC. Below is a detailed exploration of both TMC and VMMC.

### **2.3. Considerations for MMC policy**

MMC has been proven to be the safe practice of removing the foreskin of the penis without severe harm, complications or death. It is in recognition of these benefits of MMC that the Department of Health has embarked on a campaign for VMMC throughout the country. In many MMC research, informants expressed the values of health policies that promote male circumcision, stressing that policy implementers should assess peoples' cultural preferences and the need for promoting the advantages of MMC particularly in regions with low prevalence of male circumcision (Tarimo, 2012). The considerations for MMC policy have been an issue for quite some time within the DoH. This has resulted in strategies for rolling out MMC. According to Panjasaram et al (2012), it has to be borne in mind that these strategies are not for exclusive use but should be used to complement each other. He further argues that circumcision will be most effective if it is not perceived as a stand-alone clinical procedure, but as one component, and should be delivered as a part of a recommended package of HIV prevention and reproductive health services including HIV testing and counselling, information about the risks and benefits of male circumcision, condom promotion, behavioural change, counselling promotion, and the management of STIs (Panjasaram et al., 2012). These deliberations on the strategies for MMC call for careful monitoring and evaluation when providing male circumcision as a service to the public.

Through well planned regulatory strategies, MMC has impacted in various ways on the fight against HIV and STIs even though there is no existing policy that guides MMC in South Africa. The potential of MMC in the fight against HIV and other STIs are being recognised by the government. WHO and UNAIDS Joint Strategic Action Framework aimed at accelerating the

Scale-Up of VMMC for HIV prevention in Eastern and Southern Africa, 2012–2016 published in 2011, presents a joint five-year framework for Ministries of Health and diverse country, regional, and global stakeholders (WHO and UNAIDS, 2012). It guides key stakeholders to collaborate and coordinate efforts for promoting country ownership and expansion of VMMC coverage. The goal is to ensure that VMMC contributes to “getting to zero” new infections. According to Meissner and David (2007: 150), the “Joint Strategic Action Framework is consistent with, and aims to advance UNAIDS’s 2011–2015 Strategy, WHO’s Global Health Sector Strategy on HIV/AIDS 2011–2015”. Under this strategy, the South African government and the national health department has adopted the consideration for the VMMC policy.

Academic institutions and other research entities believe that “communication strategies need to ensure that clear and consistent messages are disseminated, and sociocultural implications are taken into consideration in VMMC planning and programming” (Meissner and David 2007: 156). It stresses that “SADC countries should develop appropriate policy and legal frameworks, including clinical protocols, guidelines, and monitoring and evaluation mechanisms to ensure VMMC services are accessible, safe, and without discrimination” (Meissner and David, 2007: 157).

For policy considerations, there is also a need to identify resource requirements for VMMC, identify simpler and safer methods for performing these practices, including the use of sutureless, blood-free procedures and devices such as PerPex when performing MMC. According to Meissner and David (2007: 157), “PerPex, a bloodless circumcision device for adults, was to be tested in at least nine African countries in the next years, with funding from PEPFAR and the Gates Foundation, the device has been approved by the U.S. Food and Drug Administration, and WHO approval is expected soon”. PerPex is a new circumcision device without opening the men’s foreskin blood vessels resulting in blood free circumcision. It has been approved as the safest and effective nonsurgical adult male circumcision procedure and may be used to reduce the risk of STIs and HIV in resource poor MC settings (Bitega et al, 2013). Results revealed that PerPex achieved complete male circumcision without complications or adverse events. Furthermore, the pain was minimal and the entire procedure was bloodless (Bitega et al, 2013).

In Developing countries such as sub-Saharan Africa characterised by resources and funding constraints, PerPex devices are considered to be a less expensive alternative (Obiero et al.,

2013). This means that the device cheaper than the existing VMMC practice that exists and meant that there was improved cost efficiency for VMMC. Since 2013, the South Africa government has been trying to introduce the Perpex device to replace existing MMC.

The Shang Ring is another non-surgical VMMC device that has been tested and approved based on findings from field research. According to Meissner and David (2007: 158), the Shang Ring is one of the safest approved MC devices. It has proved to be effective and acceptable with fast healing.

Given diminishing funds to HIV/AIDS prevention in Africa, the need to explore cost effective innovative HIV prevention programmes such as VMMC has been on the increase in recent years (Meissner and David, 2007: 159). In Africa, insufficient funding and lack of adequate resources deter progressive MMC practice. Against this backdrop, Meissner and David (2007: 160) argue that “accurate estimates and projections of human resource needs, policies and strategies for task shifting and task sharing should aim to maximize the use and time of trained health care personnel in resource-poor settings”. Meissner and David (2007: 160) further argue that “involvement of traditional practitioners is crucial to ensure engagement and participation where male circumcision and initiation practices are performed. In contexts where both types of practices occur, concerted efforts should be made to scale up integrated medical circumcision alongside traditional initiation practices into manhood”.

Even though there are quite a number of social, ethical and resource issues; funding from international health organisations such as WHO, UNAIDS, USAID and other large funders have advocated reduced risk and increased success and access to VMMC. This includes de-medicalization of the surgical procedure, access to VMMC health sectors and reduction of severe complications as a result of financial resources and untrained MMC staffing (May, 2014).

## **2.4 Conclusions**

Chapter 2 presented a review of literature relating to existing research on MC. The review presented an overview of the origins of MC and its practice in the traditional settings. The chapter pointed out those challenges associated with TMC that resulted in the adoption of MMC. Although the DoH adopted VMMC and has been promoting it as a component of the HIV prevention strategy, the chapter noted that there are existing challenges associated with

VMMC. The success of the VMMC campaigns is largely dependent on how stakeholders work collaboratively to address identified challenges. The next chapter will give the theoretical frameworks that guided this study.

## **CHAPTER THREE**

### **THEORETICAL FRAMEWORK**

#### **3.0 Introduction**

The intention of this research is to critically examine the attitudes and perceptions of students towards MMC. It is important to begin by emphasising that a single theory cannot work alone in exploring the implementation and understanding of the health behaviour of students affected by the policy/programme. Against this backdrop, this study draws upon the theories of public policy implementation and the concept of planned behaviour and reasoned action. The attitudes and perceptions of people affected by a policy are also crucial to the success of implementation.

#### **3.1 Public Policy and Public Policy Implementation Theory**

##### **3.1.1 Defining Public Policy**

Public policy is defined as the ethical guide to action or procedures adopted by the administrative executive concerning issues in a manner consistent with law (Howlett and Ramesh, 2003). For Houghton and Mifflin (1996: 36), public policy is viewed as “whatever government choose to do or not to do”. This definition of public policy presupposes a proposed course of action of a person, group, or government within a given environment providing obstacles and opportunities which the policy was proposed to utilize and overcome in an effort to reach a goal or realize an objective or a purpose (Houghton and Mifflin, 1996).

Houghton and Mifflin (1996) further hold that public policies are those developed by governmental bodies and officials. The notion and characteristics of public policy stems from the concept of being formulated by authorities including chiefs, legislators, judges, administrators, councillors and executives (Houghton and Mifflin, 1996). The significance of public policy is that its consequences circulate around the whole society either directly or indirectly, providing incentives that encourage certain behaviour over another.

##### **3.1.2 Defining Policy Implementation**

Policy implementation for Houghton, Mifflin and Boston (1996: 17), is succinctly referred to as “what happens after a bill becomes a law”; involving role players, organisations and target groups i.e. people who are involved in carrying policies. Houghton, Mifflin and Boston (1996: 18) further hold that policy implementation could be of “legislative, executive or judicial origin, put into effect on the endeavour to accomplish their goals”. In the process of cultivating

and affirming successful policy implementation, the wide understanding of policy implementation implies that the implementation stage should be an important phase of the policy cycle.

Howlett and Ramesh (2003: 12) maintain that “Implementation is a process whereby programmes or policies are carried out, the translation of plans into action”. This specifies the performing of duties, tasks, putting a decision or plan into effect and making sure that the job is done while simultaneously providing emphasis for careful use of evidence-led approaches to monitoring and supporting policy implementation (Howlett and Ramesh, 2003). In public policy implementation, making sure that duties, tasks and decisions are put in place would mean successful implementation of a public policy.

According to Banker (1970: 72), “policy implementation is a set of socio-political process flowing and anticipated by early phases of the policy process”. This would mean that implementation is a set of socio-political processes that is determined by segments established predominantly at the commencement of the policy process.

Pressman and Wildavsky (1984: 25) argue that “policy implementation may be viewed as a process of interaction between the setting of goals and actions geared to achieve them”. This is a formal process; an interaction in policy implementation planning that gives a policy direction towards achieving its goals. Achieving the goals of the policy in policy-making is effective if the policy informs the intended goals of that policy. A more precise working definition indicates that policy implementation encompasses those actions taken by public or private individuals or groups of stakeholders that are directed to implement a policy, a program, or a project. In this regard, the involvement of various stakeholders and public participation is considered paramount.

According to Hill and Hupe (2000: 11), “successful implementation, requires compliance with statutes’ directives and goals; achievement of specific success”. A policy that is inconsistent with the statutes and goals relevant to its plan is likely to have a flaw and is unlikely to be successful.

Policy implementation theory gives an understanding of how and why public policy is put into effect (Schofield and Sausman, 2004). This process in public policy implementation provides

the idea of how a policy was or would be implemented simultaneously providing an understanding of why a specific policy is put in place. Schofield and Sausman (2004) argue that implementation implies processes and the ability to convert policy into action by operationalizing the strategy in the form of programs. This implies putting a plan into effect in the form of actions to address social problems. In this regard, there are various stakeholders involved in the process. This is why Ryan (1996) argues that the implementation of a policy is through a series of programs influenced by the role played by various stakeholders and interest groups. In line with this argument, Pearson and Nelson (2005) argue that management of these interest groups is one of the key factors to successful implementation. Again, it can be highlighted that in every policy to be implemented or having been implemented, the influences of specific stakeholders, good management and carrying of responsibilities by these stakeholders underpins successful implementation.

The most common meaning of implementation is to carry out, to accomplish, to fulfil, to produce or to complete. This meaning could easily be equated with public services such as health service delivery. Thus, policy implementation is regarded as the accomplishment of policy objectives through the planning and programming of operations and projects so that agreed outcomes and desired impacts are achieved. Failure to achieve these impacts means poor implementation. For example, evidence may provide that new HIV infection is increasing despite extensive HIV/AIDS prevention programs including state government provision of free VMMC. This would denote that the implementation outcome has been poorly implemented.

Policy implementation is formally the province of a complex array of administrative agencies often referred to as bureaucracies. Bureaucrats are policy making groups and officials in a government department. Bureaucrats are perceived as being concerned with procedural correctness at the expense of people's needs (Smith, 1973). This, in other words, assumes that the direct actors in public policy implementation include bureaucrats who provide service delivery to people. Within this complex array of administrative agencies are low ranking street-level bureaucrats defined as the subset of a public agency or governmental institution containing individuals who carry out and enforce actions required by law and public policies (Smith, 1973). Examples of street-level bureaucrats are managers who have direct contact with the public such as housing inspectors, teachers and police officers.

Smith (1973) maintains that one reason bureaucracies in third world states find it difficult to implement governmental policies is the nature of the policies which these political systems must formulate. In addition, third world states have not been afforded the luxury of incremental policymaking. This means that policies adopted in third world countries tend to be ambitious and more of a sweeping program designed to bring about development and social reform.

Another important element in public policy implementation is public participation and communication. Public participation entails taking citizens opinions, informing them and consulting them through meetings, community *imbizos*<sup>5</sup> on policy issues (Arnstein, 1969: 221). Cogan and Sharpe (1986) provide an overview of public participation as a process that provides individuals an opportunity to influence public decisions and has long been a component of the democratic decision-making process. Wilcox (1994) notes the most frequently used tools for communication include the news media, pamphlets, posters, meetings and responses to inquiries. For Makinde (2005: 63), “communication is an essential ingredient for effective implementation of public policy”. It is, however, important to note that meetings alone can be turned into a vehicle for one-way communication by simply providing superficial information, discouraging questions, or giving irrelevant answers (Wilcox, 1994). Inadequate communication can produce inaccurate and inconsistent information that can lead to misunderstanding.

### **3.1.3 Approaches in Policy Implementation**

Within public policy implementation, there exists a policy decision approach that comprises the Top-Down Approach (or Forward-Mapping) and Bottom-Up Approach (or Backward-Mapping). There is also a synthesis approach which is the combination of both the Top-Down and Bottom-Up Approaches. Van Meter and Van Horn (1974: 447-8) argue that the “fundamental feature of public policy implementation has specific dimensions and will also depends on the success of the policy to be implemented”. The approaches used in policy implementation are important in determining the nature of policy implementation.

#### **3.1.3.1 Top-Down Approach in policy implementation**

The Top-Down approach is a method in a policy implementation process whereby decisions on implementation are made or taken by a few individuals affected by the decision. The top people typically provide plans, guidelines, and fund implementation processes. The word

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<sup>5</sup> In South Africa, *Imbizo* refers to a forum for discussing policy issues

“Top” in this model is an indication that all decisions come from the top while the word “Down” simply indicates that the decisions filter down to the people. In project initiation and implementation, the top people such as government officials establish objectives and the decisions about what should happen is communicated to those directly tasked with implementation.

It is important to highlight that in this kind of policy implementation approach, public participation or public consultation is not taken into consideration. This is one of the reasons why Sabatier (1983) argues that the concept of a Top-Down Approach has a fundamental flaw and normally would start from the perspective of central decision-makers with great influence and in most cases would neglect the input of other actors. This kind of approach often produces a situation where the public receives any service determined by the government. In this case, the government would implement a program or project without having consulted or informed the public about the policy.

Within the Top-Down process, Forward Mapping is a concept defined as the separation of planning and implementation of policies with policy planners maintaining control over implementation (Elmore, 1979). The disputed factor and concern is that this system leads Forward-Mappers to assume that the framers of public policy are the only individuals identified as an expert source of information or key actors and others are basically impediments. This method has negative implications for strategic initiatives coming from the private sector, street-level bureaucrats, and other policy subsystems (Hjern and Hull, 1982; Hanf, 1982; Barrett and Fudge, 1981; Elmore, 1979).

Forward-Mapping is a strategy that comes most readily to mind when one thinks about how a policymaker might try to influence the implementation process in the Top-Down Approach (Elmore, 1982; Sabatier, 1986). The sequence in which the Top-Down Approach develops is that it begins at the top of the process with as clear a statement as possible of the policymaker's intent, and proceeds through a sequence of increasingly more specific steps to define what is expected of implementers at each level (Sabatier, 1986). This means that decisions come from the top and flow down to lower ranking officials who have little or no influence with regards to decision making.

As I have mentioned at the beginning of this section, the concept of Forward-Mapping emphasises the separation of planning and implementation of policies with policy planners maintaining control over implementation. The logic of Forward-Mapping is that it begins with an objective and elaborates an increasingly specific set of steps for achieving that objective. It states an outcome against which success or failure can be measured (Elmore, 1982; Sabatier, 1986). Furthermore, Hjern et al., (1978) argues that the essential features of a top-down approach are that it starts with a policy decision by governmental (often central government) officials and then asks the following questions:

To what extent were the actions of implementing officials and target groups consistent with the objectives and procedures outlined in that policy decision?

To what extent were the objectives attained over time (i.e. to what extent were the impacts consistent with the objectives)?

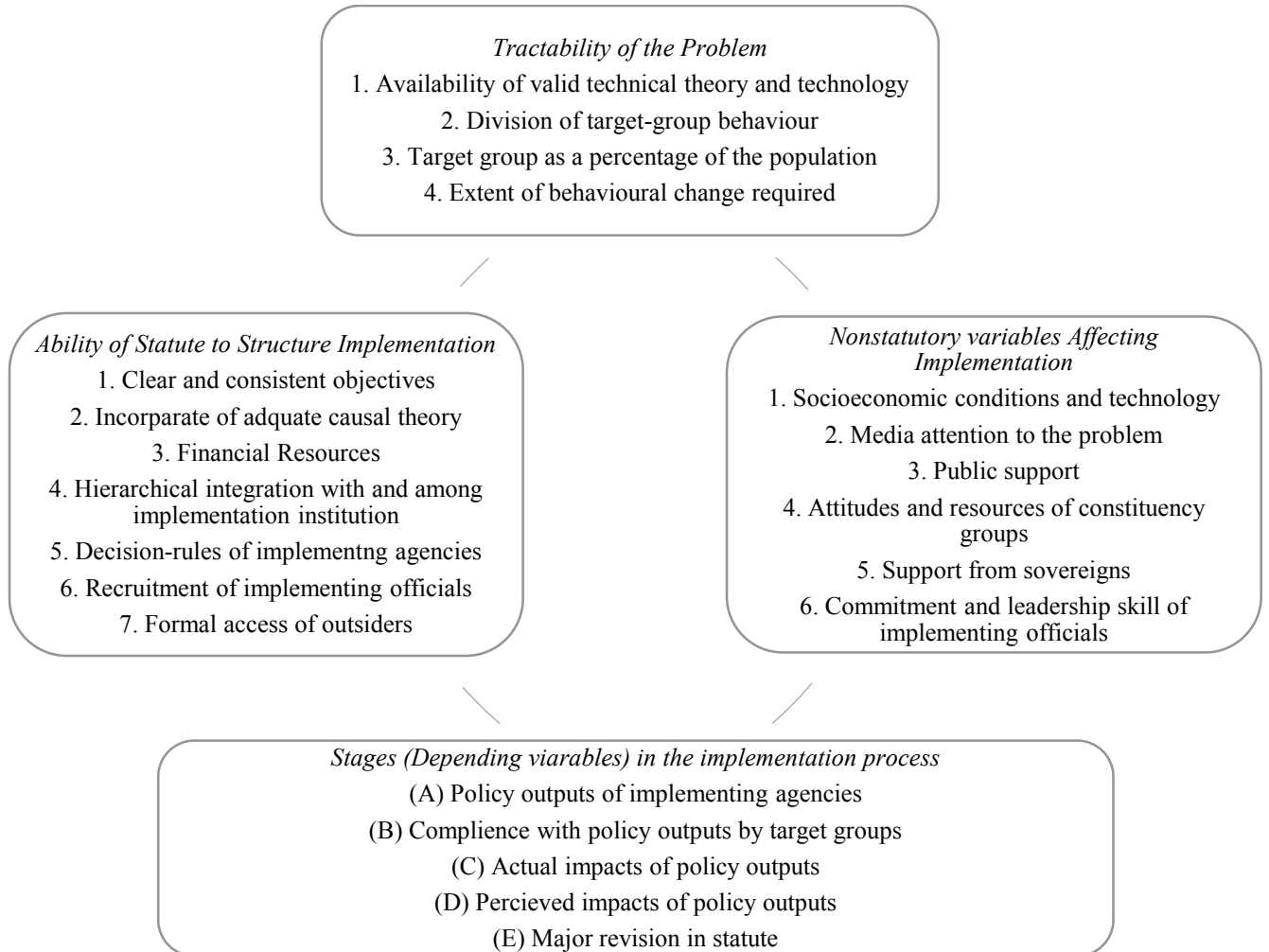
What were the principal factors affecting policy outputs and impacts, both those relevant to the official policy as well as other politically significant ones?

Was the policy reformulated over time on the basis of experience?

Examples of Top-Down Approach are derived from Sabatier and Mazmanian's (1980) analysis of implementation researchers. Their approach took as its point of departure the first generation of implementation research with its pessimistic conclusions (Pressman and Wildavsky, 1973; Murphy, 1973; Bardach, 1974; Jones, 1975; Berman and McLaughlin, 1976; Elmore, 1978). In this analysis, Sabatier and Mazmanian (1980) identified a variety of legal, political, and tractability variables affecting different stages of implementation

Below is a diagram indicating the variables impacting on different phases of the implementation process.

*Figure 3: Phases of Implementation Process*



Source: Sabatier and Mazmanian (1986: 24)

The variables indicated in the above diagram are synthesised into a shorter list of six sufficient and generally necessary conditions for effective implementation. The conditions are associated with the following objectives:

1. *“Clear and consistent objective”* (Sabatier 1986: 23)

Quoted from “(Van Meter and Van Horn, 1975), clear legal objectives were viewed as providing both a standard of evaluation and an important legal resource to implementing officials” (Sabatier, 1986: 23). This meant that working in accordance with the objectives of

law enhances positive making of judgement about the amount and value of a very crucial legal resource to bureaucrats or officials associated with the implementation process.

2. *“Adequate causal theory” (Sabatier, 1986:23)*

Argument based on the assumption that “policy intervention incorporate an implicit theory about how to effectuate social change” (Sabatier, 1986: 23). For Sabatier and Mazmanian (1979 quoted in Pressman and Wildavsky, 1973: 23) “the adequacy of jurisdiction and policy levers given implementing officials as means of ascertaining those causal assumptions” (Sabatier 1986: 23). Adequate causal theory supports and advocates that policy makers have a strong influence and effect on the implementation process by linking the program to a valid causal theory. This can be linked to the necessary influences vested upon officials to be able to ascertain causal assumptions identified. Thus, there are no limitations of responsibility among the officials.

3. *“Implementation process legally structured to enhance compliance by implementing officials and target groups” (Sabatier, 1986: 23).*

This is the ability of administration officials to effectively implement their programs; in line with the aforementioned and having been identified is the “variety of legal mechanism including the number of veto points involved in program delivery as well as the sanctions and incentive available to overcome resistance” (Sabatier, 1986: 23). Taken from (Pressman and Wildavsky, 1973) “this would include the assignment of programs to implementing agencies which would be supportive and give it high priority” (Sabatier, 1986: 23). Adequate, in this instance, means availability to handle resistance as well as prioritized task to support and give priority to the policy, program or project.

4. *“Committed and skilful implementing officials” (Sabatier, 1986: 23)*

Implementing officials have the discretion, skills and commitment to utilise the available resources to implement the policy (Lipsky, 1971; Lazin, 1973; Levin, 1980) cited in (Sabatier, 1986: 23). “While this could partially be determined by the initial statute, much of it was a product of post statutory political forces” (Sabatier, 1986: 23). This, in other words, is the compulsory willpower given to officials associated with the implementation of a policy depending on the commitment to objectives and skills in using available resources deemed crucial to policy implementation.

5. *“Support of interest groups and sovereigns” (Sabatier, 1986: 25)*

Identifying the number and target group (Downs, 1967; Murphy, 1973; Bardach, 1974; Sabatier, 1975) recognises the state that there is a “need to maintain political support throughout the long implementation process from interest groups and from legislative and executive” (Sabatier, 1986: 23). In public policy implementation, scholars such as Lipsky (1971), Wildavsky (1973) Sabatier and Mazanian (1979) have brought into the picture that in most

public policy implementation processes, the priority is given to different stakeholders in order to maintain successful implementation.

6. *“Changes in socio-economic conditions which do not substantially undermine political support or causal theory” (Sabatier, 1986:25).*

Implies a policy change especially when significant agitations from other policy areas changed the resource, “this variable simply recognised the changes in socio-economic conditions” (Sabatier, 1986: 25). An example cited from “(Hofferbert, 1974; Aaron, 1978) “the Arab oil boycott or the Vietnam War could have dramatic repercussions on the political support or causal theory of a program (Sabatier, 1986: 23)”. Again, as aforementioned in the second objective, the influences might have strong consequences on a policy, project or program.

In order to ensure successful implementation through the use of the above-mentioned conditions; the principal dogma is “that the first three conditions be considered or dealt with by the first policy decision (i.e. the written law passed by the relative body), while the last three are mainly the product of subsequent political and economic pressure at the time of the implementation process” (Sabatier, 1986: 25). This means that the principal three conditions will be considered by the policy administration solution under the written law passed by the legislative and the second three sets of conditions are mainly results of political and economic pressures.

“Policy makers have some ability to select one set of implementing officials over another; to affect the number of clearance points; to provide appropriate incentives and sanctions; and to affect the balance of constituency support” (Sabatier, 1986: 25). Policy makers will, from time to time, select a set of officials in order to maintain an equal balance of the public support or to uphold competing demands. Mazmanian and Sabatier (1979) argue that the behaviour “of street-level bureaucrats and target groups could be kept within acceptable bounds over time if the six conditions were met” (Sabatier, 1986: 25). This means that their prioritized performance can be reserved within tolerable confines if the six conditions were successfully met.

The entire Top-Down Approach in policy implementation processes was tested in various aspects. Sabatier’s (1978) work focused on state or local policy initiatives as opposed to the implementation of federal policies. The first point is the “importance the Top-Down Approach attaches to legal structuring of the implementation process” (Sabatier, 1986: 27). However, Sabatier (1978) maintains that this phenomenon is “gratifying since one of the most frequent

criticisms of the framework has been that emphasis on structuring is unrealistic” (Sabatier, (1986: 27). Secondly, “the six conditions of effective implementation have proven to be a useful checklist of critical factors in understanding variations in program performance and in understanding the strategies of program proponents’ overtime (Sabatier, 1976: 27). Thirdly, the “relatively manageable list of variables and the focus in framework on the formulation-implementation-reformulation cycle encouraged authors to look at a longer time-frame than was true of earlier implementation studies” Sabatier, 1986: 27). This has helped to discover the importance of learning by the program proponents’ overtime because they “become aware of deficiencies in the program and seek improved legal and political strategies” (Sabatier, 1976: 27).

The criticism of the Top-Down Approach was laid down by various authors including Hjern and Porter (1993), Hjern (1992), and Barrett and Fudge 1981). These criticisms include the Top-Down Approach’s neglect of lower-level officials. Identified as the “most serious problem with forward mapping is its implicit and unquestioned assumption that policymakers control the organizational, political and technological processes that affect implementation” (Sabatier and Mazmanian, 1978, 1980 cited in Sabatier, 1986: 27).

A more precise criticism of the Top-Down Model is that the model is complicated and difficult to utilise and use in conditions or situations lacking the dominant policy enactment, statute or agency, “but rather a multitude of governmental directives and actors, none of them preeminent” (Sabatier, 1986: 30). (Sabatier, 1986: 30) argues that “this happens particularly in social or public service delivery”. In this case, social service delivery may mean social development policies including support grants and pensions. Sabatier and Mazmanian, (1978 quoted in Hill, 1997: 288) recognize such situations “stating that policy implementers have very little ability to predict the outcome of such complex situations except to say that the policy they are interested in implementing will probably not be effectively implemented” (Sabatier, 1986: 30).

The “ third criticism of the Top-Down Model lies in the concerns that they are likely to ignore, or at least underestimate, the strategies used by street-level bureaucrats and target groups to get around (central) policy and/or to divert it to their own purposes” (Weatherly and Lipsky, 1977; Elmore, 1978; Berman, 1978 cited in Sabatier, 1986: 30). Another concern relates to the issue that “such models are likely to neglect many of the counterproductive effects of the policies

chosen for analysis. “While a really skilful Top-Downer can attempt to deal with such deficiencies, there is little doubt that this, too, is an important criticism” (Sabatier, 1986: 30). Another crucial criticism is that Top-Down Models undermine “strategies used by street level bureaucrats and target groups to get around (central) policy and/or to divert it to their own purposes” (Weatherly and Lipsky, 1977; Elmore, 1978; Berman, 1978” cited in Sabatier, 1986: 30). A related point is that such models are likely to neglect many of the counterproductive effects of the policies chosen for analysis” (Sabatier, 1986: 30).

Other criticisms stem from “arguments that the distinction between policy formulation and policy implementation is misleading and/or useless” (Nakamura and Smallwood, 1980; Barrett and Fudge, 1981; Hjern and Hull, 1982; Hjern, 1982 cited in Sabatier, 1986:31). The distinction ignores the “fact that some organizations are involved in both stages and/or that local implementing officials and target groups often simply ignore central legislators and administrators and deal directly with each other” (Sabatier, 1986:31). “Since it is difficult to isolate policy decisions, it is preferable to talk about action and reaction (Barrett and Fudge, 1981)” cited in (Sabatier, 1986:31). “And because policies change as they get implemented, it is better to talk about policy evolution” (Majone and Wildavsky, 1978) cited in (Sabatier, 1986: 31). The criticisms of the Top-Down approach “led to the development of the Bottom-Up Approach or street-level approach to the study of public policy implementation in the 1980s” (Sabatier, 1986: 31).

### ***3.1.3.2 Bottom-up Approach in policy implementation***

A Bottom-Up Approach is defined by Elmore (1982: 26) as a theory that “focuses on local developmental issues and the marginalized people living in the threatened areas, it provides increased international recognition for non-governmental organizations and land users by obligating the state to channel authority and resources to them”. A Bottom-Up Approach is likely to have more influence through street-level bureaucrats, moving up to top officials. Thus, local actors participate in decision making. This approach is a direct opposite of the Top-Down Approach because it requires the decentralization and delegation of power, decision making to less, smaller and territorial minor units. However, Freidman (2003) stated that it is very difficult to implement this approach in a state dominated by elites. In this view; elites may be politicians and other private groups that might not be interested in the views and contributions of

marginalized people to the policy process. The significance of this policy implementation approach is that it is a people-centered approach (Beer, 1996).

Sabatier (1983) argues that the Bottom-Up Approach emphasises more attention and focuses on (bottom) local implementation structures and is thus better and more reliable for assessing the dynamics of local disparity and variation. The Bottom-Up approach begins by clearly identifying almost all the actors involved and will be responsible for service delivery in local areas and question their intended goals including the strategies adopted, activities as well as the contacts available. The contacts will be utilised as vehicles for change, service delivery and developing a strategic technique that will assist to identify actors at all spheres including the local, regional and national levels involved in the planning, the actors involved in the sourcing of finance, as well as implementation and execution of governmental including non-governmental programs (Sabatier, 1979). This approach in policy implementation allows and provides the mechanism that enables a smooth and effective move “from street-level bureaucrats (the ‘Bottom’) moving up to the ‘Top’ policy-makers in both public and private sectors” (Hjern et al., 1978; Hjern and Porter, 1981; Hjern and Hull, 1985 cited in Sabatier, 1986: 32). This means a provision of effective communication and participation of actors from the bottom to the top actors in public policy implementation. This process means the opposite of Top-Downers. Local actors are prioritised and given authority about the strategies to be pursued in their local context.

An example of the Bottom-Up Approach is the study conducted by Hjern et al (1978) in Sweden on Manpower Training which focused on the “interactions of unions, governments, and industrial firms in different areas and then moved to looking at the networking technique to identify the actors involved in planning, financing, and executing relevant programs” (Sabatier, 1986: 32). This example has significantly revealed “that program success was far more dependent upon the skills of certain people involved in local implementation structure than upon the effort put or placed by central government officials” (Sabatier, 1986: 32). This means that street-level bureaucrats (such as teachers and police officers) should have the necessary skill to implement policies, project or programs. This is a qualifying idea because if these people lack the necessary skill, the policy is unlikely to be successful. A typical example of a public policy program failure in South Africa is the Outcome Based Education program

(OBE)<sup>6</sup>. In this example; it was found that teachers lacked sufficient training to teach the new basic education thus leading to implementation failure (Naidoo, 2011). The failure has been attributed to the lack of involving people at the bottom to express their opinions about the policy. In this situation, teachers were given a curriculum to teach but were not given the opportunity to raise their concerns pertaining to their capacity, ability, and resources to implement the OBE programme.

The key favorable and advantageous aspect of the Bottom-Up perspective lies in the assumption that it aims and directs attention consistently to the formal relationship without excluding the informal relationship constituting to the establishment of a policy sub-system involved in making, formulating and implementing policies (Hjern, 1982). This means that the approach does not endorse and neglect the other aspect of a policy sub-system. On the contrary, it tries to balance and accommodate both the formal and informal relationship constituting the policy sub-system.

The approach has a well-developed explicit and replicable methodology that is used to identify a policy network (implementation structure) (Hjern, 1982). This was proven through a well-conducted study to identify the implementation structure of a policy (Manpower training program). Using the examples adopted from the Man-power training program allows the identification of “actors involved in the planning, financing, and executing relevant programs in public policy or program implementation” (Sabatier, 1986: 32).

In this approach, policymakers have the advantage to effectively assess the importance of governmentally enacted programs the same applies to private organizations as well as market forces in trying to solve the perceived problems. This is opposed to beginning with governmental perceived problems (i.e. problems identified by the government as well as the strategies adopted and advanced for dealing with the perceived problems) (Hjern, 1982). On the contrary, “Top-Down is likely to overestimate the significance of governmental program i.e. its main focus” (Sabatier, 1986: 32). The actors are the most important characters in the policy implementation process. To be able to solve a problem in hand; it is better to start by

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<sup>6</sup> OBE: is educational theory adopted in education system around the world, the method simply bases each part of educational system around goals.

looking at the actors' perceived problems since they have the advantage to assess government programs. Top-Downers would be unlikely to consider this approach.

The strategy to refrain from starting with the emphasis on the accomplishment of recognized policy goals and objectives gives an advantage to freely identify and realize most kinds of unintended problems as well as the consequences of governmental or private programs (Sabatier, 1983). The strength of the Bottom-Up Approach is that it does not start by focusing on the achievement of formal policy. This has an advantage in identifying unwanted consequences of government including private programs.

The Bottom-Up Approach has the ability to deal with a policy/problem area involving a multitude of public and private programs with none being preeminent. This means that Bottom-Up Approach can deal with policy problems from many public and private sectors equally and favorably than the Top-Down Approach. Sabatier (1983) argues that focusing on the plans pursued by a variety of actors, gives an advantage to dealing with strategic collaboration and interaction overtime as opposed to top-downers with their focus on plans and strategies of program proponents simultaneously deserting and recognizing those of other interest groups or actors.

Backward-Mapping implies that policy planning and implementation cannot be separated. In reality, the policy-making process starts with ideas concerning specific actions to general policy plans (Elmore, 1979). The concept of Backward-Mapping adopts the perspectives of various actors or policymaker's integrated ideas and perspective on the implementation process. However, "it does not assume that policy is the only or even the major-influence on the behaviour of people engaged in the process" (Elmore, 1980: 90). Despite the fact that it starts with a specification of the desired endpoint and then works backwards, "it does not rely on compliance with policymaker's intent as the standard of success or failure, it offers instead a standard of success that is in all respects conditional" (Elmore, 1980: 90). This implies "that one's definition of success is predicated on an estimate of the limited ability of actors at one level of the implementation process to influence the behaviour of actors at other levels and on the limited ability of public organizations as a whole to influence private behaviour" (Elmore, 1980: 90). This means that a priority is placed on the assessment of the limited aptitude and ability of actors at each phase of implementation and enactment process to bring about the capacity to have an effect on the behaviour of actors at other levels.

Scholars, including Hjern and Porter (1981), Hull and Hjern (1982), cited in Sabatier, (1986:32) “argue that the bottom-up approach laid emphasis on the target groups and service deliverers and state that policy is made at this level” (i.e. policy is made at the local level). This means that local bureaucrats are the main actors in policy. In this regard, policy implementation is a Backward Mapping movement starting with the specification of the desired endpoint.

The Bottom-Up approach is more vivid in practice or nature and implies that implementation is well tacit and understood by considering a policy from the perspectives of target groups and those responsible for service delivery. In line with this view, the implementation of the policy is assumed to occur at two levels. Firstly, policy implementation occurs at the large scale level where the centrally located performers, interest groups or actors devise a government, private program. Secondly, policy implementation takes place at the wide-range level in which local level performers resort to plans and advance their own strategies and implement them (Ryan, 2004). In that regard, an indicative element of effective service delivery should include the viewpoint of target groups including service deliverers.

It is important to highlight that a Bottom-Up Approach begins exclusively and without a statement of intent. It is implemented with a statement of the specific behaviour and this is deemed to happen at the lowest level of the implementation process that has the ability to generate the need for a policy. The most significant aspect of the Bottom-Up Approach is that it “questions the assumption that explicit policy directives, clear statements of administrative responsibilities, and well-defined outcomes will necessarily increase the likelihood that policies will be successfully implemented” (Elmore, 1980: 30).

A criticism of the Bottom-Up Approach is that “just as top-downers are in danger of overemphasising the importance of the Center vis-à-vis the periphery; bottom-uppers are likely to overemphasize the ability of the periphery to frustrate the Center” (Hjern, 1982 cited in Sabatier, (1986:32. “The focus on actor’s goals and strategies, the vast majority of whom are at the periphery, may underestimate the Center’s indirect influence over those goals and strategies through its ability to affect the institutional structure in which individuals operate (Kiser and Ostrom, 1982). Hjern (1982) cited in Sabatier, (1986: 32) stresses that Bottom-Up “fails to start from an explicit theory of the factors affecting its subject interest since it relies heavily on the perception and activities of participants” (Sabatier, 1986: 32). “It is therefore

not easy to analyse the factors indirectly affecting their behaviour or even the factors directly affecting such behaviour which the participants do not recognise” Sabatier, 1986: 32).

“Bottom-uppers, are far less preoccupied with the extent to which a formally enacted policy decision is carried out and much more concerned with accurately mapping the strategies of actors concerned with a policy program” (Hjern, 1982: 90). This means that bottom-uppers do not focus on the extent to which a formally endorsed policy decision is taken but focuses on plotting and mapping the strategies of actors concerned with the policy.

### ***3.1.3.3 Synthesizing Top-Down and Bottom-Up Approaches***

It is vital to introduce a sort of conceptual understanding and common features between the Top-Down and Bottom-Up approaches. As a point of departure, it is worth mentioning that these approaches are not contradictory. On the contrary, they are complementary. The Top-Down Approach begins with a verdict or decision of the government and scrutinizes the degree to which bureaucrats carry out vis-averse fail to adopt and carry out these decisions. “It seeks to find the reasons underlying the extent of the implementation” (Howlett and Kamesh, 2005: 16). “The Bottom-Up Approach begins at the other end of the implementation chain of command and argues that the activities of street-level implementers be fully taken into account” (Howlett and Kamesh, 2005: 16). “Therefore, synthesizing the Top-Down and Bottom-Up approaches provide better insights into policy implementation than either does on its own” (Fox, 1980; Sabatier, 1986) cited in Sabatier, 1986: 34). The table below shows the comparison of some of the important features of the Top-Down and Bottom-Up Approaches.

Table 1: Comparison between Top-Down and Bottom-Up Approach

	Top-Down (Sabatier and Mazmanian, 1983)	Bottom-Up (Hjern, et al., 1982)
Initial Focus	“(Central) Government decision e.g., new pollution control law” (Sabatier, 1986: 33)	“Local implementation structure (Network) involved in a policy area, e.g. pollution control” (Sabatier, 1986: 33).
“Identification of Major Actors in the Process” (Sabatier, 1986: 33)	“From Top Down and from government out to private sector” (Sabatier, 1986: 33)	“from Bottom (government and private) Up” (Sabatier, 1986: 33)
Evaluation Criteria	“Focus on extent of attainment of formal objective (carefully analysed). May look at other politically significant criteria and unintended consequences but are optional” (Sabatier, 1986: 33)	“Much less clear. Basically anything the analyst chooses which is somehow relevant to the policy issue or problem. Certainly does not acquire any careful analysis of official government decision” (Sabatier, 1986: 33).
Overall Focus	“How does one steer system to achieve (top) policy-makers intended policy results?” (Sabatier, 1986: 33)	“Strategic interaction among multiple actors in a policy network” (Sabatier, 1986: 33)

Source: (Sabatier, 1986: 33)

With regards to a synthesis approach, Hjern et al., (1978) cited in Sabatier, (1986: 34) “began with an acute awareness of the methodological weaknesses of the Top-Down Approach, a commitment to the development of an inter-subjectively reliable methodology, and a concern with policy areas involving a multitude of public and private organizations”. This brought the idea to merge and synthesize both the Top-Down and Bottom-Up approaches to policy implementation. The Synthesis Approach will be explained later in this chapter in greater detail.

The major debates surrounding these theoretical approaches is that, “Backward Mapping shares with Forward Mapping the notion that policymakers have a strong interest in affecting the implementation process and outcomes of policy decisions” (Elmore, 1980:91). In both these implementation approaches, there is a belief that policymakers maintain a keen interest in achieving or realising positive attributes in policy implementation. But “Backward Mapping explicitly questions the assumption that policymakers ought to or do influence what happens in the implementation process, it also questions the assumption that explicit policy directives, clear statements of administrative responsibilities, and well-defined outcomes will necessarily increase the likelihood that policies will be successfully implemented (Elmore, 1980: 91). This backward movement in policy implementation challenges and seeks to limit the influence of policymakers over what happens in the implementation process. It further challenges the assumption that crafting well-structured policies and plans will increase the chances of successful policy implementation.

While the Top-Down model measures implementation success in terms of faithfulness to the goals of the programme, the Bottom-Up Approach sees successful implementation in terms of the positive outcome brought about by implementation (Matland, 1995). Successful implementation, according to the Bottom-Up Model, is not measured by the level of faithfulness to formal policy goals but the positive changes brought about by implementation. This is because some policies do not have clearly defined goals. The Bottom-Up Approach indicates a process where a decision comes at a low level of decision makers which includes delegates and other stake holders representing a community.

Scholars such as Dunsire (1997) and Saetren (1998) advocate the reconciliation of the forward-mapping and Backward-Mapping. By synthesizing the two approaches, scholars attempt to harness the strength of both approaches while simultaneously addressing their weaknesses. The Synthesis Approach uses the Bottom-Up unit of analysis taking into consideration the “variety of private and public actors involved with the policy problem including their concerns with understanding the perspective and strategies of all major categories of actors” (Sabatier, 1986: 34). This feature or approach is then combined with backward mappers concerns with the way in which socio-economic circumstances, conditions and legal instruments constrain behavior, and formerly suggests this merged viewpoint to the examination of policy alteration over periods of at least ten years. This stipulated time-frame is to arrange and deal with the role of

strategy or policy concerned with learning and then adopts the intellectual style or methodology perspective of many forward-mappers in order to utilize fairly abstract theoretical constructs as well as “to operate from an admittedly simplified portrait of reality focusing on theory construction rather than providing guidelines for practitioners” (Sabatier, 1986: 34).

Despite the interest in synthesizing the Top-Down and Bottom-Up Approaches, Dunsire, (1978) and Saetren (1986) have argued that synthesizing the two approaches might not be what is most important. On the contrary, it is advisable for policy analysts to focus on understanding the context in which each of the models is relevant as opposed to trying to synthesize the two approaches (Matland, 1995).

Having explored the meaning of public policy and policy implementation, the remaining part of this chapter will focus on examining the theory of Planned Behaviour and Reasoned Action as the second theoretical basis of the study.

### **3.1. Theory of Planned Behavior and Reasoned Action**

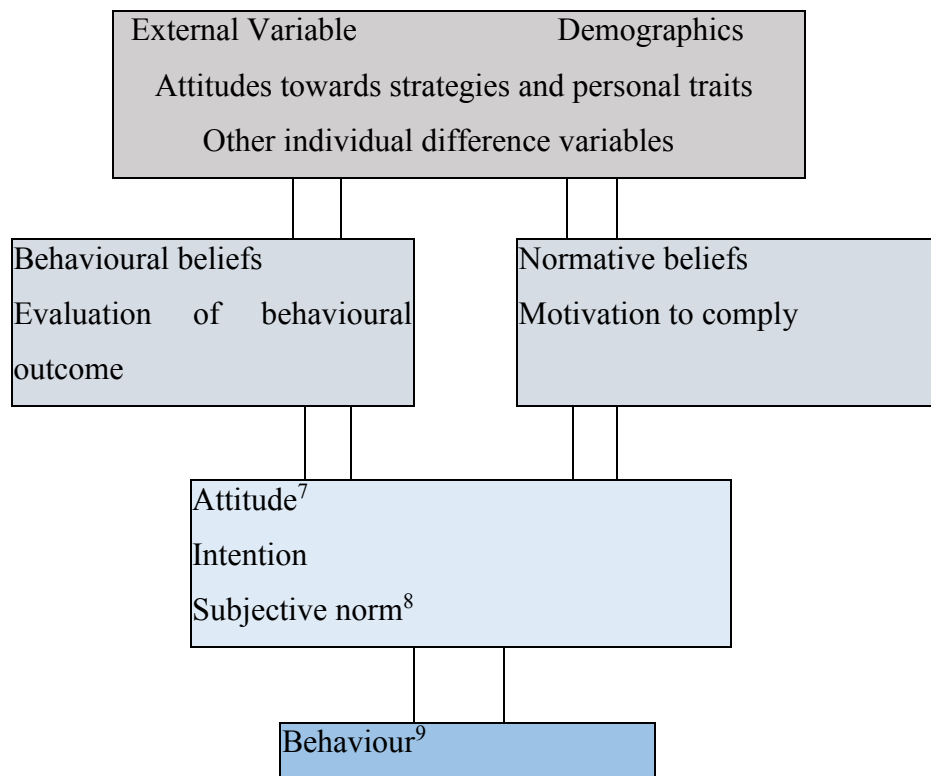
The theory of planned behaviour postulates three conceptually independent determinants of intention. The first is the attitude toward the behaviour and refers to the degree to which a person has a favourable or unfavourable evaluation or appraisal of the behaviour in question. The second predictor is a social factor termed subjective norm which refers to the perceived social pressure to perform or not to perform a given behaviour. The third antecedent of intention is the degree of perceived behavioural control which refers to the perceived ease or difficulty of performing the behaviour. It is assumed to reflect past experience as well as anticipated impediments and obstacles (Ajzen, 1991). However, as a general rule, the more favourable the attitude and subjective norm with respect to behaviour, and the greater the perceived behavioural control, the stronger should be an individual’s intention to perform the behaviour under consideration (Ajzen, 1991). Ajzen (1991) further argues that theory of reasoned action is mostly used to explain behavioural conditions of individuals.

The theory of reasoned action is largely used in health related research to analyse health-related behaviour of patients who suffer from diseases. It has been used in studies aimed at “developing interventions to promote long-term medication adherence TB and HIV/AIDs” (Munro, t2007: 17) and a “meta-analysis on condom use in relation to STIs such as HIV/AIDS” (Albarracin et al., 2001: 142-161). In most health related studies, the theory is used to show how external

variables such as attitudes, background, arrogance, personal demographics and personalities are influenced by behavioural or normative beliefs.

Below is the diagram illustrating the concept of reasoned actions. In the first inference are the external variables and the demographics. These are individual external opinions influenced by individuals' background and up-bringing. In the second inference, beliefs are evaluated through behavioural outcomes and linked to the underlining norms and motivation. The third inference, the outcomes are linked with attitude, intention and subjective norms in order to provide the understanding of a certain individual behaviour towards a practice (Ajzen and Fishbein (1991)). An example is given below.

Figure 4: Concepts of Reasoned Action




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Ajzen and Fishbein (1991:12)

<sup>7</sup> Attitude: this refers to the amount of belief perceived by an individual on a certain behaviour biased by their judgments of these beliefs.

<sup>8</sup> Subjective norms: refers to how social environment has influence over an individual behaviour or perceptions.

<sup>9</sup> Behavioural intention: indicates a combination of an individual's attitude functions in relation to certain sorts of behaviour with subjective norms that has influence and would weigh their insight of the worth of that behaviour.

The above table illustrated the procedure in which external variables of individual are influenced by different beliefs. For example, different people have different attitudes, behaviour and even expectations of the community or the society at large in which they reside. Thus, beliefs and attitude of other members of the society might have an influence on inspiration which can subject other individuals to a certain convinced expectation about the kind of life they live. For example, an influence or motivation behind an individual choosing to be circumcised or not, choosing to use a condom or not can be as a result of societal influence. An individual might come from a family that does or does not practice circumcision; however the ability for the person to choose or choose not to undergo VMMC would depend on the social, cultural and subjective norms which will have a positive or negative influence on his/her perception and attitude towards performing a certain behaviour. In this instance, Fishbein (2000) argues that the inability to have voluntary control over lifestyle or culture in which people resides will have a greater influence on their decisions as they are subject to that particular norm.

In this study, attitude refers to the way students express their perceived belief towards VMMC. Subjective norms would be the students' social and cultural beliefs; how they influence their attitudes towards VMMC, and behavioural intention would influence the likelihood of students to undergo or choose not to undergo VMMC as a result of the combination of attitudes and subjective norms.

In this study, the theory of reasoned action involves analyzing variables which influence student attitudes and perceptions towards VMMC. It facilitates an analysis of an individual's social circumstances that play a role in determining what they perceived as reasonable attribute/behavior. Identifying these personal circumstances of students will help to identify the implementation process of VMMC.

### **3.2 Conclusion**

The theoretical framework adopted to explore the perceptions, attitudes and implementation process of VMMC draws upon both the public policy implementation theory and the concept of Planned Behavior and Reasoned Actions. The two approaches will help to establish the nature of implementation of the VMMC programme and to analyze variables that influenced attitudes and perceptions of students towards VMMC. This study situates itself in the context

of the new VMMC strategy and programs. The discussion pertains to implementation and the attitudes and perception of students towards this policy/programme.

## **CHAPTER FOUR**

### **RESEARCH METHODOLOGY**

#### **4.0 Introduction**

This chapter presents the research method employed in the study. The chapter will present the sampling arrangement and ethical considerations in the research, and the method of data collection and analysis.

#### **4.1 Research Methods and Research Design**

Research methodology is the systematic and scientific procedures used to arrive at the findings of a study (Nachamias et al., 1996; Saunders et al., 2007). For Jayaratne and Stewart (1991: 85), “research methodology employed in Social Science is commonly categorized as being either qualitative or quantitative”. A qualitative method uses the concept of reflexivity in understanding people as self-reflecting (Smith, 1994) and seeks to gain in-depth knowledge about the contextual reality of research participants (Babbie and Mouton, 2001: 270). The focus of qualitative research is directed more on the study and interpretation of meanings based on the belief that human experience is worthy of examination. According to Smith (1994: 86), “qualitative research is the interpretative study of a particular issue”. Qualitative research is particularly relevant to exploratory research which attempts to understand the impact of a new development (e.g. technology and social) processes (Robinson, 2002: 271). Qualitative data are collected through semi-structured interviews, “a conversational manner that has the ability to offer the participant the chance to explore issues they feel are important” (Kirchin and Tate, 2000: 210).

A quantitative approach uses numerical analysis. It “gathers quantitative data by means of quantitative variables with the aim of determining the magnitude of variation” (Kumar, 1996: 10). Quantitative research involves the use of structured questions with predetermined responses often involving a large number of respondents. Quantitative data are collected through a survey or from an existing database.

This study adopted both a qualitative and a quantitative methodology. The use of mixed-method allowed the researcher to generate a robust knowledge of research participants about the subject of inquiry while at the same time providing quantitative measures for research

variables. Using both approaches provides a richer contextual basis for interpreting and validating data or results (Cook and Reichardt, 1979 cited in Kaplan, 1988).

#### **4.1.1 Data Collection**

For this study, the first method used to collect data was surveys. A total of 80 closed-ended survey questionnaires were distributed to a total of 40 female and 40 male students. Most of the survey questions were distributed during the forum period when students were out of lecture theatres, and late hours at student computer laboratories and libraries. The questionnaire consisted of short questions with pre-determined responses. For the survey questions, the study adopted a quantitative method grounded in the post-positivist social sciences paradigms that primarily reflects the scientific methods of the natural scientist. The post-positivist principle emphasises the meaning and the creation of new knowledge (Ryan, 2006). This approach was used to obtain data from the participant into statistical representations.

Qualitative data were obtained through individual semi-structured interviews and focus group discussions. One staff member, a student representative comprising eight students was interviewed using a semi-structured interview method with open-ended questions. Semi-structured interviews provided the opportunity to probe and investigate issues during interviews (Bertrand and Hughes, 2005). In addition to semi-structured interviews, all eight students were re-invited into two separate focus group discussions separated into 4 male and 4 female. The focus group interviews were conducted in order to get the range of ideas, perceptions and attitude of students. This allowed illuminating the differences in perspectives of different people or between groups of individuals (Rabiee, 2004).

#### **4.1.2 Sampling**

A sample is a subset of respondents drawn from a total research population. Most researchers do not consider the entire population for study due to factors such as the nature of the study, funds and time constraints. This study adopted non-probability purposive sampling to select study sample. This method was used to select research participants for the interviews. Purposive sampling requires the researcher to constantly look for knowledge and information since participants have the knowledge about the topic being studied (Mouton and Marias, 1990).

This study considered three population groups from the HCC of UKZN. The first study population were students targeted for the MMC. This category of student participants were

drawn from various study levels since attitudes and perceptions may also be influenced by age, experience and capacity. The second study population were employees of the Campus HIV/AIDs Support Unit and staff nurse from the Campus Clinic. The inclusion of these participants assisted in evaluating the implementation process as well as attitudes and perceptions towards the VMMC campaign. The third study population were members of the SRC that have been aware of the VMMC campaign. Below is a table indicating the number of participants in this study.

*Table 2: Overview of the Study Sample*

<b>Sample for individual interviews</b>						
Student representative	1					
Health Support Staff	1					
<b>Sample for focus group interview</b>						
Male	4					
Female	4					
<b>Survey Sample</b>						
Levels	Male	Female	Africans	Indians	White	Coloured
1	10	10	10	6	2	2
2	10	10	10	6	2	2
3	10	10	10	6	2	2
4	10	10	10	6	2	2

#### **4.1.3 Research Ethics**

In line with the University’s research policy, an ethical clearance (HSS/0029/034M) was obtained from the UKZN ethics committee as well as a gate keeper letter from the University’s registrar. Addressing the ethics included presenting all participants with a consent form containing clearly articulated details on the purpose and requirements of my investigation. The consent form clearly indicated that participation was voluntary and anonymous. In addition, the consent letter clearly indicated that participants could opt out at any point in time if they felt so. Participants were also informed not to answer questions they felt uncomfortable with.

Participants were informed that the notes taken will be kept confidentially and would not reflect their identity. It was explained that there was no direct compensation associated with participation in the research. Participants were, however, apprised of the valuable contributions

they will make to knowledge generation through their participation. Hence, I did not experience challenges in collecting data despite the sensitivity of the research topic

#### **4.2 Conclusions**

This chapter has explored the methodological issues including sampling techniques, study sample and methods of data gathering employed in the research. The information gathered through these methods enabled a holistic understanding of implementation, attitudes and perceptions towards VMMC. The next chapter will provide findings from the empirical component of the research.

## **CHAPTER 5**

### **FINDINGS AND ANALYSIS**

#### **5.0. Introduction**

Chapter five presents findings from both interviews and survey questionnaires administered in this study. The chapter is organised thematically to present findings from the empirical component of the research.

#### **5.1 Description of Sample**

The study comprises two categories of participants: students and staff respectively. Staff participants were only interviewed while student participants were both surveyed and engaged in focus group discussions. Most of the participants (N=88) were students while there were only two staff participants.

#### **5.2 Implementation Process and Students' Perceptions of VMMC**

The finding of this study reveals that the implementation of VMMC at HCC of UKZN had a cogent rationale (i.e. the process adopted the relevant procedures required in public policy implementation for successful public policy implementation). This is qualified by the inclusion of various stakeholders and their respective roles in the implementation.

##### **5.2.1 Awareness of VMMC Campaigns**

The response pertaining awareness gathered through surveys is shown in Tables 3 below. Table 3 shows the level of study, the gender of participants and awareness of the VMMC campaigns. Of the eighty survey questionnaires distributed, more than 72 respondents indicated that they were aware of the VMMC. The table shows that the percentage of males that were aware of the VMMC was nearly twice that of females. This is not unexpected since males are the primary targets of VMMC although females have a role to play since it has implications for their health and wellbeing. The table also shows that there was no significant percentage difference across the level study for male participants in terms of their awareness of VMMC. While first-year male students had the highest percentage of students that reported being aware of the VMMC campaigns, the converse is the case for female participants. Table 3 shows a positive relationship between awareness of VMMC and level of study for female participants and a

negative relationship for male participants. In addition to students, both staff that was interviewed also reported being aware of the VMMC campaigns on the HCC.

*Table 3: Awareness of VMMC Campaigns*

<i>Level of study</i>	<i>Male</i>		<i>Female</i>	
	<i>F</i>	<i>%</i>	<i>F</i>	<i>%</i>
1	13	16.25	2	2.5
2	12	15	6	7.5
3	12	15	7	8.75
4	10	12.5	10	12.5
<b>Total</b>	47	58.75	25	31.25

### **5.2.2 Method of Communication of the VMMC at Howard College**

The study attempted to understand the methods of communication used to inform students about VMMC on Howard College. Table 4 presents findings regarding how student participants were informed of VMMC. The responses in the table were obtained from both surveys and focus groups involving 88 student participants. The table shows that campaigns were the most common means that student participants heard (36.25% N=29) about VMMC. Of the 29 students that reported hearing about VMMC through campaigns, 16 were males while 13 were females. The second common means that students heard about VMMC is Student Notices<sup>10</sup> (29.54% N=26) as reported by 9 males and 17 females. A total of 13 students (6 males and 7 females) indicated they heard about VMMC via HIV/Support Unit. Only 6.8% (N=9) reported that they heard about VMMC from friends. Of these, 6 were males while 3 were females. An interesting finding is that (9.0% N=8) of student participants who reported that they were unaware of VMMC programme on campus. Of the students that reported being unaware of the VMMC campaigns, 5.6% were males and 3.4% were females. The foregoing shows that both staff and student participants are aware of the VMMC campaign and programme.

<sup>10</sup> The University sends daily email notifications to the student community.

Table 4: VMMC Communication Media

	Male		Female	
	F	%	F	%
Campaigns	16	18.18	13	14.77
HIV Support Unit	6	6.8	7	7.9
Student Notices	9	10.22	17	19.31
Friends	6	6.8	3	3.4
Other	2	2.2	1	1.1
No idea about the programme	5	5.6	3	3.4

The study participants expressed satisfaction with the manner in which the VMMC campaigns was being implemented. Of the eight students interviewed, six indicated that they were aware of the VMMC programme and campaign. Six of the eight student interviewees felt that communication of the programme was effective. A student participant narrated her experience about the VMMC campaign in the following excerpt:

“I am a female student and I am doing my final year in the College of Humanities. I became aware that this campus provides free Voluntary Medical Male Circumcision when I was asked to volunteer at the massive Male Circumcision campaign that was launched in 2013. My involvement was to recruit male students and inform them about the Voluntary Medical Male Circumcision.

Another respondent indicated being aware of the programme and tasked with recruiting student and informing them about the VMMC programme. His involvement resulted in him testing for HIV and getting circumcised. The respondent noted: “apart from myself, there were other students who were tasked to mobilize and inform other students about the programme. I tested and got circumcised a few days after the campaign”.

A student participant who has not been aware of the VMMC campaign observed that:

“I am a first-year student in the College of Humanities and I am doing Bachelor of Arts Degree. I do not know of the Voluntary Medical Male Circumcision programme in this campus, it is the first time I am hearing of it, and I am not used to most of the offices and other facilities within the campus”

The staff members indicated that it is their duty to implement programmes that benefit students through health promotion. The respondents further indicated that they work together with the DoH in the province to foster health education, awareness and prevention strategies at UKZN. This is achieved through an integrated effort between staff members and student representatives to successfully communicate health education, awareness and prevention within the institution. Expounding on the VMMC campaigns, a staff member stated that:

“It has been part of our mandate in this institution of higher learning to facilitate and also provide HIV/AIDs awareness, education and support as well as prevention to our students. The provincial health department contacted and informed us that they were embarking on the Voluntary Medical Male Circumcision programme and campaigns in all institutions of higher learning. The university was positive with this meaningful health benefits approach. Working together with other staff members, student representatives and the provincial department of health; we communicated and endorsed this particular initiative/programme to be implemented at UKZN Howard College and other University campuses”.

*Figure 5: VMMC at UKZN Howard College*



Source (Magantola, 2013)

## **5.2.3 VMMC Campaign and Programme (Relevant stakeholders<sup>11</sup>)**

### ***5.2.3.1 Stakeholders involvement***

Both interviews and surveys showed stakeholder involvement in the VMMC programme. Stakeholders involved in the VMMC include Kwa-Zulu Natal Department of Health (KZN DoH), Higher Education HIV/AIDS (HEAIDS), the University's HIV/AIDS Support Unit

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<sup>11</sup> Information concerning relevant stakeholders was gathered through Interviews, excluding the survey samples.

(CHASU), Student Representative Council (SRC), Non-Government Organisations (NGOs), and the eThekweni Municipality. These stakeholders were involved in the programme because of the strategic roles they play in HIV prevention (KZNDoH), is the provincial government health institute that regulates and facilitates health-related issues and problems affecting, HEAIDS is an organisation sponsored by various institutes as well as the government and is responsible for promoting health benefits related to HIV/AIDs in HEIs, CHASU is the university's body responsible for health promotion especially HIV/AIDs related matters, while eThekweni Municipality is the district government responsible for developing and regulating the municipality's affairs).

A student representative interviewed for the study outlined the roles of the different stakeholders in the following excerpt:

“The programme was brought by HEAIDS/DoH as per their strategy to implement VMMC in higher institutions of learning. Through an agreement with the University management; the staff from University HIV/AIDs programme, together with the Student Representatives and student Volunteers were part the programme or must I put it that people who were tasked to carry out the process through representing, organising, communicating and facilitating the programme within the campus. CHASU was the direct office in which student would go for VMMC information and referral. With regards to the campaign, various people including a representative from eThekweni Municipality and NGOs were part of the strategy. So to answer your question I would say that the people who were directly involved were the DOH, the University, including EThekweni Municipality, NGOs and Student Representatives as well as student volunteers”.

Another student representative that participated in the study also acknowledged that they were involved in the planning and implementation of the VMMC. The student representative participant made this point in the following excerpt:

“We as student representatives and other appointed students represented students in all the planning process before implementation of the major campaign and programme. However, we consulted with the student prior the implementation and let them know that the university together with HEAIDS and KZN DoH were planning to initiate the VMMC campaign and programme within UKZN Howard College”.

Views from students interviewed in this study showed that students were involved in the planning of the VMMC campaign through their participation in the university's support structure. A student participant made this point in the following excerpt:

“The people I know were involved in the planning process are the university HIV/AIDs Support unit and Student representatives. I know this because I work as a volunteering student at the campus HIV/AIDs Support Unit”.

Although a student participant reported being unaware of stakeholders involved in the planning of the VMMC campaign, he noted that he was aware of the campaign through the University's notice system:

“I am not aware of the people that were directly involved in the planning process; however I did become cognisant of the VMMC campaign and programme through the university notice prior its implementation”.

The general view of stakeholder involvement was that all relevant stakeholders were consulted. Each stakeholder played roles in making sure that implementation of the VMMC programme was well initiated and carried out. Most respondents agreed that stakeholder involvement was crucial in the initial process of the VMMC campaign and programme implementation. Out of the ten students and staff interviewed, eight (6 students and 2 staff members) stated that stakeholder involvement was crucial to the success of the programme. The following excerpt from a staff participant highlights the value that was placed on stakeholder engagement in the implementation process of the VMMC.

“Yes, various stakeholders were involved in the process. We were informed by the student representative that DoH and University HIV/AIDS support unit will be hosting a VMMC campaign and programme within the institution. This was done prior to the launch of the campaign. The university staff and student representatives were part of the planning of the programme”

The above response revealed three perceptions with regards to stakeholder involvement in the implementation process. The first perception was that consultation with various stakeholders

did take place prior to implementation. The second perception indicated that people directly involved in the implementation process included student representatives and CHASU in collaboration with KZN DoH, HEAIDS, NGOs and eThekweni Municipality. The last perception was that not all students knew the people that were directly involved in the planning process.

#### ***5.2.3.2 Role of Various Stakeholders in the Implementation of the VMMC***

The stakeholders listed above played various roles in the implementation of the VMMC. The staff made this point in the following excerpt:

“Our role as CHASU and the student representative within the institution was to make sure that the programme is well communicated and implemented since it brought positive benefits in terms of health and social wellbeing of our students”.

HEAIDS’ main role was communicating and making sure that the VMMC programme gets implemented within the institution. The role of KZNDoh in the implementation process was to facilitate all the necessary requirements of VMMC service in a hospital setting and during the VMMC campaign. More importantly, the KZNDoh provided the necessary equipment for the implementation of the VMMC. CHASU, together with Student Representatives, were actively involved in facilitating student engagement in the process and participation in the actual VMMC. The student representative that participated in the study reported that:

“Our role as the student representatives was to facilitate a favorable environment including consultation with students, and mobilizing and organizing student to participate in the campaign and programme. This was done through a joint venture with the university HIV/AIDs unit and other student volunteers. Non-Government Organizations (NGOs) and eThekweni Municipality assisted with funds, transport<sup>12</sup> and other materials.

A student revealed that their direct involvement in the VMMC programme gave them practical experiences. A student interviewee noted that the programme benefited nursing and medical

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<sup>12</sup> The student representative said that NGOs and EThekweni municipality provided transportation during the launch of the VMMC programme and Campaign, there after CHASU provides access to transport for student wishing to under VMMC

students through practical experience in their field of study. The view of the student is presented in the excerpt below:

“Even though the campaign was meant for male students, it also benefited me even though I am a female student. Female students were allowed to test for HIV and to encourage their male partners to undergo VMMC. Furthermore, my involvement in the programme was a meaningful experience as a nursing student because it provided me with some practical experience”.

From the foregoing, it is evident that each stakeholder had an important role to play in implementing the programme within the institution. Collaboration among various stakeholders enabled effective participation which ultimately allowed a smooth process in reaching as many students and executing the VMMC programme effectively within the institution.

#### ***5.2.3.3 Important Factors with regard to VMMC Implementation***

The general process of carrying out the VMMC that emerged from the interviews was that students who want to undergo VMMC make an appointment via CHASU. In the appointment, CHASU indicates the date, time and location of the VMMC since no VMMC was carried out within the university premises. According to a staff participant from CHASU,

“No medical male circumcision was carried within the institution or the university clinics. Students willing to be circumcised are referred to nearby hospitals linked with the university to carry out the process”.

Since the service was limited to only members of the University community, students were advised to present their student cards when they go for the VMMC.

#### ***5.2.3.4 Student Safety***

The general view of safety was aligned with the DoH VMMC safety standards. According to the WHO and UNAIDS, safety policy stipulates that VMMC be done in medical facilities that are recognised and up to standard. The safety requirement also entails that all medical facilities that implement the VMMC must have adequate resources and qualified personnel to carry out the procedure safely (World Health Organisation and United Nations HIV/AIDS programme, 2007). VMMC safety measures at UKZN are in line with policy standards made by the WHO. The aforementioned were specified by the staff member from during interviews:

“There is a policy stipulated by World Health Organisations such as WHO, USAID and UNAIDS. This policy regulates Government and non-Government health sectors globally that carry out VMMC. The policy ensures that these organisations take safety precautions including the use of trained specialists and adequate resources”.

#### ***5.2.3.5 Access and Transport to VMMC Medical Sites***

A positive implementation strategy of the VMMC at HCC is that students are given free transportation to the VMMC sites. Through the DoH (2012) strategy on VMMC, there is no cost associated with undergoing VMMC. This means that in all government facilities that offer VMMC, the service is offered free of charge to the client. In the UKZN context, transport to the VMMC sites is provided by the institution. The impact of “no cost” contributed to a positive uptake of the VMMC programme at UKZN Howard College, since the majority of the students come from disadvantaged backgrounds and cannot afford to pay for medical expenses. The staff participant from (CHASU) made this point in the following excerpt:

“In all our university campuses, access to medical male circumcision and transportation is free. Students do not pay any additional fees and these fees are neither charged on their tuition fees. If a student suffers from pain or any complication after circumcision while around university premises, we have a clinic that offers medical services free of charge. This is a part of the university health programme and aims to benefit all students within the university”.

#### **5.2.4. Students Perceptions and Attitude towards VMMC**

This section of the chapter indicates responses gathered from students via interview and the survey questionnaire concerning attitudes and perceptions towards VMMC at HCC. Below is a table indicating student perceptions and attitudes towards VMMC. The table indicates the number and percentage of students that agree with the statements.

Table 5: Attitudes and Perceptions towards VMMC

	F	%
VMMC is safe and reliable	68	85.0
VMMC reduces the risks of STIs	63	78.75
VMMC provides positive health benefits	68	85.0
There is no need to use condom once you have undergone VMMC	27	33.75
VMMC is safer compared to TMC	68	85.0
VMMC enhance sexual satisfactions	22	27.5
VMMC gives a boy a status of being man	27	33.75

#### 5.2.4.1 Safety and Reliability of VMMC

Most students believe that VMMC is a safer and a more reliable practice compared with TMC. As shown in the table, 85% (N=68) student participants agreed that VMMC is a safe and reliable means to undergo MC. In-depth interviews with regard to safety and reliability revealed that a person's judgement is linked or connected to culture and social factor including lifestyle and behaviour. Three student participants in interviews revealed that although they believe that VMMC is safe and reliable, they cannot run away from the fact that TMC is part of their culture and tradition. The views of students in this regard are presented in the following excerpts:

“Voluntarily Medical Male Circumcision is safe. Most of my friends are circumcised; I am one of the two not circumcised among the buddies. Circumcision is part of my tradition but due to the complications experienced with TMC in the homelands, my parent decided I should wait until things get better in the TMC setting. I am willing to undergo VMMC but I am still waiting for my parent to give me permission. I have seen many of my friends and other student booking to undergo VMMC; some of them have already been circumcised. In that regard, I believe it is well practiced because the student wouldn't be undergoing the MMC if it had serious complications”.

“VMMC is better and safe compared to TMC. However the reality is that though TMC is associated with complications, it is part of my culture. We normally get chopped off

our foreskin at an early stage of adulthood and I can't run away from the practice. It was done to our great grandparents; it is also done among us too. At least, we should find a way to practice it safely.”

“I believe circumcision done in a hospital setting is safer compared to traditional male circumcision done in the bush or elsewhere without proper medical benefit”.

#### **5.2.4.2 VMMC Reduces STIs**

There are different opinions with regards to VMMC and a reduction of STI identified from interviews and the survey. When students were asked about their perception of VMMC and STI reduction, majority (78.75% N=63) highlighted that VMMC reduces STIs. The view about the potential of VMMC to reduce STIs is further presented in the following excerpt from a student interview:

“I may agree that it might have the potential to reduce STIs, and this would mean that Voluntary Medical Male Circumcision (VMMC) or Male Circumcision (MC) does reduce chances of getting infected with HIV. To me, VMMC is another mere programme that is introduced to try and fight against sexually transmitted diseases, it up to a person to choose a measure of protection against STIs. In that regard I believe it better to use protection e.g. condom than undergoing MMC, MC does not fully protect a person from getting infected with STIs”.

Female student participants revealed that the VMMC process will benefit them in terms of health. A female participant revealed that the introduction of the VMMC campaign and programme within HEIs did not benefit male students solely. According to this participant, the programme provided health benefits to some female students in terms of reduced risks of females being infected with HIV and other STIs when their male partners are circumcised. In addition, the participant noted that the programme promotes condom usage which is beneficial to both males and females. One female student mentioned that:

“Minority of female student do have relationships with sugar-daddies and men outside the university. Many of the female students have partners in student residences and also partners within the university. If many male students are to remain immune from contracting HIV and STIs through circumcision and use of a condom; this would deter

the spread of such diseases and viruses neither would a female student in a sexual relationship with student be exposed to HIV/STIs either”.

Despite the positive attitude towards VMMC, a few student participants noted that there was no health benefit associated with VMMC. These students expressed a preference for the use of prevention methods such as condoms compared to having their foreskin removed. The following excerpt from a student interview highlights this point:

“I would not explicitly say that circumcision or VMMC does not provide a positive health benefit to students, certainly it does. But I believe that male students who are likely to undergo VMMC are ignorant students, who like to fool around with multiple partners, students who are unlikely to use protection such as condoms. They believe in penetrative sex. Such students are not responsible. They are likely to believe that circumcision will protect them against STIs and they will probable practice unsafe sex”.

#### **5.2.4.3 Cluster of Responses on Attitudes and Perception of VMMC**

From the in-depth interviews and the survey questionnaire, positive health benefit, risk compensation, pain and enhanced sexual satisfaction were some of the important elements associated with positive or negative attitudes and perception of VMMC. For example during the focus group session, participant mentioned the following:

“Why should I bother getting circumcised? I certainly believe it does not enhance sexual satisfaction either. It is more like one of those superstitions we know among the society. Not even one of my friends who have undergone VMMC came to me and said; my friend, ever since I have been circumcised I am feeling an increased sensation when having sex. To me MC whether Medical or Traditional is not important; I certainly think there is a great need and responsibility for circumcised boys to use condoms”.

“Risk compensations are reduced if one gets circumcised medically. However I do not believe VMMC enhanced sexual experience and that it gives the status of being a man, what I know and believe is that VMMC reduces the risk of contracting STIs”.

“VMMC is better and painless compared to TMC; you are unlikely to die if you undergo MMC, but I do not believe it enhances sexual satisfaction”.

“I do believe that VMMC is safe. That it gives status of being a man no!; but my friends told me that after being circumcised I will walk as if I have an STI because the wounds are painful and take long to heal, I am scared other students will laugh at me, but I think condoms should be used at all times when having sex to prevent STIs and unplanned pregnancy”

“I believe that the circumcision programme is best and safe for male students; but it does not give him a status, boys are promiscuous and they are likely to engage in riskier behaviours. They must use condom after circumcision, I am not sure if it enhances sexual pleasures though!

In most of the above responses, students revealed that VMMC can provide health benefits. Their decision to engage in VMMC, therefore, did not seem to be influenced by the expectation of enhanced sexual pleasure as reflected in 78.75% of students who perceived positive health benefits from VMMC. Added to this is one female participant who believes that males are promiscuous and VMMC will benefit them from contracting STIs. However, a small proportion claimed that if you get circumcised, the wounds do not heal.

The participants revealed several factors towards various health benefits of VMMC. Firstly the interviewed students at Howard College were very positive about the perceived health benefits of VMMC. However, the only positive attribute that the student raised was the measure of safety and reduced chances of contracting STIs. They did not express that VMMC gives sexual enhancement and that it gives the person a status of being a man.

### **5.3. Conclusion**

This chapter has presented the findings of the study conducted in UKZN Howard College. The examination of the data presented in the chapter covered various aspects related to the implementation, attitudes and perceptions towards VMMC. The next chapter will discuss the researching findings and provide a conclusion to the thesis.

## **CHAPTER SIX**

### **DISCUSSION AND CONCLUSION**

#### **6.0 Introduction**

The findings of this study have revealed that MMC implementation at UKZN Howard College did have a high engagement by different stakeholders. It also established a lucid and effective communication strategy as evidenced by the number of students who was aware of the VMMC programme at Howard College, UKZN. Furthermore, the findings revealed that students generally have a positive attitude and perception of VMMC. This chapter provides a discussion of relevant themes related to the implementation process as well as the perceptions and attitudes of students towards the VMMC programme on HCC that emerged from the findings of the research.

#### **6.1. Awareness and communication process**

With regards to communication and awareness, essential and informed consultation was established or recognised prior the implementation of the programme. VMMC was communicated to various stakeholders and information was passed on to students via various communication means including university notices, notice boards and word of mouth. According to Wilcox (1994), information sharing is an important first step to legitimize participation in a policy or programme. In this study, participants revealed that it was important that students were made aware of VMMC. Their inclusion was important since the programme affected both their lives and wellbeing.

Communication and awareness were further prioritized via the massive VMMC campaign that was launched within the institution. The major campaign became influential in motivating students to undergo VMMC. Wide-ranging communication and promotion of the VMMC programme in HHC, UKZN seemed to have been of paramount importance as far as the implementation of the VMMC programme was concerned.

Findings of the study showed that communication and awareness of VMMC programme is portrayed to have been well established and effective through verbal and nonverbal communication methods that were prioritized via the massive VMMC campaign, campus media, student notices and comradeship among students. These findings depict the same view reviewed the literature concerning the rollout of the VMMC Campaign and the Men's Forum

programme launched on the Howard College Campus in April 2013 through the cooperative effort between UKZN, the Department of Health, the eThekweni Municipality and partner NGOs (Dhlomo, 2013). Substantial communication and awareness are one of the priorities of successful public policy implementation. Communication is an essential ingredient for effective implementation of public policy (Makinde, 2005).

Findings of the study showed that the VMMC campaigns and programme at HCC was aimed at combating the HIV epidemic within UKZN Howard College. This rationale is consistent with the literature review which established that the rationale behind the joint venture and launching of the campaign were informed by studies which showed that in the three universities in KwaZulu-Natal, the prevalence of HIV was at 4.1% among male students and 7.8% of female students (HEAIDS, 2010). The study also found that females between 18 and 19 years constituted 1.5% of those that live with HIV (HEAIDS, 2010).

## **6.2. Stakeholders Involvement and Roles**

In terms of the relevant stakeholder; information that was raised by both staff and student was that the VMMC programme was a joint strategy facilitated by KZN DoH and HEAIDS. The programme included other stakeholders such as eThekweni Municipality, UKZN authorities and HIV Support Unit Staff CHASU and Student Representatives. All these stakeholders worked collaboratively in the planning process of the implementation of the VMMC campaign and programme aimed at combating the HIV within UKZN Howard College.

From the majority of the information provided by both staff and students, it was apparent that strategies agreed upon between the University and DoH was the necessity of a major campaign to be launched at the University premises. The SRC and the University communicated with students to take part in the implementation of the VMMC Campaign/programme. Support strategies for the VMMC campaigns were endorsed by the University and the DOH.

Students were given the opportunity to participate voluntarily in the VMMC campaigns and undergoing VMMC itself. Students also played a meaningful role in encouraging other students to undergo VMMC. The substantial participation of students in launching the campaign promoted a successful implementation of the VMMC Programme at HCC, UKZN. The involvement of different stakeholders and student prior and during the implementation process qualifies as community participation and negates an implementation process that denies public

involvement. The value of encouraging local participation has been recognised by O’Faircheallaigh (2010: 2) who states that local participation may be encouraged by decision makers, not just as a mechanism for getting information or testing its robustness, “but to help with problem solving by suggesting ideas, concepts, solutions and resources that can be mobilised to address complex social issues”. Implementation of public policy, according to this view, needs to be communicated and involve ideas of people who are affected by the policy. Meissner and David (2007: 160) offer a similar view arguing that “involvement of different people is crucial to ensure engagement and participation where male circumcision and initiation practices are performed”.

Table 6 below provides an overview of services offered to staff and students across the five campus of the university. The table shows that of the 266 MMC performed across the university, HCC had the highest. This points the success of the VMMC campaigns on the campus.

*Table 6: Services Provided to both Students and Staff in 2014*

ITEM	HOWARD COLLEGE	MEDICAL SCHOOL	EDGEWOOD	WESTVILLE	PMB	TOTAL
HIV Tests Conducted	3 565	689	1 678	2 466	2 492	10 890
HIV Positive Detected	107	7	11	20	31	176
Condom Distribution	78 000	17 639	77 950	75 000	80 436	329 025
Medical Male Circumcision	77	14	46	60	69	266

Source: (Mnganga, 2014)

### **6.2.1. Important factors with regard to VMMC Implementation**

The organising and strategic plan of the VMMC at HCC, UKZN did take respective measures of policy formulation and implementation process into account. The integration of different stakeholders and the incorporated process of service delivery to students wanting to undergo VMMC has mirrored cogent program implementation processes. According to Majola (2013), the uptake of VMMC at UKZN emerged through the cooperative effort between UKZN, the DoH, the eThekweni Municipality and partner NGOs. The Synthesis Approach uses the bottom-up unit of analysis taking into consideration the variety of private and public actors involved with the policy problem including their concerns with understanding the perspective

and strategies of all major categories of actors (Sabatier, 1983). This study reflects a synthesized public policy implementation approach.

The government, through HEIADS, opened a platform for students to undergo VMMC as part of the strategy of KZNDoh to fight against STIs and HIV/AIDs transmission. However, the approach that led to this was not a mere Top-Down strategy. The introduction of the programme was a collaborative effort of multiple stakeholders including University and Student Representatives, CHASU, eThekweni Municipality, campus clinic staff and students themselves. In addition, implementation of the policy required collaboration between students, hospitals or medical sites where students undergo VMMC and CHASU. The CHASU and student volunteers played a significant role in mobilising students to book for VMMC and to foster the promotion of free VMMC. This portrays a Bottom-Up approach in policy implementation. Hence, the strategy and approach that was used to formulate and implement the programme mirrored a synthesis approach to policy implementation. This contributed to the success of the programme as evident in the high number of students who were of the VMMC. According to Sabatier (1986: 34), “the concept of taking together the top-down and bottom-up approaches provide better insights into policy implementation than either does on its own”.

With regards to facilitating the programme, important factors that were raised by staff members and the representative of students was that VMMC in HCC, UKZN is free. This meant that all registered students who wish to undergo VMMC are allowed to do so free of charge with no medical fees charged. Secondly, it was mentioned that students are given and will be given free transport to VMMC sites to carry out the process of circumcision. This approach is in line with the KZNDoh (in 2012) stance that guaranteed males aged between 15 and 49 to undergo VMMC. Complementing the DoH policy stance, UKZN has also offered free transportation to all registered students to and from VMMC sites.

### **6.3. Student Perceptions and Attitudes towards VMMC**

In assessing students’ perceptions and attitudes towards VMMC, concerns that were raised were diverse and differed across individuals and levels of education. Attitudes and concerns were mainly centred on the view that VMMC is a better and healthier practice compared to TMC. However, what became ironic is that students’ attitudes towards VMMC cannot be assessed alone but rather be considered as their perception of TMC. The literature review

unpacked that VMMC is growing and is being prioritised in most African countries. Recent statistics on self-reported MC in a study by Anike (2013) found that 52.5% of participants in the study reported that they had been circumcised in a traditional setting. And about (40%) were circumcised in hospital or clinic (Anike, 2013). These findings show positive attribute given that TMC has been in practice for decades while VMMC has been advanced for less than a decade. Furthermore, though the majority of the student perceived VMMC as a safe practice, some students' attitude towards VMMC was that MC, either done medically or traditionally, bore no social consequences and is often a product of misconception.

### **6.3.1. VMMC Reduces Risks of Contracting HIV and Transmission of STIs**

The majority of the students expressed beliefs that getting circumcised properly reduces the chance of contracting STIs. 75% of students agreed that VMMC reduces STIs. According to Mathew (2012), VMMC reduces the chances of contracting HIV and STI. All VMMC sites provide men with education on post-procedural behaviours in order to ensure the correct understanding of all relevant issues regarding VMMC and to avoid risk compensation. The findings in this study are consistent with the literature explored regarding attributes in relation to reduced risk factors for contracting STIs and HIV when undergoing VMMC.

### **6.3.2. VMMC is safer and better Compared to TMC**

Most students revealed that VMMC is better and much safer compared to TMC. However, pain and other health related problems were raised by some of the participants as concerns related to undergoing VMMC. Some students expressed fear of the condition after circumcision especially when the wounds were not yet healed. For example, participants mentioned that.

“I do believe that VMMC is safe. But my friends told me that after being circumcised I will walk as if I have an STI because the wounds are painful and take long to heal, I am scared other students will laugh at me”

“I believe circumcision done in a hospital setting is safer compared to traditional male circumcision done in the bush or elsewhere without proper medical benefit”.

Female students expressed positive beliefs about the health benefits regarding VMMC in the focus group interviews. However, a female participant noted the importance of pre VMMC counselling in the following excerpt:

“Yes, I think VMMC is safe. However, I believe that the circumcision programme that should include counselling first is best for most male students, most of the boys are promiscuous and they are likely to engage in risky behaviours while pretending to be loyal and faithful. VMMC will protect them as well as their female partners from contracting STIs.”

Students believe that VMMC is safe and reliable. According to Lakey and Cohan (2000), the appraisal support involving the provision of information will help people (students in this case) to evaluate themselves. This will allow them to evaluate their own behaviour and the ability to control certain incentives and involuntary behaviour. This statement supports the aforementioned revealed by a study participant. In this study, it became apparent that some young men feel that they can provide security for their own health hence in future become victims of sexual consequences including STIs, HIV and teenage pregnancy. Hence, there is a need for cooperative education to support VMMC in reducing risk compensation among men having undergone MMC.

### **6.3.3. MC gives status of being a Man**

The majority of the students believe that MC does not give a man a status of being a man. All four female students in the focus group disagreed with the idea that MC confers the status of being a man. This is contrary to the literature explored concerning the significant of TMC. According to Raanjaard (2003), young men among Xhosa tradition are brought together during initiation and taught various traditional lessons and symbolic aspects of being a man within their particular clan. This means that MC qualifies these young men the status of being a man (Raanjaard, 2003). The literature also revealed that MC in traditional settings has a symbolic and significant impact in the up-bring and shaping of young boys in the society that practices the tradition or custom. Male circumcision forms a significant part of the initiation process and is strongly associated with the transition from childhood to manhood (Oommen, 2002). The aforementioned revealed that practice of circumcision has an element of ethnic identity as well as cultural significance among young men in certain societies. Although most participants were open to undergoing VMMC, the relevance of TMC still pervades their lives as evident in participants awaiting their parents' approval before undergoing VMMC.

#### **6.3.4 No Need to use Condom; VMMC Enhance Sexual Satisfaction**

In assessing condom usage and enhanced sexual satisfaction, this study found that most students saw the need to use condom after circumcision. The majority of the students hold the belief that VMMC does not enhance sexual satisfaction as expressed in the excerpts below:

“I think it is important to use condom after circumcision. Male circumcision does not fully protect a person from contracting STIs; furthermore, condom prevents unnecessary pregnancy”.

“yes it is very important to use condom for maximized protection; on a contrary I am circumcised and I have done sex prior circumcision and it is the same as now that I am circumcised, this is just a false belief I don't think it enhance sexual satisfaction”.

The explored theory of reasoned actions that informed this study reveals a correlation between the “perceived behavioural control which refers to the perceived ease or difficulty of performing the behaviour” (Ajzen, 1991: 17). From the study findings, it became apparent with perception of individual concerns that students expressed a strong sense of behavioural control noting that they would not undergo VMMC just to experience sexual sensations or protection against STIs. Students believe that condoms should be used at all times and should not be excluded because individual VMMC will protect them against STIs. The students expressed the belief that the use of condom can provide extra protection including protection against unplanned pregnancy.

#### **6.4 Medical Male Circumcision Programme in UKZN**

VMMC is performed at a medical facility by a qualified medical professional. The VMMC is supported by CHASU. The Unit is based on each campus and has the mandate of promoting VMMC to male students around the campus. The national considerations for the policy and practice of VMMC consider the aspect of an integrated package of HIV prevention service provision of safe MC services, strategic partnerships for VMMC delivery, human resources, information and communication and cultural sensitivity and collaboration (KZN Department of Health, 2013). The above mentioned allows a clinic team to deliver the range of integrated HIV services; a model package essential for HIV prevention. This facilitates a more effective program staff to communicate and foster HIV prevention programs and most importantly

information and skills approach for students including sexual risks and cultural sensitivity (KwaZulu Natal Department of health KZN 2010; World health Organisation, 2007).

## **6.5 Conclusion and Recommendation**

One of the goals of this research is to understand the nature and extent of stakeholder participation in the VMMC campaign and programme. In typical public policy research, there is a common understanding among public policy implementation theorists that policy implementation is formally the province of a complex array of administrative agencies referred to as bureaucracies. Bureaucrats are policy making groups and officials in a government department. Bureaucrats are perceived as being concerned with procedural correctness at the expense of peoples' need (Smith, 1973). The findings of this study have shown that policy implementation is not the province of only bureaucrats. It entails collective engagement of key stakeholders. Through the effort of the KZNDoH working together with NGOs, students and student representatives, UKZN, CHASU, and HEAIDS, the VMMC programme has been characterised by success on the HCC, UKZN. The findings of the study also showed that students were notified prior the implementation. Student involvement was achieved through various meetings held with different student bodies and student representatives to discuss the implementation of the VMMC programme.

HEIADS in collaboration with other stakeholders initiated a VMMC programme to foster HIV prevention and to combat the HIV epidemic within UKZN, HCC. With regards to the implementation of the VMMC programme and campaign; the study found that the implementation process of the VMMC programme at UKZN, HCC included various stakeholders and interested parties including the DOH, NGOs, university staff, Student representatives and students. The assessment of the strategy and approach that was used to formulate and implement the programme mirrored a synthesis approach to policy or program implementation. This was important because the technique took both the top-down and bottom-up approaches to implementation and provided better insights into policy implementation (Fox, 1980; Sabatier, 1986). The substantial participation of various interested parties in planning and launching of the VMMC campaigns promoted a successful implementation of the programme at UKZN, HCC.

At UKZN, HCC, perceptions and attitudes towards VMMC provided a better insight into understanding the attributes and limitation of most public health programmes. The result of

this study was not much different from other social science studies pertaining health prevention programs. The student perceptions and attitudes were centred on individual knowledge of VMMC as well as the cultural and social background of students. Most students who participated in the study saw the need for VMMC arguing that VMMC should be used together with condoms as prevention measures for STIs and combating HIV/AIDS. This is in agreement with the idea revealed within the literature that health education (most importantly directed to prevention), should not only focus on the positive benefits that prevention measures such as condoms and VMMC can give (HEIADS, 2012). Thus, there is a need to focus on intensive engagement to educating men about various sexual matters.

Student attitudes and perception of VMMC were mostly positive and consistent with those required by the WHO. These include included information regarding safety, benefits and education. However, a minority of attitudes portrayed the negative aspects and were highly influenced by misconception as well as the social and cultural background of students.

Some of the key issues prioritised among the recommendation as well as within the consideration for practice and policy for VMMC are that key concerns that are much related to male circumcision are the potential for sexual disinhibition. This is because circumcision may provide a false sense of protection that would perpetuate unsafe sexual practices such as decreased condom use and multiple partners (HEAIDS, 2012). The VMMC for the strategy stipulated that accurate information around VMMC including its benefits, disadvantages and risks for both men and women need to be clearly communicated through policies, plans and media (HEAIDS, 2012). This implies ensuring that the implementation of such programmes should ensure that the VMMC programme is explicitly about education and prevention. The emerging idea is a strategic programme for students that provides positive health benefit that will create a conducive living and learning environment while students acquire skills that will promote ethical caring and responsible graduates within the country. Through the assessment of the implementation process and the perceptions and attitudes of students, this study has demonstrated that VMMC implementation at UKZN, HCC had a rational and cogent approach.

Data gathered from this study reflects that VMMC is a safe circumcision and should be done in a medical setting by trained professionals. However, some participants made mention of traditional practice as symbolic and part of their culture. The department of health should make necessary effort to work together with traditional sites to ensure safety measures and reliability

within traditional settings. The formulation and implementation of the upcoming MC policy in South Africa should inform TMC initiation schools that they should adhere to safety practice stipulated within the current strategy as well as the upcoming MC policy in South Africa.

Findings of the study identified that 78.75% (N=63) of research participant were positive that VMMC reduces STI. However some men who had encountered or have undergone VMMC believe that they are resistant and protected against STIs and, therefore, do not need to use a condom. To avoid this, necessary procedures should be taken to ensure education and reduction of risk compensation among circumcised men. Hence, the use of condoms should be prioritized and circumcision should not encourage young men to undergo unprotected sex.

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*Appendix A*

**LETTER OF INFORMED CONSENT**

Dear research prospective participant,

I am **Wandile, Khawula**, a Masters student in Public Policy at the University of KwaZulu-Natal, Howard College. I am conducting a research on the attitudes and perceptions with regards to medical male circumcision on Howard College, University of KwaZulu Natal.

You have been identified as an individual that may make an important contribution to this study. The information you provide will not be used for any purposes other than those of the study stated above. Your anonymity will be guaranteed throughout the research process and any report that might produce based on the research.

Participation is voluntary. There is no payment or any other benefit be given to you for your participation in this study. If you feel uncomfortable at any time during the study, you are free to withdraw from the study. It is estimated that your participation will take between 15 to 20 minutes.

Please allow for the information you provide be recorded, in order for the researcher to retain accuracy and proprieties of the information gathered.

By signing below you agree that you have read and understood the above information, and would be interested in participating in this study.

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher's signature

\_\_\_\_\_  
Date

Should you need further information, do not hesitate to contact me, my supervisor or the university's research office via the details provided below

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Thank you for your time and assistance. Your information is greatly

## ***Appendix B***

### **Questions for Student Representative**

- Do you have knowledge about MMC programme and campaign at UKZN Howard College?
- As a member of the Student Representative Council, do you play any role in the MMC the implementation of the MMC campaign?
- Was the SRC consulted as representative of the students as a relevant stakeholder in the implementation of MMC or the MMC campaign?
- Do you think that the MMC campaign at UKZN Howard College was successfully launched?
- In your own opinion what mechanisms would you suggest the government should adopt in realizing genuine goals of the campaign?
- Is there any further comment(s) you would like to make?

## **Appendix C**

### **Questions for the staff member at (C/HIV/SU) and Clinic Nurse**

- Do you have any knowledge about MMC programme and campaign at UKZN Howard College?
- Were you involved in the planning and organising of the programme and campaign?
- Were the Campus HIV/AIDs Support Unit involved in the VMMC policy formulation process (if yes) what was your role/input?
- Who were the relevant stakeholders for the implementation of VMMC programme at UKZN and what was their role?
- Do you believe that VMMC campaign at UKZN Howard College was successfully launched?
- What would you identify as a flaw on the part of government when it comes to public consultation or involvement of relevant stakeholders during public policy formulation or the implementation of public programs, VMMC programme (your opinion based on the implementation of the VMMC programme)
- In your own opinion what mechanisms would you suggest the government or the university should adopt in realizing genuine public consultation in policy formulation and public programs?
- Has the number of student wanting to be circumcised increased, decreased or remained the same since the introduction of the campaign and where do student get circumcised?
- Have you encountered any problem as the Campus HIV/AIDs Support Unit with regards to promoting MMC?
- Is there any further comment(s) you would like to make

## ***Appendix D***

### **Focused Group Questions**

- Are you aware of MMC programme at Howard College UKZN and how did you become aware
- Were you involved in the implementation of the voluntary medical male circumcision? If not; do you know the people that were involved
- Do you think that the programme was well communicated?
- Do you think that MMC is safe and will provide positive health benefit to the?
- Do you think MC is important and can reduce STIs?
- Do you believe that MC enhances sexual satisfactions?
- What is your opinion on the belief that MC gives a boy a status of being man?
- Would you consider MMC Circumcision as better than the TMC?
- Would you encourage male students (you friend) to undergo MMC?
- Is there any further comment(s)?

**Appendix E**

**Questionnaire for Survey**

**(Kindly tick, for all questions, any answer that you know is truly reflective of your personal opinion).**

**1. Gender**

Male  Female

**2. Race**

African  Coloured  Indian  White

Other.....

**3. Age (Please write down the year that you were borne).**

-----

**4. What is your level of study?**

1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  More than 3

**5. Are you involved in any student service or leadership?**

Yes/  No

**6. Are you aware of medical male circumcision at Howard College UKZN?**

Yes  No

**7. How did you get to know about medical male circumcision?**

Campaign  UKZN newsletter/  
 Student governance address  other

9. Do you think that the programme was well communicated?

Yes

No

10. Do you think that medical male circumcision will provide positive health benefits to the students?

Yes

No

11. Are women parts of the medical male circumcision Campaign?

Yes

No

12. Please rate your level of agreement/disagreement with the following statements (1 being strongly agree while 5 is strongly disagree). Please tick only one option for each question.

Question	Response				
	1	2	3	4	5
12.1. Medical male circumcision reduces the risks of sexually transmitted infections					
12.2. There is no need to use condom once you have undergone medical male circumcision					
12.3. Medical male circumcision is safer compared to traditional male circumcision					
12.4. Medical male circumcision enhance sexual satisfactions					
12.5. Medical male circumcision gives a boy a status of being man					

**13.** Which of the following might prevent you from getting circumcised? (if you are female please ignore this question). Please tick all options that apply.

- 1. Painful
- 2. Fear of death
- 3. Friends do not like it
- 4. Your parent would not like it
- 5. You just don't want to do it
- 6. Other people say it is not good
- 7. Other student would laugh at you once they found out
- 8. None of the above issues

**14.** Would you encourage others to go medical male circumcision?

Yes/Yebo  No/Cha

**Thank you for your time**