UNIVERSITY OF KWAZULU-NATAL ™

INYUVESI YAKWAZULU-NATALI

EXPLORING A POSSIBLE COMMUNICATION STRATEGY TO PROMOTE VOLUNTARY MEDICAL MALE CIRCUMCISION FOR HIV PREVENTION AMONG MALES AT THE UNIVERSITY OF KWAZULU-NATAL, HOWARD COLLEGE

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Acronyms and Abbreviations

ABC	- Abstain, Be faithful, Condomise
WHO	- World Health Organization
AIDS	- Acquired Immunodeficiency Syndrome
HIV	- Human Immunodeficiency Virus
STI	- Sexually Transmitted Infection
UNAIDS	-United Nations Programme for HIV/AIDS
CCA	- Culture-Centered Approach
ART	- Antiretroviral Treatment
KFF	- Kaiser Family Foundation
VMMC	- Voluntary Medical Male Circumcision
TMC	- Traditional Male Circumcision
RCTs	- Randomised Controlled Trials
EE	- Entertainment Education
OST	- Opioid Substitution Therapy
PEPFAR	- U.S. President's Emergency Plan for AIDS Relief
HCT	- HIV Counselling and Testing
B4L	- Brothers for Life
GYT	- Get Yourself Tested
HEAIDS	- HIV/AIDS in Higher Education

ACU	- AIDS Control Unit
UCT	- University of Cape Town
HAICU	- HIV/AIDS, Inclusivity and Change Unit
NWU	- North West University
UFS	- University of Free State
VCHTC	- Voluntary Counselling HIV Testing Campaign
UniZulu	- University of Zululand
DOH KZN	- Department of Health KwaZulu-Natal
WSU	- Walter Sisulu University
UTT	- Universal
VCT	- Voluntary Counselling and Testing
AYFS	- adolescent youth-friendly health services
SRH	- Sexual Reproductive Health
Oral PreP	- Pre-exposure prophylaxis
TA	- Thematic Analysis
PhD	- Doctor of Philosophy

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Abstract

HIV/AIDS remains a global health concern with about 38 million people living with HIV globally in 2019, this consisted of 36,2 million adults and 1,8 million children. It was further estimated that there would be about 690 000 AIDS-related deaths in 2019. Following the success of three randomised trials to test the medical effectiveness of Voluntary Medical MaleCircumcision (VMMC), undertaken in South Africa, Kenya and Uganda, it was found that VMMC reduces the chances of males contracting HIV by 50% to 60%. This means that there is a link between poor VMMC uptake and HIV prevalence. As a result, WHO declared it as a strategy to be included as part of combination prevention strategies. Furthermore, WHO declared that "HIV remains the single largest cause of deaths among adolescent boys and menof reproductive age in eastern and southern Africa". The targeted adolescent boys and men are the focus because they are challenged by sociocultural factors ranging from toxic masculinityto substance abuse that may lead them to potentially infecting their partners with HIV. It is for this reason that VMMC is the key focus in this study.

This study was conducted at the University of KwaZulu-Natal, Howard College Campus. TheUKZN students have been identified as in high risk of HIV infection with a notable high number of students living with HIV. The study was conducted within the university residences reserved for students. This study had three objectives: (1) to investigate the communication strategies adopted at UKZN to promote VMMC (2) to assess the perceptions of UKZN students on VMMC communication strategies that have been adopted at UKZN (3) to identify the cultural factors that influence communication strategies adopted to advance VMMC at UKZN.

This study is framed by the culture-centered approach (CCA) in understanding students' experiences when they engage with the VMMC communication strategies that are aimed at them. The CCA is founded on the principles of listening to the voices and creating spaces for dialogue and culture to inform health strategies. However, it can still be used as a tool to understand communication strategies, as done in this study. The data was collected through 8 individual semi-structured interviews and supported with an extensive literature review that also informed the analysis.

The key findings from this study suggested that the participants have been exposed to mass media communicating about HIV prevention strategies at Howard College

Campus, however, there has been limited VMMC uptake. The students have demonstrated poor preference for mass media as they did not resonate with the platform. Instead, the findings suggested that the students prefer to be directly approached by health promoters on campus and at their student accommodations. This was because the students prefer to engage with the health promoters by asking them questions and negotiating the meanings of the promoted messages. Furthermore, it was found that students would prefer that health promoters are popular individuals holding respectable statuses around campus as that would motivate the students to pay attention to them. This recommendation is consistent with previous studies done at UKZN where students preferred role-modelling as an effective strategy for health promotion. Lastly, the minority of the respondents suggested the use of social media platforms by UKZN to disseminate VMMC messages. The study found that participating in the communication process with VMMC promotion was important for UKZN students. Therefore, the communication strategy to advance VMMC communication in the future targets of HIV prevention should be culturally sensitive, context-specific and engage with the students through a two-way dialogue to avoid their marginalisation. Another finding was that some students would prefer to have VMMC messages available across social media platforms. In the context of entertainment education, the communication strategy does include the audience in the interventions as it seeks for social change. Furthermore, it has been applied in the promotion of VMMC to some extent, including on social media. Lastly, the study specifies that these results are limited to Black African students at Howard College Campus.

Key Words: VMMC, UKZN students, health promoters, role-modelling, entertainment education

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Chapter One

Introduction

There have been 79.3 million HIV infections with 36.3 million that have died from HIV since the beginning of the epidemic WHO, 2022). HIV/AIDS remains a global health concern with about 38 million people living with HIV globally in 2019, consisting of 36,2 million adults and 1,8 million children (WHO, 2020. Moreover, by the end of 2019, there were 81% of people living with HIV knew their HIV status and 67% had access to antiretroviral treatment (WHO, 2020). It was further estimated that there would be about 690 000 AIDS-related deaths by the end of 2019 (WHO, 2020). The infections increased to 37.7 million by the end of 2020 with 680 000 HIV-related illnesses (WHO, 2022). This means that there was a 1.4 increase in infections and the prediction of HIV-related deaths was only 10 000 lesser, in a space of one year. This emphasises the seriousness of the HIV pandemic and thus the need to explore more effective HIV prevention interventions, working together with communication strategies that are effective in promoting them. The situation that HIV/AIDS was still highly prevalent and deadly by the end of 2020 despite the preventative and treatment measures, calls for a revision on the delivery of interventions and possibly newer strategies in addition. Among the first strategies was the expansion of HIV testing services and to date, approximately 81% of people living with HIV have been tested and are aware of their status (WHO, 2020). Antiretroviral Treatment (ART) was also launched in 1996 to reduce the spread of HIV infections and about 25,4 million people are accessing it. ART is medically proven to suppress the viral load and is thus undetectable and eradicates the risk of HIV transmission while people live healthy (WHO, 2020). Kaiser Family Foundation (KFF) (2020) states that "effective strategies include behaviour change programmes, condoms, HIV testing, blood supply safety, harm reduction efforts by drug users and medical male circumcision". Hence, a variety and a combination of HIV prevention interventions were implemented.

South African Status of HIV Pandemic

East and Southern Africa only make up 6.2% of the world population but had 20.6 million living with HIV, 800 000 new infections and 31 000 AIDS-related deaths at the end of 2019 (WHO, 2020:2). South Africa is one of the Sub-Saharan countries with the highest HIV prevalence (Avert, 2020). In 2018 approximately 7.7 million people were living with HIV, with a recorded 240 000 new infections and 71 000 AIDS-related deaths, the prevalence stood at 20,4% (Avert, 2020). In 2020, 7.8 million people were living with HIV, with 230 000 new infections (Avert, 2020). Furthermore, Stats SA (2019) stated a general prevalence of 13,5%,

prevalence refers to the percentage of people tested in each group who were found to be infected with HIV (OECD, 2005). The prevalence had increased to 19.1% by the end of 2020, with 83 000 related deaths (Avert, 2020). These statistics are unfavourable and require intensive curbing. Furthermore, 19.07% of cases were known to be positive in the South African population. Unitaid highlighted this seriousness by emphasizing that "South Africa also accounts for more than 10 per cent of all HIV-related deaths and 15 per cent of new infections". Therefore, South Africa having the highest HIV rate in the world requires more specific, intensive immediate interventions. Lastly, the recommended intervention must also have a more contextualised communication strategy that reflects the South African perspective.

Males as Key Audience of HIV Prevention Interventions

In 2017 adult males comprised of 37% of adults living with HIV in South Africa (WHO, 2017:2). Notwithstanding the decrease in number of new infections in 2010, incidence remained high with the estimation that 23% of 15-year-old males would be infected before the age of 60 (WHO, 2017:2). Targeting males in HIV prevention is important and this draws from the documented evidence that males are more prone to be engaged in hazardous behaviour than women because of the norms and myths embedded in the patriarchal societies in which they live in, among the norms is that sickness is unlikely to affect men (Collinge *et al.*, 2013:2). For example, there is evidence that males are less likely to do an HIV test, if they do, they are unlikely to seek timely treatment and care (Collinge *et al.*, 2013:2). The vulnerability of males to HIV infections was worsened by the lack of willingness to test, and thus necessitates the focus on male-centred prevention options in order to reduce infections in societies. The WHO (2020:89) emphasised the need to protect males from HIV infections in this statement: "Men's health requires urgent attention – for everybody's sake". Therefore, contextualised messages are necessary to inform males about responsible behaviour. Furthermore, Boyee *et al*. (2017) argued that the delivery of sexual health facilities and appropriate content to young males has been emphasised.

In the previous years, programmes by the UNAIDS for example, have focused on adolescent girls and women in HIV prevention as those in Sub-Sahara Africa have shown 450 000 new infections, with an estimated 8 600 new infections per week in 2015 alone (WHO, 2016). Given that gender inequality contributes to the high number of HIV infections among adolescent girls and women, it is necessary to address them, and this also requires the inclusion of adolescent boys and men as the target audience (WHO, 2016:3). Furthermore, in a study to investigate the association between VMMC and women's health found that high uptake of VMMC was

associated with decreased risk of several diseases such as syphilis and chlamydia in women (Grund *et al*., 2017). Therefore, VMMC could be promoted by mentioning benefits for heterosexual women as well as influencing uptake by males.

Progress in the HIV Prevention Interventions

The World Health Organization's (WHO) Global Programme on AIDS launched in 1987 aimed to mobilise global citizens and generate commitment towards the fight against the HIV/AIDS pandemic (Mann and Kay, 1991: S221; KFF, 2020). The trend in founding international organisations to help prevent and combat the spread of HIV/AIDS exposes the seriousness of the pandemic as well as the difficulty in using a single strategy whether it is direct intervention or communication. The seriousness of HIV as a pandemic required organisations to find effective interventions. Among the initial HIV prevention interventions that were found included interventions such as the Abstinence, Be Faithful and Condomise (ABC) campaigns and antiretroviral therapy (ART) of which both gave way to subsequent interventions. Noteworthy, the World Health Organisation led the designing and implementation of these initial HIV prevention interventions, therefore, the interventions were deemed legitimate at a global level.

Later in 2003, it was concluded that there was a possibility that the HIV pandemic could face some level of epidemic control through increased access to treatment for the disadvantaged resulting in lesser deaths and more children born HIV-negative by HIV-positive mothers (WHO, 2016). Key audiences from disadvantaged backgrounds could also be assisted, hence, interventions were encouraged to tailor their services for specific communities, be it mothers, children or young males. In the study to review the progress in the HIV epidemic, it was found that since the implementation of the 90-90-90 targets in 2012 there has been substantial progress, however, the progress among males has been slower (WHO, 2019). This further justifies the focus on males as a target to offer HIV prevention interventions.

The 90-90-90 targets launched on World AIDS Day in 2014 with the purpose to increase access to HIV testing and treatment and thus prevention (KFF, 2020). In alignment with the principles of the 90-90-90 intervention, Granich *et al*. (2017:342) point out that "this target calls for 90% of people living with HIV to be diagnosed, 90% of people diagnosed to be on sustained antiretroviral treatment, and, of those, 90% virally suppressed by 2020".Despite the notable progress towards reaching the targets, there remains controversy concerning the feasibility of achieving the 90-90-90 targets, given the unequal distribution of resources globally (Granich

et al., 2017:342). The current strategy to end the global HIV pandemic is mainly the World Health Organization's 2030 target to update from 90-90-90 to 95-95-95 targets which are already in effect (WHO, 2020). This necessitates intensification in the use of the combination of traditional HIV prevention strategies and exploring the possibility of more effective strategies. The most recent policies include the Joint UNAIDS programme to combat the HIV pandemic with a timeframe of 2016-2021, the aim is to encourage countries to cater for key populations such as sex workers, transgender people, and people who inject drugs (Davis *et al*., 2017). Notwithstanding any progress it has thus far, it faces some challenges such as certain countries criminalising the key populations and putting punitive measures which failed as intended because it further marginalises the key populations and therefore excluded from the programme to combat the HIV pandemic (Davis *et al.,* 2017). Also, among the most recent policies to combat the spread of HIV has been the implementation of Voluntary Medical Male Circumcision (VMMC). It has been administered to prioritised countries with the highest HIV incidence, which are mostly the 15 countries in Sub-Saharan Africa (WHO, 2020). There has been notable progress in those priority countries, as Kripke *et al*. (2016:2) stated that "the priority countries have made considerable progress in VMMC scale-up, and VMMC remains a cost-effective strategy for epidemic impact, even assuming near-universal HIV diagnosis, treatment coverage, and viral suppression". Furthermore, the UNAIDS achieved 50%, 11 million uptakes in space from 2016 to 2019 in the respective priority countries (WHO, 2019). There had been 15 million total circumcisions from the date of recommendation in 2007 by the end of 2017 (WHO, 2017). There were at least 23 million males circumcised at the date of publication of the World Health Organization report on updated VMMC guidelines in 2020 (WHO, 2020). Understanding the development of interventions to combat the spread of HIV is important to understand their separate goals, how they could be used together and their limitations so that improved interventions may be added to the package.

Limitations to HIV Prevention Interventions

There has been significant progress concerning HIV prevention, but the global target of ending HIV as a global pandemic is yet to be met, it has been noted that the number of new infections exceeds the set targets by three times, therefore, the overall progress is slower than anticipated because the progress has been unequal (WHO, 2020). Moreover, McCarten-Gibbs and Allinder (2019:6) posit that the "funding and programmatic prioritization with regards to HIV prevention interventions remain to limit factors in ensuring that prevention tools are developed and that those approved for use reach scale and coverage sufficient for impact. There is still no

cure for the virus and many people are still deprived of treatment, care, and other prevention resources (WHO, 2020). This means that the treatment of HIV intensively through the combination of strategies speedily and consistently is vital.

Communication between organisations and the intended key audience remains a vital aspect of service delivery in the mission to combat HIV/AIDS. The communication could be interpersonal, doctor to the patient or peer educator to a young male. Tzaneva and Lacob (2013:181) state that "the most important aspect of patient care is education, which should include empowering patients with basic knowledge about HIV infection, methods of transmission, progression, prognosis, and prevention". However, communicating with the key audience has proven to be difficult for several reasons from the interventions being generalized and not specific for the targeted audiences, the audience not being in a conducive state to receive the communication due to factors such as poverty and illiteracy and a problem with the communication platforms. The future of HIV/AIDS communication, therefore, lies in the use of a combination of media platforms from mass media to social networking, culturally tailoring messages to specific audiences and the alignment of goals for all stakeholders in the communication intervention, to name a few. The communication strategies are recommended to be more participatory where all stakeholders can negotiate the meanings of a health intervention, hold debates and dialogues, an example of such an intervention is entertainment education (De Fossard and Lande, 2018).

Voluntary Medical Male Circumcision as an HIV Prevention Option

VMMC was first recommended in 1986 as a possible HIV prevention strategy, following that, ecological studies and heterosexual studies have shown the relationship between heterosexual intercourse and infections, showing that HIV prevalence is higher in places with less medical circumcision (Kigozi *et al*., 2008). Furthermore, Kigozi *et al.* (2008:643) argue that "prevention [HIV prevention] is the only realistic hope since currently available measures have been unsuccessful". Given its success in the reduction of HIV infections, VMMC achieves greater results if added to the HIV prevention packages, especially in places where it is uncommon (Kigozi *et al*., 2008). Hence, there is more focus on males at places such as university institutions which were not initially the focus of VMMC promotion. The key to defeating a pandemic is fully understanding it, hence, experts recommend that HIV prevention strategies must be tailored to the epidemiology and local context by combining the old and new strategies while sustaining long-term efforts (KFF, 2020). The point above also emphasises that VMMC should not be seen as a standalone HIV intervention strategy but an addition to

the existing ones to understand the merits of VMMC as an HIV prevention intervention. Avert (2005) undertook a systematic review and meta-analysis where it was found that there is a strong association of decrease in HIV prevalence among men who undertook VMMC in Sub-Saharan Africa indicating that there is the link between poor VMMC upscale and HIV prevalence. Among the HIV prevention options available is VMMC which is effective in the reduction of new HIV infections among males. Following the success of three randomised trials to test the medical effectiveness of Voluntary Medical Male Circumcision (VMMC), it was found that VMMC reduces the chances of males contracting HIV by 50% to 60% as a result WHO declared it a strategy to be included in the package of prevention strategies (Kigozi *et al.*, 2008). The three trials were conducted in South Africa, Uganda and Kenya, respectively (Garenne, 2008). Furthermore, the WHO (2020:10) stated that "the protective effect was confirmed in extended post-trial follow-up to six years of men in two of the three RCTs (in Kenya and Uganda)".

Problem Statement

Males between the ages of 10 and 24 are at a disproportionate risk of HIV infection globally, and in 2019 it was estimated that about 3.8 million males were living with HIV (Makoni *et al.*, 2020). Of these young people living with HIV, 84% are estimated to be living in sub-Saharan Africa and it is projected that an additional 7.4 million young people in Sub-Saharan Africa might be infected with HIV by 2030 (Makoni *et al.*, 2020). These figures called for the inclusion of VMMC as an additional HIV prevention strategy by the World Health Organization and country-specific interventions. The priority countries adopted a variety of strategies to promote the intervention. The strategies were divided into the community, facility-based interventions and school and sport-based approaches (WHO, 2020). This shows that VMMC can be promoted on various levels and through several strategies including entertainment.

The progress in the VMMC promotion includes the successful circumcision of many males in the priority countries, with 23 million males medically circumcised in East and Southern African countries respectively (WHO, 2020). However, this did not result in the ending of HIV as a global pandemic as aimed by HIV interventions. Hence, there is a need for more VMMC uptake by males in the next phase of HIV prevention targets. Moreover, the promotion of VMMC is largely dependent on the implementation of an effective communication strategy, particularly one that is sensitive to the context students, and this will be explored with university students at Howard College Campus. This study therefore seeks to explore what has

been done in terms of communication for students in relation to VMMC at UKZN. UNAIDS has followed through on this initial success of VMMC and set new targets to end HIV as an endemic by 2030. The WHO (2020:72) highlighted that "reaching more men for VMMC uptake can support achieving universal health coverage by 2030". To meet this target, the use of combined methods for HIV prevention is encouraged, and VMMC communication should be aligned with new strategies. Examples of communication strategies were education entertainment, mass media, social media, community mobilisation, pamphlets, and posters (Collinge *et al*., 2013). These strategies, specifically the use of entertainment education (EE), were all adopted by *Brothers for Life* (B4L). To pre-empt any confusion, for this study, communication strategies and communication channels are terms that will be used interchangeably in some sections, this will be clarified at all relevant the cases. This was enforced by the respondents' tendency to mention both communication strategies and communication channels when they were asked about strategies that they had been exposed to. Covid-19 Implications on VMMC.

The Covid-19 pandemic has significantly disrupted the context of HIV prevention interventions, and VMMC is not an exception. The WHO (2021) identified that VMMC uptake dropped from 4.1 million to 2.8 million in the 15 priority countries. South Africa suspended VMMC programmes in March 2020 following the Covid-19 pandemic, which resulted in a 73% decline from 411 063 in the first three quarters of 2019 to 111 766 circumcisions in the first three quarters of 2020 (Kamnqa, 2020). In the Limpopo Province in South Africa, the health providers have accepted Covid-19 as an immediate threat to humanity and thus postponed VMMC at their respective initiation schools, following the suspension of non-emergency medical procedures (Matlala, 2021). Lastly, the most recorded cause of a decline in VMMC due to the partial reinstating of VMMC programmes is that men are reluctant to go to circumcision sites as they fear contracting Covid-19 (Kamnqa, 2020).

The WHO (2020) predicted a continuation of a decline in the efforts of existing HIV prevention methods but discouraged the complete abandonment of those HIV prevention interventions as this would only worsen the epidemic, and thus recommended a deeper focus on key and priority populations such as women and people living with HIV. Furthermore, other recommendations include community services to deliver essential products such as food and condoms to vulnerable households, including HIV prevention supplies as part of an essential commodity security plan, providing take-home doses for Opioid Substitution Therapy (OST) and relaxing policies aimed at reducing the number of HIV prevention resources given to an individual

(Global HIV Prevention Working Group, 2020). The VMMC interventions that decide to resume providing circumcision services are encouraged to prioritise the safety of all stakeholders involved, which are communities, workers and key audiences, and to continue assessing the local context (PEPFAR, 2020). The challenges and recommendations above-mentioned are crucial in the assessment of the progress of the 2030 targets to end HIV/AIDS as a pandemic.

Research Questions

1. What are the communication strategies adopted at UKZN to promote VMMC?
2. What are the perceptions of UKZN students on VMMC communication strategies that have been adopted at UKZN?
3. What are the cultural factors that influence communication strategies adopted to advance VMMC at UKZN?

Research Aims

HIV remains a global pandemic despite the prevention targets that have been put in place from the onset. Furthermore, prevention is still the most recommended way to combat the spread of HIV. South Africa regionally having the highest cases of HIV unsurprisingly adopted HIV prevention strategies that were administered through several public campaigns including the adoption of the 90-90-90 targets, ART, Oral PrEP and VMMC (WHO, 2020; The campaigns have been extended also to tertiary institutions to promote health, among the HIV prevention interventions were condom provision, HIV testing and counselling (HTC) and also VMMC (Mulwo, 2008; Sakarombe, 2014; Khawula, 2015; Nota, 2016:). The Howard College campus has an internal campaign to medically circumcise males which are guided by the UKZN Men's Forum that was founded and implemented in 2013 by the KwaZulu-Natal department of Health (DOH KZN, 2013). The World Health Organization has set targets to end HIV as a pandemic by 2030, and advocates for VMMC as an additional target to the prevention package. This study thus aims to explore the possibilities of a communication strategy that would be more suitable to students as the new targets of HIV prevention are in place, furthermore, the assessment on whether the potential communication strategy would be culturally sensitive to meet this criterion.

Research Objectives

1. To investigate the communication strategies adopted at UKZN to promote VMMC.
2. To assess the perceptions of UKZN students on VMMC communication strategies that have been adopted at UKZN.
3. To identify the cultural factors that influence communication strategies adopted to advance VMMC at UKZN.

Structure of the Dissertation

Chapter One served the purpose to provide the background of the study. It began by giving the current context of the HIV pandemic globally and then moves on to describe specifically the South African context. Moreover, extrapolates on how the Covid-19 context negatively impacted the rollout of VMMC interventions. Furthermore, mentions and justifies the reasons that males were targeted for VMMC uptake, and how communication strategies have been tailored to promote VMMC uptake.

Chapter Two is the literature review which presented literature that is related to the research focus of this study. The chapter began by investigating the existing communication strategies that have been adopted for HIV prevention at UKZN. Furthermore, VMMC was covered as an HIV prevention option available to students, this included the reasons for focusing on males for HIV prevention, cultural understandings of Traditional Male Circumcision and how VMMC is communicated at the University of KwaZulu-Natal. Lastly, the chapter explored the perceptions of students towards HIV prevention interventions including VMMC.

Chapter Three covered the theoretical framework. The students are also acknowledged to be embedded in cultures that may affect how they understand and respond to VMMC promotions and therefore Culture-Centred Approach (CCA) was useful in assessing the culture of UKZN students and how they would respond to VMMC promotion. Particularly by appreciating how the four constructs of the CCA namely, culture, structure, agency and voice and dialogue are instrumental in allowing Howard College Campus students to engage with VMMC interventions.

Chapter Four focuses on the methodology adopted by this study. It specifies and describes the research paradigm, the sampling techniques and the data collection method and including

the research design and data analysis used in the research. The study is located within the interpretative paradigm, whereas the research design is explorative. These informed the sampling of the respondents which was purposive. The data was then analysed through the application of Thematic Analysis (TA). Furthermore, the section discusses the known limitations of the study and the ethical considerations taken.

Chapter Five presented the data collected by the study through semi-structured interviews and is analysed using thematic analysis. Relevant themes concerning the subject matter of the study were used to present coherent data. The progress made from this chapter was useful to the subsequent chapter.

Chapter Six is focused on analysis and further discussion, concluding with discussing findings by applying the CCA to assess the collected data. The themes that emerged were grouped under the four constructs o the CCA, respectively.

Chapter Seven is the conclusion. The conclusion is a summary of the analysed qualitative data. The conclusions reached include Howard College Campus students prefer to be approached directly by health promoters, they also entertain the idea of role models such as popular individuals and celebrities. Moreover, they are also interested in the application of social media applications in the promotion of VMMC. Lastly, some of the respondents recommended the use of the integration of entertainment in communication strategies. It concluded the study and made recommendations for future research regarding what had emerged from the study.

Chapter Two
Literature Review

Introduction

This chapter aims to review the literature on Voluntary Medical Male Circumcision (VMMC) for HIV prevention within an African context where various HIV prevention strategies have been adopted over the years to advance the prevention efforts. Furthermore, the purpose of this chapter is to review and identify gaps in the literature; and ground this study in the ongoing HIV prevention discussion on VMMC as a biomedical HIV prevention method for males. VMMC has been promoted through a variety of media platforms such as billboards, posters and community mobilisation, which have been successful in reaching males in their merit.

This chapter first discusses communication strategies that have been adopted to promote HIV prevention programmes, ranging from the general youth and specifically to university students. The second section investigates the literature on students' perceptions of HIV programmes aimed at them, with a focus on VMMC. The third and last sections purport to investigate the cultural understandings of VMMC by university students, and how uptake is influenced or prohibited by the existence of Traditional Male Circumcision as an alternative male circumcision method.

The study has also consulted several sources for data to address the third research question of this study: What are the cultural factors that influence communication strategies adopted to advance VMMC at UKZN? Therefore, there has been a systematic approach in the literature reviewed in response to this question. There were 40 articles analysed by this study in total to address the research question. The researcher has searched data mostly from sources including dissertations and theses by previous students on university students and peer reviewed journals that contained studies specifically on students. Thus, these criteria have influenced the inclusion and exclusion criteria of the selected articles. The review included sources that present clinical benefits and adverse effects of VMMC on males, and studies that demonstrate an appreciation of the Black African students' cultures, specifically *Zulu* and *Xhosa* speaking and also studies that presented the perceptions of these students towards VMMC. However, this did not mean exclusion for studies that were based on cultures of males from other Sub-Saharan countries as these were similar. Whereas studies that demonstrated to present the culture of the dominant modernist culture were excluded as they this study acknowledges that they are not culturally sensitive to the key audience of the study. These articles were obtained from internet sources such as *Google Scholar*, policy documents from health organisation, also

from the UKZN theses online database and also from the theses databases of other tertiary institutions based in Sub-Saharan countries.

HIV Prevention Communication Strategies

There has been significant progress in the HIV prevention targets, specifically VMMC targets were met through the implementation of traditional communication strategies (WHO, 2020). However, HIV/AIDS remains a global pandemic, hence, the World Health Organization has recommended improvement in the delivery of HIV prevention strategies. Given the context that HIV/AIDS has no cure or vaccination, ongoing communication with the targeted populations is imperative and should inform all HIV prevention strategies (Airhihenbuwa and Obregon, 2000). Some campaigns tailored for HIV prevention have since attempted to adopt the most effective communication methods, and among them is VMMC. Furthermore, HIV prevention strategies need to be communicated effectively to the targeted communities. Some traditional mediums to communicate VMMC messages include print material, mass media campaigns, interpersonal recruitment, billboard messages and entertainment education (EE) (Govender *et al.*, 2013). Notably, these include both a communication strategy and communication channels. In a systematic review to review the progress of mass communications in HIV communication in 10 years, it was found that campaigns have changed and improved over time in their use of media platforms (Noar *et al*., 2009). Therefore, HIV prevention strategies have higher chances of reaching the targeted communities using media platforms. The mass media platform consists of traditional means of communication such as radio, print and television purportedly aimed at large audiences and other smaller types include billboards, leaflets, newsletters and brochures (Palmgreen *et al*., 2008). Among the most notable interventions to use mass media to communicate VMMC messages in South Africa is *Brothers for Life* (B4L). The campaign mobilises society, specifically males, and is not limited to the prevention of HIV, but also abstaining from abusive behaviour towards themselves and those around them (Collinge *et al*., 2013). B4L mentions that among the strategies to communicate VMMC, there is mass media, dialogues through community mobilisation, peer educators that go door-to-door and digital media (Collinge *et al.*, 2013). The B4L campaign utilised digital media which includes social networking applications such as *Facebook* and *Twitter*. However, this did not necessarily increase the promotion of VMMC but increased the interaction among males and created a platform for dialogue and responding to the needs of individuals (Collinge *et al.*, 2013). Other interventions have also utilised effective interpersonal communication by peer educators and healthcare workers and have used text messages to

communicate with key audiences, including going to their homes to educate them about VMMC (WHO, 2020). Furthermore, the meeting of VMMC targets was met because of changes in service delivery, these included delivering in diverse settings from homes, schools, and communities to health facilities (WHO, 2020).

Social media has also been a strategy adopted to communicate HIV prevention. The social media term is quite broad and includes platforms such as social networks, video-sharing, photo-sharing and microblogging. An example is the Get Yourself Tested (GYT) Campaign which utilised several media platforms including social networks to disseminate HIV prevention messages to the youth in the United States of America (Jones *et al*., 2018:16). These platforms have been used by the American audience to book for appointments for HIV testing or receive VMMC services (Jones *et al*., 2018).

In a systematic review of social media uses in the communication of HIV, it was concluded that there is an increase in usage and higher access to information in social media and that it is important to leverage the platform with pre-existing platforms (Taggart *et al*., 2015). The South African HIV campaigns such as *Brothers for Life* and *Soul City* utilised both social and mass media to communicate HIV prevention messages. In a systematic review of the effectiveness of the *Brothers for Life* campaign on social media, it was found that it was well-received, especially on *Facebook* (Clarfelt, 2017). *Soul City* did a social media training workshop which aimed to educate on sexual and reproductive health as well as HIV prevention specifically in Africa, the sessions were to direct the audience to the most effective social media platforms and develop tailored key messages to African countries where the participants expressed positive responses (Soul City Institute for Social Justice, 2019). Furthermore, the campaigns have adapted to the social media platform and are using all types of media to their convenience. With the growth and development of social networking, social media is becoming significantly useful in the promotion of HIV prevention messages, student health promoters in universities should consider using *Facebook*, student television broadcasts and group Message Services (SMS) Short messages for HIV prevention interventions (Shiferaw *et al*., 2014). These findings are consistent with those of Segopolo (2014) in a textual analysis of the ABC materials for HIV prevention at the UKZN where the use of technology/computer-mediated communication to promote HIV prevention.

Three Generations of Approaches to HIV/AIDS prevention

The plight to combat the spread of HIV/AIDS has been going on for decades till the present, and the interventions that were designed as a response have evolved. There are namely three generations, with a transition to a fourth generation. The first generation was mainly individualistic such that health information would be disseminated to key audiences with the assumption that they would act accordingly depending on their perspectives of the risks, costs and benefits of uptake of those healthy behaviours as intended by the campaigns (Campbell and Cornish, 2010).

An example of HIV prevention intervention from the first wave was Universal Testing and Treat (UTT). The UTT strategy was also among the first HIV prevention strategies to be introduced specifically to university students. The strategy aims to offer a combination of preventions, which includes placing attention on both HIV-negative and positive audiences, there is an emphasis on getting everyone tested frequently, then offering treatment to those who test negative including offering PreExposure Prophylaxis and condoms to those who test negative (Okelola, 2019). Furthermore, Mnyaka *et al*. (2021) state that the UTT purports to reduce HIV incidence and rates of transmissibility while the viral load is suppressed. This emphasises that the strategy works to combine prevention with treatment and thus keep the HIV-positive healthy and the negative uninfected. The UTT strategy reduced from a global to a local context in scale and faced challenges in reception and uptake by students. Like the ABC strategy, the UTT is also individualistic such that it assumes behaviour change may occur despite the social context of the students, this should be addressed because behaviour change cannot occur outside of interactive social context (Durden and Govender, 2012 quoted in Okelola, 2019). Furthermore, on a global and regional scale, students are hesitant to go for HIV testing because they fear getting positive test results (Okelola, 2019). The problem emphasises the perception of individuals who believe that being HIV positive is a death sentence, this emphasises the need to communicate properly to students to reduce stigma. UTT does not account for the context of the students and is thus limited in addressing all HIV prevention needs, there must be other prevention strategies integrated into it (Havlir *et al*., 2020). The first generation faced the shortfall of being too individualistic where behaviour change was expected without paying attention to the social issues that may promote or inhibit behaviour change, an example is the ABC campaign.

The second generation emphasised the importance of peers in disseminating HIV prevention messages, this is because it is the peers that have more access to access socially marginalised

social groups, and the individuals would change their behaviour from mimicking their adored and trusted peers (Campbell and Cornish, 2010). This means that despite some communities being marginalised in the dominant paradigm, there could be access to those individuals through their peers sharing the messages at an interpersonal level. Furthermore, this also exposes the importance of role-modelling as the desired behaviour can be observed and repeated by their peers. The second generation is evident in campaigns such as the Scrutinize Campaign where the students taught about HIV prevention and expected to share that knowledge with their peers to combat the spread of misinformation concerning HIV prevention messages (Mutinta, 2012).

The third generation, which is current, advances from peer-to-community mobilisation where individuals are collectively involved in the whole process of intervention development; design, implementation, and leadership, to harness the agency of groups that are marginalised and thus vulnerable to HIV/AIDS (Campbell and Cornish, 2010). This generation is aligns with the principles of the CCA where the top-down communication is discouraged but the community is empowered through involvement during all the levels of designing and HIV prevention campaign. The HIV interventions that conform to the third generation include but not limited to the *Brothers for Life* campaign as well as the community movements promoted by the *Soul City Institute*.

The first and second generations ignored that an individual lives in a social environment and thus ignored that structures may inhibit or enable behaviour change, therefore cognitive factors were inadequate (Campbell and Cornish, 2010). Criticisms of the second generation paid limited attention to the contexts of key audiences, therefore, it did not create health-enabling social environments; peers in the second generation did not enable dialogues and thus omitted a chance for an agency, critical thinking and solidarity in educational settings (Campbell and Cornish, 2010). The third generation addressed the limitation of dialogical approaches through community mobilisation but faced criticisms including that the virtue of disadvantaged communities being marginalised is evidence that they lack both the skills to maintain and lead interventions and the motivation to work together in health improvement (Campbell and Cornish, 2010). Ultimately, Campbell and Cornish (2010) present a case for a fourth generation that beyond community mobilisation, will pay more attention to the contexts of key audiences and identify how social environments enable or hinder proper HIV/AIDS management. The fourth generation seeks development from the shortcomings of the third generation as the previous have developed from one another over time.

HIV Communication at South African Universities

The importance of suitable and effective communication remains significant as a mode of achieving HIV prevention targets (Alves and English, 2016). Furthermore, Kunguma *et al*. (2018) posited that the organisations such as the South African Development Community and interventions such as *Love Life* had undestood that because there is no cure for HIV/AIDS, educating people about HIV thus becomes the recommended intervention for HIV". Therefore, communicating effectively with students should be a priority. Despite effective communication being advocated, with research it has been noted that campaigns should seek to narrow the gap between academic training and practical relevance as it has shown that students do engage in risky sexual behaviour despite knowing, an example of a campaign that has applied this strategy successfully is the *Soul City Institute* (Christofides *et al*., 2013).

The universities have appreciated their important role in assisting with the combat of HIV spread and started campaigns of their own. The most notable among the initial campaigns being HIV/AIDS in Higher Education (HEAIDS) launched to become a capacity-building campaign that is mainstream in health response rather than a once-off prevention programme (Chetty and Michel, 2005). Among the traditional communication strategies adopted at universities were the use of posters, brochures, signs and billboards (Dube and Ocholla, 2005). The communication channels mentioned were instrumental in advancing the messages of HIV prevention interventions. Campaigns such as *One Love* and *Scrutinise Campaign* were crucial in raising awareness to decrease HIV infections through media such as leaflets and roadshows (Sandy and Mavhandu-Mudzusi, 2014). This also included the management of HIV/AIDS and how providers diffuse it to the target audiences (Dube and Ocholla, 2005). Furthermore, with an understanding of the seriousness of the HIV epidemic, there was a recommendation by the AIDS Control Unit (ACU) committee for universities to develop policies that position HIV/AIDS alongside other critical issues such as violence, rape and drug use, while at the same time offering support and protection for students (Gobind and Ukpere, 2014).

The various South African universities are also proactive in creating their HIV/AIDS care units. In 1993, The University of Cape Town (UCT) passed a policy that was student-oriented by prioritising the rights and responsibilities of students and staff by providing support programmes and raising awareness (Kauffman *et al*., 2004). Furthermore, UCT founded an HIV/AIDS unit named the HIV/AIDS, Inclusivity & Change Unit (HAICU) that was aimed at developing a mandate to facilitate student engagement, while aligning HIV/AIDS with other critical issues such as safety and violence, climate change and poverty (Alves and English,

2016). The North-West University (NWU) also adopted various media platforms to raise awareness, consisting of peer educators, campus radio, posters and a campus clinic (Bigala *et al*., 2014). The University of Free State (UFS) founded The HIV and/or AIDS Wellness Centre which has prevailed for more than 10 years, and that led to the development of awareness campaigns such as the Voluntary Counselling HIV Testing Campaign (VCHTC), the New Start Male Circumcision Campaign and the STI and Condom Week to name a few (Kunguma *et al*., 2018). The University of Zululand (UniZulu) founded a programme to include HIV/AIDS information for first-year students to be exposed to HIV prevention messages during orientation and mandatorily making every faculty design a specific HIV/AIDS module in their respective programmes (Kunguma *et al*., 2018). Another important strategy adopted by universities was raising awareness among local schools and churches as first-year students tend to be vulnerable to HIV infections during the orientation and registration period (Mavhandu-Mudzusi *et al*., 2013).

Evolution of HIV Prevention Research at the UKZN

The fight against the HIV pandemic is not only pervasive in the larger scales of service delivery but also applied in specific small contexts. Hence, HIV prevention strategies were also introduced to the University of KwaZulu-Natal. Among the first interventions was the ABC strategy.

Moodley (2007) undertook a study assessing students' perception of the ABC prevention strategy at the University of KwaZulu-Natal. The findings of the study include that the students were uncomfortable with HTC as it supposedly implied one of the partners was not faithful, students did causally engage in sexual intercourse with multiple concurrent partners and hence rendering them vulnerable to contracting HIV, and that faithfulness was unrealistic, but condoms were a better option (Moodley, 2007). Furthermore, despite accepting condoms as more realistic, the students abandoned the use of condoms as their relationships got more serious (Moodley, 2007). The HIV prevention strategy uses three pillars to combat the spread of HIV, where "A" emphasises the importance of abstinence from sexual intercourse, "B" means to be faithful to one sexual partner and "C" emphasises the importance of appropriate and consistent use of condoms during sexual intercourse (Moodley, 2007). The findings of the study suggest that the ABC strategy is not aligned with the behaviour of the youth. The students were not willing to listen to the HIV prevention messages, this was evident in the study by Kunda (2008).Kunda (2008) undertook a study titled*They have ears, but they cannot hear' Listening and talking as HIV prevention: a New Approach to HIV and AIDS campaigns at three*

of the Universities in KwaZulu Natal', the researcher aimed to investigate sexual practices in the light of Abstinence, Being faithful and Condom-use as strategies for HIV prevention. The findings of the study include that despite knowing about HIV/AIDS, the students engage in risky sexual behaviour such as not using condoms even when they do not know their partner's HIV status (Kunda, 2008), like the findings from Moodley (2007). Furthermore, the condom may not be used for various reasons such as pervasive silence on sexual behaviour and contraception, opportunistic sex within university premises, and visual diagnosis of the sexual partner's status in situations where the female wants to fall pregnant (Kunda, 2008). Lastly, homosexuality is also a factor, such that other males despite having girlfriends, may be meant to engage sexually with homosexuals at gay clubs, this is exacerbated by the awkwardness of holding a conversation about homosexuality because of South African cultures (Kunda, 2008). These findings bring to light that indeed students do hear messages about HIV prevention but still do not listen, in a sense that they do not act accordingly. These findings are highlighted in the study by Vukapi (2015).

Vukapi (2015) undertook a study titled "*ZAZI-Know Your Strength"- A reception Analysis of contraceptive utilisation in correlation to unplanned and unwanted pregnancies among young female learners' in Umnini, KwaZulu-Natal*. Among the findings, was that young women did not show any behaviour change but the focus group discussions and semi-structured interviews increased the level of knowledge about HIV/AIDS and the risk of infection among participants (Vukapi, 2015). This knowledge corroborated with the research that posits that students can understand HIV prevention messages; however, this did not mean guaranteed behaviour change as the structures such as financial status may enable or inhibit behaviour change. Despite the study not being done at UKZN, it is irrelevant because it informs how HIV prevention campaigns such as ZAZI have the potential to influence behaviour change, therefore, future campaigns should consider spending more time within campuses they desire to empower students. As spending longer periods at targeted spaces increases the possibility of disseminated knowledge resulting in desired behaviour change (Vukapi, 2015). Another issue to note is that students did not only ignore the HIV prevention messages from the communication strategies, but they held perceptions about HIV interventions that led them to engage in risky sexual behaviour.

The study of Mulwo (2008) investigated the impact of the ABC campaign and VCT on students at the University of KwaZulu-Natal, the University of Zululand, and the Durban University of Technology. The ABC proved to be ineffective, as the finding in the study by Moodley (2007).

The findings of the study include that engaging sexually with multiple concurrent partners was still a reality when compared with the findings of Moodley (2007). Furthermore, the students engaged in early sexual debut, and inconsistent use of condoms they also used sex as a tool of expression, where from the communicative social constructionist perspective they could express power, control and their feelings (Mulwo, 2008). Additional findings include that the students did not perceive HIV as a threat but along the lines of viewing it as either mythical or a disease that only infects the poor (Mulwo, 2008). This is due to several shortcomings on the side of service providers. Another important lesson was the indifference of students showing disinterest to participate in accepting the message, due to that the messages come from the dominant modernization paradigm which designed interventions without involving the key audiences (Moodley, 2007). For example, the strategy assumed that the students could follow the suggestions because they were independent individuals that could make their own decisions, this is however narrow as students are in a context of structures that may either enable or inhibit behaviour (Mulwo, 2008). Furthermore, the culture and context of students vary from those of service providers, meaning that the messages received by students would be mixed (Moodley, 2007). An example of a mixed message is when individuals misunderstand the concept of using condoms such that they think it offers 100% protection from HIV transmission, this is untrue, and the truth should be properly communicated which is that condoms do not offer 100% protection (Mulwo, 2008).

The study also found that the virtue of being sexually active was encouraged, and a form of resistance against persisting cultural norms such as being faithful, and virginity automatically becomes frowned upon and therefore followed by ostracism (Mulwo, 2008). Lastly, because of the stigma around being HIV positive perceived as a death threat resulted in prevalent fear to undergo Voluntary Counselling and Testing (VCT) (Mulwo, 2008). With these findings, it is conclusive that students' attitudes and sexual behaviours and HIV prevention strategies are largely dependent on their different interpretive communities, this was demonstrated in the findings of the analysis of their perceptions towards the *Scrutinise Campus Campaign*.

Mutinta (2012) undertook a study to investigate the investigated students' sexual risk behaviour, risk and protective factors and their responses to *scrutinise campus campaigns* at universities in KwaZulu-Natal. The study found that like in Moodley (2007) and Mulwo (2008) students engaged in practices such as having multiple concurrent sexual partnerships and success in that regard earned one sense of superiority (Mutinta, 2012). It Is from those kinds of influences that students find themselves doing risky sexual behaviour for a sense of

belonging, such as the statistic that 76% of the students had engaged in sexual behaviour without using condoms (Mutinta, 2012). Further findings include that the students from across all three campuses being studied partook in risky sexual behaviour they referred to as 'towing', which technically meant having a one-night stand form of sexual activity (Mutinta, 2012). These findings anchor the idea that students still engage in risky sexual behaviour despite the *Scrutinise Campus Campaign* advocating for education in sexual partnerships and safe sexual practices, students ignore the messages regardless. Males generally did not prefer condoms because they perceived them as a barrier to sexual pleasure, whereas females did not appreciate the physical build of female condoms.

In a study to explore the perceptions of UKZN undergraduate students towards HIV counselling and testing, Rashmi (2013) did an observational, analytical; and cross-sectional study across the five UKZN campuses where it was found that among the reasons for poor uptake of HTC the fear of testing positive, having confidence in their partners and also did not perceive themselves as being in risk of infections.

Ogunlela (2013) did a study titled '*Women, HIV AND AIDS: Perceptions of the female condom among students on the UKZN Howard college campus'*. The purpose was to investigate the perceptions of female students towards the use of a female condom. Among the findings was that the primary source of knowledge about female condoms for female students was their friends, the campus clinic was second and the media was the least effective in promoting female condom awareness (Ogunlela, 2013). Furthermore, like Nota (2016), the study also found that female students were discouraged by the largeness and high cost of female condoms (Ogunlela, 2013). Therefore, the study recommended that the condoms themselves must be altered by size reduction for better appeal and that service providers should support the promotion of female condoms through the media to increase the chances of uptake (Ogunlela, 2013). This is important as it highlights the perceptions of students which serve as a basis to influence how future design and communication of HIV prevention interventions should be. Women did not only reject female condoms but also other female-targeted HIV prevention interventions because of their appearance.

Mutinta *et al*. (2013) conducted a study to investigate risky sexual behaviour among UKZN students where the findings indicated that male users who used alcohol were more prone to engage in risky sexual behaviour whereas women that were 30 years or older had more chances of engaging in risky sexual practices. Furthermore, low use of condoms was significantly high

for both older sexes whereas younger students were also prone to engage in risky sexual behaviour. (Mutinta *et al*., 2013). Thus, risky sexual behaviour was concluded to be a problem for HIV interventions that were delivered to the university (Mutinta *et al*., 2013)

Nota (2016) undertook a comparative study of students' attitudes, preferences and acceptance levels towards microbicide products; the tenofovir gel and the dapivirine ring at UKZN. The findings revealed that, like in Vukapi (2015), knowledge about HIV prevention products did not mean guaranteed behaviour change as the students believed that abstinence and the use of condoms were effective methods of HIV prevention but did not practice either adequately (Nota, 2016). Furthermore, like in Ogunlela (2013), the appearance or form of promoted product mattered to students as they desired that those microbicides be available in another form such as cream, injections, or pills (Nota, 2016). Therefore, proper communication of HIV prevention interventions was of utmost importance, this however does not undermine the importance of how students perceive the physicality of promoted products. The study recommended that for better promotion of microbicides, there is a need to involve men in development and that there is a responsibility for researchers in both the biomedical field and the social sciences to inform people about the promoted biomedical technologies. Additionally, understanding the perceptions of females towards HIV prevention interventions is important, this is also true concerning understanding how males perceive interventions aimed at them, specifically VMMC for this section.

In a study by Nene (2014) to explore the perceptions and management of risks of HIV/AIDS by black female students in sexual activity at the UKZN, Pietermaritzburg Campus, it was found that despite the black female students showed some understanding of risky sexual activities the engagement in risky sexual Behaviour was high while protective behaviour was low. Nene (2014) concluded that among the reasons for this behaviour was the social construction of sexuality by the participants which informed their perceptions and management of risk.

Sakarombe (2014) undertook a study to investigate the Knowledge, Attitudes and Perceptions of Medical Male Circumcision as an HIV Prevention Procedure by White and Indian Male Students at the University of KwaZulu Natal's Howard College. The findings of the study revealed that participants did express notions that MMC is an HIV prevention strategy aimed at black UKZN students only, due to demographic and sociopsychological variables of HIV (Sakarombe, 2014). Furthermore, the most evident finding was that Indian and white

participants expressed disinterest towards the uptake of MMC as they did not feel vulnerable to HIV infection, they fell into what the researcher titled the "I-don't-see-the-point" category (Sakarombe, 2014). Therefore, the study identified that stigma largely influenced decision-making of students towards the uptake of HIV prevention interventions, and thus recommended rectification through critical health communication strategies as well as an improvement in communication (Sakarombe, 2014). Furthermore, in the assessment of perceptions towards VMMC held by UKZN males, it was found that there were prevalent undesirable perceptions towards VMMC, even among Black students.

A study done by Khawula (2015) titled: *An Assessment of Students' Attitudes and Perceptions Towards Medical Male Circumcision on Howard College, Campus University of Kwa-Zulu Natal'* was vastly positive as students showed appreciation for VMMC, moreover, they were informed enough to know that VMMC is not a substitution for condoms but should be used in combination (Khawula, 2015). Furthermore, the student's knowledge about benefits, safety and VMMC education was adequate and aligned with those recommended by WHO (Khawula, 2015). The results pointed towards a recommendation to anchor the existing knowledge by campaigns providing more intensive service, clearer messages and explicit information regarding VMMC education and prevention (Khawula, 2015).

In another study that focused on UKZN students' risky sexual behaviour done by Mthembu (2017), the results revealed that despite knowing about HIV/AIDS, the students engaged in risky sexual behaviours. Among those behaviours is the lack of condom use, having multiple sexual partners, transactional sex and engaging in risky sexual behaviour because of alcohol influence. Moreover, the study found that lack of communication through interventions, peer pressure and socioeconomic challenges contribute to risky sexual behaviour by the students (Mthembu, 2017).

The findings from the studies discussed above provide insight as to how students in universities across KwaZulu-Natal do render themselves vulnerable to HIV infection by engaging in risky sexual behaviours. The knowledge that increases in HIV incidence result in more than just negative consequences for the individual but also impacts social factors such as poverty and education makes it imperative to understand students' risky-sexual behaviours. Furthermore, the development of HIV prevention research at UKZN demonstrates a trend of programmes developing from the limitations of the previous and at the same time promoting the use of them in combination. The ABC did not reflect students' perspectives yet particularly abstinence and

consistent condom use remain relevant in the most recent studies. The introduction of biomedical interventions also adds to the package of programmes but does not discredit the already-existing, instead showing optimism of students' in trying novel interventions if they are well communicated and are in appealing forms, microbicides for example. The development has thus paved way for VMMC to be included in HIV prevention research. It is from this knowledge that this study further research VMMC, specifically the possibilities of discovering an improved and well-suited to advance the goals of HIV prevention through desired VMMC uptake.

The evolution of research around HIV prevention at the University of KwaZulu-Natal expose several issues concerning HIV interventions and the perceptions of the students toward them. Among these issues it is that students may not uptake an intervention despite having significant knowledge about its effectiveness. Examples include the rejection of the ABC intervention, the tendency to engage in risky sexual behaviour and the poor uptake of the VCT intervention (Moodley, 2007; Kunda, 2008; Mulwo, 2008). Furthermore, the findings from these studies demonstrate that the perceptions of the students toward interventions is crucial, therefore, their perceptions should be considered in the development of an intervention. For example, the students did not use female condoms because they did not like their appearance, also, they did not readily accept biomedical interventions such as microbicides because of their appearance (Ogunlela, 2013; Nota, 2016). Therefore, the discussion above has both exposed both what has been down towards the students in terms of HIV prevention and how the students have perceived those intervention. It is through these findings that this study appreciates the importance of the culture of the students and whether HIV interventions are sensitive to it.

VMMC as a Prevention Option

Voluntary Medical Male Circumcision (VMMC), because of development in HIV prevention interventions, has been added to the package as an additional means to reduce the chances of HIV and STI transmissions. This was passed after several tests, ecological studies and heterosexual studies have shown the relationship between HIV infections and unprotected sex by heterosexual couples, showing that HIV prevalence is higher in places with less medical circumcision (Kigozi *et al.*, 2008). Following the medical effectiveness of VMMC in HIV prevention, the WHO declared it as a strategy to be included in the package of prevention strategies (Kigozi *et al.*, 2008). Furthermore, Kigozi *et al.* (2008) argue that “prevention is the only realistic hope since currently available measures have been unsuccessful”. Hence, VMMC having been tested to be effective for HIV prevention is recommended and has been

successfully used as an additional HIV prevention communication strategy. Among VMMC promotion strategies is the integration of medical and traditional male circumcision, also non-surgical circumcision where devices such as the Shang Ring, Prepex and the Taraklamp were used without the need for a medical practitioner, and neonatal and infant male circumcision as a relatively long-term intervention that is low-cost (Govender *et al*., 2013).

In a study to investigate the attitudes of students towards VMMC, both male and female students were participants, and the results showed that were positive about the effectiveness of VMMC in HIV prevention with only 14.1% of them having negative attitudes (Tsvere and Pedzisai, 2014). This is consistent with the findings from a study by Mndzebele and Motanyane (2019) to investigate the level of awareness of VMMC by university students where it was found to be high. In another study by Mbambo *et al*. (2015), to understand student experiences concerning VMMC, the students reported having experienced enhanced sexual functioning after VMMC uptake. The findings from the abovementioned studies expose that university students not only understand the benefits of VMMC but also evidence that most students have a favourable experience post-circumcision. Therefore, VMMC is proven to be effective and thus should be promoted to students as another HIV prevention strategy.

Given its success in the reduction of HIV infections, VMMC achieves greater results if added to the HIV prevention package, especially in places where it is uncommon (Kigozi *et al*., 2008). South Africa meets the profile as it is a developing country and has a high number of people at substantial risk of HIV infection. Mndzebele and Matonyane (2019) argue that VMMC is the most effective intervention for HIV prevention. This however does not mean it is a substitute for other HIV prevention interventions but should be used in combination. Furthermore, VMMC is also known to have a population effect and thus can substantially reduce HIV (Tchuenche *et al.*, 2016). Population effect means a significant reduction in HIV prevalence and incidence at the population level in a generalised HIV endemic (Garenne, 2008). The target for the South African upscale of VMMC is currently at 3 million males from 2017 to 2022 (Odama, 2020). The progress of the programme rests largely on how key VMMC messages are tailored to the culture of South African males.

Application of the Culture-Centred Approach to the Study

The Culture-Centred Approach (CCA) is a strategy applied largely in health communication interventions. It is driven by the empowering of the marginalised voices in the communication process (Dutta, 2008). The UKZN students, particularly Howard College Campus has a diverse

population of students from different backgrounds. Among these diverse groups of students some may be marginalised by health interventions due to limited cultural considerations. This study focuses specifically on Black African students, particularly from those cultures that uphold the values of Traditional Male Circumcision (TMC). These are important because this group of students may not particularly be interested to uptake VMMC because of cultural influences. Therefore, to promote VMMC uptake among students requires a deeper understanding of their understanding of the health intervention. This requires a strategy that would equip those students with a voice and thus including them in the communication strategies, the CCA is useful in this regard as it is designed to oppose the approaches from the mainstream modes of communication and uphold those from the bottom-up approach (Dutta, 2018).

Reasons for the Focus on Males

The VMMC intervention is mostly aimed at adolescent boys and men who are at reproductive ages, 15-49 years (WHO, 2016). This parameter does not however mean males below or above the age are not eligible to get medically circumcised. Furthermore, WHO (2016:5) declares that "HIV remains the single largest cause of deaths among adolescent boys and men of reproductive age in eastern and southern Africa". The targeted adolescent boys and men are not only challenged by the HIV epidemic but also other sociocultural factors ranging from toxic masculinity to interpersonal violence and substance abuse that led them to harm themselves and people around them, including women (WHO, 2016). This poses a danger for their female partners as well. Therefore, VMMC uptake can be beneficial for both males and females in heterosexual relationships as women are also protected from contracting sexually transmitted diseases Furthermore, a study done in KwaZulu-Natal to investigate transmission networks and risk of HIV infections found that men at the age of 22-40 years were the major reason for HIV infections of young women and adolescent girls at ages 15-25 years (De Oliveira *et al.*, 2017). Additionally, males are more likely to have multiple partners, and hold a belief that knowing one's status is the cause of complications such as suicide also HIV prevalence among males tends to increase with age and condom usage declines with age (Collinge *et al.*, 2013). For example, among the most common interventions directed at males, *Brothers for Life* also justified the focus on males because of documented statistics which showed that adolescents and males between 15 and 24 were at 87,4% of condom usage whereas males between 25-49 were at 56,4%, the second statistic showed approximately 43% of males to be more susceptible to engage in one-night sexual encounters because of alcohol abuse (Collinge *et al.*, 2013).

Therefore, prioritising medically circumcise young males may result in protection for the males and adolescent girls and young women that sexually engage and/or share the same social environment from HIV infections.

Impact of VMMC on Males

The key audiences being offered HIV interventions are expected to react, either negatively or positively. The youth has generally shown mixed reactions towards HIV prevention strategies before the recent VMMC, with more weight on the negative side. This does not claim that VMMC as a strategy was readily accepted by the youth. The respective cultures of the targeted audience tend to react differently to the adoption of the VMMC strategy. There is a group of men that found male circumcision uplifting and those who encountered negative experiences as well.

The males have problems with medical male circumcision at all three phases namely pre-circumcision, during circumcision and post-circumcision. The experiences tend to revolve around the issues of VMMC not being a natural procedure and therefore males being hesitant to uptake, also the risky sexual behaviours they engage in post circumcision, with an example of a cause being a misunderstanding of what a properly healed wound post-circumcision comprises of (Lundsby *et al*., 2012). There also seems to be an assumed correlation between male circumcision and the personal identities of the targeted men, with others believing that it may disrupt sexual and individual functioning and thus affect their identities as men (Nxumalo and Mchunu, 2020). Because of cultural and religious beliefs, males may perceive medical male circumcision as a threat to their masculinity (George *et al*., 2014). They may also be filled with regrets because they feel they have lost a part of their bodies and thus tainted them (Nxumalo and Mchunu, 2020). These challenges are to an extent exacerbated by the perceptions held before medical circumcision, these include the fear of engaging in HIV Counselling and Testing (HCT) and the time squandered during the duration of the healing process (George *et al*., 2014). Moreover, among the troubling perceptions is that males tend to fear the pain endured during medical circumcision (Evens *et al*., 2014). In addition to post-circumcision concerns include the survival of the family during the healing period impacted by the loss of income due to being absent from work (Evens *et al*, 2014). These concerns, therefore, require an emphasis on proper counselling of men pre- and post-circumcision (Lundsby *et al*., 2012).

Despite that VMMC is primarily intended to reduce HIV and STI transmissions, the increase in penile hygiene and pleasure seem to be noteworthy successful pull factors toward medical circumcision. Hygiene and pleasure are benefits enjoyed by both males and their female partners, hence the pressure to medically circumcise come from both sexes (George *et al*., 2014; Naidu, 2020). In addition, the females give positive peer pressure as they express an increase in sexual desire and sexual pleasure (George *et al*., 2014; Zulu *et al*., 2015; Naidu, 2020). The importance of mentioning the views and impact of female partners is that they play a significant role in the decision of their male partners to uptake VMMC or not. Furthermore, males tend to provide positive feedback post-circumcision for reasons including that they have higher chances of performing better sexually and thus satisfying their partners, an important factor that contributes to the reinforced feelings of their masculinity (Fleming *et al*., 2017). VMMC resembles a social health matter because it goes beyond the individual male, but extends to their sexual partners, their families and relatives and even friends (Lundsby *et al*., 2012). This knowledge emphasises the need to consider the experiences of medically circumcised males concerning their motivations and factors that may discourage uptake.

Cultural understandings of Traditional Male Circumcision

Medical circumcision has been clinically proven to reduce the chances of HIV transmission; however, it has not replaced traditional male circumcision practised in (TMC) as "a cultural ritual that involves the removal of the penile foreskin of a male person undertaken as part of a rite of passage from childhood into adulthood". TMC is commonly undertaken in a non-clinical setting with the help of a medically untrained service provider (Wilcken *et al*., 2010). In agreement, Maffioli (2017:2) argued that in TMC "the surgical procedure frequently takes place in non-surgical environments, in poor hygienic conditions, where practitioners have different types of knowledge when compared to Western-trained doctors or not equipped with proper supplies".

The prevalence of TMC varied between southern and east Africa, with more than 80% performed in Kenya and 20% in Uganda and southern African countries (Wilcken *et al*., 2010). This prevalence exposes the need to pay more attention to TMC and understand its purpose to those who uptake it. TMC is not merely a cutting of the foreskin but a cultural procedure that society views as a significant symbol for an adolescent transitioning to manhood, an example is the South African Xhosa tribe (Meissner and Buso, 2007; Rennie *et al*., 2015).

TMC is an important part of the people that believe in it as it is informed by their cultural beliefs. The seriousness is emphasised by how much a rebelling man must go through, these include social ridicule and demeaning insinuations and jokes (Shefer *et al*., 2007; Ratele, 2008 quoted in Siweya *et al.,* 2018). In other African communities, to be considered a man, a boy must possess certain traits and qualities other than biological and therefore the society qualifies that as a rite of passage to manhood (Siweya *et al*., 2018). Despite that, the west regards age 21 as the age of maturity, in other African countries a male is not a mature man until traditionally circumcised, regardless of their age (Ramokgopa, 2001; Vincent, 2008 quoted in Siweya *et al*., 2018:1567). Some beliefs pressure males into undertaking TMC, for example, the belief that men who do not undergo TMC would be haunted by misfortune, some believe that TMC increases male potency and that a man is not a 'real man' until traditionally circumcised (Greely *et al*., 2013). The young males who undergo TMC tend to ostracize other young males who do not undergo TMC, they refer to them as not 'real men' and cowards and traitors because they allegedly abandon their traditional practices, which leads to males uptaking TMC to avoid ostracism which impacts negatively on VMMC uptake (Khawula, 2015).

Another example is in Kenya, a Kurya ethnic group practices TMC for the same cultural meanings; practising it means upholding cultural practice and identity, and those who partake are seen as brave since anaesthetics are not used (Mshana *et al*., 2011). This means more support for the males that undergo TMC and are thus more motivated to undertake it. Whereas medical male circumcision is viewed as cowardice and thus ridicules men that circumcise at health facilities (Mshana *et al*., 2011). This means isolation, ostracism and feelings of worthlessness for males who rebel against TMC. Therefore, there is a need to pay attention to factors that set TMC and VMMC apart to provide a plausible case for later promotions.

Limitations of Traditional Male Circumcision

TMC is traditionally accepted, however, it does not meet medical standards to be an HIV prevention method since the procedure does not remove all foreskin and thus the virus can still affect resident immune cells (Maughan-Brown *et al*., 2011). Furthermore, adolescent boys that undergo TMC may be more prone to HIV infection because surgical instruments may be reused on multiple subjects (Thomas *et al*., 2011 quoted in Greely *et al*., 2013). However, a traditional leader from the Eastern Cape House of traditional leaders opposed the above assertion; he argued that TMC always prioritised cleanliness and was not merely symbolic (Nombembe, 2017). This assertion may be true, but it does not change the fact VMMC and TMC are

designed for different purposes, meaning any similarities are merely coincidental. This distinction is important in the promotion of VMMC as confusion may lead to unintended TMC uptake. Sithole *et al*. (2009) stress the importance of distinguishing between the benefits of VMMC and those of TMC so that they are not viewed as synonymous. Furthermore, the two types of male circumcisions differ such that TMC predates VMMC in South Africa, therefore identifying it as an HIV prevention strategy is not only questionable but undermines the cultural dynamics that it was founded on (Mathew, 2012).

Through the assessment of health care statistics in the Eastern Cape, South Africa, it has been found that despite TMC being accepted as a meaningful sociocultural ritual, it remains a public health hazard (Meissner and Buso, 2007). Furthermore, in addition to physical and medical complications that TMC causes, the whole sociocultural procedure may lead to socially undesirable behaviour. Maffioli (2017) argues that TMC is rather symbolic than medical because the foreskin is not removed completely. Considering the above, TMC does not meet the medical requirements and thus does not offer the VMMC benefits. This may be emphasised by the results of a Ugandan study when the Islamic KI tribe discouraged infant and adult circumcisions because it was meant for adolescents when they transition to adulthood, an infant is too young to consent and understand the cultural significance, and an adult puts his manhood in question when he circumcises too late and may face stigma (Rennie *et al*., 2015). Therefore, TMC is more culturally significant and less inclined to offer medical benefits. The fact that TMC is undertaken during the puberty stage may result in circumcised boys engaging in risky sexual behaviour such as having multiple sexual partners and early sex debut, thus increasing HIV infections (Maughan-Brown *et al*., 2011; Greely *et al*., 2013). However, despite these shortfalls of TMC, there is a need to study the cultural motivations because despite the scale-up of VMMC there is still a strong desire to undertake TMC by adolescent boys and men (Maughan-Brown *et al*., 2011; Siweya *et al*., 2018). This desire may result in TMC directly or indirectly being a barrier to the upscale of VMMC. The World Health Organisation (2020) concluded that randomized controlled trials provided high to moderate-quality evidence of VMMC being medically effective. However, Maffioli (2017) points out that despite that VMMC proved to be effective in the randomised controlled trials there is limited evidence for its effectiveness where individuals have options for different types of circumcision. The need to address the issue of the prevalence of TMC is thus emphasised. Rennie *et al*. (2015) conclude that the conflict between VMMC and TMC does result in the slow uptake of VMMC. Furthermore, research has found that TMC is relatively high in acceptance and therefore

necessary to pay attention to, specifically focusing research on the sociocultural meanings people attach to the procedure (Papu and Verster, 2006; Peltzer *et al*., 2007 quoted in Greely *et al*., 2013). Therefore, it is necessary to consider cultural context when promoting VMMC and not assume it will be readily accepted. This is because culture significantly informs an individual in how they perceive VMMC based on the cultural meanings they attach to the procedure (Khumalo- Sakukutwa *et al*., 2013 quoted in Nxumalo and Mchunu, 2020:2).

VMMC for University Students

The HIV prevention campaigns have also included VMMC as an additional strategy in their package, and this has also been adopted at UKZN. The Zulu King, Zwelithini Goodwill, on September 2009, called on males, specifically Zulu men to circumcise, due to KwaZulu-Natal having the highest HIV incidence in South Africa, also the king reversed the ban from circumcision that was implemented by the late King Shaka Zulu two centuries ago (Health-e News, 2009). From October 2017 to September 2018 there were over a million circumcisions achieved with the eThekwini and Zululand districts consisting of over 50% males (WHO, 2020). This followed a VMMC intervention whereby the end of the 2016/2017 period, there were 491 859 males medically circumcised in South Africa (NDP: 2017). Reaching these targets and continuously keeping up with completing circumcisions and adopting communication strategies to create demand and promote circumcision were central to VMMC uptake. The *Scrutinise Campus Campaign* serves as an example of an HIV awareness campaign aimed at students. In 2008 an HIV prevention campaign called *Scrutinise* was launched, the campaign consisted of short, animated commercials to disseminate HIV communication messages specifically for South African university students (Delate, 2009 quoted in Mutinta, 2012). The main goal of the *Scrutinise Campus Campaign* was to address the risk of HIV infections resulting from risky sexual behaviour with an emphasis on multiple sexual partnerships (Spina, 2009). The campaign was effective on its own merits as students enjoyed the extracurricular activities where they received HIV prevention messages while they were entertained (Mutinta, 2012). However, the *Scrutinise Campus Campaign* encountered some challenges, including that the messages disseminated by the campaign do not adequately deal with the students' sexually risky behaviours and their causes, and thus do not offer protective factors to students (Mutinta, 2012). Therefore, South African universities saw the need to address the limitations of the campaign while incorporating other HIV prevention interventions in the package.

VMMC Communication at the University of KwaZulu-Natal

The communication of VMMC messages has relied on utilising the traditional HIV communication strategies and integrating them with the new strategies. The communication strategies are categorised in terms of traditional demand-creation activities and sensitization strategies to name a few. The demand creation activities include debates, radio programmes and panel discussions of which the aim is to stimulate community interaction (PEPFAR, 2013). The sensitization activities which are intended to both promote an accurate understanding of VMMC and promote safer sexual behaviours include newspaper activities, community dialogues and education through health promoters (PEPFAR, 2013).

The South African government also extended the strategies to influence demand creation in tertiary institutions, this has led to institutions offering HIV support and delivering VMMC to their respective students. The programme to offer VMMC in South African universities resulted in the circumcision of 229 males in the KwaZulu-Natal province alone in the space of five months. The University of KwaZulu-Natal also promotes VMMC, not just with academic research but also as an HIV support unit where males can be tested for HIV and get circumcised free of charge. An example of intervention was the launch of the *UKZN Men's Forum* which did not only aim to circumcise males but to address harmful gender-related behaviour (DOH KZN, 2013). The importance of researching students' knowledge of HIV prevention and how they perceive HIV interventions is emphasised. Health promotion strategies cannot be implemented successfully without in-depth research into levels of existing knowledge of HIV prevention, or how these strategies might influence the sexual behaviours of students on campus (Kruger *et al*., 2020).

Student Perceptions of HIV Prevention

The information about HIV/AIDS is readily available on various platforms and places such that access to it is easy and not costly. However, the evidence of growing HIV infections in the Sub-Sahara does not corroborate that fact. Instead, young people still engage in risky sexual behaviours despite showing significant knowledge about HIV/AIDS. The students tend to express boredom and disinterest towards the HIV/AIDS topic (HEAIDS, 2015 quoted in Okelola, 2019). Students lean towards showing expressing disinterest in issues about HIV/AIDS, the perfection of fatalism such that students view HIV as a death sentence and information overload (Mulwo *et al*, 2009). In a study to explore the responses of students to ABC and VCT strategies across three KwaZulu-Natal universities, it was found that the majority of sexually active students did not test for HIV despite having the resources on campus

and showed significant inconsistency in condom use (Mulwo, 2008). This emphasises that the availability of information and resources does not necessarily result in behaviour change.

Stigmas Around HIV Interventions

The stigma around HIV/AIDS is perceived as a sudden death sentence is still persistent among university students, it is associated with perceptions of rejection, hopelessness and isolation (Brown, 2016). The perception that having multiple concurrent sexual partnerships gave one some sense of higher status in their respective social networks may be another reason for continued HIV infections due to possible ineffective condom usage and, that they do not consider HIV as a threat to them (Mulwo *et al*., 2009). Despite the improvement in intervention strategies and medical knowledge, there is still a relatively high number of students that perceive HIV/AIDS with factors such as gender, class and race (Brown, 2016).

There is also a notion that students undermine the threat of HIV and thus do not feel vulnerable, this is seen in the constantly high increase in pregnancies which proves high levels of poor usage of condoms (Mulwo *et al*., 2009). Also, students come from different social backgrounds and their outlook on HIV/AIDS may be affected by factors such as religion (Masoda & Govender, 2013 quoted in Kruger *et al*., 2020). Religious people may abstain from sexual intercourse because their religious moral practices may deem it sinful (Nkosi, 2019).

In a study done at the University of KwaZulu-Natal to investigate how students perceive and use contraceptives, while also investigating how they understood and interpreted its messages, it was found that students are aware of HIV prevention strategies including contraceptives but barely practice them and are thus vulnerable to HIV infections (Mulwo *et al*., 2009). Moreover, according to a comparative study done by Nota (2016) at the University of KwaZulu-Natal to compare attitudes, preferences and acceptance levels towards microbicide products; the tenofovir gel and the dapivirine ring at UKZN. A total of 100 questionnaires were self-administered through two focus group discussions and the collected data was analysed thematically, the key findings included that 62% of the females would consider using microbicides and that culture does play a pivotal role in the decisions of the females whether to uptake or not (Nota, 2016). Nevertheless, the results of the study provide some hope that UKZN female students may uptake biomedical HIV prevention intervention. Moreover, this may be due to their cultural perspectives rather than the interventions themselves being a cause.

Perceptions leading to the Inconsistent Use of Condoms

Among the strategies employed by UKZN to promote health has been the promotion of male condoms, these have been followed by female condoms. However, female condoms were not received well on the account of excessive size, high cost and overall unattractiveness (Ogunlela, 2013). The lack of condom usage is dependent on several perceptual factors, among them being that students tend to not use condoms when they are in sexual relationships where they trust their partners (Ndabarora and Mchunu, 2014). Research has shown that students are aware that condoms are readily available and accessible on respective South African university campuses, however, students are not accessing them at an expected rate (Francis *et al*., 2016 quoted in Kruger *et al*., 2020). This emphasises how perceptions of condoms can impact how they are used, despite their availability. Furthermore, in a study done at the University of KwaZulu-Natal to investigate how students perceive and use different brands of condoms, it was found that students hardly used the condoms consistently despite condom use being the most effective strategy for HIV prevention (Mulwo *et al*., 2009). Furthermore, the students are dissatisfied with the *Choice* brand condom, reporting that it is uncomfortable to use, and their smell is bad (Mulwo *et al*., 2009). In a study by Nkwei (2013) to analyse the brand positioning of male condoms among UKZN students, it was found that students were unfamiliar with the *Love* brand whilst perceiving the *Choice* brand as poor, this was exacerbated by the association of the brand with the South African government. Notably, these brands are both provided by the South African government, however, one of them is ignored by the students while the other is rejected. This is consistent with the results from the Jomo Kenyatta university study to investigate factors that are associated with condom use where brand positioning was among the reasons for poor condom use (Kithuka, 2012). Moreover, according to the results from the study investigating factors shaping condom use among South African students, it was found that preference played a role in condom use. In addition, the students engaged in unprotected sex based on the notion that they do not feel natural (Ndabarora and Mchunu, 2014). This perception may be in line with the behaviour of students who state that sometimes free condoms are not available, but they engage in sexual intercourse anyway (Mulwo *et al*., 2009). In addition, most sexually active students lacked the will to adopt condoms as contraceptives (Nkosi, 2019).

General VMMC Perceptions

Common barriers include fear, uncertainty regarding pain, injury, complications, and adverse events, also negative perceptions held by religious groups, cultural influences, lost wages from

time off work, sexual abstinence during the healing period and shame (WHO, 2020). There is also a problem with VMMC benefits that are not properly explained. For example, VMMC may reduce HIV transmission by 60% but this may be risky if absolute and relative risks are not explained, and some females prefer circumcised men when all women's preferences are not known, and VMMC protects women from cervical cancer and it is not explained that there is still a possibility of the infection (Gilbertson *et al.*, (2019). The abovementioned perceptions towards VMMC are detrimental to the whole intervention and need to be addressed with more suitable communication. Bailey *et al.* (2002:34) state that "the uncircumcised get more infections because the foreskin can keep secretions and germs which later develop into infections". Therefore, uncircumcised males were generally perceived as less unhygienic and more susceptible to infections and diseases. Therefore, VMMC promotions should be explicit and sincere with the benefits it can offer both males and females. Chatsika *et al.* (2020:9) posit that "misunderstandings and inaccurate perceptions about protection from HIV through VMMC could lead clients to opt for risky sexual practices and reduce the ability for adopting options available for safer sex". For example, the students at the University of KwaZulu-Natal, Howard College expressed that they viewed VMMC as a complete HIV prevention strategy and thus ended up engaging in risky sexual behaviours through ignoring that VMMC is a partial prevention intervention and should be used in conjunction with other interventions (Sakarombe, 2014**).**

Students' Perceptions of VMMC Intervention

There is a necessity to be critical of the effects of VMMC to address adverse effects. The World Health Organization (2020:73) recommends that "to increase VMMC service uptake, evidence-based interventions must address both barriers and facilitators in the context of adolescent boys and men's realities". The perceptions towards VMMC may be more hazardous rather than helpful if not properly addressed, one of the most hazardous perceptions is that VMMC replaces a condom, regarding it as the natural condom (Zungu *et al.*, 2016). Furthermore, circumcised males may engage in irresponsible behaviour such as having relations with multiple partners and not using a condom (Zungu *et al.*, 2016). In some circumstances, the VMMC mobilisers can mislead or coerce males to circumcise to merely increase uptake (Gilbertson *et al.*, 2019). This may be problematic because misconceptions about the procedure do not help the overall VMMC goals in the sense that males may uptake for the wrong reasons and thus engage in risky behaviour post-circumcision.

VMMC has been an addition to HIV prevention strategies at the University of KwaZulu-Natal. However, there are perceptions that it is only aimed at the black population (Sakarombe, 2014). This may be because exclusively in South Africa, as Blacks are the majority and have the higher numbers of people living with HIV, the disease is seen as a 'Black disease' (Sakarombe, 2014). These were findings of a study done at the University of KwaZulu-Natal to investigate the knowledge, and perceptions of medical circumcision as an HIV prevention intervention by White and Indian male students, it was recommended to identify a reliable communication strategy to address the stigma and prejudices for effective VMMC upscale (Sakarombe, 2014). The study sampled 40 White and Male students categorised accordingly, and data was collected through semi-structured interviews which were distributed electronically (Sakarombe, 2014).

Possible Improvements in Intervention Delivery

The research on HIV prevention programmes for students has shown that simply availing resources and educating students about HIV/AIDS is insufficient to curb infections. Some strategy that may be useful is including HIV/AIDS content in the academic curriculum to create better awareness, as was concluded in a study at Walter Sisulu University (WSU) aimed at determining whether HIV interventions influenced perceptions, attitudes and beliefs of WSU students (Twaise *et al*., 2014 quoted in Njawala, 2016). The students should also be involved in the development of programmes, for example, the ABC strategy struggled because it omitted the ideas of students in the message being transmitted (Moodley, 2007 quoted in Nkosi, 2019). Research has established that HIV testing and counselling (HTC) and Universal test and treatment (UTT) are both useful in curbing the spread of HIV, but students are not utilising them as desired. It is therefore conclusive that it is important to understand the perceptions of students towards the interventions (Okelola, 2019).

There should also be more investment in making free condoms more comfortable, this includes focusing on the distribution of male instead of female condoms as females tend to dislike them. Women generally express more trust towards the male than the female condom (Nota, 2016). Therefore, a reduction in female condom size has been recommended, including the improvement in communication strategies, with edutainment as a possible strategy (Ogunlela, 2012). Furthermore, biomedical interventions are not effective on their own but rely on a communication strategy that suits the key audience. Development in the HIV programme is the possibility of administering biomedical measures that include Microbicides, tenofovir gel and the dapivirine ring (Nota, 2016). Despite Microbicides not being available at the time of the study, the study respondents showed a willingness to use them because they empower them,

and a reliable communication strategy is recommended (Nota, 2016). There is an emphasis on the idea that interventions are not inherently the problem but how they are communicated is, specifically offering a one-size fits all strategy to diverse cultural groups. Furthermore, Padian *et al*. (2008 quoted in Kruger *et al*., 2020:157) declare that "biomedical interventions alone are not always effective and such interventions need to be combined with behavioural interventions such as sex education programmes aimed at reducing the stigma and discrimination that shroud the disease Lastly, interventions that go beyond written information such as including drama programmes to enact the education show greater increase in awareness and condom use, this could be applied at targeted universities to achieve desired results (Nubed and Akoachere, 2016 quoted in Kruger *et al*., 2020). This, however, does not take away the effectiveness of student movements against HIV/AIDS which are highly recommended (Ndabarora and Mchunu, 2014).

Conclusion

The HIV pandemic is serious and demands immediate and comprehensive response interventions. Since the start of interventions, the HIV pandemic has been curbed to an extent by a variety of interventions designed to cater to different target audiences. The interventions eventually learned from research and studies that the diversity of key audiences requires specifically tailored interventions, respectively. The chapter has investigated and discussed existing literature around communication strategies aimed at university students, also their perceptions towards HIV prevention interventions and VMMC and lastly the debated and discussions around VMMC and TMC and how that influences VMMC uptake. Culture has been deemed a contributing factor in how key audiences create meaning and therefore may understand an intervention based on their cultural language, values and norms. VMMC has been included in the intervention packages and has achieved significant progress. However, the HIV pandemic is still a reality and hence 2030 targets to end HIV as a global pandemic.

Academic institutions such as the University of KwaZulu-Natal have joined in the fight against HIV and have their own HIV prevention programmes. Among them is VMMC which is offered on various campuses, UKZN has health promoters who are responsible for assisting students with the knowledge, HIV counselling and testing and including VMMC services. This study intends to explore the possibilities of entertainment education being used as a communication strategy for VMMC promotion toward UKZN students. The next chapter will be investigating

Culture Centred Approach and how it may be best suitable to account for the culture of university students and how they understand and interpret the meanings of HIV prevention aimed at them.

Chapter Three

Theoretical Framework

This chapter presents the theoretical framework of the study. The study adopted the Culture-Centred Approach (CCA) as a relevant theory to analyse the findings from the data collected from semi-structured interviews. The Culture-Centred Approach is useful such that it brings to light that the key audience is not merely individuals in a vacuum but instead is embedded in cultures (Dutta, 2008). The University of KwaZulu-Natal consists of students from diverse cultural backgrounds and therefore may not receive the messages in the same light. Furthermore, VMMC is a topic that is controversial in South Africa because it may coincide with traditional male circumcision (TMC) and religious circumcision in other cultures and may therefore face hindrances. Furthermore, the people that are embedded into their cultures accept their understanding of circumcision as valid and true, therefore, to promote medical circumcision in the form of agentic behaviour change requires sensitivity to the diversity of cultures the key audiences are embedded in (Dutta, 2007).

This study focuses on the culture of UKZN students specifically from the Howard College Campus. Notably, UKZN is an international institution meaning that it consists of students from all parts of the globe, therefore, the students share various cultures. Hence, this study specifies to focus on the culture of Black South African students. These are ideally the males that come from a culture that embraces TMC as part of their cultural rite. The males that meet this criterion, as guided by the discussion in chapter 2, do not only consider TMC as merely the cutting of the foreskin but the procedure has a cultural meaning attached to it as males are considered to transition from young boys to adults (Maffioli, 2017). It is from this understanding that this study considers the promotion of VMMC as potentially difficult if the culture of these students is not acknowledged.

Background to the Culture-Centred Approach

The CCA was advanced by Mohan J. Dutta, which drew inspiration from the works of Airhihenbuwa (1995) who was against the disregarding of the rich culture of the marginalised by the dominant Western paradigm, arguing that culture should be the motivation for health communication theories. This perspective emphasises the position for CCA being a critical theory towards the dominant paradigm of health communication where health providers because they have tools and knowledge, assume that they are experts in the design and implementation of interventions, and thus dominate the communication process (Dutta, 2008).

This is in contrast with the CCA principles. The CCA seeks to allow the participation of the key audiences, therefore, there is a need to plan, implement and evaluate health communication programmes within the context of the culture of the key audience (Airhihenbuwa, 1995; Dutta:2008).

The Culture-Centred Approach is based on the understanding that key audiences of health communications do not live in isolation but are embedded in socially constructed cultures with shared meanings and social norms, therefore, health meanings must be negotiated not imposed upon (Dutta, 2008). This means that the engagement with the health providers would not be a top-down communication approach, instead, the approached individuals must be allowed to question and raise issues they have with the messages they receive. Furthermore, the origins of the CCA are traced back to the postcolonial and Subaltern studies, where the post-colonial aspect focused on how boundaries are blurred, and how relationships are in flux and continually shifting, whereas the subaltern aspect advocates for solidarity between the researcher and the key audience as the dialogue with subaltern voices are seen as a necessary step towards alternative writings of history (Dutta, 2008: Dutta, 2014). Therefore, engaging with the previously marginalised communities and reinstating their erased voices could result in the identification of local health problems. Furthermore, the notion that the key audience is passive, unlearned and backward is discouraged, to the contrary, engaging with them in the whole process of intervention is encouraged.

Interventions from the dominant paradigm assume that individuals can still make informed decisions leading to behaviour change merely from linear and top-down dissemination of information, which is untrue considering that the marginalised communities are impacted by the context they are embedded in (Quarry and Ramirez, 2009). That means it is rather the culture of the marginalised communities at the bottom where knowledge and meaning are created. Disregarding that the marginalised are agents of the creation of their stories ultimately leads to ineffective service delivery as the racial, socio-economic, and geographic context is ignored, emanating inherent biases from the 'experts' (Dutta, 2008). Therefore, ignoring the cultures of the UKZN students and assuming that the health promoters are experts of knowledge will not result in VMMC uptake. Earlier VMMC interventions assumed individual male students would uptake VMMC based on individual choice when reality points out to their context as an enabler or a hindrance to behaviour change.

The CCA is an approach that was inspired by four key disciplines which are critical theory, cultural studies, postcolonial theory and subaltern studies (Dutta-Bergman, 2004). The purpose of critical theory is to subvert the status quo by exposing systematic injustices and thus resisting the dominant paradigm (Thompson, 2017). Therefore, the CCA is in existence in opposition to the Western modernisation paradigm, purporting to reinstate the subaltern voices back to the mainstream. Whereas cultural studies offer insight into the context of key audiences, acknowledging that the nature of an individual is socially constructed and thus behaviours are influenced by their environment (Dutta, 2008). Whereas the postcolonial theory purports to address the impacts of colonialism by challenging and deconstructing the reality of the European paradigm, which idolised European people's reality while actively marginalising the subaltern, and thus ultimately oppressing them (Lazare and Andries, 2009; Parsons and Harding, 2011). Lastly, as for the subaltern studies project "an emphasis is put on power and representation that are often left out of discussions in the dominant literature" (Kim and Dutta, 2009:144).

The CCA emphasizes the importance of context, as meanings are not formulated in isolation but people in a culture actively construct shared meanings and norms. The context is described as a web of local contexts used by individuals to negotiate meanings (Dutta, 2007). The choices of an individual have their source on how the society that shares one culture defines and understand a health problem. Cultures exist alongside structures which are important because access and control to resources impact the creation of meanings in the context of experiences of individuals in a culture (Dutta, 2007). It is thus imperative that scholars pay attention to the fragmented and negotiated nature of the meanings of health, as health communication scholars pay attention to the increasing global flows and migration patterns (Yehya and Dutta, 2010). This means that together, all parties involved negotiate meanings and share the outcome with their initial cultures, respectively. This means student health promoters should pay attention to how VMMC communication will not be a one-way communication towards a passive audience, but a negotiation of the meaning of what VMMC means including the reasons to uptake.

The CCA approach applied to this study because the researcher considered the context of UKZN students and how their cultures defined and understood medical circumcision. This was to ensure that there was no clash in the definition of shared meanings. VMMC as demonstrated by a study done by Shumba and Lubombo (2017) to investigate the role of cultures in the delivery of messages to key audiences, revealed that full scale-up of VMMC is only feasible when socio-cultural values are respected. Therefore, there was a need to acknowledge how the

local communities understand their problems, by involving them in both identifying problems and devising solutions. In the context of the CCA approach, when VMMC programmes are created, the key audience must be involved in those organised spaces (Shumba and Lubombo, 2017).

The Need for CCA

The dominant communicative systems and processes account for the interdependent relationship with the subaltern voices, where the voices of the former are distinct and prominent at the expense of the latter which are silenced and erased (Dutta, 2014). This means that the result is the Western paradigm remaining as the mainstream one-size fits all source of knowledge. The methodologies and conceptual frameworks of the hegemonic communicative systems serve to actively exclude the marginalised by defining the content, the tools and the individuals to be deemed as worthy to make explanations and predictions (Dutta, 2008). Therefore, because the marginalised are deemed as the "uncivilised other", the production and dissemination of knowledge and information follow a linear or top-down approach (Dutta and Basu, 2008). Furthermore, the voices of the subaltern are silenced because access to communicative spaces, tools, strategies and platforms is shaped within material structures that ultimately shape messages, processes and discourses (Dutta, 2019). These are within the agency of the powerful political and socioeconomic actors with access to resources (Dutta, 2019). The CCA is thus necessary for resisting the marginalisation of the subaltern voices through a bottom-up approach where the locals participate in the definition of their problems as well as the possible solutions. The CCA seeks to empower the subaltern communities as empowerment is critical for social change (Dutta, 2011). However, this study did not purport to solve the problems of the respondents, but the CCA helped listen to their voices and thus gained insight as to what communication strategy resonated with their culture in the promotion of VMMC messages.

The subaltern voices are identified as the audiences that the dominant paradigm actively marginalises in the processes of health promotion and development. The subaltern studies and approaches such as the CCA serve as an alternative paradigm in the fight to include the subaltern voices. Moreover, the alternative paradigm developed following the identification of the absence of culture in development projects from the West (Dutta, 2015). The alternative paradigm serves the function to expand the theoretical base for addressing the complexities caused by globalization and to challenge the capitalistic and corporate approach to research and practice (Pal and Dutta, 2008). As opposed to individualistic behaviour change, alternative

social change communication is based on community participation and empowerment of the subaltern communities (Dutta, 2015). The CCA thus opens spaces for the subaltern communities to raise questions of power, ideology and hegemony within the dominant paradigm's parameters (Pal and Dutta, 2008). The CCA identifies the voice of the subaltern communities as the most crucial part of the process because health issues are dialogically constructed by community members (Dutta, 2007). Additionally, it is the dialogue with the subaltern communities that bring their narratives into mainstream sites of knowledge (Dutta and Pal, 2010). This is when meanings of health are understood in the way the subaltern communities have constructed them. Dutta (2007:307) emphasizes that "the voice of the community is central to the articulation of health problems and corresponding solutions".

The Biases of the Dominant Paradigm

Previous conceptual frameworks used in health communication included individual-level focus, cognitive bias, decontextualised bias, status quo bias and control bias (Dutta, 2007: Dutta, 2008; Dutta, 2014). The individual-level bias is a common feature of Western vultures which resulted in health communicators focusing on the individual as an object of study, which led to complications such as the ignorance of cultural, structural and community contexts (Dutta, 2008). Whereas the cognitive bias gave rise to the belief that individuals could be influenced to perform a behaviour if messages are to change their thoughts and beliefs, this proved to be narrow as individuals have the agency to assess the severity of a health problem and thus weigh their advantages and disadvantages with regards to a decision to be made (Dutta, 2008). The decontextualised bias looks at how the dominant paradigm tended to assess a health issue outside the context that surrounds it, this is problematic because other factors that may have influenced the behaviour may be omitted in artificial conditions (Dutta, 2008). The status quo bias identified the tendency of the dominant paradigm to focus on the individual that it only serves the status quo and ignores that individuals are based in communities with different social experiences such as inequality in access to resources and poverty (Dutta, 2008). Lastly, the control bias speaks to how the idea to change beliefs, behaviours and attitudes of the key audience is seen as controlling, this is often evident in how communication theories from the dominant paradigm reflect the cultural values of the West (Dutta, 2008). The biases highlight the need to appreciate the need for the CCA as it purports to critically challenge and deconstruct them.

The dominant paradigm is a Western/Euro-centric approach to delivering health communication globally. Inherent to the framework of the dominant paradigm are the linear,

top-down forms of communication where the bottom Third World is deemed passive (Dutta, 2015). Furthermore, the dominant paradigm rendered the global south underdeveloped and thus diffused health interventions in the form of development communication (Dutta and de Souza, 2008). The flow of communication typically moved in a linear direction from the centre to the periphery, hence, some scholars argued that because the communication strategies carried colonial undertones, they contributed to the underdevelopment of the Third World as their agency was undermined while the First World was privileged (Dutta-Bergman, 2005). Moreover, health is typically framed in the realm of individual behaviour change which serves the interests of transnational dominance but does not account for the cultural, economic and social processes within which health is located (Dutta, 2007). The dominant paradigm constructed the Third World as undeveloped and primitive and thus needed an intervention, hence the modernist intervention promoted to them (Dutta-Bergman, 2005). Lastly, the dominant paradigm did not only conceptualise itself as the main form of health interventions but also limited alternative means to disseminate health messages based on its idealized bureaucracy that was deemed as most effective and efficient (Pal and Dutta, 2008).

Previous Applications of CCA on Research

Shumba (2014) undertook a study titled ‘JUST A SNIP?’ Lemba circumcisers' perspectives on medical male circumcision for HIV prevention in the Mberengwa district of rural Zimbabwe. The study took an interpretive paradigm to understand how respondents understand reality. The CCA complimented the interpretive paradigm because it allowed the researcher to understand the respondents in their local contexts, and how they define and understand VMMC. These would be starting points to unpack the respondents' motivation to uptake VMMC. It is from the interpretivism ideology that individuals have shared meanings and common experiences, thus, the collected data were interpreted within the CCA (Shumba, 2014).

The study by Vukapi (2015) applied CCA “ZAZI-Know Your Strength”- A reception Analysis of contraceptive utilisation in correlation to unplanned and unwanted pregnancies among young female learners’ in Umnini, KwaZulu-Natal. The CCA assisted the researcher by allowing dialogue during data collection that resulted in gaining insight into how respondents construct meanings. Furthermore, through CCA, the campus clinic was identified as a structure that could either enable or hinder certain behaviours (Vukapi, 2015).

A study was done by Nota (2016) titled A comparative study of students’ attitudes, preferences and acceptance levels towards microbicide products; the tenofovir gel and the dapivirine ring

at UKZN. The study applied the CCA such that it allowed the researcher to have dialogues with respondents and learn how they perceive biomedical interventions for HIV prevention. Furthermore, the CCA helped analyse the structures that could infringe on young women's agencies in their decisions to uptake microbicides, these structures would be the service providers, logistics and campus clinics, to name a few.

Vukapi (2020) undertook a study exploring the role of adolescent youth-friendly services (AYFS) in primary health care clinics that offer HIV and sexual reproductive health (SRH) for adolescent girls and young women in Vulindlela, KwaZulu-Natal, South Africa. The three constructs of CCA, agency, structure and culture were instrumental in identifying factors that influenced the decisions of adolescent girls and young women of Vulindlela in engaging with the AYFS to access SRH. The participation depended on the women's agency, and how their culture defines SRH and primary health care clinic as a structure (Vukapi, 2020).

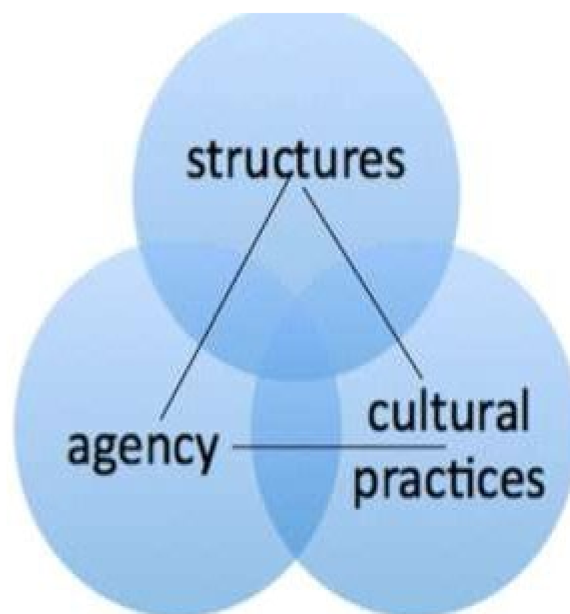
The culture-centred approach has been significantly applied by researchers at the University of KwaZulu-Natal. Masambuka (2020) applied CCA in the study to investigate the University of KwaZulu-Natal female students' perceptions of female sexuality and its influence on sexual behaviour and HIV and AIDS prevention. CCA informed research questions, methodology and data analysis of the study (Masambuka, 2020). Lastly, the CCA assisted the researcher in finding that the respondents were aware of HIV prevention messages and felt that they had the agency to uptake healthcare facilities but were still resisting continuous condom use in the long term (Masambuka, 2020).

The studies discussed above; all used the CCA as a framework for their research. They had similarities in the application, however, because they had varied topics and objectives, there were also differences. Among the similarities was that the researchers did not aim to solve problems for their respective respondents, but instead used the constructs of CCA namely, structure, culture, agency and voice and dialogue to understand their reality. Furthermore, the studies facilitated voice and dialogue in their data collection, which is a key instrument in creating a participatory environment for the respondents.

The Constructs of the CCA

The CCA has several theoretical constructs, this study will focus on four which are culture, structure and agency and dialogue and voice. The cultural construct acknowledges that an individual develops one's identity from a pool of shared meanings, values and mores (Dutta, 2008). Therefore, an individual is not a passive entity but has a shared understanding of reality.

Furthermore, Dutta (2008:5) posited that the interaction of the three constructs "creates openings for listening to the voices of marginalised communities, constructing discursive spaces which interrogate the erasures in marginalised settings and offer opportunities for constructing the voices of those who have traditionally been silenced by engaging them in dialogue". Therefore, the CCA brings about empowerment for marginalised communities. The choices of an individual have their source on how the society that shares one culture defines and understand a health problem. Cultures exist alongside structures which are important because access and control to resources impact the creation of meanings in the context of experiences of individuals in a culture (Dutta, 2007). Therefore, like agency, cultures alone are not adequate for behaviour change so long as structures remain a hindrance. Figure (3.1) presents a diagram demonstrating the interconnectedness and interaction of the three constructs.



The three constructs of the Culture-Centred Approach (Meister *et al*., 2014)

The diagram illustrates the interaction between agency, culture and structures. It is composed of three circles that overlap with one another to demonstrate that the constructs work simultaneously and are interdependent. Therefore, failure to achieve one of the constructs may result in the disturbance of the process and thus failure of an intervention. Furthermore, voice dialogue does not appear in the diagram but that does not mean that it is omitted. However, as CCA argues that it is when the first three constructs are met that the most important process

begins, where the subaltern voices are successfully engaged in the intervention and thus dialogue occurs.

Agency

The key audience anticipated to receive and engage with promoted messages are recognised as active agents that do not simply act as intended by the promoter. Agency refers to the capacity of individuals to partake in daily activities in response to their contexts and understand their contexts and structures on a deeper level (Dutta, 2007). Another definition of agency is that agency is the capability of individuals and collectives to make sense of and challenge environmental factors that stifle their progress, while actively negotiating and determining their choices (Dutta, 2008). The definitions share similarities in that individuals are identified as active agents that have the potential for capacity to act deliberately against limiting structures. The second definition is necessary because it highlights that those individual members can unite and can also have collective agency. Dutta and Basnyat (2008:443) argued that "central to the culture-centred approach is the foregrounding agency and the location of this agency within dynamic and transforming cultural contexts". This means that as culture is not static, the focus should be on empowering individuals to use their agency effectively in the changing contexts. Therefore, the agency is important because it is noted that the key audience is not passive but instead actively constructs meanings of realities (Dutta and Basnyat, 2008). This emphasises the importance of student health promoters that despite them having the information, students will selectively observe the information and maintain their agency to decide whether to uptake VMMC or not.

Agency identifies what the key audience can or cannot do in their struggle against structures that constrain their choices (York and Tang, 2021). The environmental factors are referred to as structures, agency and structure constitute each other such that agency to engage in healthy behaviour may be enabled or constrained by structures (Dutta, 2011; Basnyat and Dutta, 2012). Therefore, empowering marginalised communities to exercise their agency while ensuring the prevalence of structures is fundamental to the agency (Dutta, 2018). The CCA also "stresses the need to develop respect for the capability of members of marginalized communities to define their health needs and to seek out solutions that fulfil those needs" (Dutta, 2008:331). Furthermore, Dutta *et al*. (2018) further extrapolates that "the meanings of health thus emerge as sites of articulation of structures that constrain health, and the agentic expressions that negotiate these structures". Hence, the CCA assisted the study in investigating how the students applied their agency in making choices regarding HIV prevention strategies and how structures

enabled or constrained those choices. The importance of agency is emphasised by understanding that the key audience is made up of ordinary people, yet they are the engines of change by negotiating choices through dialogues and thus making them aware of the exploitation and systemic marginalisation oppressing them (Duta, 2018; Vukapi, 2020). It is therefore imperative to appreciate the importance of individuals as the drivers of change by voice and dialogue to identify problems and solutions, through empowering their agency.

Structure

Dutta (2011:9) defined structures as “the institutional frameworks, ways of organising, rules and roles in mainstream society that constrain and enable access to resources". Some examples of structure include resources such as health facilities, the stakeholders such as health providers and logistical issues such as transportation of resources or individuals. In this study, the structure included the UKZN institution, the campus clinics and various VMMC interventions, also relevant is how the students can access those delivered resources for VMMC uptake in the institution. The structures that enable or constrain the behaviour of key audience function on several levels namely, micro, meso and macro (Dutta, 2011). The structures are not limited to materialistic resources but also include roles, rules and patterns of organisation (Dutta, 2008; Martinez, 2017). The virtue of the key audience being marginalised, they have a limited voice in the formulation of health policies and the dominant communication structures (Dutta, 2013). Thus, subaltern communities can be hindered by structures to fulfil their health needs from available healthcare resources (Dutta, 2013). The structures tend to systemically advantage powerful stakeholders by gaining more resources while the marginalised get fewer (Dutta, 2018). This emphasises the need for dialogue through CCA since despite its potential to be dialogic with dominant structures, it can be useful by being disruptive of and opposing dominant structures (Elers *et al*., 2021).

Culture

The CCA views culture as both static and dynamic such that dominant norms do not directly influence individual behaviour uniformly while it passes on values within a community (Horner *et al*., 2008; Dutta, 2018). Furthermore, it is known as a complex network of meanings that are in a constant state of flux (Dutta, 2011). This is important because people use cultural values as a lens through which they identify problems, therefore different contexts define and identify problems differently (Dutta, 2008). Culture, as defined by Dutta (2008:1077) refers to "the contextual cues for meaning-making grounded in community values and norms, offers an overarching framework for community-driven collaborations in identifying health problems

and developing potential solutions through active community participation". Therefore, complex health information is not exclusive to the influence of health providers but is grounded in community values, and cultural ways of constructing narratives and identifying cultural stories through culture-centred processes (Dutta, 2008). Thus, this study understands culture as the values, customs, language and traditions that the target community adopts and in turn informs how they view their world, including health issues. Furthermore, York and Lang (2021:251) argue that "culture provides the communicative framework within which individuals understand health and illness". This notion anchors how the intersection of structure and culture plays out cultural values, rules and rituals through engaging with the key audience (Dutta, 2008). The key to centralising health communication key research is recognising the importance of both the context of the key audience and structures (Dutta *et al*., 2018).

Dialogue and Voice

Another important part of the CCA is the promotion of dialogue between the intervention service provider and the key audience (Dutta. 2008). This is necessary because CCA acknowledges that there is an unequal balance of power between the two parties. Therefore, there should be a meeting ground where the service provider and key audience meet and renegotiate the meanings of the proposed intervention. The intervention brings about a medicalised ideology where it publicises the body of the individual and seeks to heal it to bring it back to the capitalist machinery (Dutta, 2008). This tends to cause conflicts as there is an assumption that the key audience is passive, in truth, information must be negotiated and produced by both physician and patient by acknowledging the clashes of the stories of modern science against communal stories to result in one shared story from the inside to the peripheries (Dutta, 2008). This is emphasised on the point that meanings are rather from the bottom, at the local community spaces, not at the top, at the dominant paradigm. In addition, the individual develops a story about the illness and then identifies other members of the society faced with the same problem and this results in a shared narrative (Dutta. 2008). Dialogue and voice therefore deliberately challenge and deconstructs dominant paradigms by purposefully welcoming the marginalised voices of ordinary members of society. It is therefore necessary that the status of members of society is then switched from marginalised communities to partners with the members of the dominant paradigm in the construction of narratives through dialogue and voice.

The dialogue and voice construct of the CCA informed the methodology of this study, the semi-structured interviews allowed the respondents and the researcher to have back-and-forth

discussions emanating, respectively. The open-endedness of semi-structured interviews enabled the researcher to be flexible and ask follow-up questions that accumulated into an engaging discussion. The questions also allowed the respondents to respond freely and expressed themselves enough to allow possibilities to elicit information beyond the questions. These are in cognisance with the dialogue and voice construct of CCA, because through the discussion there are possibilities to learn the common practices and meanings that male students share about VMMC and HIV prevention altogether.

The Applicability of the CCA to the Study

The study is focused on UKZN as the population of interest. The literature around the incidence of HIV/AIDS has suggested that success in ending HIV as a pandemic still requires more effort concerning promoting interventions. The traditional interventions such as ABC, PrEP and 90-90-90 goals to name a few, have been successful in their merit but there is still more to be done. This has included the introduction of VMMC to HIV prevention interventions, which has achieved significant success. The CCA extends the focus of interventions from being individualistic to the impact of cultures and structures that key audiences are embedded in; the CCA was useful in assessing the possibility of a suitable VMMC communication strategy in future HIV prevention targets. This study adopted the semi-structured interviews to collect data because it allows for a dialogue to occur by enabling the researcher to follow-up with questions while the participant can explain beyond the scope of the question. This setup was instrumental because the study aimed to collect data that is rich, a two-way dialogue was an important part of the process. The Black African students come from a different cultural background as of the VMMC interventions. This means that the VMMC promoters develop the interventions by incorporating messages that may not relate to those of the Black African students at UKZN. According to the CCA, the VMMC interventions are regarded as from the dominant paradigm in this context. This is because they mainly follow a top-down approach where the Black African students are assumed to understand the messages as they are and are thus expected to uptake VMMC. As previously demonstrated in chapter 2, the Black African students may not uptake HIV interventions as expected, despite having significant knowledge about it. Among the factors contributing to this result are the perceptions that students may hold about an intervention. This proves that HIV interventions such as VMMC may not meet their targets if they are not sensitive to the context of the Black African students at UKZN.

In addition to perceptions held by the students, when the culture of the Black African students is not appreciated, the students may not have the agency required to uptake an intervention.

This is where there is a clear disjuncture between the health promoters and the targeted students. If the agency of the students is compromised, this means that they cannot successfully uptake the intervention, hence, they are marginalised by the health promoters. It is through this understanding of the CCA that the Black African students are regarded as the subaltern community in this context. This means that there is a misfit between what is offered by the health promoters, the structure, and the ability of the students to use those facilities efficiently, the agency. This is a shortfall as for an intervention to be successful there must be a positive relationship between agency and the structures (Dutta, 2008). Failure by the health promoters to achieve this criterion may lead to an unsuccessful intervention as the CCA's goal is to allow for a dialogue between the health promoters and the audience. When this is not met as is the case with the VMMC promoters and the Black African students at UKZN, the students remain marginalised as their perceptions are not addressed so to redesign the interventions such that they are sensitive to their culture.

This study differs with the mainstream health interventions because it fully captures the constructs of the CCA with the aim to empower the Black African students. It is through the dialogue that occurred in the interviews that the researcher managed to understand the perceptions of the Black African students towards the VMMC interventions at UKZN. The findings of this study would then be important to future VMMC interventions specially to how they are designed and how they are culturally sensitive to the Black African students. Lastly, the application of the CCA to this study was also helpful in understanding the cultural factors that influence the adoption of communication strategies aimed at Black African students at UKZN.

Limitations of the CCA

The CCA is significantly applicable in diverse key audiences as a strategy designed to stimulate the participation of the community, however, this does not come with limitations. Among some of the limitations is that the very emphasis on consensus-building, community participation and community-wide discussions, the same process can marginalise other voices in the community (Dutta, 2018). An example is despite the stakeholders sharing the same goals with the community, there would be some members driven by separate personal interests, and these could be ignored in the overall process to uplift the community (Dutta, 2018). They see the individual as still important despite being a sum of the whole, justifiably because the approach intends to uplift all members involved.

Secondly, although the CCA is effective in addressing health issues, it is not directly positioned to communicate health information, similarly limited in the application to promote specific health behaviours to marginalised voices despite having the potential to succeed (Dutta, 2018). This critique is traced back to the idea that CCA despite being effective in health education/communication, was not originally founded for such a purpose. Thirdly, the structure also plays a huge role in problem-solving and may sometimes hinder the progress when the interventions under CCA face underfunding and/or infrastructural limitations and thus poor service delivery (Dutta, 2018). The critics see the involvement of various stakeholders as a possible hindrance in the intervention because services must be delivered through infrastructure and that may require funds that the intervention might struggle to meet. Furthermore, in the attempt of the CCA to give the subaltern voices through addressing the shortcomings of the dominant paradigm through a reflexive process, stakeholders include diverse members such as academics who are often an extension of the state or funded by the private sector, the CCA, therefore, must loosen the comfort of the academics in their positions (Dutta, 2018).

The limitations of the CCA extend to the conceptualisation of the cultural constructs itself, the term is critiqued for undermining the complexity of culture entirely. The male students being at UKZN and sharing the same culture does not make a clear indication that all individuals share the same lens of viewing reality and deciphering meanings, this kind of definition works for the CCA but not necessarily for definitions of culture outside of the approach. Since culture is significantly diverse, dynamic and heterogenous, there is room for overgeneralisation of results and error if applied without definite and clear parameters. This study, therefore, must demarcate what culture the males utilise and acknowledge any heterogeneity that emanates from the data. Lastly, the CCA approach is criticised for proposing concepts that are sound but fall short for not providing a clear policy or method on how to apply them in real settings, for example, the CCA does not provide clear guidelines as to how researchers and practitioners should implement participation and dialogue and voice (Dutta, 2018). This means it is at the discretion of this study as to how the semi-structured interviews will proceed. this is advantageous to the researcher in terms of flexibility and freedom, but one would point out that various or repetitions of the same questions with the same respondents may not produce the same results. This shortfall will however be pre-empted by the researcher devising a consistent line of questioning throughout the separate interview sessions. This is to ensure that despite sessions not proceeding the same, the themes remain traceable as this will be aligned with the thematic analysis to be applied in this study.

The criticisms are acknowledged and justifiable in their merit, but the strengths outweigh the weaknesses, especially when applied specifically to this study. This is because the study does not purport to devise and deliver an intervention but was to merely research. There were no academics, or any stakeholders involved in the study that may have been suspected to evoke conflicts of interest. This includes the researcher. Instead, the study collected data from the semi-structured interviews and assessed them with the help of the CCA to explore what kind of communication strategy the students desired.

Conclusion

The purpose of this chapter was to present the theoretical framework encompassed in this study. This included a logical presentation of an argument as to why the chosen approach was the most suitable for this study. The CCA encompasses the need to appreciate the role of the key audience in HIV interventions. Therefore, the CCA was useful in the study in exploring how the development of communication strategies for VMMC has included males in the design and implementation of HIV prevention interventions at the UKZN. This was helpful in the study as it explored the possibility of a suitable communication strategy in the next phase of HIV prevention. The CCA will also inform some aspects of the subsequent chapter including research design and the data collection process, to be discussed in chapter four, as the study created a dialogical data collection process.

Chapter Four

Methodology

This chapter was aimed at describing and laying out the methodology adopted and applied in this study. The study explores the possible strategies to promote voluntary medical male circumcision in the 2030 HIV prevention targets. The University of KwaZulu-Natal is the source for the sample of the study. The chapter is divided into the following main sections: qualitative approach consisting of the interpretative paradigm and social constructionism as sub-sections, research design of an exploratory approach, the sampling technique consisting of purposive sampling and semi-structured interviews as sub-sections, which are semi-structured, data analysis which is the thematic analysis, validity and reliability and ethical considerations.

Qualitative Approach

The study adopted a qualitative approach that aims to study human behaviours, specifically human communication within a cultural context. The researcher chose the qualitative approach based on the research method for data collection, the research design, philosophical assumptions of the method and data analysis as recommended by Creswell (2007). The qualitative approach has numerous definitions which share the same sentiments in essence. Draper (2004:42) explains that the qualitative approach "seeks to understand and explain beliefs and behaviours within the context they occur". This means that the qualitative approach enables the researcher to explore selected issues with openness, in detail and depth (Terre Blanche *et al*., 2006). The approach purports to understand patterns of behaviour and how they influence and interact with health in specific socio-cultural contexts (Draper, 2004). The inquiry to males that are targeted with VMMC campaigns must be done with caution, such that VMMC messages must be tailored to meet specific sociocultural contexts because people across different cultures vary in deciphering messages (Carr *et al*., 1994; Dutta, 2008).

The approach is against the notion that the physical world is the only reality but there is also a social reality that is fundamentally different and cannot be reduced to the physical (Neuman, 2014). Due to the inductive nature of the qualitative approach, it enables the researcher and the respondent to engage in an interaction that results in the identification of themes (Guest and MacQueen, 2012). Therefore, the reality is only as true as constructed by individuals in it and only qualitative information collected from interaction with those individuals enables them to fully understand how they make sense of their everyday reality (Fox and Bayat, 2007). Furthermore, the qualitative research approach is seen as a unique tool that investigates what

lies behind or reinforces human behaviour, attitudes, decisions and other phenomena (Turner *et al*., 2014). Therefore, qualitative research positions the topic of inquiry in a sociohistorical context while acknowledging the relationship between the researcher, participants and context (Neuman, 2014). The quantitative method would not apply to this study because the units studied are not quantifiable and therefore cannot be controlled in a clinical setting. By not quantifiable, it is meant that the units are abstract, intangible and personal (Neuman, 2014).

Qualitative data is measured throughout the data collection process, and the concepts are developed and refined after the data collection phase (Neuman, 2014). This means that the qualitative approach does not begin research with a hypothesis but instead, data emanates from the study itself in an ongoing reiterative process. Furthermore, Neuman (2014:204) posits that "sometimes [data] comes in form of numbers, more often the data is written or spoken words, actions, sounds, symbols, physical objects or visual images, leaves the data in a variety of nonstandard shapes, sizes and forms". Therefore, despite that the qualitative approach may express some data in numbers, it is quite rare. The qualitative approach does not focus on amount, quantity, intensity and frequency but rather on the qualities of entities (Denzin and Lincoln, 2011). Furthermore, the advantages of the qualitative approach include that key audiences are studied within their contexts, accepting that human behaviour and action are not independent of their immediate environment (Creswell, 2007). Another advantage of the approach is that it does not only purport to understand respondents but also to facilitate a certain amount of empowerment (Creswell, 2007). Thirdly, the qualitative approach is appropriate for serious topics as it can extensively engage with and interrogate a topic at hand to shed light on complex aspects (Mason, 2002). The qualitative approach is therefore appropriate for exploring and examining complex issues such as the promotion of VMMC for HIV prevention, justifying its relevance for this study.

The Interpretative Paradigm

The interpretive paradigm falls within the ontology that reality is not independent of people's perceptions, but knowledge is subjective and constructed by the people socially (Nelson *et al*., 2014). In line with the aim of the study, this study adopts the interpretative paradigm which is interested in how different individuals in different contexts make sense of their actions and experiences, as opposed to establishing law-like explanations of natural occurrences as positivism does (Nelson *et al*., 2014). Individuals create meaning from the world around them from prior attempts to understand it (Frensham *et al*., 1996). This means that reality is not independent of what individuals that inhabit it makes sense of it. Also, Jones and Wallace, 2005

cited in Potrac *et al*., 2013:32) claim that the interpretative paradigm is "founded on the premise that the social world is complex and that people, including researchers and their research participants, define their meanings within respective social, political and cultural settings.

The focus on an individual's understanding of experiences and actions is guided by referring to the collective or social action (Nelson *et al*., 2014). This study accepts the ontology that the VMMC intervention providers and the UKZN students have varying understandings of their realities which are valid to them as individuals respectively, thus the relevant paradigm is interpretive. Ontology refers to the philosophical assumptions of individuals about the nature of their social reality (Jantzen *et al*., 2015). It is thus imperative for the researcher to approach the study through the interpretative paradigm, this means impartiality towards responses of the participants by accepting data as is without imposing one's understanding of reality (Smith and Osborn, 2007). Therefore, VMMC promoters must investigate how UKZN understand reality in the context of health promotion, specifically VMMC for HIV prevention.

Social Constructionism

The social constructionist epistemological standpoint posits that knowledge is a product of interactions between societal members, and therefore knowledge is co-constructed (Galbin, 2014; Amineh and Asl, 2015) Additionally, constructionism has acknowledged the significance of emotions and feelings, affective dimension, in learning and how it has an impact on how they construct knowledge (Frensham *et al*., 1996). Therefore, social constructionism aligns with the culture-centred approach as it acknowledges the role of culture in the generation of knowledge and meanings by society and how they view and define their reality. It is from that knowledge that this study purports to understand the perspectives of UKZN males towards VMMC, which becomes the basis to investigate the communication strategies that have been used for promotion, thus leading to possibly identifying an appropriate communication strategy for the future.

Research Design

The research design is a plan on how the research aims to answer research questions. Richards (2006:74) stated that "the overall design of the project must be aimed at answering your research questions". Furthermore, the research design is useful in being a roadmap to guide the types of data collection and data analysis tools adopted by a study (De Vaus, 2001). The study aimed to answer the following key research questions:

1. What are the communication strategies adopted for VMMC promotion at the University of KwaZulu-Natal?
2. What are the perceptions of UKZN students on VMMC communication strategies that have been adopted at UKZN?
3. What are the cultural factors that influence communication strategies adopted to advance VMMC at UKZN?

The abovementioned research questions all subscribe to qualitative research methods because they are inclined to produce words and not numbers. The research questions each serve a different purpose but form part of a complementary whole. They aim to discover communication strategies that have been used for VMMC promotion at the University of KwaZulu-Natal, then investigate how the students perceive the communication strategies that have been introduced to them, and lastly investigate cultural factors that influence the communication strategies adopted to advance VMMMC at the institution. In essence, they all explore communication strategies for VMMC upscale and what a possible strategy to communicate the VMMC interventions in the future should consist of. Therefore, the most appropriate research design for this study needed to address 'what' and 'how' exploratory research questions to learn what has been used for communicating VMMC in the promotion, and, if possible, identify a suitable communication strategy to be used in the future of VMMC promotion.

Exploratory Research Design

The study purported to explore the possibilities of a suitable communication strategy in advancing the VMMC message in the next phase of VMMC promotion. The study's objectives determine how the research questions, and the research design are tailored (Green and Thorogood, 2018). This emphasises the need to align the research design with research objectives. An exploratory research design is a tool that allows for the exploration of a certain phenomenon primarily aiming to formulate more specific solutions research questions or hypotheses, in the context of a quantitative approach, relating to that phenomenon (Bless *et al.*, 2000). Exploratory research is useful in exploring new research themes or concepts or exploring a new perspective within an existing idea (Mason *et al.*, 2010). This study adopts the latter as advancing public health messages and specifically VMMC. The study adopts a critical stance towards the concept of VMMC itself in being an additional method to HIV prevention while simultaneously researching the most effective communication strategy for the UKZN

students at Howard College Campus. Thus, the exploratory research design within the qualitative methods is the most appropriate.

The main aim of exploratory research design is to understand a broader understanding of a phenomenon, situation, person or even the community (Bless *et al*., 2000). The literature around the preferences of Howard College Campus students regarding VMMC portion strategies is limited, which makes the exploratory research design suitable for this study. Therefore, the exploratory research design was useful in ultimately attaining a broader understanding of UKZN students and paving the way to identifying a suitable communication strategy for VMMC promotion. The World Health Organization (2020) suggested that future communication strategies must consider both supply and demand factors while being sensitive to the context of the intended key audience. These are among the characteristics that the EE communication strategy had to meet to be considered a possible strategy for the next phase of VMMC communication.

Sampling Technique

A sample is drawn out of a population for purposes of study to learn about the population at large (Neuman, 2014). The population refers to the entire set of cases of which the researcher intends to determine certain characteristics (Bless *et al*., 2006; Neuman, 2014). The population of the study included UKZN males between the ages 15-49 in line with one of the age groups targeted by the World Health Organization. Whereas a sample refers to the units of study that data will be collected from (Neuman, 2014). Furthermore, sampling is defined as a technique and accounting device used to rationalise data collection, and to appropriately select persons, events, restricted set of objects and many others, where the information will be drawn from (Bless *et al*., 2000). The sampling technique adopted in this study was influenced by the type of data needed, as the students had the desirable information required. Therefore, the sample was predetermined by the inclusion criteria of the study. The sample was drawn from the population of the University of KwaZulu-Natal students, Howard College Campus.

Purposive Sampling

The study adopted a purposive sampling technique. Neuman (2014:273) defined purposive sampling as "a non-random sample in which the researcher uses a wide range of methods to locate all cases of highly specific and difficult-to-reach populations". Purposive sampling is a non-probability sampling that is selective, subjective and motivated by the objectives of the study and the characteristics of the population (Neuman, 2014). Purposive sampling is

appropriate for exploratory research and requires the discretion of the researcher to select participants (Neuman, 2014). The study selected male participants registered students at the UKZN, Howard Campus, specifically Black South African males.

A total of eight participants who meet the above selection criteria were sampled to participate. The study adopted a qualitative approach, including the IPA which means it did not require a larger number of participants. The intention was to have at least a participant from each level of education from the third year, honours, master's to PhD, arriving at four levels. However, four participants would not provide enough data for the depth of a master's dissertation, hence, each level was doubled and resulted in a total of eight participants. Seven out of all the respondents were Black African males from a *Zulu*-speaking background whereas one of them was also a Black African male but from a *Xhosa*-speaking background. The eight participants provided enough data through semi-structured interviews that allowed for a significant amount of data since they enabled respondents a level of freedom in answering questions while leading the conversation with a guiding questionnaire. Furthermore, a lesser number of participants is typical of the qualitative approach as it tends to generate large quantities of data. The lesser number allows for thorough data coding, theming and analysis (Neuman, 2014).

Tongco (2007:147) argued that "the inherent bias of the [purposive sampling] method contributes to its efficiency, and the method stays robust even when tested against random probability sampling technique". Therefore, purposive sampling can be advantageous in the sense that it directs the researcher to the most relevant sample in the population because of the predetermined selection criteria. This means that the researcher can conveniently attain the respondents based on the characteristics mentioned in the inclusion criteria. Furthermore, it is advantageous to use the judgemental selection efficiently by selecting cases that will elicit the most useful information, and purposive sampling is most useful when applied within a specific cultural domain with participants as known experts of the information they give (Tongco, 2007). The last advantage is important because it highlights how the selected participants tend to have the most relevant knowledge and thus advance the goals of the study to answer the research questions.

The study purported to address the first research question of the study "What are the communication strategies adopted for VMMC promotion at the University of KwaZulu-Natal" through data obtained from the UKZN website, this is where policies regarding VMMC programmes that occurred before the Covid-19 context at UKZN are mentioned and explained.

The second question “What are the perceptions of UKZN students on VMMC communication strategies that have been adopted at UKZN?" forms the basis of the study sample, there was an exclusion of students who were not academically registered and not residing at residences before the 2-year Covid-19 context. This is because those students have limited to no exposure to VMMC programmes that have been delivered at UKZN campus pre-Covid-19. The third question "What are the cultural factors that influence communication strategies adopted to advance VMMC at UKZN?" was addressed through the review of literature in chapter 2.

The sample was included based on four main requirements, firstly, the students should have been academically registered for three or more years. Secondly, the students should have been residing at residences for the academic years, this increased their chances of being exposed to VMMC interventions as well as communication strategies. Thirdly, the students must have met the criteria of being a Black South African to ensure that they come from a culture that understand traditional circumcision. Lastly, the students should be strictly males, as they are the main target for this study and VMMC interventions. The eight selected participants were stratified through a division into four pairs, the first pair consisted of two third-year students, the second consisted of two fourth-year students (honours), the third pair consisted of two master’s students and the last two consisted of PhD students. The stratification proved to be methodologically beneficial as a variety of participants showed diversity in perceptions, also as the higher experience of the students increased chances for more knowledge of VMMC and vice versa. The participants were not selected according to statistical representation but for the richness of their knowledge and the information they are to provide (Polkinghorne, 2005). Noteworthy, this study was conducted during Covid-19, therefore, the researcher had to adapt the collection process to accommodate the ‘new normal’. Hence, this study focused on the richness of the data obtained from the eight participants. The participants were located through a door-to-door approach where each participant was informed about the nature and he aims of the study and any ethical concerns. They accepted after understanding the nature of the study thoroughly. Therefore, the participants participated completely at their will.

Semi-structured Interviews

The study used semi-structured interviews. The semi-structured interviews are tools to collect data to produce data in qualitative research (Green and Thorogood, 2018). Interviews are a form of data collection where an interviewer attempts to elicit information from the interviewee, they are regarded as more than mere chats and depend on the interaction between all the participants (Longhurst, 2003). Interviews are explained as face-to-face interactions

between the researcher and the respondents to understand the perspectives of the respondents towards their lives (Taylor and Bogdan, 2015). A free flow of ideas during data collection is the aim of this study, making semi-structured interviews the most ideal tool as they enable such (Casley and Kumar, 1988).

There are numerous advantages of semi-structured interviews. These include the ability of the interviewees to be neutral and avoid speaking on behalf of the respondents, and through the interaction, the researcher begins to identify the opinions and beliefs of the respondents (Mitchell and Jolley, 2010). The semi-structured interviews are also useful in gathering data that involves human behaviour and actions, including how these two interact with one another (Babbie, 2011). Furthermore, semi-structured interviews are advantageous because they enable the researcher to have control over the topics during discussions (Ayres, 2008). Lastly, face-to-face interviews are advantageous because they go beyond the investigation of verbal communication and find non-verbal cues such as body language and facial expressions as useful information in understanding the actions of respondents (Taylor and Bogdan, 2015). The semi-structured interviews were done in a real-life setting where Covid-19 national regulations were followed to maintain safety. These included social distancing of two meters apart, use of hand and surface sanitisers and wearing of masks when no longer seated 2 meters apart (WHO, 2020). There was a usage of voice recorder and a set of questions as an interview guide and a notebook.

The Role of the Researcher

The researcher had the duty to listen to the voices of the males at UKZN, identifying both overt and covert meanings of speech. The role is of an insider as the researcher is also a male and therefore a target of the UKZN VMMC interventions. This means more effort was put by the researcher to remain impartial and not impose one's ideas based on experience. This allowed the possibility of new meanings organically emanating from the interaction. The positive side of being an insider was the potential to provide rich information and share relevant experiences with the respondents. The researcher shared not only physical characteristics with the respondents but also the same culture embedded in the same structures. This means the potential for more knowledge from the respondents because they were most likely to be comfortable and participated freely because they shared common traits as well as the researcher. The researcher as a master's student was somewhat wary of the potential of being covertly undermined by senior PhD respondents as they have had more exposure to VMMC

communication strategies at the UKZN, however, this was not the reality as the respondents politely shared their experiences without taking advantage of their seniority.

The positioning of the researcher in the data collection process was also crucial as the respondents' information sharing needed minimal to zero influence from the researcher. Hence, the study applied the Interpretative Phenomenological Analysis (IPA) to inform the researcher's role as it aligns with the exploratory design of this study. The IPA is a qualitative approach that purports to examine the personal lived experiences of individuals in detail (Smith and Osborn, 2015). Moreover, the IPA is more concerned with the perceptions of individuals rather than attempting to impose an objective understanding of an object or event because it appreciates that humans are sense-making organisms (Smith and Osborn, 2007; Smith, 2011; Smith and Osborn, 2015). The IPA also allows the researcher to recognize their role when making sense of the respondents' experiences (Shinebourne, 2011). Therefore, the researcher attempted not to influence the responses of the participants through the application of the IPA with the understanding that the VMMC topic can be complex and emotionally challenging to the participants. Smith and Osborn (2015: 41) posit that the "IPA is especially valuable when examining topics which are complex, ambiguous and emotionally laden". Thus, making it suitable for the researcher to apply in this study.

Data Analysis

Data obtained by the study is not useful when still in raw form, it must be coded and analysed. In the context of the qualitative approach, data analysis begins with a thorough process of repeated reading of transcribed transcripts where the researcher gains enhanced familiarity (Terre Blanche *et al*., 2006). The data analysis aims to identify consistent patterns of data (Bless *et al*., 2006). The researcher began by impartially listening to the recorded interview clips, this is to both develop familiarity with the data and critically analyse the researcher's questioning abilities. Then, the beginning of analysis started immediately after the transcription of the recorded interview clips. As the nature of qualitative data collection, the data is voluminous and this requires a tool to sort it out into meaningful units, hence, this study adopted a thematic analysis (Braun & Clarke, 2006). As thematic analysis progresses, the researcher identified patterns in transcribed data, sub-themes that related are merged into themes and consistently split into cases where they were complex.

Thematic Analysis (TA)

The study adopted a thematic analysis to analyse the collected data. Braun and Clarke (2013:57) posit that thematic analysis "is a method for systemically identifying, organising and offering insight into patterns of meaning [themes] across a data set". Thematic analysis (TA) is accessible, flexible and increasingly popular and therefore convenient and allows for a diversity of methods (Braun and Clarke, 2013). Furthermore, the TA can be used to answer questions regarding issues for respondents or groups, including identifying typical responses (Green & Thorogood, 2018). The thematic analysis was used to identify themes from the data collected through the semi-structured interviews, the targeted themes are those that show a strong link and help in answering research questions. Lapadat (2010) states that thematic analysis is a process of meticulous ordering and generation of meaning through patterns and patterns that emerge from the data. The thematic analysis can be either inductive or deductive despite the research design of the entire research, this study adopts a deductive thematic analysis which is critical in its orientation and adopts constructivism in the theoretical framework and explores how reality is socially constructed (Braun and Clarke, 2013). The TA is helpful to the researcher in describing and analysing data in a meticulous and detailed manner (Braun and Clarke, 2006). The TA is conducted through six phases. The phases include familiarisation with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report (Braun and Clarke, 2006:2013). This study adopted all six phases of the TA with a consistent and critical application.

Generation of Initial Codes

The first phase of thematic analysis begins with listening to the recording, jotting down relevant points while listening, and then an active and analytical reading of the data (Braun and Clarke, 2012). The researcher is encouraged to be active and critical during phase one as it initiates the process of making meaning from the data by deriving general ideas. The researcher proceeds to make notes by underlining and highlighting points that seem relevant and it will be useful in the following stages.

The Searching for Themes

The second phase is the development of succinct and interpretive codes from the jotted data will become the building blocks of analysis (Braun and Clarke, 2012). To code is to extract relevant segments of the data and attach labels to them because they relate to the issue, data or theme (Nowell *et al.*, 2017). The coding in this study will be guided by the culture-centred approach as the researcher seeks to identify themes that demonstrate the behaviour of UKZN

males is influenced by their culture, agency and structures. The third phase is the cultivation of themes from the data, using short phrases to capture significant data from a combination of codes (Braun and Clarke, 2013). The process includes identifying codes that are repetitive and show relatedness, thus they are extracted and organised into categorised themes (Braun and Clarke, 2013).

Review of Themes

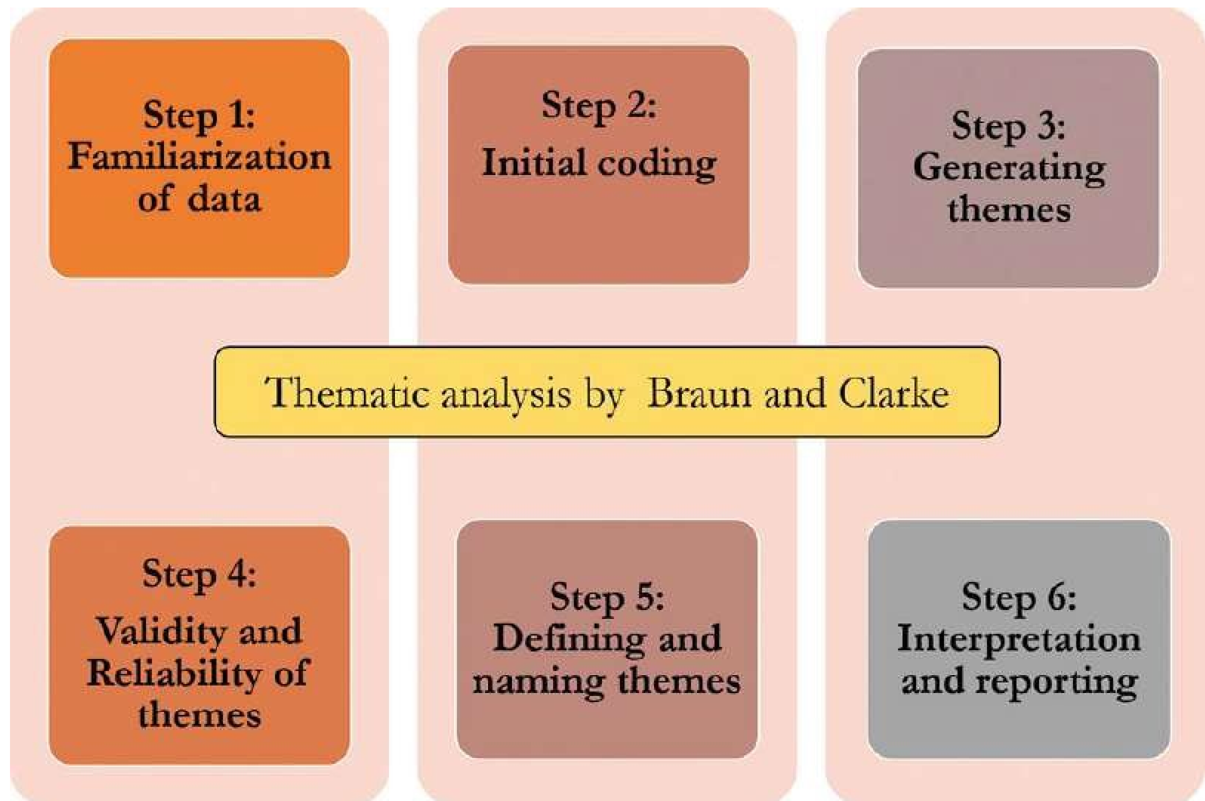
The fourth phase is the review of the established themes, this process includes collapsing themes that are not related to the data extracts and identifying those things that were merely codes but were initially identified as themes (Braun and Clarke, 2013). The process of reviewing themes is mainly a procedure to refine identified themes, this is necessary because themes vary in depth and shallowness, others may be too broad to simplify, whilst others are too shallow to stand alone (Masambuka, 2020). Therefore, not all themes make it to the fifth phase, others are merged with others, others are split into more themes and others are discarded altogether.

Definition of Themes

The fifth phase is the definition and analysis of themes, in this phase themes may be named, defined and explained in a few sentences, especially what is relevant and distinct about the theme. Furthermore, the study objectives influence how themes are linked with each other through a compelling and clear demonstration of a relationship between them, thus telling a plausible story. The researcher, therefore, must critically engage with the previously refined themes and give them clear names followed by a detailed written description (Braun and Clarke, 2013).

Report Writing

Writing a report is the sixth and final phase of thematic analysis. It is the narration of a compelling story about the analysed data, this is done through a logical and meaningful connection of themes. The narrated story is not merely a description of the available data, but an inference of meanings and interpretations linked to the study objectives and theoretical assumptions. Below in figure 4.1 is a diagram depicting the process in the thematic analysis process:



(Steps in thematic analysis, Eachempati *et al*., 2016)

Previous Applications of the Thematic Analysis

Mutinta (2012) undertook a study to investigate the students; risky-sexual behaviour, risk and protective factors as well as their responses to the *Scrutinise Campus Campaign* and applied the thematic analysis to make sense of the data collected. The TA allowed the researcher to identify how the respondents interpreted the first-order constructs concerning those of the researcher which were second-order constructs (Mutinta, 2012).

In a study by (Njawala, 2016) to explore Gender and HIV/AIDS: Examining HIV/AIDS communication among black students in heterosexual relationships at the University of KwaZulu-Natal, Howard College Campus, the researcher supported through literature that culture does play a role in the uptake of HIV prevention interventions by the key audience. Therefore, the researcher applied the thematic analysis by attaining cultural and personal information of the respondents to gain insights into the issues of the study. Ultimately, this was helpful in the coding and development of themes of the data analysis.

Mthethwa (2021) in a study to explore the role of culture in health care provided to people living with HIV (PLHIV) in uMkhanyakude District, North of KwaZulu-Natal: A Nursing Communication Perspective successfully applied the six phases of thematic analysis to their study. The researcher was guided by the cultural construct of the culture-centred approach, demonstrating that both the theoretical approach and the data analysis tool are complementary and useful in a study.

As Masambuka (2020) applied a thematic analysis in their study to investigate the University of KwaZulu-Natal female students' perceptions of female sexuality and its influence on sexual behaviour and HIV and AIDS prevention, the findings and results of that study were informed by both the study objectives and the theoretical framework.

Another researcher that applied the thematic analysis was Akpan (2021) the study where the researcher aimed to assess the role of communication in addressing sociocultural factors influencing pregnant women to drink alcohol in the Durban area, KwaZulu-Natal. The researcher adopted the TA to analyse their data where emerging themes and patterns were gathered from interviews with the purpose to meet their research objectives (Akpan, 2021).

The analysis of the above studies and how they applied thematic analysis was useful for gaining insights into identifying issues for this study. Moreover, there is a clear pattern of the culture-centred approach being influential in the coding of data and generation of themes, specifically the culture construct. This study followed the same patterns and allowed the CCA to be a guide in the assessment of emerged themes as UKZN males are acknowledged to be part of a particular culture, therefore, understanding VMMC and HIV prevention altogether through their lens would be helpful.

Validity

Validity refers to truthfulness in terms of how an idea is suitable to the actual reality, whereas reliability is how a measurement is consistent and dependable when repeated under similar or identical conditions (Neuman, 2014). This means that an instrument is as valid as it accurately measures the concept or constructs in question (Pittenger, 2003). Validity is also useful in establishing how the findings of the study are believable, truthful and credible (Neuman, 2014). The study ensured that it only followed the evidence, what comes out of the data as realities, and did not attempt to coerce the data to corroborate with the idea of EE as meritorious, to ensure validity

Reliability

Reliability is the degree of consistency of a measure when applied to a construct (Neuman, 2014). This means that a technique repeatedly applied to the same object must yield the same results consistently (Babbie and Mouton, 2001). The findings of the study were ensured to be consistent when relevant themes were analysed and reviewed, the findings were also ensured to be dependable in attempts to answer research questions. The data from the 8 semi-structured interviews were reviewed for consistency to ensure reliability, also, the same interview guide was used throughout the data collection process.

Ethical Considerations

The researcher needed to follow the necessary procedures before conducting a study. These included the attainment of documents such as the gatekeeper's letter, Approval by the Humanities and Social Sciences Research Ethics Committee from the University of KwaZulu-Natal, Durban, South Africa. The attainment of the documentation ensured that the study was ethical and that its scientific value is not compromised. The participants were given informed consent forms and the points in them were explained to them in detail and were informed of their reserved rights, including withdrawing from the study at any point in time. The identities of the participants remained anonymous.

Limitations of the Study

The study selected research tools that have many advantages and complement each other in their usage. The qualitative approach acknowledges the construction of reality by the individuals in an environment, those individuals are embedded in an interpretive paradigm as reality is not viewed as independent of them but depends on how they make sense of it. Furthermore, this allows for an exploratory research design which in turn facilitates the use of semi-structured interviews to collect data, the collected data would be analysed through a thematic analysis which is applicable in data that is in form of words and phrases rather than numbers. The result is the exploration of a suitable VMMC communication strategy in the fight against the HIV pandemic. However, this does not mean that the selected do not have their limitations. Since the qualitative approach is subjective in its comprehension of the reality of the key audience, there must be consistent attention paid by the researcher to their potential of imposing one's beliefs and thus compromising the dependability and trustworthiness of findings (Neuman, 2014).

The researcher was wary not to allow the conversation during semi-structured interviews to go off-topic and discuss irrelevant points, also, there was alertness to identify when the conversation has reached saturation. Saturation means no new information is emanating from the conversation (Neuman, 2014). This means that the researcher had to be constantly active and direct the conversation towards answering the questions, which can be tiresome on its own. Lastly, The UKZN has a diverse population and among them are students that are not native English speakers, and therefore the English language could become a hindrance if the students' languages are diverse. The researcher, therefore, had to simplify some of the questions and explained VMMC and HIV prevention-specific jargon and terminology. Furthermore, the study used a maximum of 8 participants which is a small sample and focuses specifically on UKZN progress and therefore will not be generalised over the entire campuses of the UKZN, which means not the nationwide as well.

Conclusion

The study began by situating the study in the interpretative paradigm, as a qualitative approach that allows the respondents to express themselves through their understanding of the reality around them Furthermore, acknowledging through social constructionism which posits that the reality of UKZN males is only as real as they co-construct it. Moreover, the study specified and explained the research design of the study which is exploratory. Then the study discussed the sampling technique, where UKZN males would be purposively sampled through inclusion criteria at the university residences. Lastly, the study specified the thematic analysis and its phases that would be applied to analyse the collected data with guidance from the culture-centred approach. The data collected during semi-structured interviews will be presented in the subsequent chapter.

Chapter Five

Data Presentation

This section will serve to present the data that was collected from the one-on-one semi-structured interviews. Below is the presentation of the themes that will be analysed in the subsequent chapter. The seven themes developed in this study are namely:

1. Reasons for students engaging in risky sexual behaviour.
2. Mediums of communication adopted by UKZN for HIV prevention.
3. Core messages are disseminated by communication channels.
4. Motivations for VMMC uptake among students at UKZN.
5. Understand Traditional Male Circumcision Perceived as Tradition and Being Unprofessional
6. Limitations of VMMC Communication strategies.
7. Suggested Improvements for VMMC communication at VMMC.

The study does not have the necessary scope to present all the collected data and will therefore use the themes as a guide to present the responses of the participants. Direct quotes will be used in some cases to capture the comments of the participants and quotes will be clearly labelled at the end to identify a particular respondent. Eight respondents participated in this study and were stratified according to the level of study specifically third years, honours, master's and then PhD students. Their responses are presented as such, beginning with the third-year students and ending with the PhD students. These varying levels of study were included to get diversity in age for feedback from participants. The participant labels are suffixed with their level of education, for example, L3 for third-year students, and L4 for honours. L5 for masters and L6 for PhD.

Reasons for UKZN Students Engaging in Risky Sexual Behaviour

Among the themes that were developed by the researcher through engaging with the data collected through semi-structured interviews, it was the reasons for UKZN students engaging in risky sexual behaviour among the UKZN students. There were three subthemes namely,

substance abuse, misconceptions through peer pressure and the lack of knowledge among the students. These subthemes will be discussed below as each will be a subheading on its own.

Substance Abuse

The respondents shared their concerns that students engage in risky sexual behaviours and therefore increasing the chances of HIV infections. Among the reasons pointed out was substance abuse including alcohol. A respondent posited that sexual encounters vary, and some can include substances. The honours-level respondent said:

> Hey, cases are different when you are having sex, sometimes you have sex under the influence of alcohol or any form of drugs. (Participant L4, 1)

The respondent did not specify a specific drug but pointed out that there is a possibility that any form of a drug could be in the possession of students when they engage in sexual intercourse. Another respondent anchored the idea that the sexual relations of students can be influenced by external forces. The PhD respondent said:

> But sometimes you are just carried away by external forces. It's just like alcohol and, anything and drugs and so forth. (Participant L6, 1)

Despite students not being allowed to have alcohol within the university premises, it is evident that they still utilise substances, especially at their student accommodations. Hence, respondents are confident that substance abuse is one of the reasons why students engage in unsafe sex. Substances such as alcohol and other drugs influence the decision-making of individuals, hence, students may still engage in sex without protection despite knowing the risks. This means that the individual is not in their ideal reasoning state and therefore their desires overcome their rationality, as one of the respondents said:

> Find that one is not thinking straight. Sometimes you find that the flesh is the one thinking more than the brain. (Participant L4, 1)

The honours level respondent was explicit that when the students had used substances, they are not rational, hence, they would follow their lustful desires and end up being sexually irresponsible. The issue that UKZN students do engage in risky sexual behaviour is evident in the comments provided above. Moreover, it has been shown that among the reasons for this is that students may use substances such as alcohol which limits their abilities to make responsible decisions concerning sexual behaviour. Lastly, it is important to note that regardless of the difference in the levels of education, the respondents shared similar ideas.

Perception of Condoms as a Barrier to Desired Sexual Pleasure

Among other factors contributing to risky sexual behaviour that emerged from the interviews are that students may take risks because they perceive sex without a condom as more pleasurable:

> I agree (laughs) because sex with a condom is not that 'Fire'. Maybe if they used something like oral Prep it would be better. Instead of a condom because it ends up not being used anyway. (Participant L3, 1)

The metaphor 'fire' used by the third-year respondent is an indication of how the respondent feels about sex without a condom, he considers it as more pleasurable if the condom is not used. Moreover, instead of considering using condoms, he suggests that they are replaced by other HIV prevention methods instead. This is an indication of disapproval of condoms strictly because they limit his sexual pleasure. Another respondent explicitly disapproved of the behaviour of students not using condoms for the reasons of pleasure but also believed that it was a reality.

> And also, some tell you I'm quite comfortable with sex without a condom, which is rather, I don't know, but I would say, but it's not responsible. (Participant L6, 1)

The respondent used the word 'comfortable' to describe what students might complain about when it comes to sex with a condom. This also relates to pleasure because being uncomfortable could be a cause for reduced pleasure in general circumstances. Therefore, if one is uncomfortable during sex, one might not be attaining the desired pleasure.

The last comment will feature in both subsections because it captures both the influence of peer pressure and the perceptions towards condoms being a barrier to desired sexual pleasure:

> Like they, when they're talking to their friend, like maybe they say that, uh, unprotected sex is nice. Doing it compared to condoms. Yeah. (Participant L5, 1)

The respondent believed that students did engage in risky sexual behaviour because they believe sex without condoms is more pleasurable.

Influence of Peer Pressure

As demonstrated above, the respondent concurs with the notion that students prefer sex without condoms and pleasure is the motivation. Notably, concerning this section, some respondents

identified that the students may be attaining these notions from their peers and thus applying them in their decision-making towards sexual encounters:

> Like they, when they're talking to their friend, like maybe they say that, uh, unprotected sex is really nice. Doing it compared to condoms. Yeah. (Participant L5, 1)

Another respondent empathises with students by pointing out that they have already adopted behaviours that may motivate them to engage in sexual behaviour by the time they are admitted to the university:

> The adopted, uh, stereotypes that one individual has before they entered into university. So, it's difficult for them to adjust and learn new behaviours such as using, uh, protection, contraceptives, so forth and so forth. (Participant L5, 2)

This suggests that students may have adopted those stereotypes by interacting with each other regardless of where they come from. Therefore, the students may influence each other to proceed with similar behaviour and therefore highlights the influence of peer pressure. Another respondent emphasized the role of peer pressure concerning how students make their decisions towards sex:

> Doing it compared to condoms. Yeah. And maybe someone would say, I had unprotected sex and my girlfriend loves me more now. And through social media, of course, cause sometimes they make jokes about, uh, silly jokes about having unprotected sex and how nice, unprotected sex is. (Participant L5, 1)

The respondent went on to specify how peer pressure influences risky sexual behaviour. Furthermore, the respondent highlighted that their female partners love them more when they engage in sex without a condom. Another reason is the ridiculing of having sex without a condom as it is deemed as less pleasurable and therefore 'silly' to engage in, the respondent specifies that these stereotypes are perpetuated through social media.

It is therefore clear that the influence of peer pressure and the perception of condom usage as a barrier to sexual pleasure do lead to risky sexual behaviour among UKZN students. Worth noting is that most of the respondents highlighted the influence of peer pressure.

Lack of Knowledge

The respondent claimed that students have little knowledge of HIV prevention because of a lack of advertisements. Despite agreeing that students still engage in unprotected sex, the

respondents claimed that it is not only students to blame but their knowledge is limited as UKZN students come from diverse backgrounds. However, the respondent does not deny that students do hold notions such as that sex without a condom is more pleasurable. The respondent said:

> Yeah, I think it's to a certain extent I do agree. So, uh, the reason why I agree is that, uh, students before they were university students, they were people coming from different backgrounds. So, they picked up certain behaviours and norms and stereotypes about sex. For example, others would say, if you were having protected sex, you do not feel anything. (Participant L5, 2)

The respondent thought that because the students do not come from a background that is like that of UKZN where there is information about HIV prevention, they did not know enough but instead had been making decisions based on the norms of their previous backgrounds. Another respondent claimed that students that came from different schooling backgrounds do not have the same privilege of learning about HIV prevention as those from health or communication departments. Which can also be pinned down to a lack of knowledge as a cause. The respondent said:

> Uh, some of the students, uh, there are to hospitality, cooking food. So, uh, those students, they don't really know about HIV and also the transmission of the HIV. So, they only know that HIV is existing, but they really don't know because they don't have time to read the research papers that are being published. (Participant L6, 2)

The PhD level respondent pointed out that not all departments in education focus on HIV prevention, there are students that do not attain the necessary information to abstain from risky sexual behaviour. Furthermore, he posited that even when they are exposed to such information, they may not take time to engage with it because they specialize in other fields of knowledge.

A respondent doing their third-year studies thought that students engage in risky sexual behaviour because they have not learnt enough about HIV itself. The respondent said:

> No. People, uhm I mean students did not know much about HIV. Not enough information. (Participant L3, 2)

Another respondent claimed that lack of advertisement may be one of the reasons students do not know about the risks of engaging in risky sexual intercourse. The respondent said:

> I'm not saying they're not really, uh, doing, uh, pushing for their awareness of, uh, medical of sort of, uh, protective sex, but the lack of advertisement would, eh, perpetuate, uh, the, the adopted, uh, stereotypes that one individual has before they entered into university. So, it's difficult for them to adjust and learn new behaviours such as using, uh, protection, contraceptives, so forth and so forth. (Participant L5, 2)

The respondent thought that the students were not knowledgeable enough and the problem was with the health promoters as he thought they did not advertise the interventions enough. Therefore, according to him, the students would resort to using the knowledge gained from their previous backgrounds even towards sex. The downfall is that their knowledge may be limited and therefore not helpful to them which may result in risky sexual behaviours, as the respondents had pointed out that students do engage in such because they do not know enough about HIV prevention. Noteworthy, the respondents in higher education claimed that students lacked information because of their backgrounds which did not offer them the necessary information. One of them also pointed out that students specialise in different kinds of studies and may miss out on HIV-related information. However, these respondents did not claim that UKZN did not have the information, as opposed to the third-year respondent that claimed that there was not enough information. In this case, the difference in knowledge among the respondents because of the time spent on campus is clearer.

The first theme shows us how the Black African students are well-informed about HIV prevention, yet they still engage in risky sexual behaviour. This exposes how excluding them from designing the interventions is costly as they demonstrate disinterest towards the intervention despite appreciating its course. It is thus clear once more that having structures are in place does not mean guaranteed uptake by the key audience as their agency is also crucial in the decision to uptake or not. Therefore, a dialogue between the Black African students and the VMMC promoters is necessary.

Mediums of Communication Adopted by UKZN for HIV Prevention

This theme was useful in identifying the types of communication channels that UKZN students had already been exposed to. It was found that among them were two mediums of communication, which included the use of media and the health promoters directly engaging with the students. The data presented from this theme emerged from the interviews.

Mass Media and Print Media

The respondents mentioned that students have been exposed to HIV prevention messages through mass media platforms. A respondent said:

> There have been campaigns, that have uhm… preventing HIV, testing students to find out their statuses. They had pamphlets. (Participant L3, 2)

The respondent had shed light on the idea that the campus has people approaching students and handing out pamphlets that teach about HIV. This was supported by another two senior students. The respondents said:

> Uh, there were flyers that had been passed around for HIV testing… (Participant L5, 2)

The respondent was both aware that the flyers were being distributed to them within campus premises. Furthermore, he knew that the flyers were containing information about HIV testing, which highlights some level of knowledge among students about HIV prevention. The other master's level student was also aware of pamphlets being distributed:

> Uhm, exposure on the HIV prevention around campus, uh, I've seen, eh, HIV statistics they've been posted in, in UKZN library eh, I've also seen some of those, I think it's pamphlets or something that they distribute around campus. That's eh, eh, that tells us how to prevent HIV. Also encouraging students to test for HIV. (Participant L5, 1)

The respondent also identified that the UKZN library had posters related to HIV information. The library is one place that most students use frequently, therefore, there would be a high chance that they would see the posters, especially for students like the respondents who had been on campus for a long time. Notably, a respondent that had been on campus during contact learning for one year had identified that UKZN also uses the website to disseminate HIV-related information:

> There is also available information on the UKZN website on the information a student need. (Participant L3, 2)

This is noteworthy because students can access information even when not on campus. Meaning that students with supported devices and internet data can visit the website, which highlights access to information. Furthermore, it is noted that pamphlets and flyers with HIV prevention information had been seen by the respondents including both third-year respondents

that only had been on campus for one year. This may demonstrate the usefulness of mass media when applied well. Lastly, the respondents bring to light that health promoters do not only offer knowledge about HIV prevention but also guide the students towards facilities that would advance HIV Counselling and Testing (HTC).

Direct Communication with the UKZN Students

This sub-theme will be divided into two subsections where one will discuss healthcare services which also provide information to students, and the health promoters that approach students on campus and their student accommodations.

Healthcare Services – Provider Communication and Services

The students have healthcare facilities on campus available to them:

> And also, uh, testing stations, in the Shepstone foyer, whereby you would get tested and get incentives for testing. And also, the passing around of condoms in residencies. (Participant L5, 2)

The respondents specify that at the Shepstone foyer, which is one of the campus venues where students spend most of their time, there would be set up HIV testing stations. Also, there are condoms distributed at residencies for them to use. Another respondent points out that there is a campus clinic in place:

> But the only thing I know is that they have a clinic, which specialises in people that live with HIV and AIDS and also gives us knowledge about how to prevent it and how to maintain it. (Participant L4, 2)

The respondent was aware that the campus clinic caters for the needs of people living with HIV/AIDS, moreover, the respondent knows that it is also for people who are HIV negative as they provide information on how students can prevent contracting HIV. The other respondent at the honours level shared the same knowledge about the campus clinic.

> I once heard that you are even able to go to Howard college clinic, where you can get HIV testing, where, where you would be able to test yourself. (Participant L4, 1)

After two years of being on campus during contact learning, they were both aware of the campus clinic and how it assists in HIV prevention. This implies that the campus clinic was effective as a source of health information due to the respondent's knowledge of the location

and availability of services offered by the clinic. Furthermore, one of the PhD level respondents was also aware that condoms are made available to students:

> Um, what I've seen so far is that they try by all means I've seen the condoms, um, yeah, condoms everywhere, every corner, every toilet. So, I think that's their effort, um, yeah, that's, that's me, that's my response. (Participant L6, 2)

This emphasises that condom availability is not limited to healthcare facilities but also available in spaces that students often occupy. This was further emphasised by one of the honour's students who had a lesser presence on campus:

> The only thing that I've seen when it comes to HIV prevention on campus, sometimes they put condoms in our toilets and there on campus. (Participant L4, 1)

This respondent was also aware that condoms are disseminated around campus spaces, moreover, even at the residences' toilets. Noteworthy is that respondents with a huge difference in their years being on campus are aware of places where condoms are placed which highlights access to condoms. Therefore, the healthcare services available to students include the campus clinic, the provision of condoms and the utilization of the Shepstone foyer for providing HTC services.

Health Promoters Approaching Students

The data shows that students do not only have access to healthcare facilities but there are health promoters that approach them directly:

> And then they promote this thing of testing for HIV there by the Shepstone foyer building. (Participant L4, 1)

The respondent at the honours level had been exposed to people setting up healthcare facilities and then approaching students and inviting them to uptake the services. Among these services was HIV testing. Other respondents also pointed out that students are aware of health promoters as some have come to their student accommodations to promote HIV prevention:

> Also, the… I don't know if you call them peer educators as well. (Participant L5, 2)

> I think what really has been happening is, um, the effort through residence life. Most of the things I learned personally watched through the student life programs. (Participant L6, 1)

The first quote reflects that the master's level respondent knows about peer educators on campus. Whereas the PhD level respondent was exposed to HIV prevention interventions through programmes where peer educators would go to their residences and teach them about HIV.

This theme presents a contrast between two forms of communication towards the students where the prior speaks to the mediums of communication presented to them and how they lack the interpersonal aspect of communication. Whereas the latter speaks to the form of communication that was mostly preferred by the students as it exposes the need by students to be part of the designing and delivering of VMMC interventions. Directly communicating with the health promoters would allow them to participate in the communication process through the means of a dialogue.

Core Messages Disseminated by Communication Channels

HIV Prevention Among Students

With regards to exposure to HIV prevention messages, it was found that the respondents had been exposed to communication channels and that they understood the motives of those

interventions. Which highlights that they had received the messages. It was thus reasonable to enquire them respectively on their thoughts concerning what the HIV prevention interventions emphasised. A common focus that was raised was that the interventions emphasised the imperative to prevent the spread of HIV: The two third-year respondents said:

> In my opinion, the main focus of these is for… is to prevent HIV or the spread of HIV. (Participant L3, 2)
>
> Their focus is on teaching people about their health, it's about health education, it's about preventing the spread of HIV. It's about reducing the number of HIV people. (Participant L3, 1)

These were the respondents with the least exposure to HIV prevention interventions as they had only been on campus for one year. However, they thought that the interventions teach students to avoid contracting HIV. Furthermore, in the second quote, it is identified that the respondent understood that HIV prevention interventions also aimed to reduce the number of those living with HIV, this was done through health education. This was emphasised by the respondent doing their honours:

Their main focus is for people they should know their statuses and people should make sure that they practice safe sex. (Participant L4, 1)

The respondent also shed light on that HIV Counselling and Testing (HTC) services were available on campus, moreover, they were also taught how to practice safe sex. The other honours level respondent also pointed out that raising awareness was the core focus of the interventions:

> And also, they make their means to make sure that their students are not exposed to HIV and AIDS. That is why they implement these programs. (Participant L4, 2)

The respondent was explicit that the intention was to offer information that would lead students to practice safe sex. This focus was emphasised by the two master's level respondents:

> Okay. Um, according to my experience, the intention is to inform students how dangerous HIV positive is. (Participant L5, 1)

> I think their main focus, was to spread awareness, and raise awareness about the presence of maybe HIV and AIDS in a university setting, uh, especially in university residences. (Participant L5, 2)

The two respondents expose that the interventions aim to raise awareness, especially on the seriousness of the HIV pandemic also, that the second respondent specifies that contracting HIV would be more feasible in a university setting, specifically at their student accommodations. One of the PhD level respondents thought that the UKZN had a specific HIV prevention target to be achieved. The respondent said:

> It was on 2019 saying this university has a high rate of students with HIV. So, I think they are trying to reduce that number. (Participant L6, 2)

He was also referring to the reduction of the number of people living with HIV at UKZN. The respondent had been exposed to a report that in 2019, UKZN had a significantly high number of students infected by HIV. Therefore, the institution made a direct and deliberate intervention to reduce that number. Another PhD-level respondent thought that raising awareness was key as an add on to the existing HIV prevention package:

> So, I think that that's one of the things that stood out for me and the main focus for this was to really raise awareness and really test that like several people so that they know what their status is. (Participant L6, 1)

He did not demonstrate knowledge of the programme specified by his fellow PhD level respondent; however, he thought that the interventions had two main focuses which were HTC and raising awareness about HIV. When dissecting from the third-year level students to the PhD level respondents it is noted that raising awareness concerning HIV prevention was the common focus. Implications of this will be covered in the analysis chapter. Lastly, when students are exposed to VMMC they are also exposed to HIV prevention interventions, this will be discussed in the following theme.

It is exposed once more that the students do have a grasp of the core messages being presented by HIV prevention interventions, however, because the culture of the Black African students is not appreciated in the designing of these interventions, the students do not uptake as expected. Instead, the communication is not bottom-p up and therefore lack the cultural interpretations of the students.

Motivations for VMMC Uptake

This theme is relevant in that identifies factors that could contribute to the decisions of UKZN students to uptake VMMC. Furthermore, the existence of facilities at the university to promote VMMC does not mean guaranteed uptake by students, but it is the students that must be motivated to undergo VMMC. Therefore, it is important to investigate the students' motivations. The subtheme to be discussed under this theme is health benefits.

Health Benefits

Beginning from the comments of the third-year level respondents they do not believe that the university can support VMMC mainly because they had never seen any promotion regarding it. The respondents respectively said:

> Yes, my motivation, as we have said in the last question that it's reduces the chances of spreading diseases. Also, because I want to set a good example for other people they will circumcise and reduce the chances of contracting diseases. (Participant L3, 1)

The respondent was explicit that the main motivation is protection against HIV infection. Whereas the other respondent was not as specific:

> I think from the things that I know, personally, I would like to be protected from STIs. (Participant L3, 2)

The second respondent mentioned protection from sexually transmitted infections as a motivation, he did not specifically mention HIV. This may reflect his level of knowledge about

VMMC benefits. However, it is noted that despite the respondents being the least exposed to VMMC messages because of their lesser presence on campus, they had an idea that is aimed at HIV prevention. One of the respondents doing their master's thought that HIV prevention would be a good motivation to uptake VMMC as well:

> So, I think that's one itself could motivate me also. It's also decreasing many chances of getting HIV and AIDS and many sexually transmitted diseases. So, I guess that's all it could motivate me to do something. Cause I feel like it's, it's helpful. (Participant L5, 1)

The respondent was more explicit compared to the third-year participants and specified that protection from HIV/AIDS would be the primary motivation to uptake VMMC. This relates to the response of one of the PhD level respondents:

> I'm talking about by me now, uh, uh, what can motivate me, um, the only thing that can want to be to me, um, is, um, because now I know, uh, the consequences of not circumcising, while indulging in unprotected sex. So doing the circumcision can help me reduce, uh, 60% chances. (Participant L6, 2)

It is noteworthy that the student was not only motivated to uptake because of HIV prevention but he knew the exact clinical effectiveness of VMMC. There is an identifiable trend when assessing the responses from the various levels of education, they begin with vague

understanding of VMMC, and they get more specific as levels go higher. This is expected as the higher levels of education could mean higher chances of exposure to VMMC messages on campus, hence, more specific responses.

In relation to the previous theme, it is shown that the Black African students do understand the medical effectiveness of VMMC and its benefits, however, the overall uptake of the intervention is lower than expected. This further emphasises the need to be sensitive to the culture of the students and to minimise the top-down communication approach while encouraging interpersonal interaction.

Traditional Male Circumcision is Perceived as Tradition and Unprofessional

This theme serves the purpose to uncover the perceptions of students towards TMC. This is relevant because UKZN students are a part of cultures that may practice TMC, therefore, TMC remains an option for them and therefore cannot be ignored. The subthemes to be discussed in

under this theme are that the UKZN students perceive VMMC as a traditional procedure and that they perceive it as unprofessional concerning medical expertise.

Traditional Male Circumcision as a Tradition

The one-on-one interviews also provided data that showed how students understand what TMC is about. A respondent said:

> The only people I know who do traditional circumcision, are those who are from Xhosa, because it's culture, it's what you do to climb from… to move from a teenage stage to the stage of being a man now. So that's their main motivation for them to be accepted by their communities as men. (Participant L4, 1)

The honours-level respondent understood that TMC was motivated by the belief that it is a rite of passage from boyhood to manhood. uptake. The other honour's respondents had undergone TMC and as expected he was biased in its favour. However, his response helps outline the motives of TMC. The respondent said:

> To such an extent, yes because I'm also subject to the idea that it should be a journey to manhood, they prepare you that as a man now be time that you need to endure pain. And also, they make you to understand that you also don't want, because sometimes you'll be alone in trying to solve those problems that could harm to you. So, they prepare you to that. They prepare you to that moment. And also, it is they've had, as I said, it has not just been like, it's not just being circumcised and also there are teachings around what does a man want men to do and what also, and what also men should not be doing. So as the whole process of teaching you, how to be a responsible man, but the problem at is in the circumcised part because others, they do it wrong. (Participant L4, 2)

The respondent explained that in the *Xhosa* culture, the process of TMC means that the young male is deliberately put under harsh conditions so he can grow and be strong. Additionally, that is to teach him to be able to bear and deal with the life hardships he would encounter in the future. Additionally, teaching the young male to be a responsible man in the community. It is clear that because of affiliation with the culture, the respondent was the most knowledgeable. However, important to note is that the respondent shared similar ideas with the other respondents who are not from the *Xhosa* culture. The two master's level respondents shared the same ideas. One of them said:

> Okay. Uh, what I understand about traditional male circumcision, it's more of a rite of passage as opposed to a health benefit for those who go for, for it. And, yeah, so it's more of a rite of passage. So, people engage in it to belong to their respective cultural groups, eh, so that they cannot be alienated. There are no, eh, medical-related, eh, benefits that are associated. (Participant L5, 2)

The respondent also pointed out that defying the culture had negative consequences such as being isolated and excluded by the community. Furthermore, the respondent mentioned that TMC is not done specifically for medical benefits. The other master's respondent held the notion that TMC is a procedure that is used as a rite to the passage, this is where young males are seen as transitioning to manhood. The respondent said:

> I think, eh, in another the time in that, uh, a tradition like the, do it in order to, to prove that they, they are men enough? Eh, I think that the thing more traditional like Xhosas, eh, they are more, they're more influenced by the fact that, eh, you know, that to be a man enough, you have to do a traditional male circumcision. And so, the motivation behind it, I think it is manhood, I think so, I think that the motivation behind TMC. (Participant L5, 1)

One of the PhD level respondents demonstrated no judgement towards TMC but shows that they understand TMC as a cultural procedure as well: The respondent said:

> Um, I believe when it's established to cultural or traditional circumcision, it's things that were done before, particularly by the Xhosa tribe, if, I guess it's their culture still that the way they used to do. (Participant L6, 1)

The respondent thought that it was a cultural procedure as well, which is upheld from generation to generation. This may give hints as to how other students would find it hard to defy it, as tradition may bring upon pressures.

The respondents expressed that they understand that TMC and VMMC are done for different reasons. TMC has a cultural significance, where undergoing it may result in acceptance by their cultural group and rebellion may result in isolation, exclusion and rejection. Therefore, it must be done consistently by the boys of that group that should transition to manhood. Noteworthy, the respondents were mostly referencing the Xhosa tribe, understandably as it is one of the most known cultures that undergo TMC in South Africa, However, TMC is also upheld by other South African cultures and religious groups, as covered in the literature review. Lastly,

the respondents at all levels of education understand TMC motivations, especially that, unlike VMMC which is centred around the circumcision process, TMC is more of a ritual that includes various ceremonies and circumcision is merely a part of it.

Unprofessionalism of Traditional Male Circumcision

Some of the respondents expressed the idea that they are sceptical about TMC standards because it is not administered in a medical setting, and they do not think that the providers are medically trained for it. One of the third-year level respondents demonstrated minimal appreciation of TMC:

> Personally, I don't understand it because I think its torturous, and according to researchers, they say that it is a stage of becoming a man to go and do circumcision. Yes. Because traditional male circumcision doesn't have facilities for circumcision and many people die. (Participant L3, 2)

The respondent went as far as describing the procedure as torture for those that undergo it. This judgement may reflect that the respondent makes these conclusions based on the comparison with VMMC which is done in a medically safe setting. The other third-year level respondent does not indicate that they are against TMC, but it shows that he would not recommend it for someone as he thinks it is risky. The respondent said:

> What I understand is that it's very risky. People do it to respect… or to keep on going with their traditions and culture. Yeah, there is an impact because people like the Xhosa for example they love it, they question your manhood if you circumcise at the hospital. Which may lead one to reject VMMC and undergo TMC. (Participant L3, 1)

Whereas the other PhD level respondent also understood TMC as a cultural procedure, he also showed judgement against it as he pointed out that it is administered by unprofessional people. The respondent said:

> Um, uh, okay. I think, um, I think it's because it's their culture it's coming from, um, ages ago. People, uh, who were practising that thing, uh, in ages ago, so people now are trying to continue with it. Uh, but so, um, my understanding on a traditional circumcision is that the people who are doing it, they didn't go to school for it, so they are unprofessional." (Participant L6, 2)

The respondent mentioned that because the people who administer TMC services are not trained medically, they are unprofessional. Also, their only motivation to practice TMC is that

e it had been a tradition and therefore done for a long time by the communities, which undermines the values of the procedure. The respondents' understanding of TMC as an unprofessional procedure may have emanated from the comparison with VMMC which means medical incompetence equals unprofessional to the respondents. Furthermore, this notion is evident in both the third-year level and the PhD level respondents which emphasizes that there is a great difference in exposure to VMMC messages between them, and its pervasiveness among students. This is another crucial factor when students on campus must decide which circumcision type to uptake.

Important to this theme is how the Black African students show disinterest towards undergoing TMC but still appreciate its cultural significance. They do acknowledge that it is a traditional procedure that other students may uptake merely to avoid ostracism from their communities. Furthermore, TMC enforces the belief that the procedure acts a symbol of a young male transitioning to manhood and thus students that hold that notion my uptake TMC over VMMC. It us thus imperative for VMMC promoters to acknowledge this cultural aspect of the Black African students as it is influential to their agency.

Limitations of VMMC Communication Channels at UKZN

The respondents also shared their thoughts on the reasons they think that VMMC promotion did not do well with UKZN students, specifically on the communication side. Two subthemes that emerged were that the programmes were unsuccessful in raising awareness which will be divided into two subsections which are lack of VMMC focus and limitations of communication channels, as well that VMMC clashed with TMC as they were both options for UKZN students.

Unsuccessful Awareness Programmes

Despite that the health promoters have been seen by the students promoting HIV prevention, there is an identifiable lack of focus on VMMC as another intervention for students. Hence, this sub-theme will be divided into two sub-themes, namely, the lack of VMMC promotion in HIV prevention interventions and the limitations of communication channels chosen.

Lack of VMMC Focus

The collected data also demonstrates the thoughts of the respondents regarding the limitations of VMMC communication interventions aimed at them. Among issues that were raised was that the students were not aware of VMMC messages because they had never been exposed to them, A third-year level respondent said:

> They have failed in reaching mass populations to get them circumcised because there are still people who have not been circumcised and don't believe in VMMC. (Participant L3, 1)

The respondent held the sentiments that because he thought fewer students' uptake VMMC, that proved that the health promoters were not doing enough in spreading awareness about VMMC. The other third-year respondent concurred with the first respondent that as he was explicit that the VMMC promoters did not approach students enough:

> I think they never came to tell people that they can go do something and get help. Telling us about it makes us see but they never came to teach students. (Participant L3, 2)

The third-year respondents pointed out that they were not being approached enough, hence, poor uptake. Therefore, the issue was not with the students resisting VMMC, but they were not exposed enough to VMMC messages. One of the PhD level respondents pinned it down to a lack of education about VMMC:

> Okay. Now you are asking me about, uh, where the medical circumcision failed? uh, firstly, if they wanted this thing of, um, medical circumcision to succeed or to progress in the future, they were supposed to start by putting in maybe, um, subjects at school when you are growing. Also, they were supposed to put the courses and what you call, in universities. So, educate the students and try to convey the messages that the traditional circumcision is not, um, uh, safe is not accurate, so someone could die there. So, they failed to educate people about them. (Participant L6, 2)

He thought that the interventions should have incorporated the VMMC information in the education curriculum. According to him, this would have been done from as early as school education, which would be continued at the university level where there would be modules specifically for VMMC information. Furthermore, he was explicit that the education would also promote the idea that TMC was unsafe and should be avoided. Noteworthy, the respondent also thought there was not enough VMMC focus on HIV prevention interventions.

Another respondent thought that the gap was in educating the students about VMMC. A master's level respondent thought that they could have advertised more in the spaces that students occupy:

> Uh, I think, uh, the strategy missed the mark by, uh, not being a full-on, uh, advertising. So, if you are promoting uh, is it VMMC? Yes, you need to cover all aspects. For example, you cannot just put-up posters where you are only based. You need to cover the entire campus. As I mentioned before, your libraries, your LANs and hangout spots that kids hang out in. (Participant L5, 2)

The respondent did not support the act of putting up posters on healthcare facilities only, he thought that it would be more effective to post them anywhere feasible around on campus.

Limitations of Communication Channels

One of the honour's respondents was also expressive on how they thought that the interventions were not advertised enough on both print media and social media:

> Advertisement. They failed dismally. Because I'm a person who's always on social media, at UKZN pages. I've never seen anything about them. I've never even seen one student or worker of them wearing their t-shirts on campus. (Participant L4, 1)

The respondent demonstrated that they were frequent users of social media, and he visited the UKZN website, but he had never seen VMMC promotions on them. Moreover, he had never seen a health promoter promoting VMMC on campus. The other honour's level claimed that the interventions were not successful because of being too traditional in their ways of communicating with students, specifically being stuck on print media. The respondent said:

> I think what they've done wrong, but they're dwelling on the part they called old media, they use pamphlets. (Participant L4, 2)

The respondents had two years of experience being on campus, respectively. They both claimed they had never been approached by health promoters. One of them thought that they were unsuccessful because they did not shift promotion mediums from print media to more recent channels, which would be social media and the UKZN websites as the other respondent had pointed out that he can access them.

At all levels, it is noted that the students thought that the interventions did not do enough in raising awareness. The respondents thought that the reason was that the interventions did not use enough UKZN facilities to advertise VMMC information, these include the UKZN website and social media pages. Therefore, time spent on campus is not a factor, as they could have accessed the information through other online channels. Furthermore, it is concluded that the respondents are in support of a shift in VMMC communication channels, from the traditional

to modern ways of communication of which will be discussed further in the suggestions for improvements in the VMMC communication theme.

Clash with Traditional Male Circumcision

The respondents also shared their thoughts on whether students would be conflicted when deciding whether to uptake VMMC because of the existence of TMC. A third-year level respondent said:

> What I understand is that it's very risky. People do it to respect… or to keep on going with their traditions and culture. Yeah, there is an impact because people like the Xhosa for example love it, they question your manhood if you circumcise at the hospital. Which may lead one to reject VMMC and undergo TMC. (Participant L3, 1)

The respondent, despite that he thought TMC was not recommended because it was risky, understood its value to people who practice it. He understood that the young boys would be excluded by their communities if they rejected to uptake TMC and therefore they had more motivations to traditionally circumcise as opposed to VMMC. These beliefs were further emphasised by the honours' respondent that was affiliated with th*e Xhosa* tribe and had undergone TMC:

> Yes, there is a clash. And that was a huge one, especially if you, uh, if you are a student that believes in culture, especially the Xhosa culture, because medical circumcision, and so not just being circumcised, it also a journey to manhood, that is also with this idea that men should endure pain to prove that they are men, or they are like men. So, once you've taken the part of the medical circumcision, they don't consider you as a man, because obviously you, didn't endure pain that one that is much safer than the other one. And also, but also is that is much less painful. (Participant L4, 2)

The respondent was also clear that TMC can be risky for boys but brought out the idea that that is the essence of the TMC process as it is not merely about circumcision. Moreover, the boys are put under struggle to teach them strength and resilience as they transition to manhood. Therefore, VMMC would be deemed too safe and thus not an option for boys affiliated with that culture. One of the master's level respondents also thought that culture would be more influential in decision-making:

> Um, yeah, I think it does [impact on the decision to uptake] because a university is a broad community. We get people from different walks of life and here at UKZN

> students from different provinces, so they cannot come here and abandon their culture. So, they will, uh, engage in their traditional circumcision as opposed to a medical circumcision, because a university is not permanent, but they are existence or belonging or status in their cultural group is permanent. So yes, I think, uh, that is why they would opt for traditional circumcision as opposed to medical circumcision. (Participant L5, 2)

The respondent brought to light that the students are permanently connected with their cultures, and they thus owe allegiance to them. This means that they would choose TMC because it holds more cultural significance for them. One of the PhD level respondents also thought that tradition will be more relevant to a student from a culture that practices TMC. The respondent said:

> Well, um, for me I think the bashing or the use of discrimination against students, for men especially. There is a tendency of bashing out you know, students, uh, both men in fact, would stay late because this is mainly for men. Um, there is the bashing of males who are not circumcised [traditionally]. So, I think that in his, his home does really have a, an indirect motivation for people to go out for circumcision. And it's a cultural thing. So, they are motivated to just go for it, because now you are not referred to as a man enough, and also women also don't tend to like males [that did not uptake TMC], according to research. (Participant L6, 1)

In his case, he pointed out that that is because people do not want to face the consequences that come with rebellion. Men that do not undergo TMC run the risk of being isolated, bashed and excluded from the group. Lastly, the other PhD candidate was not clear about which procedure students would choose but emphasized that there is an evident clash. He said:

> So, um, the uprising of the medical circumcision, uh, I think it does cause the conflict in, uh, the confusion, I mean, in, in students, because the students who are coming from, uh, Eastern Cape, yes, they are emphasized to do it, their traditional, uh, circumcision. Whereas the other ones coming from other provinces. They just know the one, uh, circumcision, which is the medical circumcision. So now, uh, I think it caused more confusion. (Participant L6, 2)

The respondent thought that because students come from cultures that are in support of TMC there would be difficulty in making a choice when they are approached by VMMC promoters.

He also reflected that the UKZN accommodates students who come from other provinces that uphold TMC, such as the Eastern Cape.

The above-collected data demonstrates that the respondents do believe the cultural factor will play a role in the decision-making of young males. This is because the students understand the cultural importance of TMC, therefore, they would be conflicted if VMMC interventions are presented to them. To maintain impartiality, below will be the responses from the respondents that think students will be more prone to choose VMMC. One of the respondents said:

> I think the UKZN students wouldn't have a problem choosing with knowing what is done before and after (circumcisions), the outcomes. I think the UKZN students would prefer to do the medical circumcision. (Participant L3, 2)

Whereas the respondent who was not explicit about whether TMC would compete with VMMC, shared that he would expect students to uptake VMMC because it is safer and painless because of the use of anaesthesia. The respondent said:

> What I can say is that… In my opinion, medical circumcision is good because it is done in a safe environment, safe space where you can get all forms of medicine you may need. Yes. I've heard so many bad stories about traditional circumcision. Well, so I don't trust it. So, in any time I would advise people to go for medical circumcision. Not traditional, that's what I can say concerning that question. (Participant L4, 1)

He also mentioned that because he does not trust TMC, he would discourage other students from undergoing it. Another respondent also seemed to have undermined the influence of cultural motivations when individuals undergo TMC, he thought that students would choose to feel less pain and therefore they would opt for VMMC:

> Ah, well I think it does because first of all, I think TMC is more painful than VMMC. So, I think it also influences students to go for VMMC instead of going in those, eh, mountain and stuff and doing all of those things. I think it's, at some point it does influence them. It, it does give them choice, a simple choice that one didn't feel in pain of being removed foreskin without using an injection, I think at some point it does. (Participant L5, 1)

The interview data presented above tells us that some of the respondents think that despite noting the cultural importance of TMC, students would still choose to undergo VMMC because it is done in a medically safe environment and has minimal pain in comparison to TMC.

The levels of education were not a huge factor in this section. The comments seemed to have depended on how much the respondents appreciated the value of the cultural factor in relation to VMMC. The respondents who did appreciate it were clear on that TMC would be more favourable for students, whereas those respondents who underappreciated thought that the students would choose VMMC as it is medically safer.

Suggested Improvements for VMMC Promotion

This theme serves to discuss what the respondents have suggested in terms of how they thought VMMC promotion would be improved. The two subthemes to discussed below include the suggested integration of VMMC into the TMC process and also an increase in raising awareness of students.

Integration of TMC and VMMC

The interviews also provided data where respondents shared their ideas on how they think VMMC communication could be improved at the university. One of the third-year students was explicit that the VMMC and TMC should be integrated:

> Maybe with regards to TMC, they must use anaesthetics from the hospital for pain relief and integrate the two strategies. (Participant L3, 1)

The respondent suggested that VMMC promoters should offer pain anaesthesia to the boys when it is time to circumcise during the TMC process. Noteworthy, the honours level respondent that underwent TMC was in support of integration with VMMC, however, he maintained that the boys should be circumcised traditionally. Moreover, healthcare providers should be allowed to monitor the health of the circumcised boys to keep them healthy and safe, with the condition that they were also circumcised traditionally. The respondent said:

> They (TMC groups) are registered to the department that now are opening initiation school and also there is a guideline of how to they follow, they need to follow in terms of making sure the boys are healthy as possible, even after the circumcision, even before they circumcised, there are guidelines. And also, these, there are people who constantly go there and check that the boys are in good health. Obviously, it should be the people from department, but obviously it should be the people that had undergone

> traditional circumcision, but also members of the board of the department. (Participant L4, 2)

Despite that the respondent supported TMC, he also recognized that the procedure could be too harsh for the boys and thus suggested that there should be medical providers who are affiliated with the culture as well, who should do check-ups with the boys throughout the process. Because of the cultural aspect with regards to VMMC, these suggestions may be complicated in both theory and practice, hence, further critical analysis of these will be addressed in the analysis chapter.

Another respondent was also in support of integration but was not optimistic that people would shift away from their cultures. Therefore, the focus should not be on attempting to change the boys' mindsets but instead they must focus on making TMC less harsh for the boys:

> So, they should also, uh, pay attention to people's cultures as well, or try and maybe include a way to introduce a male, uh, a medical circumcision in the traditional settings, or maybe be there, teach them about, uh, what they can do to prevent a dangerous of traditional circumcision instead of trying to completely shift their mindset about other traditions. Yeah, I think that would work. (Participant L5, 2)

The respondent was in support of VMMC being introduced into the TMC process when it was time to circumcise. This meant that VMMC procedures would be followed, this is slightly different from the suggestions of the previous respondents that suggested that the boys must be looked after but still traditionally circumcised.

The other master's candidate supported integration as well, he suggested that VMMC should be performed instead of TMC during the circumcision process. Moreover, he suggested must be protected from the cold. This would be controversial as the honour’s level respondent that underwent TMC mentioned that going through hardships is part of the TMC ritual. The respondent said:

> I guess that one they should consider like maybe implementing some of the VMMC measures on TMC. I don’t know if maybe clothes could be allowed because it is very cold there, but I think if they could maybe consider to, uh, like now and talking about TMC, if TMC could consider implementing some of the measures that are made in VMMC, like the injection also maybe the, the use of other, these plastic gloves for not contacting like blood. I think that's why they should do. (Participant L5, 1)

Like the previous respondent, he also suggested the use of anaesthesia during the TMC process. Moreover, there should be provision of clothes to keep the boys warm, including the use of anaesthesia and medical gloves. This may be ambitious as the suffering is part of the TMC process. It is noted that including the third-year respondent that disapproved of TMC understood the value of cultural influence in the TMC process and thus recommended the integration of the two strategies. The honours level respondent also recommended integration despite being affiliated with a culture that practices TMC. The master's level respondents were in support of integration, exposing these views of respondents across all different levels further shows that the respondents understand culture is vital and therefore context should be considered when VMMC is promoted.

Increase Awareness/Education

This sub-theme will be divided into two subsections namely, directly approaching students and the use of social media.

Direct Approach of UKZN Students

The respondents thought that low uptake is also due to a lack of knowledge about VMMC. Therefore, they suggested that more awareness programmes are necessary to increase knowledge about the intervention:

> I would include more knowledge what happens when people practice unsafe sex. Mention in detail for example the risks. Face to face seems most useful because I get a chance to ask questions. (Participant L3, 1)

> I think they can uhm… they can tell people about circumcision and then uhm they can circumcise. If they want us to do something, they have to come back again and tell people to go circumcise. (Participant L3, 2)

Both third-year respondents suggested that being approached directly would be effective as they have a chance to engage with the health promoters. This was emphasised by the honour's level respondent that they should approach students where they spend most of their time on campus:

> They should understand that they're dealing with youth, it's how youth, where you spend more of their time. Where do they spend more time to one, things that they value, things that could make them glued to it and stand off more focusing on the idea of education, because students don't want to read, that is the fact about either their

> students. So, if you have an awareness, but also you make them to read, obviously don't, this could not get to students because they don't want to read anyway. (Participant L4, 2)

The respondent discouraged the use of print media as he claimed that students are not interested in reading them, but they must go to the students physically instead. This was like one of the other respondent's ideas who shared that the health promoters should target students at the campus spots they spend most of their time at. He also added that these health promoters should be popular individuals around campus that are influential. He said:

> Okay. In future, one, uh, people who are in charge of promoting such things, they should target, uh, popular people around campus each and every campus in the university has those people who are regarded as popular, they should use those people because they carry the most influence if they use and employ those people as peer educators, eh, students who look up to those people who find it easy to relate to what is being said, as opposed to having posters, eh, at selected locations. And when, eh, the occasion comes, they use, uh, ads, maybe nurses, or those few peer educators to promote a VMMC by using a popular individual would really help individuals or services, I think that would be the best option to do. (Participant L5, 2)

He suggested that the individuals that students hold respect for around campus should be used as health promoters that would approach students where they spend most of their time. The use of public figures is also supported by an honour's level respondent who went beyond recommending that popular individuals should be used on campus but suggested that celebrities may be more useful as students idolize them, moreover, students prefer entertainment. This is drawn from his claim that students do not have the time to engage with information not academically related, but they do make time to go and watch when celebrities come to campus to perform. Therefore, students could pay attention to VMMC's promotion if the approach was entertaining. He said:

> I think it should be the entertainment part because students like entertainment. If you could see that if ever there is a celebrity or a singer that they come to the campus, how many students, they are trying to get the attention, of that particular singer, of that particular celebrity and how they listened to that celebrity, and how they sacrifice their time in going there and make sure that they will be there in the, the day in the venue at the where the celebrity would be that they could use that as the strategy or use that as

their tool to get the attention of the student, obviously not to give that platform on the pamphlet, but also use that celebrity as to be the one, the mouth of the organization, but the mouth of the programmes to teach them. (Participant L4, 2)

The respondent suggested that because when celebrities come to campus to entertain students, also, the students do pause their studies and pay attention to them, the VMMC promoters should thus target celebrities to be used as health promoters and integrate the information into the entertainment.

Notably, even though one of the respondents had seen VMMC promotion on a pamphlet at the campus HIV/AIDS Unit, he thought that interventions should be physical, he suggested that the health promoters should do surprise visits to students and teach them about VMMC directly. One may conclude that even though pamphlets may be effective in getting the message across, students may not prefer it. Another master's level respondent suggested directly approaching students as well:

> They could improve in a word of mouth. Maybe programmes that could you know what I mean, like some sort of a programme that will advise people to come, just maybe come by surprise, surprise students and come to their rooms, talk to them about HIV and encourage them to do male medical circumcision, encourage them to prevent HIV and AIDS like by using condom and stuff. Yes. I think a word of mouth could also be suitable for VMMC as well. (Participant L5, 1)

He suggested that the health promoters should approach the students by surprise, including at their residences, not just to offer large audience programmes but to go from room to room and educate students about VMMC. Another respondent recommended that they resume outreach programmes that had been put on hold and seek to mobilise students at their student accommodations. He said:

> Um, the, the outreach programs they must go to students and mobilize students, invite students, physically engage them. And then they come to test, and they need to do that. Even if they had to do medical circumcision, they must do that. And also, within the residence, the residence life programs as led by the department of student. Um, they need to speak to those situations, particularly, HIV preventions. (Participant L6, 1)

The respondents shared that they prefer direct communication with health promoters as they believe that this approach would be more effective. They emphasize that health promoters

should target them at the common places they visit frequently on campus. Furthermore, others also suggest that there must be something particularly specific about the health promoters, they could be popular people from campus and including celebrities. Lastly, it is noted that despite the respondents vary at their education levels and thus their exposure to VMMC promotion, they shared the similar idea that students should be directly approached.

Use of Social Media

Whereas one of the honour's level respondents mentioned that he utilised social media frequently and suggested that UKZN should exhaust all their social media platforms and share the VMMC messages there. He said:

> Yeah, use every UKZN social media platform. So that everybody who watches those pages would be aware that there's something like this happening here. (Participant L4, 1)

The respondent thought that VMMC information should be spread across all the social media platforms that UKZN uses to engage with the public, especially students. This means that students that have access to those social media platforms would be exposed to the information. One of the PhD level respondents shared the same ideas but also specified specific social media platforms as examples:

> Uh, I could both communicate them through WhatsApp, through Facebook because nowadays the social media is high. Then the best communication in the world is through social media. So, I think I could communicate them with social media, including Twitter, Facebook, WhatsApp, and Instagram. Yeah. (Participant L6, 2)

The respondent even included *WhatsApp* which could be controversial as it is a messenger for personal use and direct one-on-one communication. The two respondents thought that fully taking advantage of social media was going to be useful in disseminating VMMC messages.

The consistent findings from both the limitations and suggested improvements to VMMC interventions is the recommendation to increase a bottom-up approach when engaging with students and reduce the use of mass media as the students prefer to be part of the conversations. Repeatedly, it is seen that the students are aware of mediums of communication being used around campus to promote HIV prevention, but they demonstrate a lack of interest in using them. Furthermore, the students mentioned that they were aware of the HIV interventions but there were limited interventions that focused solely on VMMC. Noteworthy, these were

specifically interventions where the health promoters visited the students at their campus and university residents, further exposing their preference to be directly approached for VMMC messages.

Summary of the Data

The students are vulnerable to HIV infections because of various factors that influence risky sexual behaviour. These risky behaviours have been noted to be a result of external pressures. The first factor that came up was substance abuse. Students can engage in risky sexual behaviour because they are under the influence of alcohol or drugs. The respondents were explicit in that when under the influence of substances, they are not rational and could therefore have sexual intercourse without the use of a condom. Another factor that came up is the prevalence of peer pressure among students which leads to pervasive stereotypes. Among these stereotypes are that sex without a condom feels unique, or even more pleasurable. Additionally, other respondents thought it was not completely fair to blame students only as they posited that they lacked enough knowledge to understand the risks of being exposed to risky situations that can lead to HIV transmission.

The respondents shared how they have received HIV prevention messages which were through print media such as pamphlets and posters on campus, and the second direct communication from nurses and health promoters. Furthermore, the respondents specified that the core messages that they received stressed HIV prevention and the idea that living with HIV is not a death sentence. Also, the HIV prevention campaigns emphasise raising awareness to educate students about HIV.

The data collected from the interviews also provided the research with the possible motivations that would lead the students to uptake VMMC. Most of the respondents mentioned that they would uptake VMMC for medical and good hygiene benefits. Others were to uptake to experience a different sensation when engaging in sex. Whereas one respondent did not decide to medically circumcise by themselves but was instructed by their mother.

The study also explored what perceptions students held regarding TMC, specifically how they understand it. Some respondents mentioned that TMC is a cultural procedure seen as a rite of passage for young males when they transition to manhood. This did not mean that they all fully supported it, as some respondents understood minimally and claimed it was a torturous and painful procedure that should be avoided, they held the same sentiments as they claimed that the service providers were untrained and therefore unprofessional. The respondents were

divided into two groups where the majority thought the students would uptake TMC instead of VMMC because belonging to a cultural group is a stronger motivational factor. The rest of the respondents mentioned that if students had to choose, they would pick VMMC because it is performed in a medical setting with professionals and because there is minimal pain when compared to TMC.

The respondents shared that among the reasons for the VMMC communication strategies to meet their targets are that they had poor advertisement, they did not do enough to directly communicate with students through community outreach, they are stuck on traditional media and the interventions are no longer working as hard as they used to. Noteworthy, the respondents identified communication channels as communication strategies as well. Lastly, the respondents shared that the presence of TMC itself is a hindrance for VMMC because it would conflict with the students in deciding which to uptake.

The study then proceeded to investigate the ideas of the respondents in terms of what they think could be done to improve VMMC communication campaigns in the future. Increasing awareness in the form of educating students was a prevalent recommendation. The respondents thought that campaigns should directly communicate with students by targeting their spots around campus and going to their student accommodations. Furthermore, with the understanding of the threat of TMC, the respondents suggested that there should be an attempt to integrate the interventions. Other respondents suggested that the VMMC interventions should target popular people around campus to use in the spread of awareness because they would grab the attention of students, and these could even be celebrities that would entertain the students. Lastly, other respondents thought that the interventions should take advantage of the UKN website and social media to spread VMMC messages.

Conclusion

This data presentation chapter fully presented the data collected by this study. The data presented was collected through one-on-one semi-structured interviews. The next chapter will be reserved to analyse and discuss the data that is presented in this chapter.

Chapter Six

Data Analysis and Discussion

Chapter six will draw from the previous chapter where the data collected from the eight one-on-one interviews was presented in quotes, and the themes and sub-themes guided the process. This chapter is responsible for the analysis, interpretation, and further discussion of the collected and presented data.

As done in chapter five, the process of analysing and interpreting in this chapter will be guided by the themes. Furthermore, the theoretical framework which is the culture-centred approach (CCA) and the literature from chapter 2 will be useful as a guide as well, as they also informed the study. Data presentation is merely the beginning of making meaning of the collected data as it is still required to summarise and organise the data to show significant patterns (Braun and Clarke, 2012). Instead, that data must be analysed by accurate ordering, structuring and thus making meaning of it (Patton, 2002).

The CCA is a methodological and theoretical framework applied in health communication to analyse and interpret lived experiences of marginalised communities (Koenig *et al*., 2012). The approach is best understood through the intersection of its three pillars, namely, culture, structure and agency (Dutta, 2008). Where culture is understood as a combination of perceptions, values, communication patterns and values that are in a process towards political, social and economic web (Basu and Dutta, 2009). Furthermore, culture is understood as dynamic rather than static, as it continually transforms itself from generation to generation (Yehya and Dutta, 2010). Whereas structure includes but is not limited to rules, communicative resources, logic and assumptions that a community holds (Dutta and Thaker 2016). Whereas agency is understood as an enabler that allows for the possibility for individuals or the community to transform their relationship with the structures that constrain them and thus result in social change in real time (Koenig *et al*., 2012). The three constructs have a dynamic relationship as they interact with each other during a communication process (Dutta and Thaker, 2016).

The CCA is the beginning of steps towards allowing the subaltern voices to be heard in the discursive spaces within the dominant paradigm (Dutta and Thaker, 2016). The dominant paradigm is noted to be devoid of cultural sensitivity to the marginal communities, thus enables

the negotiating of health meanings through understanding that cultural contexts are the key to achieving theoretical insights (Dutta, 2008). Cultural sensitivity can be defined as "the extent to which ethnic/cultural characteristics, experiences, norms, values, behaviour patterns and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery and evaluation of targeted health promotion materials and programmes (Resnicow *et al*., 1999:11). In this case, health is understood through lived experiences of cultural members instead of a universal concept (Yehya and Dutta, 2010). The CCA emphasises that health communication strategies should be cognisant that the marginalised communities are not devoid of agency, however, bottom-up approaches would be more effective in communicating health (Basu and Dutta, 2009). Furthermore, (Aubel in Dutta, 2008:8) posited that "programs that build on existing cultural systems are more likely to influence community norms and thereby have a greater and more sustained impact on community knowledge, survival strategies, and well-being". Therefore, VMMC's promotion strategies should seek to be sensitive to the culture of the students from the beginning of the intervention and communicate through their culture for sustainability.

The data in this study showed that the UKZN students despite having been exposed to mass media platforms promoting HIV prevention would prefer to be approached directly by the health promoters. This brings some insight into how VMMC messages could be promoted more effectively to UKZN students. Through the CCA, it had been noted that the students desire to participate in the promotion process, which means that they could engage and negotiate the meaning of VMMC and thus be involved in the process towards a solution (Dutta, 2008). This is crucial as the CCA points out that it seeks to give the subaltern a voice which will enable them to enact their agency as they find their ways through the structures affecting them (Acharya and Dutta, 2013). Furthermore, it is through engaging with the students that their culture would be identified and therefore communicate with them with sensitivity to it (Dutta, 2008). Thus, an intersection between culture, structure and agency is achieved as the student's voices are heard (Acharya and Dutta, 2013). Lastly, it is important to note that this study applied all three constructs of CCA with the addition of voice and dialogue which is important in understanding what the VMMC's previous communication strategies lacked in relation to the findings of this study, the CCA was instrumental in assisting the researcher to unpack the meanings of the data collected through the interviews. It was through the dialogical process of the semi-structured interviews that the perceptions of Black African students were identified. Among these findings were that the students did not resonate with the mainstream mediums of

communication adopted by the VMMC promoters at Howard College Campus. These typically included flyers, pamphlets, and other mass media platforms. The students discouraged the use of such media platforms and recommended direct communication with the health promoters. It is thus conclusive that the students do not simply want to be exposed to VMMC messages but intend to be part of the process to negotiate its meanings. Thus, the students can voice their perceptions towards existing VMMC interventions and recommend improvements that are relevant to the culture of Black African students. It is when these conditions are met that the CCA becomes useful to an intervention, the Black African students must be empowered and the communication becomes bottom-up, thus, their agency is enables which will result in a productive interaction with the structures put in place by the VMMC interventions.

Culture

Cultural Insensitivity Towards UKZN Students

The findings of this study expose that the biggest misfit between the VMMC communication strategies, and the students is the lack of sensitivity towards the culture of the students. An example of this was the undermining of Traditional Male Circumcision's (TMC) presence as a choice for students to undergo. The mere existence of TMC as an alternative could be a limitation as students are part of a culture that upholds their traditional customs. The role of culture in this situation cannot be dismissed. Dutta (2008) considers culture as the most important aspect of the constructs of the CCA as it is the basis on which the intended community make meaning of the health issue they have and therefore how it is supposed to be addressed. Ignorance of that cultural factor in the participation will lead to misunderstanding thus poor uptake. It is, therefore, crucial to understand how students understand TMC and VMMC respectively as a step towards finding a solution viable for the students. The CCA emphasizes agency being instrumental in understanding how the local community behaves towards a health communication issue, however, it should be noted that culture remains the strongest stimulus towards shaping knowledge creation as it holds the context of life (Koenig *et al*., 2012). Therefore, it should never be ignored during health communication. One of the respondents is affiliated with the *Xhosa* culture and therefore underwent TMC. Hence, they provided the most comprehensive meaning of TMC:

> Yes, there is a clash. And that was a huge one, especially if you, uh, if you are a student that believes in culture, especially the Xhosa culture, because medical circumcision, and so not just being circumcised, it a journey to manhood, that is also with this idea that men should endure pain to prove that they are really men, or they are like men. So,

> once you've taken part of the medical circumcision, they don't consider you as a man, because obviously you, didn't endure pain that one that is much safer than the other one. And also, is that being much less painful. (Participant L4, 2)

The respondent begins by saying, "if you are a student that believes in culture…", this comment alone exposes that he was biased and what he said next would be determined by the culture he subscribes to, and those who do not believe in that culture will not understand it. This is important as the VMMC promoters may be part of the latter group that is not affiliated with culture. Already, a disjuncture between the two parties is realised, hence, the participation of parties that is expected may be impossible. It is therefore important that promoters of VMMC approach that community with sensitivity to their culture.

The respondent was clear that enduring pain was part of the TMC process. Meaning that TMC is not merely a circumcision process but a process where the boys are put under certain conditions where they learn certain principles. Therefore, comparing VMMC to TMC without acknowledging that fact means reducing TMC to merely a circumcision process and thus neglecting the cultural aspect this informs it. Ultimately, this would cause a conflict between the VMMC promoter and the intended community. Koenig *et al*. (2012) posited that when interventions are not aware of how context shapes agency, they often resort to making recommendations based on what they think they know about the local community. This error may not be made by the promoters only but including other students that are not part of the culture. This is evident when one of the respondents was confident that choosing which procedure to uptake between VMMC and TMC would be easy because students would simply compare the outcomes and decide that VMMC was the right choice. Here, it is noted that the respondent had made the mistake of reducing TMC to merely circumcision. It had been discussed above why this is an error, the cultural aspect is undermined. When the communication strategies make the same error, they prioritise biomedical discourse over the discourse of the local community which results in resistance and thus compromised individual and community health (Koenig *et al*., 2012). In truth, for students that are affiliated with the culture, it is a tough decision as it is choosing between a medical intervention and their tradition.

Students Understand Tradition Male Circumcision as a Cultural Procedure

Through the analysis of the literature around the motivations of young males to uptake TMC, the study discovered that tradition is the prime factor. The removal of the skin is part of the

process but not the main factor, the procedure is rather taken as a rite of passage to manhood (Siweya *et al*., 2018). This notion is in alignment with some of the respondents' understanding of TMC and what they thought would motivate students to uptake TMC. It is thus evident that students may be influenced by their cultures in deciding to uptake. The culture constructs in the CCA advocates for the culture to be given due attention by health communicators as the audience has a shared understanding of their health problem (Dutta, 2008). Furthermore, it is when the health promoters understand a health issue through the audience's shared norms and ideas that they are then included in the negotiation of the possible solution.

Most of the respondents were explicit in that they understood that TMC is not only about circumcision but about upholding tradition and customs, where the males circumcise as a rite of passage as they transition to manhood. Only a few of the respondents have a questionable understanding of TMC principles. This means that it would not be beneficial for VMMC promoters to overlook the role of culture regarding TMC. Culture is dynamic and provides the lens for the people in understanding phenomena, therefore, health promoters should be culturally sensitive to the audience when promoting VMMC. The study stressed the importance of the participation of the male students during VMMC promotion, it is also important to understand that those students are part of a culture, and it will be influential in their interpretation of meaning during participation. The CCA thus recommends that VMMC promoters must listen to the voices of the targeted UKZN males to ensure that the communication is not a top-down passing of information that recognises them as passive (Dutta, 2008).

In a study to explore the perceived influence of value systems on the VMMC among men in Kweneng East, Botswana, it was found that values systems including religion and culture lowered the chances of VMMC uptake and thus concluded that health promoters should consider the influence of these value systems (Mavundla *et al*., 2020). Culture is important because it provides a lens for how individuals understand a medical issue well as how they decide to address them (Dutta, 2018). This means that the young males that undergo TMC are motivated by culture, and it is through that culture that they define what type of circumcision is suitable for them. Therefore, the VMMC promotion campaigns should be sensitive to the culture of UKZN students. This is important because the community is involved in the process where the members can raise queries and critique the agendas of HIV prevention interventions (Basu and Dutta, 2009).

In the literature, it was found that some scholars explicitly expressed that they would not recommend the uptake of TMC as it is not administered by medical professionals and therefore unsafe (Maffioli, 2017). Another respondent understood the importance of the cultural aspect and the rituals to uphold were done appropriately, except for the circumcision part. Moreover, the notion that despite that TMC has a circumcision part, it is not aimed to reduce HIV prevention, therefore, any benefits similar to those of VMMC are purely coincidental. Most of the respondents understood the role of culture in TMC and its motivations but still discredited it because of the circumcision part. Those respondents need more education on the part of TMC so that they understand that the pain and suffering those males endure is part of the TMC process and thus cannot be discredited with those points. However, it is important to note that respondents varied in their reasons to label TMC as an unprofessional method.

Some respondents thought it was because the people providing circumcision were not medically fit to execute the procedure, whereas others thought it was because TMC was done under harsh conditions there were chances of complications and possible deaths. Important to note that is that most of the respondents did not share the culture of those that were practising TMC, therefore, they were not understanding it from their point of view. Dutta (2007) stressed that it is important to attempt to understand the views of the local community by being sensitive to their culture and thus imposing external views. The communication strategies that lack knowledge about the local community may be the cause for the constrained agency of the community members and thus marginalise them (Koenig *et al*., 2012). Therefore, like the VMMC promoters, the respondents were not sensitive to the culture of those in support of VMMC as TMC makes sense to them and therefore professional according to their standards. The VMMC promoters should be cautious about not making the same error.

The Recommendations to Include Cultural Sensitivity

The health promoters do not only wait for students to access the healthcare services, or only distribute flyers to them but they also approach students on campus and in their residences. One PhD-level respondent said that he learned about HIV mostly through student life programmes. The respondent learned about HIV/AIDS when the health promoters went to his residence and administered programmes. This is where they share information about HIV with the students. This is different to mass media because the students can engage with the health promoters and can ask questions about things they do not understand. The voice and dialogue construct of the CCA play an important role here as it acknowledges that the audience is also part of the meaning-making of the intervention being communicated, the definition of the

health problem will be negotiated, and the solution would emanate from the bottom-up (Dutta, 2008). This means that the intervention does not impose solutions, they recommend them, and all stakeholders can then negotiate them. This is relevant to the voice and dialogue construct of the CCA, which stresses the importance of collaboration between promoters and the intended males to enforce participation (Dutta and Thaker, 2016). When the males participate, they gain a voice that equips them with the platform to become agents of change and thus improve their lives (Creswell, 2009). Furthermore, participation is central to the CCA as it enables the articulation of health issues in the language that the local community understands, thus, moving towards change that is meaningful to them (Basu and Dutta, 2009).

The study noted that the respondents did not only prefer to be directly approached by the health promoters because they can engage with them, however, but they also wanted the promoters to meet certain criteria. These included that the health promoters should be popular individuals on campus. One of the respondents recommended that nurses from the campus clinic must be the ones to approach students as students would be keener to listen to them. Another respondent extended with the criterion that the popular individuals should be other individuals on campus that students have respect for, moreover, these individuals may be celebrities who can disseminate HIV prevention messages through entertainment. The respondent arrived at that suggestion because he had posited that students are not keen to read documents and flyers neither nor are interested to take their time off to listen to health promoters, but they make time to listen to their favourite celebrities that come to perform on campus.

In the previous chapter, it was noted most of the students were in support of being directly approached by health promoters. Therefore, there should be more resources allocated to that strategy, the use of entertainment may be useful to strengthen the strategy's ability to attract the audience. This is important because students may prefer to be directly approached but sometimes may feel bored and prefer something else to do. The desire to engage with the health promoters is exposed once again in this section, the students want to participate in health communication which emphasises how crucial giving the targeted community a voice is important, as stipulated in the CCA (Dutta, 2008). It is crucial to understand that the context needs to be the core of a sense-making process where the community takes control of and participates (Basu and Dutta, 2009). It is through this way that the community is not marginalised as the CCA seeks to produce alternative knowledge rather than mainstream biomedical knowledge (Yehya and Dutta, 2010).

Recommendations for VMMC and TMC Integration

Another evidential case of the lack of sensitivity towards the culture of the students is the assumption that VMMC and TMC could be integrated into practice. It is one thing to allow the TMC participants to go uptake VMMC in a medical setting and then return to the TMC process as it has happened before (WHO, 2020). It is another, to allow anaesthesia and clothing to the TMC participants to ease their suffering, this would be undermining the cultural aspect of TMC. This was evident in the comments of the students as to be discussed next.

The integration of VMMC and TMC was a result of responding that TMC is not a procedure to be ignored as it is motivated by cultural factors. Additionally, a significant number of UKZN students were affiliated with the culture. However, it is noted that despite the respondents accepting that TMC should not be ignored and suggesting integration, it seems that their understanding of TMC remains limited. This is evident in the very idea that they thought the two procedures could merge in real practice. One of the respondents recommended the use of anaesthetics during the circumcision when it was time for circumcision during TMC. It is important to remember that circumcision is only another part of the TMC procedure. Therefore, simply introducing anaesthesia will not amount to integration. Furthermore, even more concerning, as the other respondent specified that pain is part of the TMC process, introducing anaesthetics would be against the culture. What is learned here is this comment is not only impractical when it comes to TMC but also that the respondent has limited knowledge about TMC. The culture of the local community must influence their experiences even towards healthcare (Koenig *et al*., 2012). Culture is crucial in the sense that it offers the context within which the meaning of a health issue is negotiated (Yehya and Dutta, 2010). Therefore, ignoring culture is marginalising the students according to the CCA. Koenig *et al*. (2012) defined marginalisation as an act of voicing out the discourse of the dominant paradigm while silencing the discourse of the local community. In this instance, ignoring that TMC is a cultural procedure would be marginalising those participating in it. Therefore, culture should not be undermined even when promoting VMMC. As Paulo Freire used the metaphor: “you must swim in the cultural waters of the people”, there is an imperative for VMMC promoters to delve into the culture of the students to gain more understanding about how they understand male circumcision (Tufte, 2005).

The respondents thereafter shared their thoughts on how they thought VMMC communication strategies could be improved. These recommendations included the integration of VMMC and TMC. This recommendation was deduced from the acknowledgement that because culture is a

critical aspect as a motivation for TMC uptake, students consider it as a valid alternative. Therefore, VMMC promoters should accept that reality and consider going to places where TMC is undertaken and medically circumcise the males. In the study by Nxumalo and Mchunu (2020), respondents generally accepted VMMC as a health promotion intervention but also believed that it did not replace the value of TMC. Furthermore, Koenig *et al*. (2012) propose that "structure and agency are embedded within culture, which is an ever-changing system of values that influences attitudes, perception and behaviours that enable and constrain social action". Despite the interdependence of agency and structure, they would not be in effect if culture is not acknowledged as it is the initiator of social action. This means that even if the students were given resources and decided to uptake, they would be constrained by the culture if it is neglected. As in this stance, the leaders that are meant to foresee TMC would refuse the introduction of anaesthesia to a TMC setting. Thus, the practical integration of TMC and VMMC would not be feasible, however, the students can uptake VMMC and still undergo TMC for the cultural rituals. In light of VMMC promoters, they should keep this in mind when approaching students with VMMC messages. It is through the discussions above that the study concludes that the limitation of the VMMC promotion interventions is the lack of sensitivity to the culture of the students.

Agency

Substance Abuse Despite Known Risks

The literature from the chapter demonstrated that UKZN students have habits of engaging in sexual intercourse that are unsafe due to influences such as alcohol abuse. As Collinge (*et al*., 2013) concluded from a study that 43 % of males engaged in one-night sexual relations because of alcohol abuse. This study collected data from respondents to analyse their views on the matter and some specified that alcohol does reduce their ability to make reasonable decisions because alcohol lessens control over themselves. y. This is undesirable as the agency is achieved when the male students can enact their choices and participate in the negotiation with the structures around them (Dutta, 2008).

A respondent said that when they are under the influence of substances they cannot think clearly, and that interferes with their decision-making. The respondent spoke about the issue where students are vulnerable to risky-sexual behaviour because they are under the influence of substances. Moreover, they acknowledged that when under influence of substances they are not rational but cannot control themselves. This is an undesirable situation as the agency is

crucial in the decision-making of students, respectively. The CCA construct, which is an agency, speaks about the ability of individuals to make their own decisions in their day-to-day lives (Dutta, 2008). However, this may be compromised when individuals are under the influence of substances that interfere with their reasoning.

In a study to investigate the association between HIV infection and alcohol use, a systematic review, and meta-analysis of studies based on the studies that were done in Africa regarding the association was done, a finding was that people who abuse alcohol are more apt to be infected by HIV compared to those who do not (Fisher *et al*., 2007). Furthermore, Leigh and Stall (1993) conducted a study to review research on the relationship between substance abuse and risky-sexual behaviour, the findings highlighted a correlation between heavy drinking or drug abuse with poor usage of condoms and having more sexual partners. Additionally, in a study to investigate the relationship between substance abuse and its contribution to STD infections among university students, it was found that students under the influence of substances suffer higher cognitive impairment in comparison with those who are sober (Sutarso *et al*., 2016). It is thus conclusive that the agency of students is compromised in such instances, meaning that students are not able to make rational decisions under the influence of substances. This means that even if the UKZN has structures in place to assist students in HIV prevention, it may not be achieved because their agency is compromised through substance abuse. The structures are the constellation of organisational and institutional networks that can promote or hinder the availability of resources (Koenig *et al*., 2012). Whereas agency refers to the actions that can be executed both individually and, on a community, level and challenge the existing structures (Basu and Dutta, 2009). This means that both the structures and agency must be feasible for a successful VMMC uptake.

In the previous chapter, it was noted that the respondents accepted the influence of substance abuse on more chances of engaging in risky sexual behaviour as true across all levels of education. This means that years of exposure are irrelevant, however, the respondents have at least witnessed the incidence, heard about it through word of mouth or perhaps have been involved in such behaviour as well.

Inconsistent Use of Condoms Despite Known Risks

Previous studies suggest that students do have significant knowledge about HIV and how it is spread, and they are also aware of the effectiveness of condoms. However, they still do engage in sexual intercourse without condoms with anticipation of increased sexual pleasure (Parsons

et al., 2000; Rahamefy *et al*., 2008; Masoda and Govender, 2013; Elshiekh *et al*., 2020). The motivation for this behaviour was identified to be perceived reduced sexual pleasure done by condoms.

The data from the interviews concurred with those findings. Among the reasons found in the interviews was that students may believe that sex without condoms feels different, particularly more pleasurable. The latter point is emphasised by the respondent that said sex without a condom is 'fire'. Meaning that it is more pleasurable. He was explicit that the use of condoms should be reconsidered because despite their presence they might not be used. After all, sex without a condom is more pleasurable. These perceptions may not be limited to him but also, among other students on campus. In a study to determine whether pleasure derived from sex for protected and unprotected vaginal intercourse would be related to condom use, it was found that many males believed that condoms decrease sexual pleasure and that belief led to decreased usage (Randolph *et al*., 2007). Hence, the respondent used the metaphor of fire to express how they felt about sex without a condom, he believed that it was more pleasurable.

In this study, it is thus evident that condoms are catered for students to achieve protection from HIV infection and are being abandoned for anticipated increased pleasure. This may be problematic because the agency speaks about the student's ability to make their own decisions, meaning that even if the structure such as the campus clinic is in place, students will not uptake if they do not decide to. It is the agency that "creates the possibility for actors to transform their relationship to structure and offers the possibility for social change through time" (Konieg *et al*., 2012:820).

It is thus imperative to find means to address the misconceptions of the students. Randolph *et al*. (2007) recommended that interventions that promote condom use should emphasise the attractive aspects of a condom such as its ability to increase pleasure. Although this may need more research to support, it would be more effective to influence students to appreciate using condoms instead of merely availing them as an HIV prevention method. Furthermore, this emphasises the link between structure and agency, they need to be accounted for towards a successful intervention because despite the availability of the campus clinic, the students, through their agency resist them because they are not presented in a way that is sensitive to their culture.

In the data presentation chapter, it was noted that the respondents with higher exposure to HIV prevention methods acknowledged that condoms were perceived as barriers to sexual pleasure

but judged it as irresponsible behaviour. This means that despite being aware of the risks of engaging in sex without a condom, this may be ignored because they anticipate increased sexual pleasure. Moreover, the respondents were not explicit on whether they ascribe to the perception as well, however, since they do engage in sexual intercourse for pleasure and still use condoms. Another source of these perceptions arises from listening to their friends and the people around them. This means that other factors may be in play, such as the influence of peer pressure, to be discussed next.

Vulnerability to Peer Pressure

The UKZN students may not be engaging in risky sexual behaviour because condoms do reduce sexual pleasure, but it could be influenced by the opinions of their peers. Where a peer would talk about having sex without condoms as more pleasurable and the student internalises that knowledge and thus believes in that notion as well. In a qualitative study done by Selikow *et al*. (2009) to explore how peer pressure may influence risky-sexual behaviour among adolescents in Cape Town, it was found that peer pressure influenced risky behaviours such as poor delay in sexual debut and undermining the principles of ABC intervention in both boys and girls. This meant that peer pressure was a reason for the adolescents to engage in sex before they were fully mature to make rational decisions, also, less faithful to their partners and condom use was poor. This behaviour may be directly linked to what the adolescents have shared about sex. One of the master's level respondents concurred by exposing this notion that a friend could tell another that sex without condoms is more pleasurable, and the other friend may believe it and thus limit their use of condoms. Furthermore, in a study by Kim (2016) to explore the effects of peer pressure on HIV infection expectations among adolescents in Malawi, it was found that adolescents that lacked knowledge about HIV/AIDS were more susceptible to being influenced.

The views of the respondents that students may have picked certain undesirable behaviours from their adolescents are supported by the studies as the adolescents were engaging in risky sexual behaviour before being admitted to universities. It may thus be difficult for them to unlearn those behaviours. The students must not be taken as passive individuals that are incapable of making their own decisions despite being influenced. It is appreciated that the students may be exposed to ideas and norms from their peers, but they still possess the agency to decide whether to follow them or not. The students act as agents of change, meaning that despite being constrained by structures, at the same time they seek to transform them through participation (Basu and Dutta, 2009). It is through their agency that the students can enact their

everyday decisions and choices despite the structures that constrain them (Dutta and Thaker, 2016). This means that despite being influenced to behave in a certain way, the students retain the agency to behave in a particular way.

This means that they do accept those ideas because they make sense at that time based on the HIV knowledge available to them. One would therefore posit that students do not engage in risky sexual behaviour because they do not have any knowledge, they do but it may not be aligned with the HIV/AIDS knowledge authorised HIV interventions. This emphasises the need to find more effective ways to communicate HIV prevention messages to key audiences. Hence, another factor that influenced risky-sexual behaviour that was identified in this study was the lack of knowledge about HIV/AIDS, to be discussed next.

Knowledge of HIV Prevention Messages

The HIV prevention strategies transmit one main message across all types of audiences, which is a matter of seriousness to prevent HIV infections and end HIV as a pandemic (WHO, 2020). The interventions discussed in the literature including the ABC strategy, oral Prep and VMMC prioritise the message that ending the pandemic requires a reduction in further infections. The respondents selected by this study shared the same sentiments. One of the respondents even posited that the UKZN had a specific target to reduce the high number of students living with HIV on campus, by emphasising prevention. He was aware of a programme by the UKZN where the prevention of HIV was promoted through a reduction of the existing number of HIV-positive on campus. Even the third-year student that had the least presence on campus understood that the interventions aimed at enforcing HIV prevention. Among perceptions held by students that may hinder the intervention of HIV prevention is that students may perceive being HIV positive as a death sentence (Mulwo *et al*, 2009). Furthermore, Brown (2016), as identified in the literature, found that university students are still victims of fatalism where they view HIV as a death sentence which results in feelings of hopelessness. This perception is dangerous because it can lead to students avoiding getting tested at available healthcare facilities because of the fear of testing positive. Thus, leading to higher risks of an HIV-positive person having HIV advancing to AIDS. Whereas it would have been prevented with treatment should it have been discovered on time. Therefore, addressing such perceptions are among the strategies employed by HIV prevention interventions. One of the respondents was aware of this perception and knew that the HIV prevention strategies aimed to eradicate that perception. The respondent abovementioned understood that the HIV prevention strategies were not only targeted to people with a negative status. But also, those who are HIV positive should

understand that living with HIV does not mean sudden death, however, one can still live a healthy life. Hence, Nkosi and Rosenblatt (2019) recommended that more healthcare resources must cater for the support of the people living with HIV on a social level to address stigmas around HIV, as opposed to biomedical resources. HIV prevention communication strategies have focused more on the provision of services and somewhat neglected the need to invest in better communication about HIV prevention.

It is noted once again that the communication strategies have assumed that having the structures in place would be sufficient to influence uptake, this has been proven untrue as the students maintain their agency and thus decide not to uptake because they are not fully knowledgeable about the message. This is rather a linear form of thinking that contrasts with the principles of the CCA where alternative understandings of health are recognised by allowing the subaltern voices to be heard through participation (Yehya and Dutta, 2010). Participation of the communities should be integral to the design, implementation and evaluation of health communication strategies (Basu and Dutta, 2009).

As identified in the previous chapter, the respondents were aware that the HIV prevention interventions were sharing the core message that HIV infections must be avoided at all costs. The evidence is that students have at least been exposed to mass media with HIV prevention information or had been directly approached by a health promoter. Furthermore, the data from chapter five demonstrated that the students learned about VMMC through HIV prevention programmes, following theme will identify the motivations for students to consider undergoing VMMC.

Knowledge of VMMC Benefits

The VMMC strategy has been clinically proven to reduce the chances of HIV transmission by 50% to 60% (Kigozi *et al*., 2008), as noted in the literature. This is a health benefit that a respondent echoed in the interview. He understood the clinical benefits of VMMC and thus feared the repercussions that may be due should he not be circumcised and engage in unprotected sex. Furthermore, a study conducted to analyse circumcised men's perceptions, understanding and experiences of VMMC in KwaZulu-Natal, South Africa found that males may uptake VMMC from a personal motivation to reduce chances of HIV and STI infection, including improving general good penile hygiene (Nxumalo and Mchunu, 2020). The respondent was explicit that they may sometimes engage in unprotected sex and therefore VMMC could be useful as it reduces chances of contraction. This should be taken with caution

as this study has made it clear that VMMC is an additional HIV prevention intervention and thus should be used with other interventions, such as the proper use of condoms. This means that VMMC is not an HIV prevention strategy only by itself. The agency of the students should be influenced in the correct direction in this regard.

Understanding the importance of good health, it makes sense why the HIV prevention aspect of VMMC is the predominant motivator for VMMC uptake. Although, the HIV and STIs. Also, the HIV prevention motivator may be good for the promotion of VMMC, it should be noted that the students may appreciate it because they accept that they might still engage in unprotected sex. This emphasises the need to always keep the agency of the students in mind when promoting VMMC.

The literature does address the notion of the partner's influence on the decision-making of the males to uptake VMMC. The males reported that they are motivated by that post-circumcision they can sexually satisfy their partners (Fleming *et al*., 2017). Furthermore, females generally prefer males that have been circumcised. However, the respondents did not bring up this motivation as one of theirs. Instead, one respondent referred to the influence of their mother in their decision to uptake. The respondent was explicit that they did not know what VMMC is, this includes any of its benefits. The study conducted to investigate the barriers and facilitators to the uptake of VMMC among adolescent boys in KwaZulu–Natal, South Africa it was found that despite that study, data showed that not all families advocate for circumcision, parents can be instrumental in influencing young boys to uptake VMMC (George *et al*., 2014). It is not clear from this study why the respondent's mother recommended him to uptake VMMC, despite that the common motivator is usually better hygiene and HIV prevention. However, this is important to emphasise the health benefits of VMMC. Except for the recently mentioned respondent, it is evident how the agency can be instrumental when the students understand a health problem they are faced with, they are more readily to uptake a health intervention. Meaning that the students would be keener to uptake VMMC with these health benefits in mind. Emphasising once again that structure and agency are dependent on each other (Achaya and Dutta, 2013).

Denial of HIV Prevention Knowledge

The literature review demonstrated that students are knowledgeable about HIV, what it is and how it could be prevented. In the study by Moodley (2007) to investigate the sexual practices of students in the light of the ABC strategy, it was found that students do know about

HIV/AIDS, however, they have their reasons not to uptake, regardless of the perceived negative consequences. Furthermore, a study done by Menon *et al*. (2016) to assess risky- sexual behaviour among university students found that senior students were less likely to use condoms and they were more inclined to have multiple sex partners compared to junior students. Considering that senior students had higher exposure to HIV prevention messages, this emphasised the tendency to adopt risky-sexual behaviours despite having the knowledge

about HIV. Additionally, in another study to assess risky-sexual behaviour among university students, it was found that the students were well-informed about HIV as well as the perceived risks of engaging in unprotected sex, however, they still did not use condoms consistently, continued alcohol abuse and having multiple sex partners (Mthembu *et al*., 2019). Some of the respondents from the interviews made comments that were contrary to the abovementioned findings. They were convinced that another reason for students to engage in risky sexual behaviour is the lack of awareness of HIV prevention methods. One of the third-year level respondents said. The respondent was explicit that there was a lack of knowledge among students concerning HIV prevention, therefore, he did not judge them for engaging in risky-sexual behaviour. In this case, the respondent identified students as victims instead of irresponsible individuals. Furthermore, a master's level respondent blamed it on poor advertisement by the HIV interventions. The respondent mentioned that the students may be engaging in risky sexual behaviour because of ignorance. He did give the HIV interventions some credit in that they do attempt to raise awareness, however, this would not be successful without enough advertisement. He also emphasised how the students had diverse understandings of how to engage sexually, which means it would be difficult for them to abandon those learned behaviours and adopt the newly presented ones. This may be plausible for third-year students which only had one year of exposure. However, as the students spend more time on campus and are exposed to HIV prevention strategies, they should have the ability to unlearn their old behaviours.

In conclusion, in the previous sub-theme, it was noted that condoms are available to students, which means the structure is accounted for. In this sub-theme, it is learned that the respondents claim that they do not have enough knowledge regarding HIV prevention. In terms of agency, this means the students would not use condoms still if they have not been educated well about them despite their availability. However, this should be taken with caution as literature has shown that information is available for students, but they are ignorant of it. It is evident through the discussion above how the CCA principles would not be achieved with theme one: the

UKZN students may not be able to use their agency because they could be under the influence of substances, pressured by their peers or deliberately engage in unprotected sex for perceived pleasure, the literature does not corroborate with that they lack knowledge about HIV prevention.

Students' Desire for Interpersonal Communication

The respondents expressed significant knowledge about HIV prevention facilities and messages that they had been exposed to on campus. VMMC is among the interventions that the HIV prevention interventions promote, therefore, it would be expected that the students have received VMMC messages as well. However, this is not the case, students expressed ignorance towards them. Instead, the respondents were echoing that were not approached enough. The respondents reported that the promoters did not approach them enough on campus. Two of the respondents mentioned that they would have expected the health promoters to go to them in person to share the VMMC messages. Therefore, it is conclusive that in the case of VMMC, students do not seem to be knowledgeable about VMMC as much as they are about other HIV prevention strategies. This may be because of the communication strategies adopted. Furthermore, most of the respondents prefer to be directly approached, as well that they think that the fault is with the interventions that they do not know enough about VMMC. The respondents, as suggested by the voice and dialogue CCA construct, would prefer to be approached directly because then the conversation will go two ways (Dutta, 2008). This means the students would not be mere recipients of knowledge, but they can assess it and seek explanations from the promoters. Furthermore, if students should be approached directly, they would express how their cultures and how they interpret the messages as the culture can be a lens to understand concepts (Dutta, 2018). The participation must emerge from within the culture of the students to appreciate their culture and context and thus resulting in the enactment of VMMC practices (Basu and Dutta, 2009).

One of the respondents thought that the interventions were doing well in the past years to share VMMC messages but posits that they have noticed a decline in their performance. As identified in the study, it is known that in the context of Covid-19, the VMMC promotions have not been as active as before. Noteworthy, the respondent brought up the notion that the HIV communication strategies were doing well but eventually reduced their effort. This should be approached with caution as most of the data collected in this study suggests that the communication strategies have not been done enough. Perhaps, the respondent commented that he was one of the senior students, meaning that he was among the two respondents with the

highest exposure to HIV prevention messages on campus. Furthermore, this was the same respondent that said he learned about VMMC through an HIV prevention campaign, where VMMC was mentioned in passing.

The communication strategies were unsuccessful because they did not allow the students to participate in the communication process. This would seem simple to attain in theory, "however, to do so, healthcare structures must be open to critical interrogation by the community to create a shared communicative space in which the silenced voices may speak for themselves" (Koenig *et al*., 2012:824). This means that the communication strategies should have been prepared for and allowed students to define the health issues communicated with them by themselves. This would not be possible when the students did not receive VMMC messages at all.

The seriousness of how much students desire to participate in VMMC promotion interventions is evident in how they emphasise that they desire to be directly approached. Despite that the literature anchored the notion that students know enough about HIV prevention, the respondents maintained that there should be more awareness campaigns to promote HIV prevention and VMMC. Among the strategies that they emphasised were face-to-face where health promoters are expected to approach students in their frequently occupied spots on campus, use of popular and public figures around campus, and one respondent was specific that the use of celebrities may be useful as students are attracted to entertainment.

The respondents were strongly in support of the idea that strategies should directly approach them to promote VMMC. This suggestion alone emphasises the core of the CCA which is the need to engage with intended communities to promote participation (Dutta, 2008). This is a step towards allowing the students to voice out their opinions and perceptions towards HIV and its prevention strategies and thus leading to a two-way dialogue. It is through participation that meaning emerges, where the promoter becomes a listener instead of an expert, and thus engages in a dialogue with the students (Basu and Dutta, 2009). The respondents recommended this strategy because they thought that students are not keen to read and therefore must be approached directly.

He thought that targeting the students where they spent most of their time on campus would be more effective. This may shed light on the issue of mass media having been identified by all respondents yet HIV prevention not reaching its targets. The students may have received the pamphlets and flyers but may have not engaged with them, or they may have engaged with

them but did not understand the message well on their own. This is where the need to engage with health promoters is important. The notion that students do not want to read is questionable in the light that they are university students in an institution where reading is pivotal, however, this speaks more to how the students choose not to engage with print media content because it is not allowing them to participate. Therefore, participation should emerge from within the students' population within the context of their culture which would result in more effective communication of VMMC messages (Basu and Dutta, 2009). Furthermore, the respondents recommended that the use of popular individuals around campus as health promoters would be more effective,

One of the respondents was explicit in that he thought that posters should be replaced by a more intimate approach where the people regarded as popular around campus are used as health promoters that would directly approach the students to share VMMC messages. Furthermore, another respondent supported this notion with the extension that he thought the target should be more than just popular individuals around campus, but celebrities that the students are already exposed to.

The respondent also discouraged the use of mass media such as pamphlets but recommended that a celebrity be used as the voice of the VMMC intervention. Furthermore, the respondent stressed that the students would be keener to make time to see their celebrities performing, that is when the celebrity can incorporate the VMMC messages into their performance. What should be noted is that programmes such as the *Brothers for Life* had already applied these types of approaches, perhaps it is in the tertiary education context where it would also effective. The issue to pay attention to is that both respondents recommend that the VMMC promoters should replace the mass media approach and put more effort into talking directly with the students. This is where participation of the students is more possible instead of handing out pamphlets and putting up posters that they may not understand. Through a direct approach, the students may ask questions to the health promoters and influence the process as they negotiate the meaning of HIV and VMMC with the students.

These suggestions emphasised the importance of giving the targeted community voice during an intervention. It is through the dialogue that the students can speak for themselves, make their own decisions and contest notions that clash with theirs regarding a health issue (de Souza, 2009). Furthermore, Koenig *et al*. (2012:820) posit that it is "through dialogic engagements with locally constituted stories, culture-centred interrogations seek to understand how

community members at the margins of mainstream health care negotiate meanings of health and constitute the actions located within dominant structures of meaning". Therefore, the students can apply their agency to negotiate the meaning of VMMC and attempt to transform the structures around it (Giddens, 1990 quoted in Basu and Dutta, 2009). Furthermore, it is an error on the part of communication strategies to view the agency of the students as mere abstract choices, however, the agency is exercised by the cultural participants as part of daily experiences and thus makes practical judgements in real-time (Koenig *et al*., 2012).

Low Desire for Print, Mass and Social Media

Another evidence of that student's desire to participate in the number of respondents that recommended social media for VMMC promotion. Out of eight participants, only two suggested that VMMC messages should be available online. One of the respondents mentioned social media platforms that UKZN can utilise.

The respondent made it clear that he thought social media was the best form of communication, which made him an exception to the previously identified data. What these respondents have informed is that some students are not interested in engaging with the health promoters, instead, the university can keep the information available on social media platforms for all students to access. However, this may be at risk of facing the same shortfalls as the mass media platforms, where information would be attained but still not engaged with accurately, leading to poor uptake of VMMC. Considering the emphasis on the need to participate in VMMC promotion, this study is doubtful that students would appreciate content merely posted on social media. Perhaps social media can still be used to communicate with the students through webinars that are both live and recorded.

The UKZN has not been inactive concerning adopting HIV prevention policies and communicating them with students using various mediums of communication. The Centre for Rural Health (CHR) is among the policies that the UKZN has been involved in designing VMMC interventions (CHR, 2019). Moreover, the UKZN has also a policy in place to integrate HIV/AIDS education to raise awareness to students irrespective of their study fields (The University of KwaZulu-Natal AIDS Programme, 2005). Furthermore, The UKZN has developed 'The HIV and AIDS Programme and Disability Support Unit' that is directed specifically to disabled students that are infected or may be affected by HIV/AIDS. Additional policies include the SA Voices HIV museum where the students and the staff of UKZN can engage in discussions on HIV for educational purposes. In this initiative there is also a channel

for the participants to listen to recorded inspirational stories from 'HIV Champions'. Among other means to educate the UKZN population, the institution also has information on videos that were filmed by both the UKZN intervention and other organisations.

Structure

Healthcare Services Available to Students

It is important to explore what resources students have at their disposal to uptake when HIV prevention messages have been disseminated, the CCA refers to those as structures. The structure refers to the aspects of a social organisation that "both constrain and enable the capacity of cultural participants to participate in communicative platforms and in utilizing the fundamental resources of mainstream societies" (Acharya and Dutta, 2013: 226). Furthermore, the structure can be understood as constraints or enablers of access to resources (Basu and Dutta, 2009). The availability of necessary structure may impact how the UKZN males apply their agency when are exposed to HIV prevention messages. This is because a poorly organised structure can constrain the ability of students to uptake VMMC despite having decided to (Dutta, 2008).

The literature has specified that the task to protect university students has been done as early as students were admitted into their first-year education as those are rendered as the most vulnerable HIV infection (Mavhandu-Mudzusi *et al*., 2014). Furthermore, as universities acknowledged that HIV does not have a cure, they stressed the importance of educating students and raising awareness (Kunguma *et al*., 2018). The respondents have reported having been learning about HIV from the nurses at the clinic, as well as the health promoters that approach them directly on campus and in their residences. The university targets the students in the spaces they occupy frequently on campus, where they provide healthcare services to the students. The respondent mentioned that the Shepstone foyer is where students can access HTC services. This is a useful resource as tents are set up for students to access the services during the day. Those are temporary services that may be accessed at random times, there is also a campus clinic for those seeking convenient services. Having the resources in place may assist in the fight against the HIV pandemic, as this may increase overall satisfaction and guarantee patient confidentiality among people with people living with HIV (Asghari *et al*., 2018). Another important service provided to UKZN students is condoms which are targeted at spaces frequently accessed by the students, which includes the toilets, residences and on campus.

This section is crucial because it is important that while there are HIV communication strategies at the university, there should be healthcare services that students can access should they decide to uptake. Dutta and Thaker (2016) emphasised the need to acknowledge that the participants should be included in the framing of the communication strategies as their agency is always active.

Lastly, when students go to spaces such as the temporary tents and the campus clinic, they meet with health promoters or nurses who teach them about HIV/AIDS. There are also posters posted at the clinic, including pamphlets that students can access. Given that structures and agency are independent of one another, and the UKZN has the structures in place provides the platform for the possibilities of agency for UKZN students. This means that students can engage with HIV prevention messages that can be disseminated as they access campus healthcare services. Therefore, this study has identified that UKZN did have the structures to allow for VMMC uptake in place and the students were aware of them.

Print and Mass Media Used in Communication

In chapter 2, it was learnt that among communication channels to advance HIV prevention strategies were print media and mass media. Some types of mass media identified were billboard messages, print material and interpersonal recruitment (Govender *et al*., 2013). Furthermore, mass media such as posters, brochures and signs have been applied at South African universities to promote HIV prevention (Dube and Ocholla, 2005). Among the most notable campaigns to promote VMMC in South Africa is the *Brothers for Life* (B4L) campaign which utilised diverse mass media types to promote VMMC.

The one-on-one interviews provided data that demonstrates that mass media remains a part of HIV prevention communication strategies at the University of KwaZulu-Natal. The respondents reported having been exposed to print material that disseminates HIV prevention messages. Sterin and Winston (2017:4) posit that "the mass media of the 21st century are dynamic, complex and all-encompassing". This contrasts with the notion that mass media consist of basic communication platforms that may omit some vital messages. Musaeva (2021) anchored this notion by explaining that because mass media is prevalent it is thus effective in shaping our worldview. Furthermore, the mass media are suitable because they can allow messages to be disseminated to large audiences, and any type of information can be shared (Musaeva, 2021). This means that health messages can also be shared through it, hence, the

HIV prevention messages through pamphlets on campus. One of the respondents identified that people were going around campus and handing out flyers with HIV prevention information to students. The flyers are among the print material used by interventions for communication. The students can read the content about HIV on their own and then apply their agency in deciding whether to uptake services such as HTC or not. Important to note, is that the promoters do not only share posters, flyers and pamphlets with students but also talk about the healthcare services in place. The respondent also mentioned that he had seen pamphlets being handed out to students on campus, these included posters on buildings that students occupy frequently, such as the library. Furthermore, the students know were provided with facilities should they want to uptake HIV prevention services. This means that the structure is in place, therefore, the agency of the individuals would not be hindered should they decide to uptake.

Based on the understanding of agency by Dutta (2018), the mass media however does not override the agency of the audience, the UKZN students can receive and actively engage with the content and thus decide whether to uptake or not. The flyers and pamphlets handed out to students are regarded as structure, however, alone they cannot lead to the uptake of VMMC as they must be related to the agency of the students. Jones and Karsten (2008) posit that structures and agencies are not independent of each other. Therefore, handing out pamphlets is only the beginning of the promotion of VMMC, there must be a follow-up on how the students have engaged with the content.

The notable effectiveness of mass media in reaching large audiences is evident in that even the third-year level respondent had been exposed to people distributing flyers. This means all participants at their various levels had been or had a chance to have been exposed to HIV prevention messages on campus. However, this would not lead to uptake as the students did not resonate with the mass media platforms because they did not allow them to participate in the HIV prevention interventions. Basu and Dutta (2009) identify the participation of the key community as the foundation for applying health communication and developing interpretive frameworks. Dutta and Thaker (2016:7) posit that "the core methodological tool for the CCA is dialogue. Dialogue creates communicative processes, structures, and spaces for gathering input from community members in the development of communication solutions". Therefore, despite the mass media platforms reaching the students, they would succeed in leading to uptake because the students did not engage in a dialogue with the health promoters to voice out their issues and ask relevant questions.

The important aspect to note is that the UKZN has healthcare facilities in place, including the campus clinic. Moreover, the students are aware of the presence of health promoters around campus. However, the students do not prefer to receive messages at those spaces where health promoters set up healthcare facilities. However, they prefer to communicate with the health promoters directly so that they can engage with the messages promoted to them.

The failure of the communication strategies to attain their targets can be traced back to how the communication channels were used. The respondents have voiced that they mostly prefer to be directly approached. However, it seems that UKZN has invested more in mass media approaches. Despite that, the respondents at all levels of education have been exposed to some form of a mass media platform and yet still posit that the UKZN has not done enough to promote VMMC messages may prove that students do not prefer that method. Alternatively, the notion that availability is structure does not guarantee uptake is highlighted in this instance. The students may have not resonated with the print media channel because it does not allow them to participate with the promoters through dialogue (Dutta, 2008).

Discussion of Findings concerning the Research Questions

The first research question purported to explore communication that has already been implemented at the University of KwaZulu-Natal to promote HIV Prevention. The findings of this study included those students who have identified HIV communication strategies through mass media and meeting health promoters face-to-face. The second question aimed to explore the VMMC communication strategies that students have been exposed to at the university. The findings include that many students were not aware of VMMC communication strategies, and the two respondents that have only heard about it in a student life programme for HIV prevention communication where VMMC was mentioned in passing. The other respondent had seen a pamphlet at the campus clinic. The third question aimed to identify the cultural considerations for promoters aiming to disseminate VMMC messages. The findings were that because UKZN students are part of a culture that accepts TMC as another valid means of circumcision, it will remain a hindrance to VMMC uptake. Therefore, VMMC promoters must be sensitive to the culture of UKZN students. The recommendations were that there should be an attempt to integrate VMMC with TMC, the people involved can still practice their customs and traditions but allow medical practitioners to enter their space and medically circumcise the males.

Conclusion

The chapter has discussed the themes that the researcher developed when making meaning of the codes generated from the collected data. Furthermore, the chapter has drawn from the literature ideas and findings to compare with findings from the comments of the respondents in this study. Additionally, the constructs of the CCA namely, culture, agency, structure and voice and dialogue were useful in assessing the ideas and the positioning of respondents within the campus context, and how they relate to the facilities and communication strategies aimed at them. The following chapter will serve to conclude the analysis undertaken in this chapter, including making recommendations for future research based on this topic.

Chapter Seven

Conclusions of the Study

The purpose of this chapter is to summarise and synthesise the analysis of the data concerning the possible communication strategy suitable for UKZN students. This includes uncovering the reasons for the limited uptake of HIV prevention services by students. Thereafter, the chapter discusses the future of VMMC communication strategies at UKZN based on the discussed findings. Furthermore, the chapter discusses how entertainment education could be a possible communication strategy to promote VMMC messages based on the findings of that study. The findings of this study indicated that the communication strategy suitable for VMMC promotion includes peer educators, social media, celebrities, and entertainment education.

Main Findings of the Study

The study sought to explore a possible communication strategy to be used in the future promotion of VMMC to students at the University of KwaZulu-Natal. Among the steps to achieve that, the researcher undertook eight individual semi-structured interviews with students that reside at the university accommodations. The participants were males and were divided into four pairs based on their education levels, with the assumption that a higher level of education meant higher exposure to HIV prevention communication strategies on campus. The study did not make arguments because it undertook an exploratory design, meaning that the findings would emerge organically from the study. Furthermore, the themes developed from the study were assessed with the assistance of the CCA. Hence, the study found that the previous communication strategies did not take the cultures and context of the UKZN into account, which would be a starting to allow for participation where the students would negotiate the meanings of VMMC messages (Basu and Dutta, 2009). It was from this finding that the study concluded that students preferred to be directly approached by the health promoters at both campuses and the student accommodations.

A total of six out of the eight participants recommended that the communication process should be held physically, as opposed to the use of mediums such as mass media, or social media as the other two participants suggested. The suggestion to utilise peer educators is consistent with findings from a study done by Rashmi (2013) where it was found that peer advocacy is one of the key instruments in encouraging students to undergo HTC. Further confirmed by findings from a study by Mazibuko (2019) where the respondents considered peer educators as role models and were positively influenced by them which emphasised the importance of peer educators in the fight against HIV/AIDS. Noteworthy, whether the peer educators have been

updated about the students' requirements such as direct approaching is identified as a gap in the research done at UKZN since 2009.

The participants voiced out that despite having been exposed to print media platforms such as flyers, pamphlets and posters being posted on the campus clinic and the library did not resonate with them because they either lacked the interest to read them or because they did not allow them to engage with the health promoters to discuss the content and raise queries. The researcher foresees that depending on how the information is portrayed on social media, such that the platform might run into the same issues as the mass media platforms. Notwithstanding that social media comes in various forms and therefore some can allow for more participation than others. Therefore, a communication strategy that would be identified to be more useful in communicating with the students physically, an attempt to mimic it as much as possible would be necessary when taken to social media. At least two of the respondents recommended social media as another medium to disseminate VMMC messages. A study done by Segopolo (2014) found that HIV prevention messages can also be disseminated through technological means such as social media platforms. Moreover, Okelola (2019) also found in a study to explore the uptake of HTC among students, that social networks such as Facebook, Twitter and Instagram were prominently used by students at UKZN and were therefore possible mediums to promote UTT. This was consistent with the recommendation from the study by Nkosi (2019) to explore the implementation of the UTT strategy by health promoters at UKZN, that the health promoters are encouraged to utilise communication channels that depicted viewership or readership.

In the analysis chapter, it was revealed that culture was largely underappreciated when concerning understanding a communication strategy suitable for UKZN students. The students displayed signs of misunderstanding how TMC is largely influenced by culture rather than the desire to circumcise. Thus, they suggested the inclusion of VMMC facilities and procedures into the TMC process to minimise the risks that the males may be faced. However, this study has noted that when it comes to TMC, going through hardships was part of the ritual. The cultural motivation for TMC was that the boys were transitioning to manhood, therefore, they had to endure those painful circumstances to strengthen them. The relevance of this analysis is emphasised when compared to how the VMMC promotion strategies were culturally insensitive towards the UKZN students. Like the students that recommended the integration of VMMC and TMC, the VMMC promoters took the cultural context of the students for granted when they handed out pamphlets and flyers without engaging them. In practice, the students

should be involved all parts of the process, from the design, implementation and evaluation of the VMMC promotion process (Basu and Dutta, 2009).

Involving the students in the process gives them a voice to participate, the alternative is to marginalise the students as it had transpired with the previous VMMC communication strategies. The health promoters listen to the voices of the students to challenge the monolithic understanding of health where VMMC is strictly understood in biomedical terms (Yehya and Dutta, 2010). When the students are allowed to be part of the communication, they may offer more insights as to the reasons they held certain perfections and engaged in certain behaviours that are counterproductive to the HIV prevention strategies. However, if they feel marginalised, they resort to resisting the information being directed to them (Koenig *et al*., 2012). In a study to explore the knowledge, attitudes and practices of [medical] male circumcision among VCT clients in a Namibian hospital, it was found that culture was influential in the decision whether to uptake VMMC or TMC by males, which resulted in the recommendation to integrate the two procedures to increase the acceptability of VMMC (Ngodji, 2010).

The students had engaged in risky sexual behaviour because of substance abuse and the influence of peer pressure, respectively. The participants thought that among the reasons that the students engaged in such behaviour was that the students lacked comprehensive knowledge about HIV prevention. However, data from previous studies mentioned in this study as well as the data collected by this study is in contrast with those claims. The respondents at all levels of education had been noted to have at least been exposed to some the of HIV prevention strategies, and thus it is conclusive that they do have some knowledge of how to stay protected from HIV infections. Furthermore, the students were aware of the health promoters handing out pamphlets around campus as well as the availability of condoms in spots that they occupy frequently. Additionally, the respondents had confirmed the existence of structures to allow for HIV prevention services uptake feasible on campus, these include the campus clinic. Notwithstanding that the respondents had mentioned that sometimes they engaged in risky-sexual behaviour because when under the influence of substances, they are not rational enough to be responsible, this study pins down the reason for poor uptake of VMMC on their agency.

As it had been noted that the students were excluded from participating in the communication process, there might be a form of resistance. It is through engaging with the students that the health promoters would identify reasons that students engaged in risky sexual behaviour despite being in a space with enabling structures (Mulwo *et al*., 2009; Dutta, 2011).

Furthermore, agency and structures are dependent on each other and therefore the students maintain their agency during health communication, and it is through the agency that they resist communication strategies that ignore their cultural context (Dutta, 2008; Koenig *et al*., 2012). Furthermore, addicts being an exception, the students use substances knowing the possible undesirable results, However, they still use them and end up engaging in risky sexual behaviours (Chawla and Sarkar, 2019). Furthermore, the students may engage in unprotected sex because they believe it is more pleasurable, but as pointed out by some of the senior-level respondents, this is irresponsible as the students understand the risks (Chawla and Sarkar, 2019). The evidence is that one of them even recommended that condoms be replaced with other interventions such as Oral PrEP, and this was a third-year level student that had only been on campus for one year before the Covid-19 pandemic. In a study to assess knowledge and practice towards risky-sexual behaviour by adolescents, it was found that despite the adolescents knowing about it, they still practiced unsafe sex (Keto *et al*., 2020). Again, the agency is seen taking control, but in an undesirable way about the overall HIV prevention targets. A study done by Ndabarora (2009) at UKZN revealed that students engaged in risky sex despite knowing HIV prevention. Furthermore, in line with the findings from a study done by Nene (2014) where it was found that students perceived themselves to be at low risk of HIV/AIDS as opposed to the risk of pregnancy. Hence, in a study to explore risky sexual behaviours among UKZN students, it was recommended that more research was required to be conducted so that relevant interventions can create coordinated efforts towards addressing the risky sexual behaviour of students (Mthembu, 2017).

In addition, what the students have recommended is the use of popular individuals as the faces of VMMC promotion strategies. The nominees that had met the criteria included individuals that students respected around campus such as the nurses at the clinic. The nurses are already available at the clinics, however, it the recommended that they are used health promoters that would approach them. This may also be noted as a resistance that displays that despite being able to access the clinic, the space is not conducive for an engaging conversation with the nurses. However, when the nurses take the role of a 'peer educator' as the respondent has phrased, the students would be more comfortable engaging in a dialogue and asking relevant questions. This is important as it is revealed that it is not only about the message, but also the person communicating, they should be appropriate (Keil, 2005). Furthermore, another respondent recommended that celebrities would attract the attention of the students as they are willing to sacrifice their busy schedules to be entertained by their favourite celebrities. The

respondent that the VMMC messages would be incorporated into the entertainment package. The study notes that this is not something new in VMMC promotion, *Brothers for Life* had used such a strategy on several occasions and were successful in their merit. In a study done by Mulwo (2008) to examine how students from UKZN, UniZulu and DUT make sense of the cultural meanings offered by HIV prevention messages, it was found that mass media programmes that incorporated entertainment into their content, especially television, were more effective in HIV prevention promotion. This was consistent with the findings from the study by Okelola (2019) where it was found that incorporating entertainment into interventions increased the chances of eliminating popular misconceptions about HIV prevention and transmission among university students.

The recommendation to use popular individuals and celebrities as educators brings forth the issue of the effectiveness of role-modelling in health promotion. Modelling can persuade community members by altering their perceptions towards a health issue, especially by enhancing their beliefs in self-efficacy (Galavoti *et al*., 2001). Despite the acknowledgement that the study was not done in a large community-based randomized trial, a study on using professional African soccer players as role models to influence learning in students, it was found that the students in the intervention demonstrated a higher increase in knowledge and attitudes even after five months after the study (Clark *et al*., 2006). However, identifying the strengths of role modelling alone is not sufficient as there are other factors to be addressed for its success. This arises from the critique of role modelling that behaviour learned from role modelling does not happen immediately despite being reinforced, if it is not culturally appropriate to the community members as uptake occurs gradually (Corby *et al*., 1996).

Among the issues, it brings into scrutiny is the appropriateness of the use of individuals that are not from the targeted community members. For instance, Corby *et al*. (1996:56) posit that "the appropriate role model is an individual from the priority population who has made some change in a positive direction on a specific behaviour to be modelled”. From this suggestion, the appropriate role model must be from Howard College males and must have been involved in VMMC. Furthermore, Berkley-Patton *et al*., (2009) added that role modelling depended on singing community-based participatory research practices to fully represent the targeted community. Additionally, it is not only the models that must have been involved with the community, but the community members must be involved in the development of the intervention to achieve cultural appropriateness (Corby *et al*., 1996). Therefore, future VMMC promotion strategies that intend to use popular individuals and celebrities must consider

recruiting them from the previous Howard College Campus males that have undergone VMMC and involve the males in the development of those interventions. The suggestion by the respondents to use role models for HIV prevention is consistent with findings from a study done by Satande (2008) to explore the use of peer education in the promotion of HIV/AIDS awareness where it was found that the respondents responded better to role models that shared the background, age and language. Thus, confirming the significance of having a role model that identifies with the community members.

Based on the findings of this study, the communication strategy required by the UKZN students must engage them. The students desire to be part of the process to have a voice as they engage in a dialogue with the health promoters. It is through participation that their voices would be dialogic and thus activate their agency (Dutta, 2008). Furthermore, the students prefer health promoters that they could relate with so that they would be comfortable to engage freely. Age is not a contributing factor in this regard as the respondents only referred to nurses changing their roles from that of a dominant source of knowledge to a peer educator that students can challenge with questions and comments. It is concluded that the issues are rather the role and location of the educator.

Recommendations for Future Research

The respondents were consistent in that they were interested in being directly approached by the health promoters that would teach them about HIV prevention. Furthermore, it was found that the students were resistant to the previous communication strategies as they were not culturally sensitive and thus marginalised them. A gap in the literature was identified regarding the feedback to the peer educators, therefore, future research could delve into exploring how the peer educators have received the feedback from the students and what has been done since. Furthermore, the issue also points to the use of celebrities as VMMC promoters, more research could be done in this regard especially exploring whether they can be culturally sensitive to university students.

Another possible research that would be useful is undertaking similar studies in the other four UKZN campuses as this one is based on Howard College Campus and therefore limited to a small percentage of male students. That would shed light on whether the UKZN students share the same culture across all the campuses, and thus identify if they would prefer to be directly approached by health promoters as well.

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