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Effectiveness of medical male circumcision communication differentiation for HIV prevention in gay men

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Abstract

Voluntary Medical Male Circumcision (VMMC) is currently being implemented in South Africa as a prevention mechanism for HIV infection. Scientifically, research has shown that circumcision decreases the rate of heterosexual vagina-to-penis HIV infection. It has not been proven to provide the same effect in anal sex. This limitation has implications for gay men who engage in anal sex. This limitation is not communicated through current media and can place gay men at risk of believing that circumcision may prevent HIV infection via anal sex. This may lead to increased HIV infections in that population. Using a qualitative research strategy and semi-structured interviews, gay men's perceptions and understandings of VMMC revealed that VMMC media can be misinterpreted and that the anal sex limitation is not present in communication messaging. VMMC policy implementers were interviewed and results revealed that gay men are not considered in VMMC policy. Recommendations from this study include proper policy analysis with the inclusion of consideration of gay men in VMMC policy, so that policy evaluation can include the detection of unintended outcomes on the gay population, such as the increase of HIV infections due to misinterpretation of policy communication.

Declaration

I confirm that this report is my own unaided work. I have followed the required conventions in referencing the thoughts and ideas of others. I am aware that the correct method for referencing material and a discussion on what plagiarism is are explained in the P&DM Style Guide and these issues have been discussed in class during Orientation.

I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong. I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to correctly acknowledge the source of the ideas or words in my writing.

I confirm that this research has not been submitted before for any degree or examination in this or any other University.

Signed: _____

Deon Poovan

Date: _____

Dedication

To God, for His glory!

Acknowledgements

I am grateful to my supervisor, Mr Murray Cairns, for his guidance and encouragement during the research process; my parents, Morgan and Thomalene Poovan, for instilling in me the qualities which have brought me this far; my partner, James Middleton, for supporting me through this process; the Faculty of Commerce, Law and Management, especially faculty staff and lecturers.

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List of Abbreviations

HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IMF	International Monetary Fund
MSM	Men who have sex with men
NGO	Non-governmental Organisation
PEPFAR	United States President's Emergency Plan for AIDS Relief
RCT	Randomised Controlled Trial
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
US	United States (of America)
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation

Chapter 1: Introduction

The purpose of this study was to understand the communication aspects of the Voluntary Medical Male Circumcision (VMMC) policy in South Africa as they relate to gay men. By doing so, the study highlights any potential gaps that need to be filled in order to ensure that gay men are aware of the limitations of VMMC, with the potential of preventing gay men from undergoing a procedure that has not been proven to be effective in HIV prevention in their cohort and providing a false sense of security that could lead to increased HIV infections. The research is positioned and explored within the context of policy implementation and communication.

In 2012, an estimated 35.3 million people, globally, were living with HIV, with 2.3 million new infections occurring on an annual basis (UNAIDS, 2013), the majority which occur during sex (homosexual and heterosexual), sharing of drug needles and mother-to-child transmission (Singh & Chhikara, 2014).

HIV infections are spread across the world and the levels of infection differ by continent and by country. Africa is the most affected continent in the world and reasons for this has been attributed to economic conditions and education. The differing levels between countries have been attributed to differences in policies, HIV awareness and resources for medical care. In sub-Saharan Africa (SSA), almost 1 in every 20 adults (4.9%) is infected with HIV (Singh & Chhikara, 2014, p. 17) and the number of people living with HIV equals 69% of all people living with HIV in the world. Within SSA, South Africa has approximately 5.6 million (2011 estimates) infected people, the highest number of people living with HIV in one country (Singh & Chhikara, 2014).

Currently, there is no cure for HIV. The fight against HIV has provided challenges to the medical world from a prevention and treatment perspective. Anti-retroviral (ARV) drugs are used for treatment and their mechanisms of action results in a decrease in the viral load of HIV infected persons. ARVs have increased the life expectancy of HIV infected people but there is no drug that cures HIV. Research efforts have seen more ARV molecules being brought through the drug pipeline, as well as adding to the development of HIV infection prevention methods.

HIV prevention strategies include education, free distribution of male and female condoms and ARV therapy to reduce the potential of HIV positive people transferring the virus (Hontelez *et al*., 2013). In SSA, the annual new infections dropped from 2.4 million in 2001 to 1.8 million in 2011. Despite this drop, SSA accounted for 71% of all new infections globally in 2011 due to a lack of preventative efforts and facilities for medical care. Increased attention to prevention tools are therefore necessary to combat the HIV pandemic's disproportionate impact to the region. (Singh & Chhikara, 2014)

Globally, the rates of HIV infection in men who have sex with men (MSM) have been reported as either being stable or increasing across all income brackets. Of particular concern is the rate of infection in the younger generation of MSM (Beyrer, 2014). The efforts to reduce infections for MSM are not sufficient. Across the globe, MSM lack the basics of HIV prevention tools such as condoms and water-based lubricants and do not receive enough HIV education and risk reduction support. In SSA, international funding for MSM HIV support is less than domestic funding (UNAIDS, 2013) which should be seen in the light of broad homophobia and policy stigmatisation of MSM (Moisan, 2014; Senzee, 2014). In South Africa, where the rights of MSM are protected by the Constitution, there is a recognition of the need to address the HIV infection rate in the MSM population but acknowledgment that not enough has been done to adequately address it. (Republic of South Africa, 2012).

Transmission of HIV between MSMs is a major contributor to HIV infections in South Africa (UNAIDS, 2013). Despite the evidence that VMMC is not meant for certain populations such as MSMs, South Africa, like other SSA countries, have been implementing and creating demand for circumcision based on the assumption that the HIV epidemic is based on one sexuality (Bell, 2014). In the light of this, research and analysis is necessary to determine the impacts of new HIV strategies on the MSM population.

VMMC was identified by the South African Government as an HIV prevention strategy in its National Strategic Plan on HIV, STIs and TB, 2012-2016 (SANAC, 2011). Other SSA countries that have also implemented VMMC as a health policy include Kenya,

Zimbabwe, Tanzania, Swaziland and Uganda. By the end of 2012, the estimated number of African men circumcised totalled 3.2 million (UNAIDS, 2013).

This study was conducted to determine whether the current implementation and communication of VMMC in South Africa was providing gay men with appropriate messages about the benefits and limitations of the procedure. Such a study has not previously been conducted in South Africa. Circumcision has been proven to reduce the chances of HIV infection from female to male vaginal intercourse by 60% but has not been proven to provide this reduction in anal sex, the mode of sexual intercourse that is prevalent in gay male sexual interactions. If gay men are not provided with this information, it may lead to misinterpretation and could lead to gay men increasing risky sexual behaviours under false perceptions of lowered sexual risk, which could lead to increased HIV infections in that population.

This study has shown that there is potential for gay men to misinterpret the mass media that is currently being broadcast to advertise VMMC. This study has also gathered data from policy implementers that shows that gay men and other MSM were not considered in the policy at various stages of the policy cycle. Data was collected qualitatively to allow the subjects of interviews to give their perceptions and to allow any new perspectives to be collected and noted, outside of the identified expected themes derived from the literature review. Conducting this research in the context of the policy cycle allowed findings to be documented in line with various stages of the policy cycle. Recommendations that arise from this research include proper analysis of the policy cycle, to enable the content, formulation, implementation, monitoring and evaluation of the VMMC policy to consider gay men as an unintended population of VMMC, thus preventing any communication misinterpretations that could lead to increased HIV infections in the gay population.

1.1 Background to the Study

The drive for circumcision for HIV prevention in South Africa is a response to the outcomes of three randomised controlled trials (RCTs) that involved HIV-negative heterosexual (self-reported) men in three African countries viz. South Africa, Kenya and

Uganda. The reduction in HIV incidence measured in the South African study was 60%. In Kenya, the reduction was 53% and in Uganda the reduction was 51% (Auvert *et al*., 2005; Bailey *et al*., 2007; Gray *et al*., 2007). The RCTs were conducted to test hypotheses drawn from previous studies that observed that non-circumcising areas in Africa had high HIV prevalence (Moses *et al*., 1990) when compared with circumcising areas. The relationship between HIV and circumcision demonstrated in the RCTs was consistent with the observational studies. The effect of circumcision in the RCT trials was described as that of a "high efficacy" vaccine (Auvert *et al*., 2005). However, the protective effect is limited as circumcision does not provide total protection from acquiring HIV. It lowers the chances of infection (Williams *et al*., 2006).

Following the RCT trials, the World Health Organisation (WHO) conducted a technical consultation. The resulting document contained policy considerations for the implementation of VMMC as a public health policy (WHO/UNAIDS, 2007). As early as 2008, South Africa has embarked on a drive for VMMC as part of its HIV management programme, as specified in the National Strategic Plan on HIV, STIs and TB, 2012-2016 (SANAC, 2011). One of the first VMMC sites is the Bophelo Pele Project in Orange Farm, Gauteng (Lissouba *et al*., 2010).

As a measure to prevent HIV viral transmission, circumcision's efficacy is dependent on sexual practice. Therefore, the findings of the three African RCTs, which showed efficacy for vaginal but did not test for anal intercourse, cannot be inferred onto the gay male population.

Studies have been conducted to determine if circumcision has the same HIV infection reduction effect in men who have sex with men (MSM) (Weiss *et al*., 2008). These observational studies do not provide evidence of the same protective effect in homosexual anal sex as demonstrated in heterosexual vaginal sex. Therefore, implementation of VMMC for MSM is not substantiated. As per WHO (2007) recommendations, communication strategies for VMMC should provide clear messages to the public particularly that circumcision does not lower risk of HIV infection in both heterosexual and homosexual anal sex. In the light of this, communication regarding

VMMC should clearly state that it has not been demonstrated to have the same protective effect in anal sex (WHO/UNAIDS, 2007).

1.2 Research Problem, Purpose and Questions

1.2.1 Research Problem Statement

Scientifically, research has shown that circumcision decreases the rate of heterosexual vagina-to-penis HIV infection. It has not been proven that circumcision for HIV prevention is as effective for MSMs/gay men as it has been demonstrated for heterosexual men. This limitation is not communicated through current mass media and can place gay men at risk of believing that circumcision may prevent HIV infection via anal sex. The voluntary male circumcision policy is being implemented within a South African context where homosexual sex is legal but is not socially acceptable to large proportions of the population. Being in the South African context, where MSM's may not admit to having sex with men, proper communication of the limitations of circumcision for HIV prevention is imperative. It is not known whether MSMs fully comprehend that circumcision is unproven as a measure of protection against HIV infection in anal sex. Exploring gay men's perceptions and understandings of VMMC with the current policy communication in the country will reveal whether the policy is communicated effectively to show the limitations of VMMC for this group of men. Such a study is currently not documented in South Africa. Findings of this study may assist in closing any potential gaps in this health policy communication strategy and prevent gay men from undergoing a procedure that provides false security. Closing these gaps could prevent increased HIV infections in the gay men community who are not the targets for current VMMC policy.

1.2.2 Research Purpose Statement

The purpose of the research is to explore the space where scientific knowledge becomes public policy and is communicated to a particular public audience to invoke a change. In this research, the implementation and communication of the circumcision for HIV prevention policy will be explored to determine how policy implementers view their gay audience, what clinics communicate to men about the limitations of circumcision for

HIV prevention and what gay men perceive about this procedure and its limitations or advantages.

1.2.3 Research Questions

Main Research Question:

Does the communication of the policy for circumcision for HIV prevention take the gay population into account in terms of the messages it intends to send, the limitations of VMMC and the population it intends to target?

Sub-Questions:

1. What are the perceptions of gay men regarding circumcision and circumcision for HIV prevention?
2. What information do circumcision clinics provide to men who undergo the procedure?
3. What are the perceptions of the policy implementers regarding circumcision policy communication to non-targeted populations?

Chapter 2: Literature Review

The literature review is discussed from a policy perspective. Policy cycle theory is summarised to provide an understanding of how the literature is discussed in this review. The literature debates that form the current dialogue around VMMC policy is discussed to highlight issues that affect both heterosexual and homosexual men, such as circumcision acceptability and risk compensation. Thereafter, the reviewed literature demonstrates that scientific data about VMMC efficacy in the MSM population needs to be considered in VMMC policy implementation and public health communication strategies.

The literature consists mainly of published journal articles sourced electronically using Google Scholar. Access to the electronic journals was provided by the University of the Witwatersrand. The initial search string used was “perceptions of men of circumcision for HIV prevention”. Article reference sections were scrutinised for further applicable articles. Searches for the articles found in the reference sections were searched for by author and article name using Google Scholar. The second search string used was “perceptions of gay men of circumcision for HIV prevention”. The downloaded articles were also reviewed for further applicable articles listed in the reference sections and searches for these articles were conducted using the author’s name and article name in Google Scholar. The literature also consists of policy theory extracted from textbooks. Theory on public health communication was sourced via Sara Nieuwoudt of the University of the Witwatersrand School of Public Health during a meeting held to discuss Social and Behavioural Change Communication.

2.1 The Public Policy Cycle

The policy process consists of seven common phases: (1) Policy initiation (2) Policy Design (3) Policy Analysis (4) Policy Formulation (5) Political Mandate (6) Policy

Implementation (7) Policy Monitoring and Evaluation. The policy process is cyclical (Kaul, 1997).

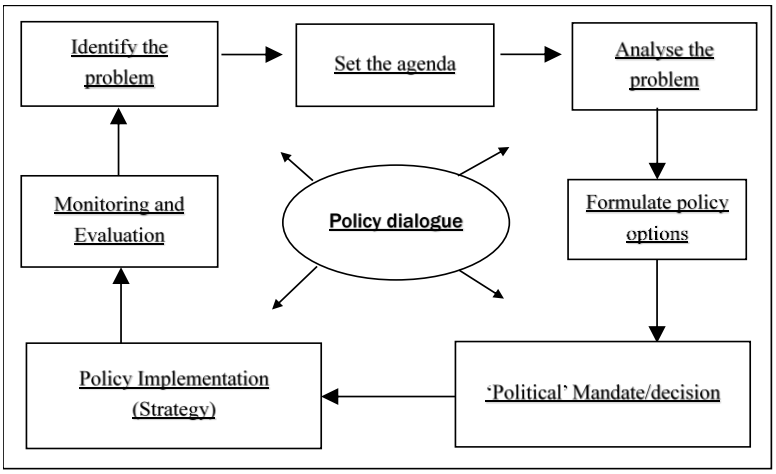


Figure 1 Typical policy cycle or process- Adapted from Kaul (1997, p. 7)

The importance of demonstrating this cycle is to provide a roadmap which guides the literature discussions and arguments. It provides contextual significance to the literature and assists in understanding why certain literature exists and how this literature ties in with the policy cycle itself. Using the cycle adapted from Kaul (1997), the "roadmap" for this literature review takes the form in Figure 2.

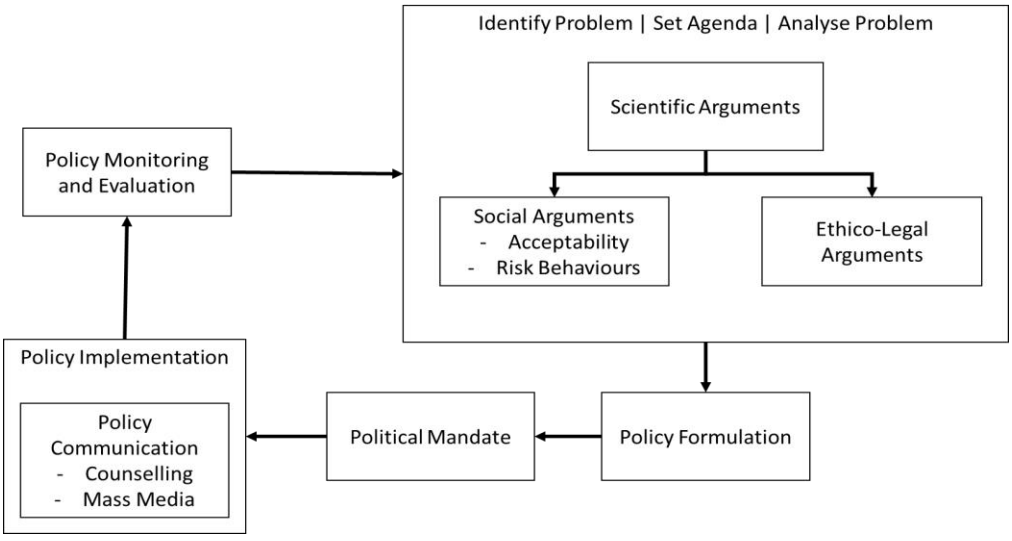


Figure 2 Setting of literature within the policy cycle for VMMC

HIV prevention through circumcision was scientifically demonstrated through three RCTs (Auvert *et al.*, 2005; Bailey *et al.*, 2007; Gray *et al.*, 2007). Circumcision is a surgical procedure, but implementing it as a public policy has social and legal implications (Fox & Thomson, 2012). To translate the science into policy, the impact of the scientific data was subjected to analysis within the literature and this analysis took place within the operational, legal, ethical and social realms. Literature demonstrating the arguments within the legal, ethical and social spaces have been reviewed for this study. In keeping with the policy cycle, policy is formulated and implemented after policy analysis. Thereafter, monitoring and evaluation takes place and the outcomes of the evaluation exercises are fed back into the policy cycle for analysis. Literature for these stages in the VMMC policy cycle have been reviewed.

This literature review provides an overview of how the arguments for VMMC have supported the implementation of it as a policy within the African and South African contexts. This review also demonstrates that scientific data regarding MSMs has not been fed into the South African VMMC policy cycle after evaluation. It will show that the failure to include this information has an impact on the policy communication aspect of policy implementation and may be misinforming gay men, a population group that VMMC is not intended for.

2.2 Identify Problem, Set Agenda, Analyse Problem

2.2.1 Scientific Arguments

The scientific argument for the mechanism of HIV infection through the penis is supported by the description of the type of cells found on the penis and how they interact with the HIV virus.

The point of entry for the HIV virus on the human penis is through the Langerhans cells found on the inner foreskin. The rest of the penis is protected by the keratinised stratified squamous epithelium, which includes the outer surface of the foreskin. This epithelium does not have receptors that allow the HIV virus to enter. The inner foreskin does not have this type of epithelium and it is rich in Langerhans cells. During sex, the inner foreskin is exposed to secretions that contain HIV viruses in HIV infected persons,

which allows the virus to potentially enter through the foreskin's Langerhans cells. (Szabo & Short, 2000)

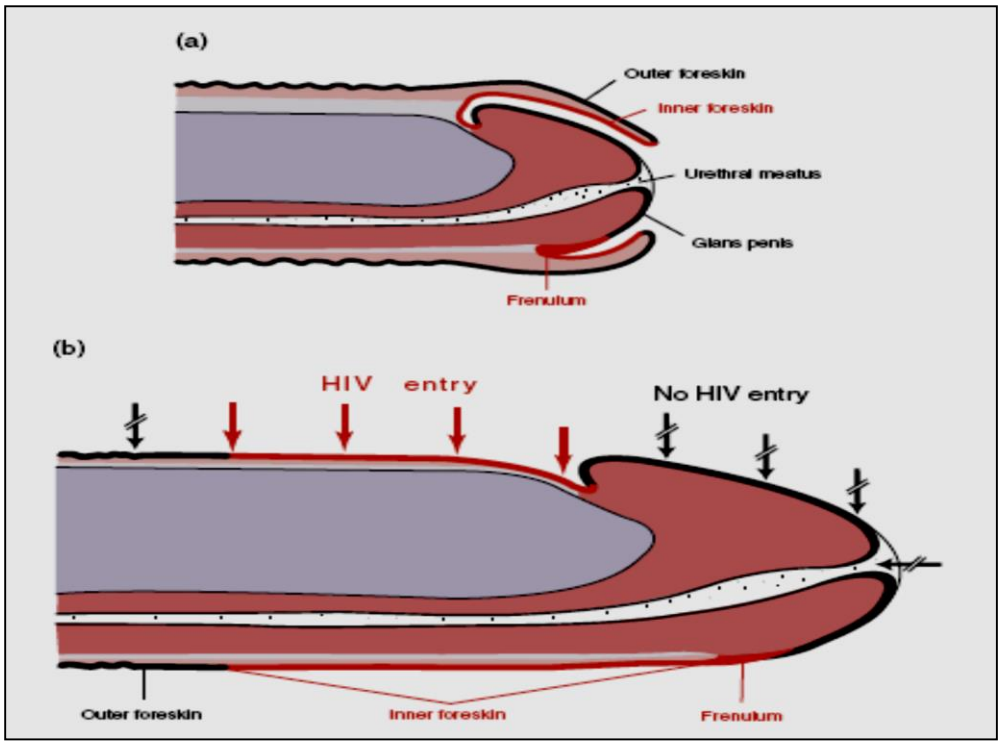


Figure 3 HIV entry points on an uncircumcised penis (McCoombe & Short, 2006)

By removing the foreskin, there is a reduction in the number of entry points for the HIV virus through the penis, and by deduction, removing the foreskin will reduce the chances of HIV infection (Szabo & Short, 2000).

The efficacy of circumcision as an HIV avoidance mechanism depends on a range of factors including the state of the male's penis (and any STIs), culture and safety of sexual practices.

The removal of foreskin may reduce the number of Langerhans cells but the action of removing the foreskin may introduce a scar that Hill and Denniston (2003) deem as problematic. The scar may cause scraping of the vaginal wall which may increase the risk of HIV infection (Hill & Denniston, 2003)

The transmission of HIV is related to sexual practices which may be related to cultural settings or religion (Siegfried *et al.*, 2003). An example of a sexual practice that increases risk of HIV transmission is "dry sex". This sexual practice makes the penis

skin vulnerable and more prone to HIV Infection (Gwandure, 2011). “Dry sex” may render the protective effect of circumcision useless.

The wound that is created by foreskin removal is the most risk-prone area for HIV infection during the six weeks of post-circumcision recovery. Early resumption of post-circumcision sex increases the prevalence of HIV infection in men from women (Wamai *et al.*, 2012). A study conducted in Westonaria found that 4.7% of participants had sex within the healing period (Lagarde *et al.,* 2003) therefore sex within the recovery period is a concern.

Despite the scientific arguments for and against circumcision for HIV prevention, the most compelling scientific argument, and the reason for the widespread support of VMMC, was the results of the three RCTs conducted in Africa (Auvert *et al.*, 2005; Bailey *et al.*, 2007; Gray *et al.*, 2007). As a result of this scientific data, the World Health Organisation endorsed the implementation of VMMC as an HIV prevention strategy (WHO/UNAIDS, 2007).

2.2.2 Social Arguments

The introduction of scientific knowledge of HIV prevention via circumcision into the policy sphere generated discourse in other disciplines. The literature was in some instances a reminder of pre-VMMC discussions around circumcision, especially legal and ethical arguments. In other instances, it was new information that was generated out of the social impacts that VMMC has. The social impact literature centers on acceptability of circumcision and increased risk behaviours[1].

2.2.2.1 Acceptability of Circumcision

The mechanism of HIV prevention by circumcision is scientifically understood, but the procedure has a social impact. Acceptability studies were conducted in African non-circumcising communities to understand and anticipate the level of VMMC acceptability.

[1] Increased risk behaviour occurs as a result of risk compensation due to the introduction of an intervention that reduces risk. The increased risk behaviour nullifies the intervention (van Howe & Storms, 2011)

The acceptability studies performed in African communities revealed both advantages and disadvantages of circumcision. Advantages of circumcision were perceived as increased hygiene (Bailey *et al.*, 2002; Lukobo & Bailey, 2007; Ngalande *et al.*, 2006; Rain-Taljaard *et al.*, 2003; Scott, Weiss, & Viljoen, 2005), decreased risk of STI infection (Lagarde *et al*, 2003; Lukobo & Bailey, 2007; Ngalande *et al.*, 2006), perceived increase in sexual pleasure (Ngalande *et al.*, 2006; Rain-Taljaard *et al.*, 2003), decreased risk of HIV infection (Bailey *et al.*, 2002) and full protection from HIV infection (Bailey *et al.*, 2002). Barriers to circumcision were perceived as culture (Bailey *et al.*, 2002; Lukobo & Bailey, 2007; Scott *et al.*, 2005), pain (Bailey *et al.*, 2002; Lukobo & Bailey, 2007; Ngalande *et al.*, 2006; Rain-Taljaard *et al.*, 2003), bleeding (Bailey *et al.*, 2002; Ngalande *et al.*, 2006), cost (Bailey *et al.*, 2002; Ngalande *et al.*, 2006), increased risk of infection (Ngalande *et al.*, 2006; Scott *et al.*, 2005), death (Scott *et al.*, 2005) and religion (Ngalande *et al.*, 2006)

The following sections will discuss specific areas within the acceptability literature viz culture, sexual pleasure, partner acceptability, pain and perceived reduction in HIV and STI infection

2.2.2.1.1 Circumcision Acceptability and Culture

Circumcision practices are part of tradition and culture in the African setting. Culture in a traditionally non-circumcising community was identified as a barrier to accepting circumcision (Bailey *et al.*, 2002; Lukobo & Bailey, 2007; Scott *et al.*, 2005). Men from non-circumcising communities who get circumcised may face sexual rejection from female partners. They may also lose cultural identity by being circumcised. For example, women in the Lou tribe of Kenya may reject men that are circumcised, as circumcision is not part of Lou culture. The Lou tribe culturally identify themselves from other tribes in Kenya by their circumcision status (Bailey *et al.*, 2002). The Zulu culture distinguishes itself from the Xhosa through circumcision traditions. Zulu acceptability study participants objected to circumcision as it is identified with Xhosa culture (Scott *et al.*, 2005; Sithole *et al.*, 2009). Societal integration is affected by cultural nonadherence. Fear of family stigmatisation in non-circumcising communities was expressed by

participants in a Zambian study (Lukobo & Bailey, 2007). Even religion, as a culture aspect, was a concern of Malawian study participants, where they felt that circumcision would be against Christianity (Ngalande *et al.*, 2006).

2.2.2.1.2 Circumcision Acceptability and Sexual Pleasure

The acceptability of circumcision by uncircumcised men depends on their perceptions of its effect on sex (Kigozi *et al., 2007)*. This section discusses inputs on sexual pleasure impact from both international and African-based sources.

International literature on post-circumcision sexual pleasure has captured the dissatisfaction of circumcised men and the science behind it. Circumcision can lead to a decreased pleasure in masturbation and sex (Eaton & Kalichman, 2009; Kim & Pang, 2007). Boyle *et al.* (2002) attribute this sexual pleasure decrease to the loss of the foreskin, which is rich in nerve endings. Uncircumcised men's penises are more sexually sensitive and this leads to uncircumcised men being more satisfied with sexual performance than circumcised men. Circumcised men may experience functional problems including issues of intimacy, loss of glans sensitivity and the need for more stimulation to achieve ejaculation (Boyle *et al.*, 2002). The international literature paints a negative picture of the influence of circumcision on sexual pleasure and performance.

The literature on African acceptability studies is inconclusive on perceived sexual function and pleasure impacts. The foreskin may tear during sex so being uncircumcised may be a hindrance to sexual pleasure (Bailey *et al.*, 2002). There are beliefs that circumcision can increase sexual performance. Focus groups in Zambia believed that the heightened sexual pleasure afforded by circumcision would cause men to want more sex (Lukobo & Bailey, 2007). Indifference to circumcision status was noted by Kigozi *et al.* (2007) who found that found that circumcision has no effect on sexual satisfaction or function in men, before and after the procedure. (Kigozi *et al.*, 2007)

When analysing the responses of participants in African studies as beliefs, experiences and intention, the impact of circumcision on sexual pleasure is not consistent. Clinical

evidence demonstrates a decreased sexual satisfaction in international literature, but the African acceptability studies show a mostly positive perception of circumcision impact on sexual pleasure.

2.2.2.1.3 Circumcision Acceptability by Partners

Partner perception of circumcision plays a role in circumcision acceptability. Penis hygiene was a major factor in female perceptions in reviewed acceptability studies. Kenyan female participants perceived the dry glans of a circumcised penis to be more hygienic. They also indicated that circumcision would prevent a foul smell caused by smegma, a secretion that collects under unwashed foreskins (Bailey *et al.*, 2002). Malawian females felt that circumcision would alleviate concerns about hygiene and foreskin washing (Ngalande *et al.*, 2006).

From a sexual intercourse perspective, females in the acceptability studies mostly preferred circumcised men. South African female participants felt that circumcised men are better sexual partners (Rain-Taljaard *et al.*, 2003) and Malawian female participants felt that the removal of the foreskin would decrease the penis length, thereby preventing cervix contact which could lead to painful intercourse (Ngalande *et al.*, 2006). Because of female preference for circumcision, Malawian men felt peer pressure to circumcise as it would attract more women, as they believed that women felt that sex is better with a circumcised man (Ngalande *et al.*, 2006). Not all female participants in the reviewed studies found that sexual performance was more enhanced. Zambian females felt that there was no difference between a circumcised and uncircumcised man’s performance (Lukobo & Bailey, 2007).

The literature has shown that partner acceptability is influenced by hygiene and sexual performance. Circumcision status can be used to attract sexual partners depending on what they find acceptable. The literature shows that females mostly prefer a circumcised male.

2.2.2.1.4 Circumcision Acceptability and Pain

Pain was seen as a barrier in five of the reviewed acceptability studies (Bailey *et al.*, 2002; Lukobo & Bailey, 2007; Ngalande *et al.*, 2006; Rain-Taljaard *et al.*, 2003). South Africans perceived that the older the person, the more pain they experience post-circumcision (Rain-Taljaard *et al.*, 2003). Pain during erections after circumcision was a concern for Kenyans (Bailey *et al.*, 2002). Kigozi *et al.* (2008) found that the dry state of the glans could be a factor that leads to pain or discomfort in circumcised men (Kigozi *et al.*, 2008).

2.2.2.1.5 Circumcision Acceptability and perceived reductions in HIV and STI's

The acceptability of circumcision was shown to be related to the perceived reduction of risk of infection of HIV and/or STIs. Men may or may not want to be included in a circumcision programme if it only provides partial protection (Eaton & Kalichman, 2009), however, the majority of the men in two Gauteng studies showed interest in circumcision if it reduced STIs (Lagarde *et al.*, 2003; Rain-Taljaard *et al.*, 2003) and HIV infection (Rain-Taljaard *et al.*, 2003). In Kwa-Zulu Natal some male participants felt that HIV infection can occur whether the penis is circumcised or not. Others believed that circumcision would protect them completely against HIV infection (Scott *et al.*, 2005).

The reviewed literature does not show consensus on how men view the perceived reduction in HIV and STI infection. It must be noted, however, that the perceptions may be related to the participant level of knowledge of HIV transmission, which may be vastly different between the populations sampled for the studies reviewed.

2.2.2.2 Risk Behaviours

VMMC reduces the risk of female to male HIV transmission but does not protect the male partner completely. Extrapolated data from the Orange Farm RCT (Auvert *et al.*, 2005) shows that male circumcision alone cannot decrease the number of infections in the pandemic (Williams *et al.*, 2006). While circumcision reduces the risk of HIV infection in heterosexual intercourse approximately 60 % (Auvert *et al.*, 2005; Bailey *et al.*, 2007; Gray *et al.*, 2007) there is social impact in the form of possible sexual

behavioural changes by men as a result of decreased risk of infection. The link to behaviour science is an important area of impact analysis when introducing new HIV prevention strategies (Crosby, Ricks, & Young, 2012). In the context of circumcision as a new strategy, increased risk behaviour[2] negates the impact of circumcision on HIV infection rates (White *et al.*, 2008). The literature on risk behaviour was reviewed to gain an understanding on how men behave post-circumcision and to determine whether the reduction in HIV transmission risk via circumcision is negated by an increase in sexual behaviours that place men at an increased risk of HIV infection.

To understand risk behaviour, it is necessary to understand how humans deal with risk. Each individual has a certain comfort level with a particular level of risk. Individuals will balance the reward of taking the risk against the hazards perceived. Risk compensation occurs when a mechanism of safety is introduced. This lowers the perception of risk and increases risks taken to increase the rewards (Richens, Imrie, & Copas, 2000). In the context of VMMC, this means that risk is reduced by the removal of the foreskin and that the newly circumcised man may increase risk behaviours based on this new "safety net". Even though the risk has been demonstrated to be reduced, the reduction is not absolute (Williams *et al.*, 2006). Circumcision does not provide total protection from female to male HIV transmission. The amount of risk compensation may also increase depending on the initial perceived risk and individual risk behaviours. Risk compensation is not a concern if high risk men seek circumcision. Low risk men seeking circumcision presents a concern as they may seek riskier situations based on increased perceived levels of HIV protection (Eaton & Kalichman, 2009). The biggest concern in the risk behaviour context is the man who perceives that he is fully protected from HIV, post-circumcision (Williams *et al.*, 2006).

Newly-circumcised men may increase the number of sexual partners based on the claimed reduction in HIV transmission risks afforded by circumcision. In a Westonaria acceptability study, circumcised men felt that they were protected enough to have

[2] Increased risk behaviour occurs as a result of risk compensation due to the introduction of an intervention that reduces risk. The increased risk behaviour nullifies the intervention (van Howe & Storms, 2011)

multiple partners (Lagarde *et al.*, 2003). In a similar study conducted in Gauteng, participants felt that a newly circumcised man may commit adultery as a consequence of wanting to try out his modified penis (Rain-Taljaard *et al.*, 2003). Two years after these acceptability studies, an increase in number of partners among circumcised participants was recorded in the Orange Farm RCT (Auvert *et al.*, 2005).

Condom use decrease falls under increased risk behaviour. Men may refuse to use a condom, post-circumcision (Rennie, Muula, & Westreich, 2007). It has been postulated that circumcised men are less likely to use condoms as condoms further reduce sexual sensation that has been lost due to removal of erogenous tissue during circumcision (Boyle *et al.*, 2002; Hill & Denniston, 2003). This does not assist the proposed HIV risk reduction by circumcision (Gwandure, 2011). Contrary to possible negative reactions to condoms proposed by the above authors, a quantitative survey was conducted in Johannesburg to determine if condom use would decrease post circumcision. The results revealed that the participants would use condoms and that the demand for circumcision is not motivated by the need to use fewer condoms. The study found that the need to circumcise was motivated by the reduction in HIV infection risk. It must be noted that this study was measuring intent and not actual actions (Bridges *et al,*, 2011).

2.2.3 Ethico-legal Arguments

Implementing circumcision programmes without considering ethical issues may cause implementation problems. If the ethics of the circumcision programme is not considered, it may cause rejection or regret within the community or the population. This section discusses the ethical issues found in the literature.

Neonatal and child circumcision as part of circumcision for HIV prevention policy has been proposed and debated. The debate centers around consent (Rennie *et al.*, 2007) as forcing circumcision on males has ethical implications (Sidler, Smith, & Rode, 2008). Within the African context, encouraging neonatal circumcision may interfere culturally, as most circumcising cultures circumcise at an adolescent age. The introduction of neonatal circumcision in South Africa should undergo a full community participation process (Rennie *et al.*, 2007) and a legal review as circumcision is illegal for children

under 16 under the Children's Act 38 of 2005 (Sidler *et al.*, 2008). The law stipulates that neonatal and child circumcision is only legal for religious and medical reasons. The legal debate on circumcision also stems from a gender difference i.e. cutting of the foreskin is seen as a medical procedure, whereas cutting of the labia or clitoris is seen as mutilation (Fox & Thomson, 2012).

Introducing circumcision as a health policy implicates the South African state as a legal person. Whereas circumcision was a previously private medical matter, the state has now undertaken a role in the circumcision procedure by introducing it as public health policy. Simultaneously, circumcision now enters a political space (Fox & Thomson, 2012).

Anger and resentment may occur within the population undergoing circumcision policy implementation. Africans may feel resentment if VMMC is proven to be ineffective after successful circumcision policy implementation and they may feel resentment for the leadership who endorsed it. Negativity could be added to the relationship that Africa has with the West who encouraged these programmes (Hill & Denniston, 2003).

A major ethical debate found in the literature was the role that the West and traditionally circumcising nations had on the VMMC policy implementation in South and East Africa. Circumcising countries like the United States are influencers in the studies and policies aimed at mass circumcision in the South (Johnson, 2010; Ncayiyana, 2011). Sawires *et al.* (2007) warns against imposing circumcision policy, adding that African men may be perceived as carriers of disease if the implementation of the policy is exclusively introduced to Africa (Sawires *et al.*, 2007). "Policy Elites" as described by Grindle & Thomas (2011) act as outside influencers of policy. In the context of the VMMC policy, policy elites can be categorised as technical elites and international elites. The technical elites are persons that use technical knowledge to influence decision makers that do not possess sufficient technical knowledge (e.g. politicians, ministers). In health policy, politicians and policy implementers rely on technical expertise, both national and international. International elites, most typically the WHO, IMF and World Bank, influence developing country contexts with both expertise and financial aid. The ethical

implication of the influence of policy elites comes in the form of their own ideologies filtering through into policies (Grindle & Thomas, 2011). Such influence may cause local policy makers to implement policy without proper policy analysis.

To illustrate the international and technical influence in VMMC policy, the following list of core partners for VMMC was taken from the *Joint Strategic Action Framework to accelerate the scale up of Voluntary Male Circumcision for HIV Prevention in Eastern and Southern Africa:*
Bill & Melinda Gates Foundation; Centers for Disease Control and Prevention; Department of Defense, U.S. Government; Office of the U.S. Global AIDS Coordinator; UNAIDS Secretariat Headquarters; UNAIDS Regional Support Team for Eastern and Southern Africa; U.S. Agency for International Development; WHO Headquarters; WHO Regional Office for Africa; The World Bank Global HIV/AIDS Program; The World Bank country-level Health Team and Task Team Leaders of World Bank Health Operations (WHO/UNAIDS, 2011).
The core partners are tasked within the framework to develop, implement and monitor the joint framework, whilst the Ministries of Health are the owners of the policy and the leaders in upscaling VMMC in the country (WHO/UNAIDS, 2011). This scenario is in keeping with the theory that the policy elites are influencers and not actual decision makers in public policy (Grindle & Thomas, 2011).

Even though the circumcision programme is voluntary, the pace at which these programmes are being marketed and implemented is causing the programmes to take a "top-down" approach towards medical circumcision (Gwandure, 2011, p. 90). Gwandure (2011), in his ethical analysis of VMMC, criticises the "top-down" approach by stating that policy implementers are protecting their rushed policy with science and medical facts without fully analysing the social and cultural impact of VMMC as a policy (Gwandure, 2011) .

The reviewed literature revealed many ethical questions:
What happens when all infants and men have been circumcised in the name of HIV prevention and then a cure is found? (Rennie *et al.*, 2007)

Will HIV testing be done at the point of circumcision? (Rennie *et al.*, 2007) A lack of awareness of HIV status increases the likelihood of unprotected sex. (Harawa *et al.*, 2004)
Will it be fair to circumcise all persons irrespective of the type of risk they exhibit in their sexual behaviours? (Newell & Barnighausen, 2007)
Will HIV positive men be turned away from circumcision clinics and will this lead to stigmatisation? (Kigozi *et al.*, 2008)
Will men who contract HIV post-circumcision become angry and resentful? (Boyle & Hill, 2011)

The answers to the above questions are not answered in this report, however, it demonstrates that the approach to the policy formulation of circumcision for HIV prevention is affected by the ethical issues that surround it.

Following the discussions on the scientific, social and ethico-legal arguments found in the literature, this review continues to the next step of the policy cycle to discuss the current VMMC policy in South Africa.

2.3 Policy Formulation and Mandate

Policy formulation is the process of documenting the policy and it also refers to the crafting of alternative policies or options for handling the issue. Policy formulation also entails narrowing down the outcomes of arguments in the analysis of the policy to produce a final outcome (Kaul, 1997). The policy for VMMC in South Africa has been documented and mandated through the *National Strategic Plan on HIV, STIs and TB, 2012-2016* (SANAC, 2011). The document does not contain specifics for VMMC policy implementation. It merely states that VMMC is part of the South African package of HIV prevention strategies, that national guidelines must be developed and that VMMC should be scaled up.

2.4 Policy Implementation and Communication

Proper implementation of a policy requires clear objectives. A policy has to include strategies that map out how the intended policy outcomes are going to be achieved.

Content of the policy must include target groups and incentives for compliance to the policy. A policy should detail manners to ensure compliance, governance and accountability role-players, resource management particulars, and the leadership and the stakeholders who are supporting the policy. Implementation should involve a participation process from a democratic and effectiveness point of view (Kaul, 1997).

Policy implementation involves the presentation and communication of the policy to the public. Policy communication methods differ depending on the nature and intent of the policy. It coerces people to buy into the intentions of the policy and also to comply with policy requirements. The purpose of policy communication is to create an informed public and to also determine how the public responds to the messages in the communication (Kaul, 1997).

Science and communication play an essential role in health policy, and communicated information should be based on sound scientific fact. As health is affected by the context of the person, the communication needs to consider the ecology surrounding the person, whether social, economic or political. Public communication in health aims to intervene and to induce change. It may target how a human being behaves or may inform how the ecology of the human being is changing. Communication is also aimed at either an individual, a group, a community or a nation, and must be crafted to suit the audience. Communication must consider the person's knowledge levels, cultural background and, in the case of a group or larger, the level of diversity (Bernhardt, 2004).

Communication for VMMC takes on two forms: 1. Communication to the public about VMMC and 2. Counselling.

2.4.1 Public Communication

The benefits and limitations of VMMC needs to be properly communicated to the public (Rennie *et al.*, 2007). WHO (2007) recognises the criticality of communication in VMMC policy (WHO/UNAIDS, 2007). The WHO stresses that communication should be clear that the prevention of HIV infection through circumcision is not absolute and that public communication should not create a "false sense of security" (WHO/UNAIDS, 2007, p.

5). The report emphasises that VMMC communication to the public should take existing HIV prevention strategies into account (WHO/UNAIDS, 2007).

Diversity of languages and cultures in South Africa requires communication to be unambiguous. In Kwa-Zulu Natal, there are different types of “circumcision”. One is called “*ukusoka*” which is the full removal of the foreskin and one is called *“ukugweda”* which is a cut done to make the foreskin move easier (Sithole *et al.*, 2009). VMMC communication should consider possible language ambiguities.

Uncircumcised men could seek VMMC to prevent condom use if media communication regarding VMMC does not emphasise condom use (Gwandure, 2011) This is called a “therapeutic misconception”, explained as the following:

> *When the positive effect of medical male circumcision advertisements and publicity results in participants overestimating the benefits of medical male circumcision and underestimating HIV infection risk* (Gwandure, 2011, p. 92)

Mass media currently informs the public about VMMC, but more and more, mass media and other communication channels are being used for demand creation. VMMC demand is being created in South Africa to meet targets set by WHO/UNAIDS to have at least 80% of 15-49 year old men circumcised (WHO/UNAIDS, 2011). A study on demand creation has been conducted in South Africa to determine the barriers to increasing circumcision rates (Nieuwoudt, Frade, Rech, & Taljaard, 2012). The study is similar to an acceptability study, but more focused on how to overcome acceptability barriers through communication channels, based on the audience. Thus, as with scale up studies, the focus on communication studies within VMMC policy is based more on increasing circumcisions than improving communication about benefits and limitations of the procedure.

Marketing of circumcision programmes through political persons may be unethical. A review of the expansion of circumcision programmes in Kenya noted that the rapid scale up was due to the involvement of government leadership and a documented strategy for implementation (Mwandi *et al.*, 2011). Having government leaders marketing the

circumcision programme may be seen as manipulative or even deceptive. These persons may not even be qualified to speak about the subject. This may cause people to participate without thinking about the impact it will have on their own lives. (Gwandure, 2011)

From a government ownership perspective, African countries that are implementing VMMC like Malawi and Swaziland have published communication strategies for public policy communication in their countries. During this literature review, a communication strategy for VMMC in South Africa could not be sourced.

2.4.2 Counselling prior to circumcision

The counselling session held prior to circumcision is seen as an integral part of the circumcision process and is the last opportunity to relay information to the candidate. Participants in circumcision programmes must be informed that they are still at risk of contracting the virus if condoms are not used. Counselling was a necessary process in the RCTs (Auvert *et al.*, 2005; Bailey *et al.*, 2007; Gray *et al.*, 2007) and its use is emphasised in the WHO/UNAIDS technical report (WHO/UNAIDS, 2007).

The technical report recommends educational methods to inform VMMC candidates that VMMC does not provide full protection and that wound healing time is important. Communication strategies should address the resumption of sex, the use of condoms and should take cognisance of both sexes. The communication should be clear that circumcision for HIV prevention does not cover heterosexual and homosexual anal sex (WHO/UNAIDS, 2007).

Risk reduction counselling is integral in circumcision programmes to reduce risk behaviour. Counselling is needed to ensure that condom use is emphasised (Eaton & Kalichman, 2009). The effectiveness of counselling in reduction of risk behaviours is debatable, as the literature shows. A Kenyan study suggested that the difference in risk behaviour between uncircumcised and circumcised men was not different, even with adequate counselling (Weiss *et al.*, 2008). Another study found that changes to behaviour after circumcision was positive (Grund & Hennink, 2012). Men in Swaziland reported decreases in partner numbers and increases in condom use. HIV counselling

and counselling throughout the circumcision process was found to be the main influence in the positive behaviour change in the study. The participants felt that they were more educated after counselling sessions during the circumcision process and adapted their behaviours accordingly. They also described condom use as much easier and therefore increased their use of condoms. The article acknowledges that the responses could be due to the Hawthorne[3] effect. (Grund & Hennink, 2012)

It has been argued that counselling has an unknown effect on transmission of HIV infections. It may initially reduce risk behaviour but this may not be permanent nor may it be consistent. It is still up to the individual to make a decision about the information and act on it as the individual sees fit (Lie, Emanuel, & Grady, 2006) There is no guarantee that communication of risk will affect behaviour (Richens *et al.*, 2000). Having counselling and behaviour change initiatives may not be enough to change behaviours (Gwandure, 2011).

2.5 Policy Monitoring and Evaluation

Policy monitoring and evaluation is the end of the policy cycle and its results restart the policy process. The results, which are outputs or outcomes, may either change or end a policy. Policy outputs are "readily counted, totalled and statistically analysed" data (Anderson, 1994, p. 240) whereas policy outcomes are the "consequences for society, intended and unintended" (Anderson, 1994, p. 240).

Policy Evaluation provides knowledge about the differences between expected and actual performance of the policy and assists the policy analyst to critique the actual policy and the values that are embedded in that policy (Dunn, 1994). Policy Monitoring is the routine checking of progress against a plan (Kaul, 1997). It checks compliance to the policy, implementation barriers and root causes for noncompliance to policy intentions, as well as who is responsible for not meeting the intentions of the policy (Dunn, 1994). The reviewed literature shows that scaling up activities, demand creation

[3] "The alteration of behaviour by the subjects of a study due to their awareness of being observed" ("Oxford Dictionary Online," n.d.)

and communication are activities that are being done in the name of increasing the results of policy monitoring.

The outcomes and consequences of VMMC have been discussed in the literature, but literature on policy outcomes in terms of its impact on unintended populations in South Africa could not be sourced. Policy often affects only a portion of a population that is often defined in the policy. The effect on that group is also defined, but the effect cannot be confined to just the intended group. Policy outcomes may affect or have potential impact on an unintended group. This unintended effect may be due to the policy being too broad. (Anderson, 1994)

The literature explored thus far has demonstrated how VMMC has evolved into a public health policy within South Africa and has discussed the arguments that have shaped the policy. The review will now explore Men who have Sex with Men (MSM), a group of men that VMMC has not been intended for in the eyes of WHO and South African policy (SANAC, 2011). This review will focus on gay men, who fall under the definition of MSM. The literature will restart the policy cycle in the next section with the scientific studies that have been done to determine whether VMMC has the same effect for MSMs as it has for heterosexual men. It will discuss acceptability studies performed and the impact of the African context on MSM. Thereafter, it will frame the research gap in policy formulation and policy communication.

2.6 VMMC Policy Cycle and Gay Men

2.6.1 Scientific Arguments – Circumcision and Gay Men

The literature reviewed to discuss circumcision for HIV prevention and gay men, discusses homosexual sex under the group termed MSM. MSM stands for Men who have Sex with Men. For the purposes of this report, the definition of MSM includes:

> *Gay-identified men, heterosexually identified men who have sex with men, bisexual men, male sex workers who can have any orientation, men engaging in these behaviours in all settings such as prisons and the rich and wide array of traditional identities and terms for these men across cultures and subcultures* (Beyrer *et al.*, 2012, p. 368)

The above definition does not include transgender men. Although this research report is focussed solely on gay men, the literature on VMMC impact on MSM will be used to discuss gay men and VMMC. The justification is that even if a male has sexual preference for both sexes, when he engages in homosexual sexual intercourse, the intercourse is the same as when two gay men have intercourse. The scientific arguments within the VMMC / MSM debate relate to the nature of homosexual intercourse and not sexual preference.

The scientific difference between heterosexual and homosexual transmission of HIV lies in the manner in which sexual activities differ. MSM's have a wider range of sexual behaviours than heterosexual men (Templeton *et al.*, 2009b). Interventions for HIV/AIDS need to consider the sexual behaviours of MSMs (Pando *et al.*, 2013; Stokes, Vanable, & McKirnan, 1997). For example, mutual masturbation with other men and exposure of the inner foreskin to HIV infected semen may cause infection (Szabo & Short, 2000). A male can become infected with HIV through receptive anal sex, and he, in turn, can infect others through insertive anal sex (Beyrer *et al.*, 2012; Vermund & Qian, 2008). Therefore results from RCT studies in heterosexual men regarding circumcision for HIV prevention cannot be automatically inferred into the MSM group of men (Templeton *et al.*, 2009b).

The evidence from the African RCTs is not applicable to MSMs as the prevention mechanism of circumcision has only been demonstrated in heterosexual HIV transmission from vagina to penis. There is no demonstration that circumcision reduces anus to penis HIV transmission, regardless of whether the anal intercourse is heterosexual or homosexual (Templeton, Millett, & Grulich, 2010). Moreover, the risk of transmission of HIV to the penis during anal sex is higher than the risk of transmission in unprotected vaginal sex (Beyrer *et al.*, 2012), thereby complicating inference of the RCT studies onto the MSM group even further.

The studies that have been conducted to investigate any protective effect by circumcision have revealed no conclusive evidence of HIV infection risk reduction (Gust *et al.*, 2010), although it is biologically possible that circumcised insertive partners may

be protected (Weiss *et al.*, 2008). A 2008 meta-analysis conducted on 15 studies examined the relationship between circumcision status and HIV infection among MSMs. The analysis revealed little evidence that male circumcision prevents HIV infection in MSMs (Millett *et al.*, 2008). At the same time as the 2008 meta-analysis, Templeton *et al.* (2009a) observed a possible protective effect for the insertive partner in homosexual sex (Templeton, *et al.*, 2009a). In 2011, another review of studies was conducted. The 2011 meta-analysis looked for RCTs and observational studies. There was no evidence of a conducted RCT, but 21 observational studies were found. It was noted that one RCT was underway in China at the time of the 2011 review. The meta-analysis observed that insertive partners may be partially protected, but concluded that the role of circumcision in MSM HIV risk is still unknown. No evidence was found to recommend circumcision for HIV prevention in MSM (Wiysonge *et al.*, 2011). In 2013, an acceptability study was performed in Argentina. Circumcision status was not significantly related to HIV infection, when taking all the participants into account. When restricting the study to the insertive partners, a significant difference was observed. The circumcised group had a lower incidence of HIV infection. This demonstrates, by observation, that being circumcised has a partial protective effect. (Pando *et al.*, 2013)

The literature repeats that the insertive partner is possibly partially protected from HIV infection by being circumcised. The level of HIV infection reduction in homosexual sex cannot be quantified until an RCT provides evidence of reduction through circumcision (Weiss *et al.*, 2008). The possible protective effect is negated by the manner in which MSMs conduct sexual intercourse. As much as MSMs may have a preference, many do not exclusively maintain the same sexual role. If MSMs had to exclusively maintain either an insertive or receptive sexual positioning then the rates of HIV transmission could reduce, due to the possible partial prevention effect of circumcision observed in insertive partners (Beyrer *et al.*, 2012).

2.6.2 Circumcision acceptability and MSM

In terms of acceptability studies, a survey was conducted among uncircumcised MSMs at a number of Gay Pride festivals. The men surveyed indicated that they are willing to be circumcised if the procedure reduces risk of HIV. In this survey they were not

informed about the level of protection being partial and that condoms will still need to be used (Sullivan *et al.*, 2007). In the survey mentioned by Sullivan *et al.* (2007), the uncircumcised mens' biggest concerns was the pain that would be experienced after circumcision and any possible wound infection that may occur (Begley *et al.*, 2008).

The effect of circumcision on sexual behaviour affects its acceptability. In terms of sexual experience differences between circumcised and uncircumcised gay men, no differences were found regarding condom use or libido loss. (Mao *et al.*, 2008). By contrast, an acceptability study of circumcision in MSM was performed in Argentina and the study found that 70% of interviewed men refused to be circumcised even when knowing about the partial prevention of HIV infection (Pando *et al.*, 2013). This refusal could be culture related.

Literature on partner acceptability of circumcision in gay men could not be found as well as literature on any type of acceptability of circumcision in gay men in South Africa.

2.6.3 MSMs and Africa

Male to male sexual contact and its relationship to HIV infection is rarely looked at in Africa's HIV research (Jewkes *et al.*, 2006). MSM focussed interventions in Africa are reduced due to social, political and cultural "barriers". The presence of underground MSM populations leads to underreported MSM HIV levels in Africa. Same sex relationships in most African countries are criminalised, and punishment in some countries is death. In the healthcare sector, health care workers may be discriminatory to MSMs that reveal their sexual preferences to them. This may cause MSMs to not reveal their preferences, which hampers the quality and applicability of the healthcare that they receive (Mcintyre, 2010).

Communications for HIV prevention in Africa do not cater for the MSM population and do not address anal sex, for both homosexuals and heterosexuals. Knowledge of HIV transmission via anal sex is low. Studies have shown than the majority of participants did not know that unprotected anal sex with an HIV positive person may lead to HIV infection (Mcintyre, 2010). The rate of anal sex without condoms in Sub-Saharan

Africa's MSM populations is high. African MSMs are four times more likely to be infected with HIV than the general population. Most African countries don't include MSMs as risk groups in their national strategic plans. Homosexuality is illegal in most of Africa and this presents barriers to data generation and research (Lane *et al.*, 2011). South Africa is the exception. In the 2007-2011 HIV and STI National Strategic Plan, MSMs were included and considered. (Lane *et al.*, 2011).

Research into how gay men in the African context perceive HIV prevention strategies and the communication of HIV prevention policies will assist in ensuring that such policies cater for the gay community. Data from such studies could inform policy and clarify limitations of HIV prevention strategies, thereby reducing possible future HIV infections in the gay population.

This research report will explore how MSMs are catered for in the VMMC policy which is part of the South African HIV and STI National Strategic Plan. It is clear that MSMs are on the policy agenda, but it is not clear how the policy has been implemented and communicated, considering the scientific data that demonstrates the inappropriateness of VMMC as an HIV prevention tool for MSMs. Although freedom of sexual orientation is protected by the Constitution of South Africa, discrimination against homosexuals does exist and there is a possibility that men that are "in the closet"[4] may seek to have the circumcision performed. Such men require clear communication about the limitations of VMMC.

2.6.4 VMMC Policy Formulation, Policy Communications and MSM

In the WHO/UNAIDS (2007) technical report released in 2007, it was clear that the VMMC procedure is strictly for heterosexual men only. The report acknowledges that there was insufficient evidence for circumcision to reduce HIV transmission in MSMs (WHO/UNAIDS, 2007).

With regard to policy formulation, transmission of HIV in African homosexuals has been described as a "blind spot" (Fox & Thomson, 2012, p. 264) and that policy makers

[4] Not openly gay in society

cannot see it when creating policy. Fox & Thomson (2012) describe the reason as "social and institutional homophobia" (Fox & Thomson, 2012, p. 264). When seeing the spread of HIV as purely heterosexual, policy makers become blind to the other modes of HIV prevention.

If policy makers cannot properly analyse the policy and stakeholders, then the content of the policy will be skewed towards the intended groups and may not consider groups for which content is not applicable for (Bernhardt, 2004). Policy communication, as an aspect of policy implementation, is dependent on policy content (Brynard, 2000). VMMC policy communication should be clear that VMMC is not for homosexual men. An example of a miscommunication could be a receptive partner getting circumcised and believing that he is protected. Being a circumcised receptive partner will not provide protection from HIV infection from an HIV-positive insertive partner (Templeton et al., 2010). VMMC communication strategies should be clear that VMMC has not be proven to protect men who engage in homosexual sex, both insertive and receptive partners.

2.7 Conclusion

The literature review reveals areas of the VMMC policy that requires exploration, viz. how policy implementers view their MSM audience, what clinics communicate to men about the limitations of circumcision for HIV prevention and what MSM men perceive about this procedure and its limitations or advantages.

This report sought to understand these areas of concern. The research gathered information from policy implementers to ascertain how the policy was formed and whether the scientific data of MSMs and VMMC is incorporated into the policy. This research gathered data on what gay men perceived from the current media advertising and communications around VMMC and determined whether the messages they are receiving are the intended messages. This research explored the counselling process to determine whether the limitations of VMMC for MSMs is communicated prior to the circumcision procedure.

2.8 Conceptual Framework

Theme / Concepts / Issues	Author(s)	Measuring	Measurement tool	Interviewee(s)	Questions asked	Importance
Perceptions, understanding and acceptability of Circumcision	Bailey *et al.* (2002) Lukobo & Bailey (2007) Ngalande *et al.* (2006) Rain-Taljaard *et al.* (2003) Scott *et al.* (2005) Lagarde *et al.* (2003) Kigozi *et al.* (2007) Kim & Pang (2007) Eaton & Kalichman (2009) Sullivan *et al.* (2007) Begley *et al.* (2008) Mao *et al.* (2008) Pando *et al.* (2013)	1. Perceptions, understanding and acceptability of circumcision in gay men 2. Knowledge of circumcision for HIV prevention	Semi-structured Interview	Gay Men	1. What is your understanding of circumcision? 2. What is your personal view on circumcision? 3. What do you know about the relationship between circumcision and HIV?	To gather data about the perceptions, understanding and acceptability of circumcision. To gather data about the knowledge of circumcision and its relationship to HIV.
Risk Behaviour	Crosby *et al.* (2012) White *et al.* (2008) Richens *et al.* (2000) Eaton & Kalichman (2009) Rennie *et al.* (2007) Boyle *et al.* (2002) Hill & Denniston (2003) Bridges *et al.* (2011) Gwandure (2011)	1. Behaviour change based on risk reduction	Semi-structured Interview	Gay Men	1. What does the HIV infection reduction rate mean for you? 2. What does this mean you can and can't do? 3. What does this mean to you in terms of condom use?	To gather data about how the interviewee views the risk reduction and how the interviewee will possibly compensate for the perceived reduction in risk

Theme / Concepts / Issues	Author(s)	Measuring	Measurement tool	Interviewee(s)	Questions asked	Importance
International and Political Pressures on VMMC Policy	Fox & Thomson (2012) Hill & Denniston (2003) Johnson (2010) Ncayiyana (2011) Sawires *et al.* (2007) Grindle & Thomas (2011) Gwandure (2011)	1. The influence of international and political actors on VMMC policy	Semi-structured Interview	Policy Implementers	1. Who is leading the drive for VMMC internationally? 2. Who is leading the drive for VMMC locally? 3. Please explain the relationship between the Department of Health and organisations such as CHAPS and Brothers for Life	To determine who is setting the priorities in the policy agenda for VMMC
Policy Implementation and Communication	Kaul (1997) Bernhardt (2004) Fox & Thomson (2012) Brynard (2000)	1. Content determination in VMMC policy 2. Objectives and target groups of VMMC policy 3. Objectives of public communication 4. Content of public communication	Semi-structured Interview	Policy Implementers	1. What is the VMMC communication strategy in South Africa? 2. Who determines the content of VMMC policy? 3. What are the objectives of VMMC policy? 4. How has gay men been considered in the content of VMMC policy? 5. What are the objectives of VMMC public communication 6. How are these objectives addressing gay men? 7. How is the content of public communication derived and how are unintended groups considered?	To gather data about the roleplayers in policy content and communication. To determine if and how gay men are considered in VMMC policy communication

Theme / Concepts / Issues	Author(s)	Measuring	Measurement tool	Interviewee(s)	Questions asked	Importance
Mass Media Communication	Nieuwoudt *et al.* (2012) Mwandi *et al.* (2011) Gwandure (2011)	1. Messages received by gay men in VMMC public communication	Semi-structured Interview	Gay Men	(Advert was presented and interviewee was asked to interpret) 1. What does this advert tell you? 2. What does this mean for you?	To determine how gay men interpret public communication for VMMC. To determine whether gay men know that VMMC is not effective for homosexual sex
Communication in Circumcision Counselling	Eaton & Kalichmann (2009) Weiss *et al.* (2008) Grund & Hennink (2012) Lie *et al.* (2006) Gwandure (2011)	1. Messages received by men during counselling prior to circumcision	Semi-structured Interview	VMMC clinics	1. Please explain the process that men undergo when they express interest in VMMC 2. Please take me through the counselling process that men receive 3. Please highlight the benefits and limitations of procedure	To determine if limitations of VMMC are communicated, thereby informing gay candidates that VMMC is not effective for homosexual sex
Policy Monitoring and Evaluation	Anderson (1994) Kaul (1997) Dunn (1994)	1. How VMMC policy outputs are monitored and how outcomes are evaluated	Semi-structured Interview	Policy Implementers	1. Please explain how VMMC policy monitoring and evaluation takes place in South Africa 2. How do the outputs and outcomes reinfluence current policy? 3. How are impacts on unintended groups evaluated and how are they considered in current policy?	To determine whether policy outcomes are being considered for policy changes and whether gay men are being considered in current policy dialogue

Chapter 3: Research Methodology

3.1 Research Strategy

A research strategy is a “general orientation to the conduct of social research” (Bryman, 2012). The research strategy used for this study was a qualitative research strategy. This type of strategy places an emphasis on words as units of data, rather than numbers which are employed in quantitative research. Quantitative and qualitative research strategies exhibit differences in the following areas: the role of theory, epistemological differences and ontological differences. Quantitative research has a deductive approach in its relationship with theory, where the emphasis is on the testing of theory. The epistemological approach is positivist in nature and the ontological position is that of objectivism. Qualitative research employs an inductive approach in its relationship to theory. It is usually employed in the generation of theory. The epistemological approach employed is that of interpretivism where the emphasis is on understanding the social world by analysing what people interpret about their environment. The ontological position of qualitative research strategy is constructionism, which implies that the social world is created by the people within in it, rather than external influences or its physical construction (Bryman, 2012).

Qualitative research allows researchers to see the world through other people’s perspectives. This allows them to gather people’s perceptions of the world as data, by involving themselves in that world. This requires them to play an active role in gathering data on the perspectives and the meanings people attribute to their experiences in their environments. (Bryman, 2012)

Qualitative researchers provide more detail with regard to the context of their studies. They are more descriptive about the environment they are researching in. As people interpret their worlds based on their environments, it is important for the qualitative researcher to understand the environment. Behaviours that may seem strange from an outsider’s perspective may make sense when viewed against the backdrop of the context in which the behaviours take place (Bryman, 2012). Qualitative research allows

participants to describe their world as a series of processes that may be before or after significant events (Bryman, 2012).

Qualitative research allows the researcher to keep the structure of enquiry to a bare minimum, allowing the participants to reveal their perspectives. It also allows the researcher to gather information about concepts that may not have occurred to him during his initial research. This allows the researcher to gather more information about the new phenomenon encountered. Having a flexible structure allows the participants in the research to describe their interpretations, meanings and contexts of their environments, allowing the researcher to further submerge himself in the perspective of the participant and to interpret their worlds (Bryman, 2012).

Qualitative research was chosen as the research strategy for this study as the research question required the data to be the perceptions, understandings and perspectives of people. The researcher needed to understand how people viewed and interpreted topics and concepts. This could only be achieved through qualitative research.

3.2 Research Design

Research design guides how the research strategy will be implemented and how the data derived from the research will be analysed. A basic interpretive study research design was employed in this research.

In a basic interpretive study, the researcher seeks to understand how the research participants make meaning out of their world. The researcher is the main instrument of data collection. A basic interpretive study allows the researcher to understand "a phenomenon, a process, the perspective and worldviews of the people involved, or a combination of these" (Merriam, 2002, p. 6). Data derived from this type of study may be collected through interviews, observations or analyses of documentation. Analysis of the data is done so as to identify patterns or themes. Once the data is analysed, the themes are discussed with reference to the literature found during literature review (Merriam, 2002).

A basic interpretive study design was chosen for this study as it exhibits all characteristics of qualitative research design (Merriam, 2002) and offers the most flexibility.

3.3 Research Method

The data collection method for this study was the semi-structured interview using interview guides. The method was used to allow the researcher to gauge the interviewee's perspective. Each question in the interview guide covered aspects of the study's focus area, and were derived from the literature review. There was some flexibility allowed in the interviews and the questions deviated from the interview guide where applicable. The questions also changed, where necessary, from interview to interview within a particular group, depending on new information gathered during initial interviews (Bryman, 2012). Semi-structured interviews were used to assist the researcher to be focussed on the research topic, as opposed to the unstructured interview which usually starts with one question and then becomes conversational based on both parties' responses (Bryman, 2012).

The interview guides consisted of questions that covered the different aspects of the study's focus. Three interview guides were developed and can be found on Appendix 1, Appendix 2 and Appendix 3.

The questions on the interview guide consisted of introduction questions, open ended questions and ending questions. Depending on the responses and the need to delve further into certain aspects of the interview, the researcher asked probing questions, indirect questions, direct questions and interpreting questions. These questions are not listed as part of the interview guides (Bryman, 2012). Appendix 1 contains twelve questions that were directed to gay men. These questions were also directed to a group of heterosexual men for comparison purposes. Appendix 2 contains three questions that were used to interview VMMC clinic counselling staff. The interviews with the VMMC clinics focused on the counselling process, and had more probing questions depending on the information provided during the interview. Appendix 3 contains thirteen questions for VMMC policy implementers.

3.4 Research Procedure

Interviews were set up by contacting participants and setting up appointments. Participants were interviewed in private settings, at a location and time that was convenient for them. The interview times ranged from approximately 40 minutes to one hour. One interview with a policy implementer lasted a duration of 2 hours. Interviews were done face to face. After seeking permission from respondents, the interviews were recorded on a recording device for later transcribing. All participants agreed to the interviews being recorded.

3.5 Sampling

This study used purposive sampling, which is a form of non-probability sampling. Purposive sampling encompasses the selection of a case or cases that are most appropriate to answer the research question, and respond to the goals of the research. Its use allowed the researcher to choose the sample according to the goals of the research. Sampling for this study did not involve random sampling. Participants were chosen strategically. The findings of this research are thus limited, as the type of sampling used does not allow the researcher to infer the outcomes to a wider population (Bryman, 2012).

The units of analysis for this study are categorized per research subquestion:

Table 1 Units of analysis per research subquestion

Research Subquestion		Unit of Analysis
1.	What are the perceptions of gay men regarding circumcision and circumcision for HIV prevention?	Gay men
2.	What information do circumcision clinics provide to men who undergo the procedure?	Circumcision Clinics
3.	What are the perceptions of the policy implementers regarding circumcision policy communication to non-targeted populations?	Policy Implementers

One of the reasons that qualitative research requires the use of purposive sampling is that the researcher needs to ensure that only individuals that effectively contribute to the study become respondents. This allowed the focus to not be so much on the inferability of the information gathered, but more on the perspectives of the persons under study, which was the focus of this research (Bryman, 2012).

Two types of sampling methods were used in this research study: convenience and snowball sampling.

This study used convenience sampling which is a non-probability sampling method that allows the researcher to choose a sample based on its availability or accessibility, and therefore does not allow one to infer the results of a study to the population (Bryman, 2012).

In addition to convenience sampling, the study used snowball sampling which is a method that allows the researcher to choose a small group of participants to engage with, initially, and from these people, get referrals to other persons that fit the profile of the type of participant the researcher is interested in engaging. The second group of participants will then refer the researcher to others, and so on. This sort of sampling is helpful when the type of participant the researcher is looking for, is part of a network of similar people relevant to the study. (Bryman, 2012) Taking into account often secretive nature of gay men in the African context, snowball sampling was used to gather gay men that are “in the closet”[5]. Snowball sampling was also helpful in sourcing participants for the policy implementer and clinic interviews as the researcher was not familiar with persons that are employed in those roles.

The following table illustrates which sampling method was used for each research question and unit of analysis.

[5] Not openly gay in society

Table 2 Sampling method per research subquestion

Research Subquestion		Unit of Analysis	Sampling Method
1.	What are the perceptions of gay men regarding circumcision and circumcision for HIV prevention?	Gay men	Convenience; Snowball
2.	What information do circumcision clinics provide to men who undergo the procedure?	Circumcision Clinic Counsellors	Convenience; Snowball
3.	What are the perceptions of the policy implementers regarding circumcision policy communication to non-targeted populations?	Policy Implementers	Convenience; Snowball

For Sub-question 1, the researcher selected and contacted persons known to the researcher, who were asked to refer other suitable candidates. For sub-question 2, the researcher arranged meetings with policy implementers by email and telephone. For sub-question 3, the Gauteng Department of Health was approached by email for permission to interview counsellors at clinics that offered VMMC. Permission from the Gauteng Health MEC was provided via email.

Sample size is not easily established for qualitative studies. Bryman (2012) mentions that the scope of a qualitative study has an impact on the sample size. Bryman (2012) also states that the number of samples one has could also be determined by the theoretical saturation one experiences during the study. Theoretical saturation happens when no new data or relevant data regarding a certain category is being noticed during the study and the category is well understood by the researcher i.e. each sample is now revealing the same information as previous samples (Bryman, 2012).

Onwuegbuzie and Collins (2007) state the following:

> *In general, sample sizes in qualitative research should not be so small as to make it difficult to achieve data saturation, theoretical saturation, or informational redundancy. At the same time, the sample should not be so large that it is difficult to undertake a deep, case-oriented analysis* (Onwuegbuzie & Collins, 2007, p. 9)

Considering the above, this study proposed the adoption of the minimum sample sizes stipulated below

Table 3 Proposed minimum sample sizes per research subquestion

Research Sub-question		Unit of Analysis	Proposed sample
1.	What are the perceptions of gay men regarding circumcision and circumcision for HIV prevention?	Gay men	12
		Heterosexual men	5
2.	What information do circumcision clinics provide to men who undergo the procedure?	Circumcision Clinic Counsellors	3
3.	What are the perceptions of the policy implementers regarding circumcision policy communication to non-targeted populations?	Policy Implementers	3

The actual number of interviews conducted is stipulated in the table below

Table 4 Proposed vs. Actual number of interviews conducted

Research Sub-question	Unit of Analysis	Proposed number of interviews	Number of interviews conducted
1.	Gay men	12	12
	Heterosexual men	5	4
2.	Circumcision Clinic Counsellors	3	1
3.	Policy Implementers	3	2

For research sub-question 1, a group of heterosexual men was interviewed with the same interview guide used to interview gay men so that a comparison could be drawn between the responses of the two groups. The proposed number of gay men interviews was achieved. The majority of gay men interviewed were coloured. Only one black gay male was interviewed. This was an effect of the convenience sampling. Most of the gay men known to the researcher were coloured. Sampling and interviews for gay men

reached a maximum of twelve and was not continued as concurrent analysing of the data during the data collection process revealed that the gay men were responding with similar themes. This implied that theoretical saturation was being achieved (Bryman, 2012). The sampling and interviews with heterosexual men ended with four interviews as concurrent analysis of interviews also revealed a repetition of themes and theoretical saturation. The heterosexual men that were interviewed were representative of the four race classifications in South Africa.

The number of interviews for clinics could not be achieved. The time taken for processing permission to interview the clinic counsellors through the Gauteng Department of Health was longer than anticipated. The process for gaining authorisation was approximately two months. This limitation was overcome by the fact that the clinics that perform VMMC in Gauteng are operated by one NGO. This means that the counselling process is standard with little variation.

The initial number of interviews with policy implementers consisted of interviews with two implementation partners, one for operations and one for communications, as well as an interview with the National Department of Health. An interview could not be secured with policy implementers in the National Department of Health. This is a limitation to this study.

3.5.1 Description of Interviewees

Table 5 Code names and descriptions of gay men interviewees

Gay Men		
No.	**Code Name**	**Description**
1	GM1	Coloured male, mid-30's, in a relationship, employed in the beauty industry and resides in Cape Town
2	GM2	White male, mid-30's, single, employed as a retail manager and resides in Cape Town
3	GM3	Coloured male, early 20's, single, employed in the information technology sector and resides in Cape Town
4	GM4	Coloured male, early 40's, single, employed in the beauty industry and resides in Cape Town
5	GM5	Coloured male, late 40's, single, employed as a retail manager and resides in Cape Town
6	GM6	Coloured male, late 20's, single, employed in the healthcare sector and resides in Cape Town
7	GM7	Coloured male, late 30's, single, employed in the beauty industry and resides in Cape Town
8	GM8	Coloured male, early 20's, in a relationship, employed in the financial sector and resides in Cape Town
9	GM9	Coloured male, late 30's, in a relationship, employed in the manufacturing sector and resides in Cape Town
10	GM10	Black male, early 40's, single, employed in the fitness industry and resides in Johannesburg
11	GM11	Coloured male, early 30's, single, employed in the financial sector and resides in Johannesburg
12	GM12	Coloured male, early 30's, single, employed in NGO sector and resides in Pretoria. He has experience in the HIV/AIDS sector and has collaborated with the National Department of Health in his work.

Table 6 Code names and descriptions of heterosexual men interviewees

Heterosexual Men		
No.	**Code Name**	**Description**
1	SM1	Coloured male, early 20's, single, employed in the government sector and resides in Cape Town
2	SM2	Black (Zulu) male, mid-30's, married with children, employed in the manufacturing industry and resides in Johannesburg.
3	SM3	Indian male, early 30's, married, employed in the manufacturing industry and resides in Johannesburg
4	SM4	White male, late 20's, engaged, employed in the healthcare industry and resides in Johannesburg

Table 7 Code names and descriptions of policy implementer interviewees

Policy Implementers		
No.	**Code Name**	**Description**
1	PI1	Managing Director of a non-governmental organisation (NGO) that implements HIV programmes as well as handling communication aspects of HIV programme implementation. The interviewee has more than 10 years' experience in the HIV/AIDS field especially in HIV prevention. As a policy implementer, the interviewee is also a participant in the technical group that co-ordinates the implementation of VMMC in South Africa.
2	PI2	Board member and Chief Executive Officer of an NGO. The NGO's main focus is the implementation of VMMC as an HIV prevention tool. The interviewee's experience dates back to the initial RCT conducted in Orange Farm, South Africa. The interviewee is currently involved in the technical team of policy implementation partners that co-ordinates the implementation of VMMC in South Africa.

Table 8 Code name and description of clinic counsellor interviewee

Circumcision Clinic Counsellor		
No.	**Code Name**	**Description**
1	C1	Counsellor employed in a VMMC clinic on the East Rand, Gauteng. The counsellor actively participates in facilitating group information sessions and "one on one" sessions with circumcision candidates.

3.6 Data

Data collected during interviews were analysed using thematic analysis (Bryman, 2012). Only primary data were used in this research study. Secondary data sources were not used as the academic literature and the primary data from the respondents were found to be sufficient enough to satisfy the aim of this study.

Transcribing of recorded data was done by listening to the recording and capturing the data using Microsoft Word®. Once data was transcribed, it was coded. Taylor and Gibbs (2010) define coding as the following:

> *Coding is the process of combing the data for themes, ideas and categories and then marking similar passages of text with a code label so that they can easily be retrieved at a later stage for further comparison and analysis.* (Taylor & Gibbs, 2010, p. 1)

The codes that were created were done on "themes, topics, ideas, concepts, terms, phrases (or) keywords" (Taylor & Gibbs, 2010, p. 1) found during review of the interview transcripts. Coding was done after every interview, where possible, so that any adjustments to the interview schedule could be made if necessary, to assist the researcher in further focussing the subsequent interviews (Bryman, 2012).

After coding, the data were reviewed for themes. Themes were identified by looking for repetitions, similarities, differences, theory-related material or colloquial sayings (Bryman, 2012). Expected themes from interviews with gay men included lack of VMMC knowledge, misunderstanding of VMMC limitations for gay men and misunderstanding of messages in policy communication. It was anticipated that the interviews with clinics would reveal themes such as lack of information regarding VMMC limitations and indifference to male sexual orientation. Expected themes from interviews with policy implementers consisted of knowledge of VMMC limitations and a lack of resources to fully cater for unintended audiences of VMMC policy communication. Expected themes were derived from the literature review.

The actual themes derived from the data will be discussed in Chapter 4 and 5.

3.7 Validity and Reliability

Validity and Reliability was established as per the alternative criteria for qualitative research, by establishing Trustworthiness of the study (Bryman, 2012). To prove Trustworthiness, four criteria were met. The first is credibility, which is consistent with internal validity in quantitative strategy. It establishes whether the findings of the study is credible and whether the manner in which the researcher came to his findings is credible. There are two methods for establishing credibility: Member Validation and Triangulation (Bryman, 2012). This study employed triangulation to establish credibility. This was done by interviewing the policy audience (gay men), the clinics that provide circumcision and the policy implementers.

The second criterion for Trustworthiness is transferability which is consistent with external validity in quantitative strategy. Qualitative research data is linked to the context of the study area. Providing detailed descriptions of the context and the findings allow the readers of the study to determine if the context is similar to other environments. This will assist in determining whether the findings can be transferred to another context. The provision of detailed description is called “thick description” (Bryman, 2012, p. 392) and this is employed in this report.

The third criterion is Dependability and it is consistent with reliability in quantitative strategy (Bryman, 2012). To ensure Dependability of the finding of this study, an audit trail has been kept of all interview transcripts, interview schedules and other relevant documents and electronic files, which enables any finding to be justified upon inquiry or peer review. The documentation has been kept securely to preserve confidentiality agreements with the participants.

The fourth and final criterion for establishing Trustworthiness is Confirmability. This is consistent with objectivity. As the researcher is the main tool of research in qualitative research, it should be shown that the researcher has not affected the findings of the study by allowing his/her biases to influence the research (Bryman, 2012). To accomplish this, all possible biases and relevant background details of the researcher are noted.

The researcher is a 33 year old gay coloured male qualified as a healthcare professional, with an interest in male sexual health, specifically homosexual health. The researcher is not against circumcision, but has concerns regarding forced circumcision. The researcher believes that circumcision should be a personal choice, unless it is done for religious, medical or cultural reasons. The researcher also believes that the VMMC policy should be implemented properly or not at all. He is deeply concerned that the voices of homosexual men are not heard against the backdrop of heterosexual issues and that general men's health issues are often clouded by concerns for the health of the female population. During this research, the researcher did not provide any coaching during the interviews. There were instances during interviews that the researcher summarised the responses of interviewees and asked if their thoughts were correctly summarised. The researcher maintained objectivity throughout the data collection process and did not force his point of view during interviews, results write up and analysis.

3.8 Significance of the Study

Gay and other MSM related studies are rarely performed in Africa's HIV research (Jewkes *et al*., 2006) due to social, political and cultural barriers. The fight against HIV in Africa has more challenges in groups such as MSM, injecting drug users, sex workers and migrant workers (Vermund, 2014). More research in these marginalised groups will add to developing prevention measures that can assist the rates of infection in these groups to decrease at the same rate as the efforts in preventing HIV infection in heterosexual sex scenarios.

3.9 Limitations of the Study

This study was limited to the areas of Cape Town and Gauteng. The participants were chosen non-randomly and therefore the resulting data cannot be inferred to the population. The study is limited as the sampling was convenient in nature. This allowed the researcher to tailor the units of analysis to the needs of the study. The researcher sampled initially from known persons in the areas of Cape Town and Gauteng. As the majority of gay men sampled were known to the researcher, the majority of men

interviewed were coloured, with only one black gay male and one white gay male included. This study is also limited in that the National Department of Health could not be reached for an interview. This is significant as the VMMC policy is mandated by the National Department of Health.

3.10 Ethical Considerations

Bryman (2012) notes that ethics plays a role with there is possible “harm to the participants”, “a lack of informed consent”, “an invasion of privacy” and when deception may be used during the study.(Bryman, 2012)

It must be noted that this study did not involve deception of any kind to gather information from interviewees. To address the remaining three ethical considerations, a consent form was drafted. The consent form was adapted from the HRSC Generic Consent Form (HRSC, n.d.). The consent form explained who the researcher is, what the study is about and explained what was expected from the interviewees when they participated. For the purposes of this study, the interviewees were only required to provide knowledge, understanding and opinions about VMMC policy. It was made known on the consent form that their participation is voluntary. A confidentiality section was included on the consent form to ensure the participant’s right to privacy. The consent form was read by the participant and was also explained verbally by the interviewer prior to signature.

3.11 Research Report Structure

The outline of chapters in this research is as follows:

Chapter 1: Introduction

Chapter 1 provides introduction and summary of the study. It also includes the research problem, research purpose, research question and provides the background to the subject of the research.

Chapter 2: Literature Review

This chapter provides an overview of the literature surrounding the research study, which frames and defines the research gap.

Chapter 3: Research Methodology

Chapter 3 illustrates the methodology employed to answer the research question and also compares what was proposed against the actual process undergone during the research.

Chapter 4: Research Results

This chapter contains the responses of the interviewees; quoted, summarised and paraphrased in line with identified themes to answer the research sub-questions.

Chapter 5: Findings and Analysis

This chapter compares the identified themes and responses to the reviewed literature to identify findings which answer the main research question.

Chapter 6: Conclusions and Recommendations

Chapter 6 summarises and concludes the study with recommendations based on the findings in Chapter 5.

Chapter 4: Research Results

This chapter contains the responses of the three groups of interviewees. Responses are reported per group and are detailed as themes.

The first set of results details the responses of interviewed men to determine what the perceptions of men are regarding circumcision and circumcision for HIV prevention. The second set of results maps out the process that men undergo when visiting a circumcision clinic. Details of communication within the circumcision counselling process are reported. The third set of responses are from policy implementers who were interviewed to gain their perceptions of VMMC policy communication to non-targeted populations. This chapter provides the evidence that will support the discussion of findings in Chapter 5.

4.1 Interviews with gay and heterosexual men

Interviews were conducted with gay men to answer the first research subquestion: *What are the perceptions of gay men regarding circumcision and circumcision for HIV prevention?* The same interviews were conducted with heterosexual men to draw a comparison between the two sexual orientations.

The interviews were conducted to measure the knowledge that the men had of the relationship between circumcision and HIV. The interviews were also conducted to determine the perceptions, understandings and acceptability that the men had regarding circumcision. The interviewees were requested to give their views on risk behaviour modification and their interviews were scrutinised to determine whether they would compensate for any perceived reduction in risk. As part of the interviews, men were presented with examples of current media and were asked to interpret the messages that they received, with an intention to determine whether they were aware that VMMC is not effective for anal sex.

4.1.1 Knowledge, perceptions, understanding and acceptability of circumcision and VMMC

Knowledge of the relationship between circumcision and HIV

Prior to presenting any formal information to the interviewees, they were asked whether they were aware of the relationship between circumcision and HIV. Fourteen of the sixteen participants understood that circumcision reduces the risk of contracting HIV, though not all reported accurate information regarding actual data.

> *I heard that men have a 30% reduction in HIV… I've seen stuff in district clinics* (GM12, November 12, 2014)

Those that were aware of the relationship were asked how they knew about it and they cited various media for receiving this information. This included the internet, print media, television, radio, billboard advertisements and posters in clinics. It was also mentioned that the Department of Health is the originator of these messages.

> *This is what I have been seeing on media and those kinda things… mostly I read it on the internet* (GM2, September 16, 2014)
>
> *Most information these days is from ads from the Department of Health… it's on TV and print media and not so much radio.* (SM1, September 18, 2014)
>
> *I have seen billboards encouraging men to get circumcised* (SM4, October 31, 2014)

Feedback often included participant knowledge or understanding of how VMMC works and the accuracy of the knowledge was dependant on the background of the participant.

> *What I've also learnt at varsity and what I've read in papers… is that it is safer… it keratinises and becomes harder… and it prevents or lessens the chance of transmitting HIV* (GM6, Healthcare Professional, September 17, 2014)

Participants that were not aware of the relationship between HIV and circumcision were informed of the RCT trials that were conducted and how circumcision was proven to reduce the chances of HIV infection by 60%. Those that did not accurately understand

how VMMC reduces HIV infection were given accurate information to prevent any misunderstanding.

Perceptions, understanding and acceptability of circumcision and VMMC

Participants were asked to give their understanding of circumcision and to give their personal views on circumcision.

Although participants felt comfortable in discussing circumcision during the interviews, some felt that circumcision was not usually a topic of conversation that they would have with family and friends, and that circumcision was mainly heard about in the media. It was also mentioned that, although the topic of conversation in social circles could revolve around sex, sexual health and HIV was rarely discussed. One participant attributed the lack of openness to such discussion to the type of culture in South Africa that doesn't allow people to discuss issues such as circumcision.

> *Unfortunately, I feel that our culture is that we don't speak openly about these things… It's not easy to have this discussion with your wife and your children and they should make it more acceptable or more easy to talk about.* (GM2, September 16, 2014)

Most interviewees understood that circumcision is the total removal of foreskin. They also understood that circumcision is done for hygiene and health reasons, or at least, being circumcised contributes to improved hygiene and health. Certain participants were circumcised for health reasons but also mentioned that having another family member undergoing circumcision was motivation for having the procedure done.

The relationship between STI reduction and circumcision was understood by certain participants, although the understanding of the mechanism of the reduction was not always accurate. One participant that did report this relationship felt that the foreskin provides an environment that is conducive to STI infection (GM11, October 1, 2014). Others felt that the increased chances of STI infection in uncircumcised men was attributed to the inherent physical characteristics and sensitivity of the foreskin, in that the foreskin is prone breaking or tearing. One participant strongly felt that his

experience of frequent infections were caused by his foreskin (GM9, September 18, 2014).

Although there was consensus on the hygiene benefit of circumcision, two participants felt that circumcision was not necessary if foreskin hygiene is adequate. One participant mentioned that the foreskin has a protective purpose in that it protected the glans during toilet use (GM9, September 18, 2014).

> *Now that I'm older I don't think it's necessary as I'm clean and thorough. Yes, I'm quite clean and thorough so I don't see the necessity* (GM10, October 17, 2014)
>
> *Look here, for me, seeing that I'm not circumcised, it doesn't mean that I'm dirty. It just means that I have to put a little bit more effort in the shower* (SM1, September 18, 2014)

In relaying their understanding of circumcision, eight interviewees mentioned that circumcision is done for religious purposes, particularly religions such as Judaism and Islam. Culture was mentioned as a reason that circumcision is done, where participants distinguished the difference between having the circumcision done by the traditional african method or the western clinical procedure. It was also mentioned that culture was a reason that circumcision is not done, as it is not required by that culture. The participant that mentioned this spoke specifically about "coloured" culture.

> *Where coloureds are concerned, we haven't really adopted certain standards or a certain viewpoint where that [circumcision] is concerned. It's either you do it or you don't* (GM9, Coloured, September 18, 2014)

The opinions on pain in circumcision were spoken from points of view of actual experience versus perception. These points of view differed based on circumcision status. Two circumcised participants reported that circumcision is painful. Two uncircumcised interviewees perceived circumcision to be painful, whereas one understood it to be painless.

Sexual pleasure and the effect of circumcision on the penis was mentioned in a few interviews. The effect of circumcision on the sensitivity of the penis glans was seen to be both an advantage and disadvantage in terms of sexual pleasure, as some men felt

that being uncircumcised increased sexual pleasure by increasing sensitivity of the glans and some men felt that the decreased sensitivity of the circumcised penis made sex more enjoyable. One interviewee felt that circumcising the penis prior to puberty would have a diminishing effect on adulthood penis size, based on his experiences (GM11, October 1, 2014).

During the interviews, some participants voiced their opinions about circumcision as a concept. None of the participants interviewed were against circumcision. Three circumcised participants recommended circumcision, based purely on the health and hygiene benefits. One pro-circumcision interviewee also felt that child circumcision should be implemented in South Africa (GM2, September 16, 2014).

The uncircumcised participants revealed varying opinions on willingness to circumcise. Two participants felt willing to circumcise, for health and hygiene reasons.

> *One of the main concerns or main reasons for circumcision is health and well-being… If I have a choice I would probably want to be circumcised* (GM7, September 14, 2014)

One interviewee was willing to circumcise but felt that the impact the procedure would have on his time was a hindrance. The same interviewee felt that age was a factor in his willingness to be circumcised. He indicated that he would have preferred to have been circumcised at a younger age. He also felt that making a decision to be circumcised at an older age meant that his lifestyle required it to make him less vulnerable to STIs. He felt that in his life this was not the case (SM1, early 20's, September 17, 2014). Medical need for circumcision was a factor for one uncircumcised participant, who felt that this would be the only reason he would get undergo circumcision (SM4, October 31, 2014). A married interviewee felt that his marriage status prevents him from having multiple partners and therefore felt that circumcision was not a necessity. (SM3, October 24, 2014) Two participants were not willing to be circumcised due to personal choice. Another was not willing to be circumcised as he felt that his personal hygiene habits were sufficient and that it may affect his glans sensitivity (GM10, October 17, 2014). This was echoed by another interviewee who cited the effect on sexual pleasure as a reason for not circumcising. He mentioned that being circumcised is a hindrance in

homosexual sex and that the foreskin was an aid to sexual enjoyment (GM5, September 17, 2014). The need to use protection after circumcision did not persuade one interviewee to circumcise.

> *I wouldn't rush off to go have my foreskin chopped off… if I'm circumcised it doesn't mean that I can go have unprotected sex. I still need to protect myself, so for me if I'm protected it's not going to make a difference if I'm circumcised.* (GM3, September 15, 2014)

Some of the interviewees felt that personal choice to circumcise was important, outside of the requirements of religion and culture.

> *In certain religions there is no choice but especially like Christianity, this is one religion that there is a choice… You can decide whether you want to go or don't want to go. That's just my opinion about circumcision. It's a personal choice* (GM5, September 17, 2014)

The homosexual interviewees provided feedback in the interviews regarding their sexual preferences related to circumcision status of their partners. Their views ranged from pro-circumcised to pro-foreskin with some participants being indifferent to their partner's circumcision status. It must be noted, however, that none of the participants stated that the circumcision status of the partner would change their attraction to the person. Aesthetic acceptability was a factor in that one participant felt that circumcised penises are more visually appealing. Preferences for a circumcised partner was also motivated by hygiene as well as knowledge of the reduction in contraction of HIV and STIs afforded by circumcision.

> *If you were looking at a one night stand, I would always choose a circumcised over [uncircumcised]… because of the cleanliness, because of what I've heard and read.* (GM7, September 14, 2014)

> *From my personal preference, now, would be a circumcised man, because you don't want to find any funny things under there. Yeah, which makes it a little more easy to have sex with him* (GM6, September 17, 2014)

Participant GM6 also felt that he saw men who are willing to be circumcised for health reasons differently, following the launching of the VMMC campaign. He felt that these men are took more responsibility for their own health and the health of their partners. He

also felt that they are better educated. Other interviewees felt that circumcision status did not matter to them sexually, but they had certain conditions that had to be met regarding HIV status and hygiene. They felt that being regularly tested for HIV and maintaining penis hygiene was more important.

> *…for me personally, I don't have a preference. If you gonna have it, to me you have to keep it clean all the time. Keep your skin or cut it off. Sometimes I want that skin and sometimes I don't want it* (GM11, October 1, 2014)

One interviewee felt a strong sexual preference for uncircumcised men. He did not prefer circumcised men sexually and also reported that he knew of other men that did not prefer circumcised men. He described himself as "proforeskin". He did, however, stress that he was pro-circumcision for HIV prevention purposes and was in support of the VMMC program (GM12, November 12, 2014).

4.1.2 Risk Behaviour Modification

The interviews were scrutinised to determine how the men would react to the HIV risk reduction afforded by the circumcision procedure and to determine what potential they had for risk behaviour modification. The interviewees were informed about the 60% HIV reduction afforded by circumcision and were asked to provide feedback on how this statistic would influence their relationships.

Participant potential to change risk behaviours

Most interviewees mentioned that the 60% risk reduction afforded by circumcision would not increase the risks that they take in their sexual practices. The interviewees felt that the reduction afforded was not enough for them to change their risk behaviours. Most interviewees spoke about risk changes in general sex, whereas certain homosexual interviewees spoke about it from an insertive, versatile or receptive sex perspective. Some of the reasons mentioned for not changing their risk behaviours included the involvement of body fluids, understanding that the reduction is not 100% and that sex is high-risk activity when performed unprotected.

> *No, it doesn't affect me. I've always tried to have safe sex and so whether it was circumcised or uncircumcised it doesn't influence. I know the fact that me as a male who is versatile the risk is higher. It hasn't changed my preference, I wouldn't change my behaviour.* (GM12, November 12, 2014)

> *So you have 6 out of 10 chance… no I don't like those odds… Its my life I'm playing with… if you had a gun with ten chambers and you put six bullets in and you keep it on my head, am I gonna say shoot?... No, you risk your life.* (SM1, September 17, 2014)

A few interviewees were concerned as to how the communication of the 60% reduction statistic would influence the general public's risk behaviours. The general perception was that people would increase their risk behaviours.

> *Some people would think "ok, I'm going to have it done, so now I can become a slut and sleep around because I've got a 60% less chance of contracting HIV.* (GM1, September 14, 2014)

> *They think that "I'm circumcised now so I can have more unprotected sex". In actual fact, its not. Because of that statistic that's out now.* (GM2, September 16, 2014)

One of the interviewees that was concerned about the risk behaviour changes in other people gave his understanding of why he thought people would increase their risk behaviours. He felt that condom use would decrease with the VMMC campaign. He mentioned that people's background in terms of education fields create different insights into concepts and this affects how people understand them. It must be noted that the respondent is a health care professional (SM4, October 31, 2014).

> *People oversimplify things. And I think this person could say, "I'm circumcised and thus what would be the need for a condom?"…. And I do think that in the general population, people don't necessarily understand what the 60% entails. It does not immunise you or protect you. It just decreases the likelihood.* (SM4, October 31, 2014)

> *…people who work in healthcare fields… they got more insight… People, if it's not their field or expertise, they tend not to think about something* (SM4, October 31, 2014)

Condom use

The interviewees were asked to convey their perceptions on condom usage after they were informed about the 60% HIV reduction statistic. Eight of the interviewees felt that they would not change their usage of condoms. This was linked to their inclination to not change risk behaviours. Some of the reasons given to continue condom use was related to the 40% chance that circumcision does not prevent HIV infection and the potential for other STI infection if a condom is not used. It must be noted the eight interviewees were not in long-term relationships at the time of the study.

> *I still think I would be very careful and use protection. And also advise other people to be safe. I wouldn't say if you come to me and say, "listen, I'm circumcised", and I go "Yippee, you got like a 40% of getting HIV".* (GM4, September 17, 2014)

Two of the eight interviewees felt that, although they would not change their usage of condoms for penetrative sex, they would also not change their usage of condoms for oral sex. They felt that condoms should not be used in oral sex.

> *No, condoms must be used. But not when I'm giving a blow job. That doesn't feel right* (GM2, September 16, 2014)

Other interviewees felt that the usage of condoms was based on personal choice. They felt that each individual involves decision making in their sexual activities, which either leads to condom usage or unprotected sex. Two interviewees felt that the trust in the person they were involved with was a factor in the decision to use condoms or not. One individual felt that the choice to use protection negated the need to be circumcised for HIV reduction purposes.

> *Unless you're 199% sure that the two of you are totally committed, I suppose it would be ok. If you trust your partner and your partner trusts you I think you can not use a condom but you have to be careful as well* (GM1, September 15, 2014)

> *It doesn't make sense because I'm using a condom so I'm safe, no risk. I'm going to be going for this awkward process with penis bleeding and six weeks without any sort of sex and then go back to using a condom*

> *and I went through this whole process. For what?* (SM1, September 18, 2014)

Interviewees that were in relationships had differing opinions on the use of condoms. Some did not use condoms whereas others did. One individual felt that even if he was in a steady relationship, he would want to continue using condoms (GM8, September 18, 2014). A married interviewee felt that he would stay faithful to his wife in order to have unprotected sex. In any other circumstance, he would use condoms or not have sex. (SM2, October 24, 2014)

4.1.3 Interpretation of the VMMC mass media

The interviewees were presented with mass media (see Appendix 5) and were asked their interpretation of the adverts, to comment on the content and to determine whether the limitations of anal sex were known before and after the adverts.

A common perception amongst a majority of the interviewees was that the adverts were creating demand for circumcision. Some respondents felt that personal choice was being ignored in the bid to create demand for circumcision. It was also mentioned that the advertisements were using words that sell circumcision to the public, rather that the advertisements educating the public about circumcision.

> *They taking away the personal choice from the people. The message I'm getting from the ads is that they want people to go… they not asking… they saying "Go, get it done". Not "You guys need to consider" or "You guys need to think about it".* (GM5, September 17, 2014)

Another respondent also felt that the advertising was selling a product to the people, but also in a way, informing them that progress is made in HIV prevention methods. He felt that an underlying message in the advertisements was that the South African government was creating an anticipation that the fight against HIV was gaining strides. He felt that the government was communicating their efforts to the public to show action with regard to the HIV epidemic. (SM1, September 18, 2014)

One respondent felt that some men may not be interested in getting circumcised as they may believe that they may not be affected by HIV.

> *I'm just thinking about the men out there that look at this and think "But I don't need that… I don't have AIDS… I don't see how it can cause me not to get AIDS".* (GM9, September 18, 2014)

Two respondents touched on the "top-down" approach that government was taking in the implementation of VMMC, with one commenting on the influence of international pressure on South African health policies.

> *Government is definitely pushing it* (GM10, October 17, 2014)

> *You often see that when international associations get involved in SA and Africa… It's very easy to be clinical about such things if you come from a first world country. It's very easy for them, because they struggled with it for a lesser extent or not at all. But they say "look at how many of your people are dying, you must take drastic action". So it's easy for them to implement these 'slash and burn' techniques.* (SM4, October 31, 2014)

The common theme in the discussions was the target population of the advertisements. The respondents felt that the advertisements were only targeting heterosexual, African males. One interviewee mentioned that the adverts target heterosexual, African men, but he questioned the stigmatising effects of such advertising by saying that these men would be seen as men who have numerous sexual encounters with multiple partners (SM3, October 28, 2014). Some interviewees felt that the heterosexual black male demographic was targeted to steer African men away from traditional circumcision.

> *I see adverts like this going out and saying let's not do the bush circumcision, let's rather have the medical circumcisions. It's safer and it's free.* (GM4, September 17, 2014)

One interviewee perceived the target to be black people as he believed they were seen as the demographic that has the most number of people infected with HIV and that black people are the majority that use government health services. He was one of a few respondents that questioned why other races in South Africa were not used in government health advertising.

> *I would like to know why we most of the time use black people in our advertising… I do think that it's because black people are predominantly the people that are seen as having HIV… the stats are that black people do make use of government facilities… Where are the other races? The*

> *Chinese, Indian and Coloured people? Is it because they go to private hospitals?* (GM6, September 17, 2014)

The same respondent (GM6) stated that the target market was heterosexual men as circumcision was only proven to reduce HIV infection in heterosexual sex but later felt that the advertising was not just targeting heterosexual men, but that the messages were targeting all men. The same sentiment was shared by another respondent.

> *It's aimed at men. Gay, bi, straight, whatever. It says cut it off and go for it.* (GM11, October 1, 2014)

Age and economic status of target groups were also spoken about in the interviews. It was felt that the advertisements are targeting males over the age of 20 and it was felt that the advertisements excluded certain income groups.

> *It seems like they are encouraging or target the older 20-plus male… I know that your 20-plus men are more sexually active than your teens.* (GM7, September 14, 2014)

> *They not telling a middle-class Indian that circumcision can work for him or a black MBA living in Sandton.* (SM3, Indian, October 28, 2014)

In contrast to some of the homosexual respondents stating that the advertisements are targeting heterosexual men, one heterosexual respondent felt that the advertising was not specific to any type of man. He felt that the adverts targeted men in general.

> *I think they trying to take a general take, the average guy, what they think the average guy is to appeal to the masses, not a specific group of people* (SM1, September 18, 2014)

The logical conclusion behind some of the respondent's thoughts on the circumcision advertising was that circumcision protected those men whose female partners were being promiscuous outside of the relationship. Respondents felt that the shown advertisements insinuated that people have multiple partners and that monogamous relationships not considered by the creators of the mass media.

> *It's almost a promotion that people don't necessarily stick to the same partner, even in marriage* (GM3, September 15, 2014)

> *This is supposed to be a monogamous relationship… So for a male in a monogamous relationship, why would he want to do it?* (GM12, November 12, 2014)

Respondents were also concerned that the mass media was encouraging men to get circumcised and increase risk behaviours. It was felt that there was risk in some men misinterpreting the advertisements which could cause some respondents to be more promiscuous. One respondent felt that South Africans lacked enough maturity to grasp an understanding of the 60% reduction in HIV contraction (SM4, October 31, 2014). Another respondent (SM2, Black Male, Zulu) felt that Zulu men prefer to note use condoms and that they would use the information as leverage to decrease condom use. During discussions about misinterpretation of the advertisements, some interviewees were concerned about circumcised men receiving the messages of the advertisements incorrectly and believing that they are 100% protected from HIV contraction. These men would not be subject to a counselling session where the limitations of circumcision are discussed.

> *They give people the idea that having it done prevents HIV. I think how they bring the message across or trying to encourage men to have it done is wrong… I think some of the ads on its own increase risk of HIV infections, because men get the idea that "Now I'm circumcised that I don't have to use condoms". They have licence to 'chow'… When I look at the ads, ok now you telling me I can go sleep around* (GM11, October 1, 2014)

> *Some people cannot interpret the message the same… That's what I had seen when I was in KZN. Zulu men don't like to use condoms. They will tell you condoms is a waste of time and that they are circumcised.* (SM2, October 24, 2014)

The subject of education within the adverts was repeated during one respondent's discussion about increased risk behaviours. He felt that people would increase their risk behaviours because he felt that people may not understand the full spectrum of risk as the information in the advertisements may not be full educative (SM4, October 31, 2014).

Most interviewees were not aware that the 60% reduction in HIV infection was not proven effective for anal sex. Most homosexual interviewees expressed shock when

they were informed about the anal limitation and they felt that it was not communicated in the shown media. Their previous assumptions were that the 60% reduction was for all types of sexual encounters. After relaying this information to those that were not aware of the anal sex limitation, it was acknowledged by some that the risks of having anal sex with a circumcised penis was the same as having sex with an uncircumcised penis. There was also concern that the advertisements may have encouraged gay men to have the circumcision performed thinking that anal sex with a circumcised penis reduces the chances of being infected with HIV by 60%. It was generally felt that the advertisements should include information to inform people that circumcision does not reduce the risk of HIV contraction when engaging in anal sex.

> *It does not reduce the risk of HIV infection in anal sex and I do think that it is not advertised as it should be.* (GM6, September 17, 2014)

> *Motivation on TV for circumcision doesn't say it doesn't work for anal sex. How many gay men had circumcision done so that they can have the reduced risk? No one says that on TV or magazines or newspapers.* (GM11, October 1, 2014)

The one interviewee that knew about the anal sex limitation also felt that the limitation was not included in the communication media. Having worked within the health sector, he stated that health communication for gay people was not a common focus, even in the Department of Health.

> *It's a message I'm quite familiar with but the communication materials don't spread that message in the communications… But messages for gay people is not the mainstream sort of communications. Not even in the Department of Health* (GM12, November 12, 2014)

Anal sex is not limited to homosexuals. Despite this, the heterosexual interviewees were not particularly concerned about the anal sex limitation. Only one interviewee gave a reason for the non-inclusion of the anal sex limitation. He felt that it was due to bias within government because of the generational gap between government officials and the target market. (SM2, October 28, 2014)

Two interviewees felt the limitations of VMMC were not included in the communications as a result of the advertisement focusing on the positive aspects of VMMC. This

occurred after the presentation of the brochure (see Appendix 5), the only brochure that mentions the anal sex limitation.

> *It's only giving you the positives… the brochures should detail the procedure and they should talk about the negatives as well… It only looks at positives. It doesn't look at negatives.* (SM3, October 17, 2014)

The common reaction to the lack of communication of the anal sex limitation of VMMC centred on the subject of discrimination. The interviewees that reacted felt that there was discrimination against MSM in general because the anal sex limitation was not being communicated. They felt that MSM were not included in the communications by way of informing them about the anal sex limitations. Similarly, some felt that MSM were not sufficiently excluded from the target markets of the advertising campaign for VMMC in that the advertisements don't specifically state that VMMC is solely targeting heterosexual males. It was also felt that men that fall into the MSM group would not be included in mass media such as television as creators of mass media are biased towards MSM in general.

> *For me, a lot of the time they discriminate against homosexuals… most of the time they just target the heterosexual sex… they making it clear they are not worried about the homosexual… basically it's "let the homosexual die, we don't care".* (GM5, September 17, 2014)

> *I don't think they are protecting the gays… its one way of getting rid of the gays. Don't inform them. Sorry for being facetious, but its like, "We are protecting you, but actually we hope you all die".* (GM10, October 17, 2014)

In contrast, one homosexual respondent that was in favour of the VMMC programme felt that the campaign was strategic in targeting heterosexual population first. He felt that including homosexual people from the commencement of the programme would have hindered the progress of the VMMC campaign (GM6, September 17, 2014). Only one heterosexual interviewee felt that the advertisements excluded homosexuals. He felt that the advertisements were discriminating against homosexuals and even described the advertisements as homophobic. (SM3, October 17, 2014)

There were concerns about the public, and especially gay people, misunderstanding the messages that are being brought across by the media. Reactions to the concerns included suggestions that communication material be made for MSM; to instil awareness and to prevent the risk of MSM believing that they have a 60% less chance HIV infection when engaging in anal sex. It was mentioned that the advertisements are not specific with regard to the sex of the partner that the man engages with and that the advertisements should specifically mention “women” or “heterosexual vaginal sex”. One respondent felt that the advertisements spoke only about the penis and not where or how the penis is used during sexual intercourse.

> *It is nowhere stated having sex with woman, it [the advert] only says “those that I love”* (GM6, September 17, 2014)

One homosexual interviewee felt that the adverts were further misinforming in that they do not differentiate the men by sexual orientation and do not include females as sexual partners in the adverts.

> *I think it’s misinforming…. There’s no woman on these ads, telling you how it helps woman. …It’s just a man, telling me it’s the best thing he could have done. I mean, I’m a man and it’s telling me about sex. And how it helps him with regard to sex. I have sex. It doesn’t say anything about how it’s not helping me different from him.* (GM10, October 1, 2014)

Generally, interviewees felt that all groups, which include gay men, should be considered in advertisements and that the advertisements should be specific in the information that is relayed to gay men. It was suggested that there could be separate advertisements for men that fall into the MSM group of men. There was also an opinion stated that the advertisements should be as detailed as possible, irrespective of the time of the advertisements.

> *Straight and gay people should know. There should be an advert for gay guys… especially now that I know that your risk is exactly the same as anal sex. There should be an advert telling gay people, “Hello, being circumcised is not enough”.* (GM2, September 16, 2014)

> *There should be adverts that have a gay flavour to it that are directed at gay men* (GM10, October 17, 2014)

Other suggestions, particularly for anal sex limitation communication to gay men, included distributing information in gay clubs and placing VMMC information media for gay men next to VMMC information media for heterosexual men, which would allow men to choose and read the information that is applicable to their orientation.

One interviewee considered the sensitivity of discussing sex and sexual orientations on public television advertisements and suggested that the limitations of VMMC be communicated in schools and during HIV testing counselling sessions. The same interviewee made a suggestion on how messages should be created to consider all people that are receiving communication. He stated that messages should be formed so that they speak to all that engage with that communication, without singling out a specific orientation. (GM9, September 18, 2014)

A few interviewees felt that the circumcision program should be promoted simply for hygiene and health purposes. When voicing this, they felt that implementing VMMC for HIV purposes would increase HIV. One interviewee suggested that by not informing people about the HIV reduction benefit, thereby pursuing a circumcision programme mainly for health and hygiene, the benefits of HIV reduction protection would still be achieved, without the loss of the condom message and increased risk behaviours.

> *I feel that by encouraging people to get circumcised, highlighting its benefits…people are free to find out what they need to and do research, but not perhaps to advertise the HIV part so much… I feel that it should be promoted on a large scale, that they should feel that it has got other benefits to it as well…cleanliness for example… in essence you will reach the benefits for HIV* (GM8, September 18, 2014)

Respondents felt that the condom use message was not well communicated in the present media. They felt that the use of condoms was not present in the videos that were shown and that safer sex was not promoted. There was a feeling that the use of condoms was no longer a priority and that condom use was being overshadowed by circumcision. It was also felt that previous messaging regarding safe sex was being diminished.

> *The usage of condom message is becoming less and its more about circumcision.* (GM10, October 17, 2014)
>
> *If this [circumcision] was the "best thing" you could have done for yourself, then condom is second best.* (GM, October 1, 2014)
>
> *I think they blew the whole protected sex thing* (SM1, September 18, 2014)

Some respondents spoke around the topic of HIV knowledge and self-education and they felt that people educate themselves differently and therefore have varying knowledge of HIV. It was felt that people who are not knowledgeable about HIV would engage in riskier sexual behaviours. It was also felt that that the advertisements needed to provide more education to people regarding HIV prevention instead of just promoting circumcision. In contrast, a respondent (GM9, September 18, 2014) felt that messages regarding VMMC limitations would not be appropriate if presented in the mass media and felt that they were better suited to be discussed in counselling sessions and workshops.

> *The most important parts that people need to be educated on you can't put in an ad on TV. That can be done on workshops and things.* (GM9, September 18, 2014)

4.2 Interview with a VMMC clinic counsellor

An interview was conducted with a counsellor at a VMMC clinic to answer the second research subquestion: *What information do circumcision clinics provide to men who undergo the procedure?* The interviews were conducted to measure messages received by men during counselling prior to circumcision. The importance of this interview was to determine if limitations of VMMC are communicated, thereby informing gay candidates that VMMC is not effective for anal homosexual sex.

4.2.1 The VMMC process

The process for circumcision was determined from the interviewee to gain a better understanding of the process and to determine at which point communication to the circumcision candidate occurs. A diagram summarising the process flow is depicted below.

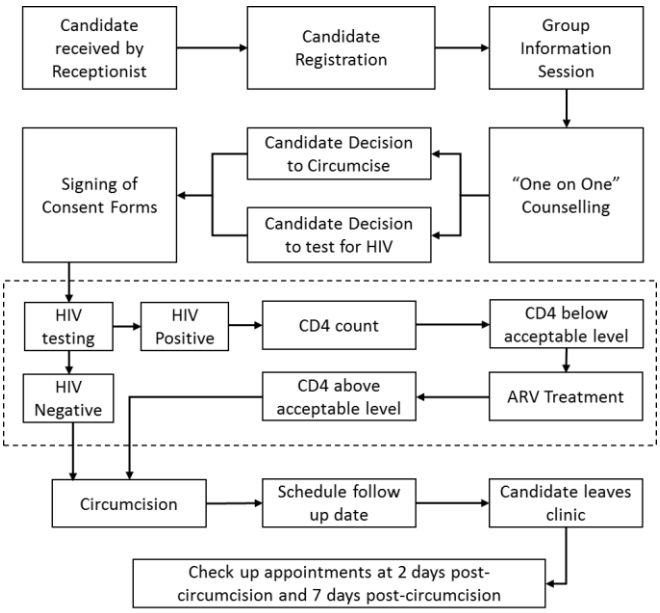


Figure 4 Circumcision process as described by counsellor (C1, December 3, 2014)

The circumcision candidate is received by the clinic receptionist. The receptionist registers the candidate and organises the relevant clinic documentation. The candidate proceeds to participate in a group information session which is facilitated by a counsellor. Groups are segregated by age.

> *We deal with different groups… young, adults and young adults* (C1, December 3, 2014)

The information session is followed by a counselling session where the candidate meets privately with the counsellor. Within this session, the candidate makes two decisions. He makes a decision to continue with the circumcision and he makes a decision to undergo HIV testing. According to the counsellor, the HIV testing is encouraged and not forced. The candidate signs consent forms for the circumcision and HIV, respectively, for the process that he agrees to. In the event that the candidate is HIV negative, he proceeds to the circumcision stage of the process. Should the candidate be HIV positive, he is referred to the medical clinic to determine his CD4 cell count. If the CD4 cell count is above the acceptable level, the candidate proceeds to the circumcision stage of the process. If the CD4 count is below the acceptable level, the candidate is given ARV treatment. Once the candidate CD4 cell count is above the acceptable level, he proceeds to the circumcision stage of the process. Following circumcision surgery, a

follow-up appointment is made for the candidate to return to the clinic for a check-up within 48 hours. The candidate is given the option to receive pain medication and is then provided transport home. The circumcision wound is checked at the 48 hour check-up and any concerns or complications are addressed. The candidate returns 5 days after the 48 hour check-up, where the wound is checked again. As the VMMC clinic is not open 24 hours, an emergency number is provided should the candidate have any complications at home.

4.2.2 Communication within the VMMC process

Communication in the circumcision process occurs in the group information session and in the private counselling session. The counsellor explains to the candidates that circumcision is the full removal of the foreskin. The circumcision benefits to males are explained in terms of hygiene, health and the 60% HIV infection reduction.

The counsellor ensures that the candidates understand that circumcision is not a cure nor a prevention tool for HIV infection and stresses the use of protection during sex.

> *Circumcision is not a cure or a prevention for HIV. After circumcision, when you are healed after 6 weeks, you still need to protect yourself* (C1, December 3, 2014)

The information session includes education about STIs. The counsellors explain that the risk for contracting HIV is increased with the presence of an STI. Should a candidate be infected with an STI, he is first treated for a minimum of 14 days prior to circumcision. The simultaneous treatment of his partner is encouraged. Circumcision benefits to female partners are communicated to the candidates during group information sessions.

The surgical complications of the circumcision procedure, such as bleeding, pain and swelling, are explained to the candidates as well as post-procedure care of the penis. The candidates are advised to elevate the penis for two weeks, by ensuring that the penis is up kept against the body, in the direction of the navel, with the assistance of underwear.

The healing process is communicated to the candidates. The time period communicated is 6 weeks, where the candidates are informed to abstain from sex for 6 weeks and encouraged to abstain from alcohol and tobacco for 2 weeks. The counsellor understood that the candidates may have sex within the healing period, to which she replied that they don't recommend it but do advise the use of condoms if having sex within the 6 week healing period.

The counsellors inform the candidates about the limitations of the circumcision procedure. Limitations are communicated in the group information session as well as in the private counselling session. Communication regarding limitations centers mainly on dispelling myths that the community may have regarding circumcision. The candidates are informed that circumcision does not cure HIV or STIs and that circumcision does not affect penis size.

The counsellors perform condom demonstrations for the candidates at the end of the group information session, when vaginal, oral and anal sex is discussed.

> *…Especially when we do condom demonstration, we go deeper into vaginal, oral and anal sex* (C1, December 3, 2014)

The counsellors do not inform the groups about the various levels of protection afforded by circumcision depending of the type of intercourse. The counsellors only inform the candidates that anal sex requires the use of a condom. The interviewed counsellor was of the opinion that the anus is not meant for sexual intercourse.

> *Even if you practice anal sex… it's not meant for sex, but people practice it. We don't judge anyone but we are here to teach them. If you practice anal sex, you must use condoms.* (C1, December 3, 2014)

The counsellor felt that there is no need to determine the sexual orientation of the candidate as she felt that the education given in the group must cover all orientations. The counsellor did not feel the need to determine the sexual orientation of the candidate as she was concerned about discrimination.

> *Especially with gays, if you discriminate, then where will they go, they need help from us. So you just need to talk about it. If he says "I'm a gay",*

> *I don't get shocked, then I just continue with my work normally and give them the help they need and they go.* (C1, December 3, 2014)

The counsellor stressed the importance of talking about sex with the candidates so that they can understand the sexual needs of their female partners.

The circumcision clinic that was used also performs circumcision and counselling on children from 10 years and above. The boys are recruited by field recruiters. The recruiters engage with the parents and arrange signing of consent forms, which are completed by the time that the boys are brought to the clinic for circumcision. The parents are encouraged to accompany the boys so that proper wound care is ensured. The information provided to young boys is censored, compared to boys aged 14 and up who are considered sexually active and are provided all information pertaining to VMMC.

> *…so we censor some of the information. From 14 years and up, some are sexually active, so we cover them.* (C1, December 3, 2014)

The counsellor reported that the clinic is subject to audits. These audits are conducted by USAID and the National Department of Health. The audits are conducted on documentation and clinic control processes.

> *They do come to our clinic once or twice a year. Some is from USAID, those who fund us for male circumcision. And from the Department of Health. They do come and check if you're still doing recording and everything, your files… if everything is packed well, is clean, the surgery, if its working… the infection control…* (C1, December 3, 2014)

The counsellor confirmed that the communication of the limitations of VMMC in group information sessions is monitored during the audits to ensure that counsellors are providing the required information.

4.3 Interviews with policy implementers

Interviews were conducted with VMMC policy implementers to answer the third research subquestion: *What are the perceptions of the policy implementers regarding circumcision policy communication to non-targeted populations?* The interviews were conducted to determine who influences policy and how policy implementation,

communication, monitoring and evaluation occurs. The importance of these interviews was to determine the policy considerations pertaining to communication differentiation and gay men.

4.3.1 International and local influences on VMMC policy

The interviewees were asked who influences VMMC policy from a local and international perspective. The interviewed policy implementers stated that the international influences on South African VMMC policy were mainly from the UN, UNAIDS and WHO.

> *In 2007, UNAIDS and WHO convened a meeting… they were saying that it [VMMC] should be part of a combination prevention strategy* (PI2, October 10, 2014)

One respondent stated that the pressure was not by the UN to make policy considerations, but that the UN was pressured by other influencers, which were not mentioned in the interview. He also stated that the policy announcement was to implement VMMC in countries with high HIV prevalence.

> *There was pressure on the UN and UNAIDS to immediately make a policy pronouncement that would expand male circumcision throughout the world, as a policy decision for high prevalence countries.* (PI1, October 6, 2014)

The same respondent emphasised that the UN was limited, in that it could only recommend VMMC scale up and that it did not have the power to enforce it in countries. Therefore, countries that want to implement had to adopt the guidelines and enforce it themselves.

The local driver for VMMC policy implementation was reported to be the South African Department of Health, which leads a technical group that oversees policy implementation.

> *…you have a technical working group who is led by the Department of Health* (PI1, October 6, 2014)

The mandates for the implementation for VMMC in South Africa were reported to be driven by both the Department of Health and the funder of the policy implementation, which is the United States government. The United States government provides this funding through the United States President's Emergency Plan for AIDS Relief (PEPFAR).

> *The United States government is the biggest funder in the space of HIV prevention and it's not just medical male circumcision, it's across a broader network.* (PI1, October 6, 2014)

4.3.2 VMMC Policy implementation and communication

The policy implementer interviews were conducted to understand who the role-players are that form the content of VMMC policy and policy communications. During the interviews, questions were asked to understand the objectives of policy and policy communication, as well as to determine if gay men were considered in policy communications.

It was reported that VMMC policy in South Africa is co-ordinated and implemented through a group of policy implementing partners called a technical working group. This group is led by the Department of Health and convenes once every three months. The implementing partners consist of non-governmental organisations (NGOs). NGOs are involved to in the policy implementation as they are reportedly more efficient in implementation.

> *Government…they can do long integrated programs but they can't do vertical programs. They don't have the staff or the resources. They can't do project stuff. As soon as you need a rapid scale up kind of programme, government can't do that… NGO's do that. They are nimble and quick* (PI2, October 10, 2014)

The policy implementers that were interviewed were the heads of two NGO's and are active members of the technical working group for VMMC.

The VMMC policy document for South Africa could not be found during the literature review of this report. During the interviews, the policy implementers confirmed that there is no published policy document for VMMC. One respondent stated that a guideline had

been written, although it was never published. He also stated that the written guideline had been revised since being initially written.

> *There has been a policy since 2010… In 2010, me and some other people spent…time writing policies and guidelines, to the detail…To this day it hasn't been signed off. Now we've gone through the revision process…The Department of Health has not signed it off.* (PI2, October 10, 2014).

When asked why the policy document was not published, the reason given was that circumcision was perceived as an existing procedure with new benefits and that is was part of existing policy.

> *There are no guidelines on medical male circumcision and the Minister [of Health] took the point of view as far as I can remember that we didn't need a policy because male circumcision was always part of our policy. Remember, male circumcision is not a new intervention in South Africa… It just has new benefits to what it had previously.* (PI1, October 6, 2014)

As a policy document could not be sourced, the objectives of the VMMC policy could not be determined. The interviewees were questioned to determine what the objectives of the policy is. It was reported that the objectives of government is to ensure that HIV prevention is promoted as a combination of testing, condom use and circumcision. Another objective for the VMMC policy is to create an HIV free nation with no new infections.

Respondent PI1 is head of one of the NGOs that co-ordinate VMMC communications. His organisation sees primarily to the mass media aspect of the VMMC campaign. The objective of his organisation is to promote HIV combination prevention i.e. promoting the use more than one HIV prevention tool, which includes male circumcision.

> *We promote combination HIV prevention which means we talk about male circumcision within the context of condoms, HIV counselling and testing* (PI1, October 6, 2014)

Respondent PI1 reported that the objective of communication in VMMC policy is to get more men tested and to enforce condom messaging. The communication should also

ensure that limitations of medical male circumcision, as a medical intervention, are not misunderstood by the recipient of the communication.

> *We are very aware that on the one level you are promoting a biomedical intervention but at the same it is not a fool-proof biomedical intervention. So it is about trying to balance those different messagings* (PI1, October 6, 2014)

Other objectives reported included providing people with a choice about prevention, to promote all methods of prevention and to communicate the risk of having multiple partners, all at a mass media level. A special emphasis was placed on the communication objective to inform the public that they have a choice about their lifestyle. Other objectives included increasing the knowledge of HIV and the benefits of circumcision.

The types of communication employed are radio, TV, billboards, print media and social media. It was reported that communications are also done in all 11 official languages of South Africa on various radio stations.

The head of the communications NGO, respondent PI1, stated that the main media that their NGO produced was mass media, which includes radio, TV and billboards. The NGO also created the leaflets that are distributed to the public as well as the “toolkit” brochures that are used to discuss circumcision with clients.

Different areas in South Africa have different NGO’s handling communications. Communication works as a multiple partner network to tailor communications to the relevant areas of NGO responsibility. The messaging is guided by a national communication survey and it is ensured that implementing partners use the same messaging to prevent contradictions.

> *The reason for multiple communication interventions is that we know from the national communication survey that one size does not fit all.* (PI1, October 6, 2014)

Communication brochures that are used in discussions with clients and are not meant to be read alone. They are not mass distributed. Community services workers (CSWs) are

employed to make contact with the clients and to discuss the brochures with them. They were reported to be an integral part of communication in the VMMC campaign. Personal contact with clients by CSWs is seen as necessary for circumcision as circumcision is seen to be a sensitive and invasive topic.

> *The toolkit is a flipchart that we have developed basically a field worker would use to facilitate a dialogue with potential clients of medical male circumcision.* (PI1, October 6, 2014)

At the time of writing the literature review of this report, a documented communications strategy for VMMC could not be sourced. During the policy implementer interviews, an enquiry was made to determine a source for the documented communications strategy for VMMC in South Africa. It was confirmed that a strategy was created and it was never published. It was reported that the strategy was dynamic and that it would not make sense to document it as it often changed. The current communication strategy was reported to be documented in a primary, unpublished state.

> *The strategy is an ongoing process as medical male circumcision really evolves at a rate of next to nothing… We had a very detailed one in 2008 and the updated version we basically put in [Microsoft] Powerpoint.* (PI1, October 10, 2014)

The communications strategy is divided into tiers and the creative aspect of the respective communications is delegated to the communications implementation partner, who must ensure that the messaging remains the same as all other communications implementation partners.

The target audience for VMMC communications was reported to fall with LSM[6] brackets of 3-7. This meant that the communications for VMMC was specific in terms of the audiences they were targeting. These audiences were termed as “priority audiences” and were described as populations that were primarily black people that lived in informal / periurban environments with high levels of HIV. The target age at the time of this

[6] Living Standards Measurement

research was reported to be men from 16 to 30 years of age with further characteristics of being unemployed and having high risk behaviours.

> *From a communication point of view we have specific target group… We call them priority audiences… At this point in time it men from 16 to 30... So now the communication interventions is around how do we deal with out of school user, the unemployed user, most probably youth who have risktaking behaviours and how do we capture that audience.* (PI1, October 6, 2014)

> *Our target audit is LSM 3-7…predominantly black population, informal or periurban environment, high levels of HIV… When we delineate we go by age and race, because the LSM and age determine whether they buy the media.* (PI1, October 6, 2014)

The policy implementers were asked if gay men were considered in VMMC policy and VMMC policy communication. It was confirmed that there is no mass media communication for the limitations of VMMC. It was also confirmed that there is no specific messaging for MSM. MSM's are also not discussed in the technical working group for VMMC.

> *We haven't [been doing limitation communication]. We haven't focussed on MSM at all. No specific messaging for MSM.* (PI2, October 10, 2014)

It was, however, reported that MSM representative groups were initially involved in the technical working group but were no longer involved as the data revealed that VMMC does not assist in MSM populations.

It was also reported that gay men are generally not a focus for VMMC policy and policy communication and that the communications were focussed on specific audiences due to budget constraints.

> *Where do MSM groups fall on the radar for circumcision? I'll be honest, not very high. Focus demands sacrifice. We get a budget and we have to use the budget to maximise effect.* (PI1, October 6, 2014)

The communications was reported to be hetero-centric as South Africa's HIV epidemic is mainly situated in the heterosexual population of the country. It was admitted that MSM is a neglected population from a communications perspective.

> *I would be the first one to say that it's a neglected area from a communications point of view.* (PI1, October 6, 2014)

It was reported that the position of the policy was not to discriminate against gay men getting circumcised and that it was not part of the circumcision process to determine the sexual orientation of the client.

Respondent PI1 also reported that he had knowledge of the increase in infections in the MSM population in First World settings, particularly younger men, due to a decrease in communications to that population regarding HIV. He was concerned that the same effect was occurring in South Africa. The respondent felt that MSM interventions for HIV are going to get less with more donors moving out of South Africa. He did however state that the MSM population is on the agenda for consideration during policy making and policy decisions but this was not focussed on the VMMC policy specifically.

When questioned about the communication of the limitations of VMMC in mass media, respondent PI1 stated that additional time on advertisements for advertising the limitations of VMMC would not be feasible as the extra time would cost extra money and would burden the budget.

> *What people don't realise is how expensive media actually is. So even if I do that, it's another 3 seconds and media works in terms of 5 seconds so we would have to stretch it…An additional costing of 5 second on all the radio [stations] for one month would be the cost of running an entire campaign on another radio station for another month. So where do I put my money?* (PI1, October 6, 2014)

Respondent PI2 felt that including the limitations in mass media would distort the understanding of VMMC in the public and create confusion.

Despite the confirmation that VMMC limitations are not included in mass media, it was confirmed by Respondent PI2 that the anal sex limitation is communicated during the VMMC counselling process that all potential circumcision clients must undergo prior to circumcision. It was felt that the communication in the counselling session was imperative as it informed gay men about the anal sex limitation.

Although Respondent PI1 felt that the communication of the anal sex limitation could not be included in mass media, Respondent PI2 felt that communications should include the anal sex limitation so that gay men are aware of the low protective effect. The respondent was concerned about risk behaviour changes that gay men may make if proper communication about the low protective effect is not done.

> *If you circumcise a gay guy and you're not telling him that he's not getting a protective effect from that, then you're doing him a disservice because he might think he's getting a 60% protective effect and he doesn't* (PI2, October 10, 2014)

Condoms and condom use featured as a common theme from the policy implementers. The general take from both implementers is that condoms had failed or are ineffective as an HIV prevention method.

Respondent PI2 stated that the activists that are anti-circumcision often used the argument that the promotion and use of condoms is sufficient as HIV protection. He felt that the sole promotion of condom use is not effective.

> *But that's often their [anti-circumcision groups] argument…you should anyway use a condom so you might as well just promote condoms. It hasn't worked in 20 years and it's not going to work now…People don't use condoms correctly and consistently.* (PI2, October 10, 2014)

He further motivated for circumcision by saying that condom use in new relationships decreases with increase in trust. His concern was not so much about risk behaviour changes at the point of circumcision, but more the reduction of condom use with the increase of trust in new relationships.

4.3.3 VMMC Policy monitoring and evaluation

The policy implementers were interviewed to understand whether policy outcomes are considered for policy changes, what form policy monitoring and evaluation takes and if policy monitoring and evaluation takes cognisance of outcomes in intended and unintended groups.

The policy implementer respondents reported that the VMMC technical working group performs monitoring and evaluation. The technical working group monitors risk behaviour changes and condom usage, as well as the number of men being circumcised. It was reported that the outcomes of the policy are evaluated by the number of new infections that occur.

It was reported that policy monitoring and evaluation was only recently started in terms of measuring intended and unintended outcomes. The monitoring and evaluation started as resources such as finance and experienced people became more available.

Monitoring also occurs for US funded medical male circumcision sites and this is conducted by the funder. A quality assurance team conducts regular audits at the sites. As part of the audits, communication messaging is also scrutinised to ensure that the messaging ensures minimal risk behavioural changes. It was also confirmed that monitoring is also conducted by the Human Sciences Research Council (HSRC).

Two surveys are used in the monitoring and evaluation of the VMMC policy viz. the national communication survey and the HSRC studies. The feedback is presented to the technical working group and the various implementation partners look at the feedback that impacts their respective portfolios.

> *There's two surveys for that, the HSRC survey and the national communication survey…That goes to the technical working group. They will reflect on it and we will look at it from a communications point of view.* (PI1, October 6, 2014)

It was reported that one of the changes that was in progress at the time of this report is the reinforcing of the use of condoms in communication messaging and also the reinforcing of correct behaviours. It was reported that current evaluation research is not detecting any behavioural risk changes in men. It must be noted that circumcision NGOs are compensated for each circumcision that they perform, and this could negatively influence the evaluation of the policy from an ethical perspective, in that the evaluation may be skewed towards the intended target populations of the VMMC policy.

In terms of consideration of MSM, it was confirmed that the technical working group was not looking at the impact of VMMC policy on its unintended groups, such as MSMs.

Summary

VMMC policy communication has filtered through its various channels and the responses of men in this study shows evidence that its messages have reached the public. Responses from men have provided evidence that there is knowledge of the relationship between circumcision and HIV. Discussions with men revealed themes such as religion, culture and willingness to circumcise. The interviewed men were generally not inclined to change their sexual risk behaviours based on information that circumcision reduces HIV infection by 60%. There was also a lack of awareness that VMMC does not afford the same protection in all modes of sexual engagement, such as anal sex.

Anal sex is addressed during the counselling session when condom use is discussed. The use of condoms is emphasised during counselling but the differing levels of protection per mode of sexual intercourse is not addressed. Sexual orientation of the candidate is not determined during counselling sessions. The counselling process is subject to audits by USAID and the National Department of Health, where the communication of VMMC limitations is ensured.

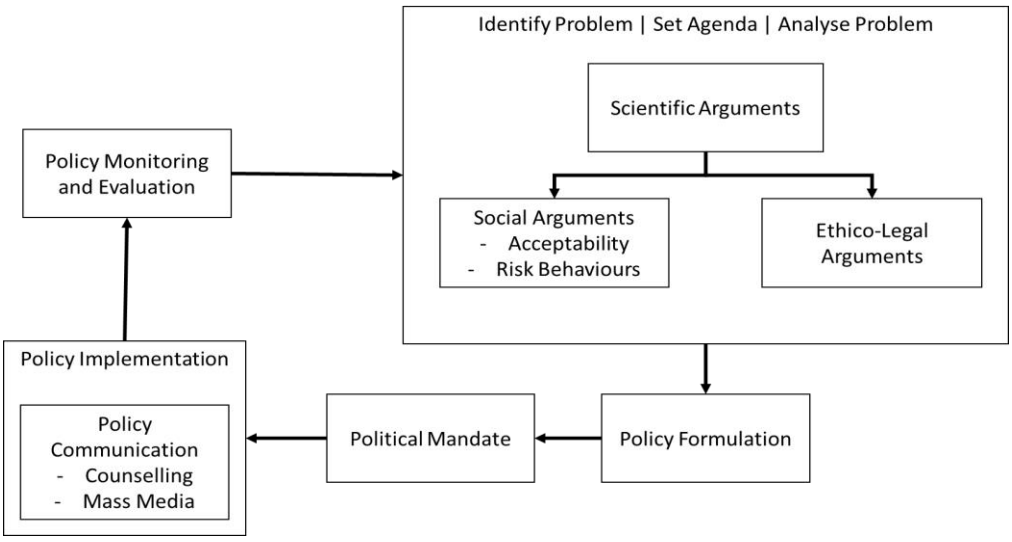
Responses from policy implementers have revealed that the implementation of VMMC in South Africa is under the influence of both local and international bodies. Global bodies such as WHO and UNAIDS have recommended the implementation of VMMC, with the United States providing the funding for South African VMMC implementation through PEPFAR. The National Department of Health mandates the implementation of VMMC in South Africa, which is implemented through NGOs. The VMMC policy document is not finalised, nor published, and neither is the policy communications strategy. The target population of the policy communication was informally established to be predominantly black persons, living in informal areas with high levels of HIV. MSM are not considered in policy communication nor are they considered during policy monitoring and evaluation.

The responses documented in this chapter will be discussed in conjunction with the reviewed literature in Chapter 5, where findings are documented and analysed to determine the answer to the research question of this study.

Chapter 5: Findings and Analysis

This chapter discusses the findings of the study, which are analysed in conjunction with the reviewed literature in Chapter 2 Literature Review. The research question and its origins, which are situated in the research gap, are recapped. Responses of the interviewees are discussed within the VMMC policy cycle. These responses are correlated to reviewed literature, where applicable, and new information that surfaced during interviews are recorded. The chapter concludes with the answer to the main research question of this study.

Chapter 2 Literature Review described the policy cycle in terms of the VMMC process. The diagram is shown below for easy reference.



The research gap was identified by following the policy cycle from the initial studies that demonstrated the 60% HIV contraction reduction afforded by circumcision and then incorporating the scientific studies that prove that circumcision has not been demonstrated to have the same effect in anal sex. The research gap invoked the main research question of this report:

Does the communication of the policy for circumcision for HIV prevention take the gay population into account in terms of the messages it intends to send, the limitations of the procedure and the population it intends to target?

To answer the main research question, various concepts in the above policy cycle were explored by asking three subquestions to different interview groups that would be able to provide insight, information and perspective on that concept.

Research Subquestion		Unit of Analysis	Concept
1.	What are the perceptions of gay men regarding circumcision and circumcision for HIV prevention?	Gay men	Social Arguments: - Acceptability - Risk Behaviours Policy Communication: - Mass Media
2.	What information do circumcision clinics provide to men who undergo the procedure?	Circumcision Clinics	Policy Communication: - Counselling
3.	What are the perceptions of the policy implementers regarding circumcision policy communication to non-targeted populations?	Policy Implementers	Policy Formulation Policy Mandate Policy Implementation Policy Monitoring and Evaluation

Circumcision acceptability

Circumcision acceptability studies for gay men in South Africa could not be sourced during the literature review of this study. The literature base of the review consisted of literature based on international and local literature, with the majority of literature found to be focused on heterosexual relationships in the context of VMMC.

This study has generated data regarding acceptability of circumcision by South African gay men, which was generated during interviews where gay men were requested to give their understandings of circumcision. Themes that coincided with literature included hygiene benefits, pain, culture, effects on sexual pleasure and partner acceptability. Increased hygiene was seen as an advantage of circumcision and this coincided with the reviewed literature (Bailey *et al.*, 2002; Lukobo & Bailey, 2007; Ngalande *et al.*, 2006; Rain-Taljaard *et al.*, 2003; Scott, Weiss, & Viljoen, 2005).

Pain was a common theme in the responses of the interviewed men and the literature in that pain was a consequence and potential barrier to circumcision (Bailey *et al*., 2002; Begley *et al*., 2008; Lukobo & Bailey, 2007; Ngalande *et al*., 2006; Rain-Taljaard *et al*., 2003).

The literature reviewed around cultural acceptability of circumcision demonstrated that culture in noncircumcising communities may be a barrier to circumcision in African settings (Bailey *et al.*, 2002; Lukobo & Bailey, 2007; Scott *et al.*, 2005) and international settings (Pando *et al*., 2013). Although the interviewed men of this study were aware of the cultural and religious influences of circumcision in their surroundings, the interviewees were not held to circumcision traditions nor religious obligations. Most interviewees were coloured which does not require circumcision by tradition, unless their religion required it. None were practicing Muslims, which would have required them to be circumcised by religion.

The results of the interviews with the gay and heterosexual men showed differing views on the effects of circumcision on sexual pleasure, in that the men felt that either circumcision increased or hindered sexual pleasure. The variations in respondent perceptions correlated to the variations in the acceptability studies that reported on effects on sexual pleasure (Bailey *et al*., 2002; Boyle *et al*., 2002; Eaton & Kalichman, 2009; Kigozi *et al*., 2007; Kim & Pang, 2007; Lukobo & Bailey, 2007).

Willingness to circumcise in the literature was seen to be affected by levels of protection afforded by circumcision (Eaton & Kalichman, 2009) and culture (Lukobo & Bailey, 2007). Studies have also revealed that men were more willing to circumcise if circumcision reduced the chances of contracting STIs (Lagarde *et al*., 2003; Rain-Taljaard *et al*., 2003) and HIV (Rain-Taljaard *et al*., 2003). The interviewed men in this research also felt that they would be more willing to circumcise for general health and hygiene, as well as for the potential reduction in STI and HIV infection. This study also found that the uncircumcised participants were not keen to circumcise due to their age and the time needed for circumcision. Other factors that men felt negated circumcision was being married, having to still use a condom, the personal choice to use a condom

and the loss of sensitivity of the glans. Overall, most respondents felt that circumcision was a personal choice, outside of the requirements of culture and religion.

Homosexual and heterosexual responses carried similar themes with regard to circumcision acceptability. Only homosexuals differed in that they gave more insight into partner acceptability, as some of them had preferences for either circumcised or uncircumcised penises. It must be noted that a few gay men were indifferent to the circumcision status of their partner, as they were more concerned about how their partner maintained personal hygiene and what the HIV status of their partner was. When compared with the partner acceptability studies that were reviewed, where females were the respondents, the gay men provided similar reasons for preferring a circumcised partner: hygiene (Ngalande *et al*., 2006) and aesthetics (Bailey *et al*., 2002). Other reasons for preference of a circumcised partner included better prevention of HIV contraction.

This study finds that gay men and heterosexual men have similar understandings and acceptability of circumcision. The gay men have added more data to this by including their preferences for their partners in terms of circumcision. The results correlate well with previous research.

Risk Behaviours

White *et al.* (2008) stated that the reduction in HIV infection afforded by circumcision may be offset by increases in sexual risk behaviour. Increases in risk behaviours have been shown in studies to be the increase in sexual partners (Lagarde *et al*., 2003; Rain-Taljaard *et al*., 2003) and decreased condom use (Boyle *et al*., 2002; Gwandure, 2011; Hill & Denniston, 2003; Rennie *et al*., 2007). Having determined that the interviewed men were aware that circumcision reduces HIV infection by 60% in female to male transmission, they were asked how they would possibly change their behaviours based on this knowledge. Overall, all respondents, both homosexual and heterosexual, stated that they would not change their risk behaviours, as the risk reduction of 60% was not sufficient to allow them to perceive sexual intercourse with a circumcised penis to be of less risk. The homosexual group perceived this for both insertive and receptive anal

sex. The interviewed men that were single did not provide much information regarding a potential increase in sexual partners, whereas the men in relationships and marriages emphasised their fidelity to their partners. Participants endorsed the use of condoms during sex irrespective of circumcision status. Concerns from the respondents regarding the public's view of circumcision and the potential for increased risk behaviours echoed that which Gwandure (2011) stated, in that people may misunderstand the 60% reduction and increase their risk behaviours (Gwandure, 2011). The respondents felt that condom use would decrease in the population and also felt that people's backgrounds influenced their perception of risk. It must be noted that this study did not explore the use of condoms pre- and post-circumcision, but focused on men's perceptions.

This study finds that the interviewed subjects were disinclined to increase their sexual risk behaviours based solely on the knowledge that circumcision reduced HIV infection by 60% in female to male transmission. It must be noted that the results for exploring respondent potential for increased risk behaviour were taken from responses that were given to the researcher prior to the respondents receiving the knowledge that circumcision does not afford the same protection for anal sex. This study also finds that there was no difference between the responses of the heterosexual and homosexual respondents regarding potential for increased risk behaviour.

Policy Formulation and Mandate

Theory around policy formulation states that the formulation of a policy includes the documenting of its content and the creation of alternate policies or options for addressing the issue. It includes the focussing of the various arguments that arise out of policy analysis to produce a final policy (Kaul, 1997). Interviews with policy implementers confirmed that the VMMC policy document for South Africa has not been published at the time of this study.

The VMMC policy in South Africa is influenced by both local and international role-players. This study has revealed that international role-players in the VMMC policy include the WHO, UN, UNAIDS and PEPFAR, who is the largest funder of the VMMC

policy implementation in South Africa. The policy is mandated locally by the National Department of Health and it implements the policy through a technical working team which comprises of various NGO implementation partners. There were perceptions from the interviewed gay and heterosexual men that the policy was being forced down onto the population. This echoed that which Gwandure (2011) cautions about in his ethical analysis of VMMC, where he mentions that policy implementers may rush a policy without considering social and cultural impacts. (Gwandure, 2011)

This study finds that the lack of a policy document represents a weakness in the VMMC policy, in that proper policy formulation has not occurred. This has implications on policy content, which affects policy implementation, policy communication and policy objectives (Kaul, 1997). This study also finds that the mandating of this policy may be influenced by outside actors, which may cause policy makers to implement policy without proper analysis (Grindle & Thomas, 2011)

Policy Implementation

Implementation of the VMMC policy is done through the technical working group, which comprises of NGO implementation partners, led by the National Department of Health. It was confirmed in this study that roles within the technical working group include operational implementation partners and communication implementation partners. Communications are influenced by a national survey and it is ensured that all communications partners use the same messaging to prevent contradictions. Kaul (1997) states that policy implementation involves engaging with the public and communication the policy to them. He also states that the implementation of a policy has to include the strategies that will assist the intended policy outcomes to be realised. (Kaul, 1997). A published communications strategy for the South African VMMC policy could not be sourced during this study's literature review. Interviews with policy implementers have confirmed that the communication strategy is not a formally published document.

This study finds that a lack of a formally published communication strategy presents a weakness in the policy implementation aspect of the VMMC policy.

Policy Communication: Mass Media

Men's interpretations of the mass media showed that the communications were creating demand and that the media content ignored personal choice in the decision to circumcise. Men felt that circumcision was being sold to them. This is in line with research that has been done to increase demand creation for the VMMC programme in South Africa (Nieuwoudt *et al*., 2012). The respondents' almost unanimous awareness of the demographics of the actors in the advertisements, coincided with responses from a policy implementer, in that the target population consisted of African males over the age of 20. This did not deter the men from perceiving that the advertisements were communicating to all men, irrespective of race, age or sexual orientation. Negative responses from the men included that the advertisements were advocating promiscuity and there were also perceptions that condom use and safer sex was not promoted. The respondents also felt that the advertisements lack an educative element, which may lead to the public increasing risk behaviour as a result of a lack of information regarding circumcision and HIV. Responses from the men included that the advertisements do not take into consideration the already circumcised man, who may misinterpret the messages and increase his sexual risks, without the option of receiving information through counselling. The above represents the concerns of all the men interviewed, irrespective of sexual orientation.

All respondents, except one, were unaware that circumcision does not reduce the risk of HIV infection by 60% in anal sex. Further concerns taken from the men's interpretations of the mass media were almost exclusively expressed by the homosexual respondents surrounding the topic of circumcision and anal sex. The gay respondents were concerned that gay men may misinterpret the mass media and that these gay men may believe that circumcision reduces the chances of HIV infection, irrespective of the mode of sexual intercourse. The gay respondents generally felt discriminated against and also expressed that they are not considered in the campaign as a group. This phenomenon relates to homosexual exclusion and discrimination in African policies, as described by Fox & Thomson (2012), where policy makers become blind to other modes of HIV transmission when the HIV burden is seen primarily as heterosexual (Fox & Thomson,

2012). The homosexual respondents suggested that MSM should be informed about the anal sex limitation through the advertisements or they should be properly excluded from the target population of the advertisements. Discussions with policy implementers confirmed that there is no mass media messaging for the anal sex limitation and that there were no specific messaging plans for MSM. Budgetary concerns were cited for not including anal sex in the mass media communications.

This study finds that the advertisements are lacking in providing important, comprehensive information to the recipients of their messages, especially with regard to the anal sex limitation of VMMC. This study also finds that gay men or MSM are not considered in, nor are they sufficiently excluded from, the target population of the VMMC policy. Therein lies the risk that recipients of the mass media communications for VMMC may misinterpret its messages and this may lead to false perceptions of HIV protection levels afforded by circumcision. This is especially a concern for men who engage in anal sex with other men, as exclusion of the anal sex limitation leaves them open to interpret that circumcision provides a 60% reduction in HIV infection in all modes of sexual intercourse.

Policy Communication: Counselling

Counselling was found to include the defining of the concept of circumcision to candidates as well as the explanation of the benefits that circumcision has regarding health and hygiene. The counselling takes an educative format, both in group sessions and in individual counselling sessions. This is in line with recommendations from WHO (WHO/UNAIDS, 2007). Communication in counselling sessions include STI education, surgical complications, post-operative care and the candidate lifestyle changes during the post circumcision healing period of 6 weeks. Condom use is stressed during the counselling session, as required by WHO and emphasised by literature (Eaton & Kalichman, 2009). Modes of sexual intercourse that are discussed during condom demonstrations include oral, vaginal and anal sex.

All the elements of the counselling session were perceived to be comprehensive, however, the counsellor does not explain the differing levels of protection between

vaginal and anal sex. This is not in line with WHO recommendations that state that the anal sex limitation must be clearly communicated to both heterosexual and homosexual candidates (WHO/UNAIDS, 2007). Anal sex is only addressed by the counsellor, when it is stated during the counselling session that condoms should always be used during anal sex. Sexual orientation is not discussed during the counselling session, both in group sessions and individual sessions. It was cited that sexual orientation is not determined by the counsellor during counselling as the counsellor is concerned about the candidate experiencing discrimination.

This study finds that the counselling session does insist on condom use for anal sex, but doesn't sufficiently educate the circumcision candidate in terms of the differing levels of protection between vaginal and anal sex.

Policy Monitoring and Evaluation

It was confirmed that policy monitoring and evaluation for the VMMC policy was recently started by the technical working group that implements the policy. Lack of a published VMMC policy and VMMC communications strategy meant that objectives could not be determined and policy implementers could not be asked if the current policy is meeting its intended outcomes (Anderson, 1994). A policy should define the target population which it means to affect. This does not mean that the policy effects are confined to that population. Policy evaluation needs to evaluate the effects on unintended groups (Anderson, 1994). Interviews with policy implementers confirmed that MSM are not the focus population for VMMC. It was also confirmed that policy evaluation for VMMC does not consider the effects of the policy on MSM as an unintended group.

This study finds that policy monitoring and evaluation does not consider the effects of VMMC policy implementation and communication, especially on the MSM population. It does not evaluate its unintended outcomes on unintended groups that may be affected by the policy (Anderson, 1994).

Summary

This research report finds that the policy communication of the VMMC policy does not take into account the gay / MSM population in terms of the messages it intends to send nor the communication of VMMC limitations. The policy has not taken into account the effects it may have on unintended groups. It is perceived that the policy is highly influenced by global pressures, from WHO/UNAIDS recommendations to implementation funding by the United States, which sees the policy implementation taking a top-down approach by the National Department of Health with little consideration for population group mix on a local scale. The policy is being implemented in a vigorous nature to ensure its legitimacy and sustainability, and it ignores the proper fundamentals of policy process in its mission to ensure implementation.

Chapter 6: Conclusion and Recommendations

The purpose of this study was to determine whether gay men are taken into consideration in the VMMC policy and to determine if the policy communication effectively differentiates information to ensure that intended and unintended groups of the population are aware of the limitations of VMMC. In order to obtain this information, it was necessary to explore the various parts of the VMMC policy in terms of the policy cycle process. Policies exist in a cyclical nature and analysis of the arguments for intended policy leads to policy formulation and implementation. The analysis of policy is expected to be an ongoing exercise for existing policy, with effective policy monitoring and evaluation providing new information for analysis of policy, thus leading to change. Ineffective analysis of a policy and its stakeholders leads to the content of the policy being skewed towards intended target populations of the policy and this may negatively impact groups for which the policy is not intended (Bernhardt, 2004).

A review of the literature within the VMMC space provided the frame for this study, and supported the research question, in that there was a lack of knowledge as to whether the South African VMMC policy process properly considered that all modes of sexual intercourse do not offer 60% protection from HIV infection, post-circumcision. The methodology of this study was formulated to explore the messages that VMMC policy communication sends and determined whether the creators of those messages were considering gay men within the context of VMMC's anal sex limitation.

In the case of VMMC policy, this study has demonstrated that gay men are not considered at various stages of the policy i.e. analysis, formulation, implementation, communication, monitoring and evaluation. Policy implementers interviewed in this study have stated that gay men are not considered during population targeting, communication message formation and policy monitoring and evaluation. The effects of this is evident in the responses of gay men when interpreting the current mass media. In the problem statement of this research, one of the stated concerns was that the lack of communicating the limitations of VMMC to gay men in mass media may lead to gay men undergoing a procedure that provides a false sense of security. Evidence in this

study from gay men ratified this concern. Despite confirming that anal sex with condoms is emphasised in VMMC counselling sessions, the data revealed that already circumcised gay men may misinterpret the mass media and may feel protected as they are not subjected to the communication in the VMMC counselling session. The exclusion of the consideration of gay men in the VMMC policy may be a symptom of the lack of inclusion of studies that demonstrate that VMMC is ineffective for anal sex, into the analysis of VMMC policy. It is acknowledged that modifying the VMMC policy agenda in South Africa in this regard is possible, however, with condemnation of homosexuality in other African countries who are implementing VMMC, the consideration of gay men and the anal sex limitation in their policy agendas may not become a reality. As this study has demonstrated, the possibility exists for gay men to misinterpret the messages of VMMC media and undergo a procedure that does not afford them the same protection in their mode of sexual intercourse. This may ultimately lead to increased HIV infections in the MSM population.

The following recommendations of the VMMC policy in South Africa are proposed:

- Circumcision acceptability studies across all races, economic backgrounds and sexual orientations.
- Proper policy analysis by incorporating the arguments that VMMC has not been proven to reduce HIV infection by 60% in anal sex.
- Formulation and publication of the VMMC policy with objectives, target populations and unintended groups included.
- Formulation and publication of the VMMC communications strategy with objectives, target populations and unintended groups included.
- Effective policy monitoring and evaluation with new objectives from the published policy.
- Adequate and competent resources to evaluate the intended and unintended outcomes of VMMC policy.
- Inclusion of VMMC limitations in mass media or the proper exclusion of MSM from the target audience in mass media messaging.

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Appendix 1

Interview Questionnaire: Semi-structured interviews with gay men and heterosexual men

- Introduction
- Explaining and signing of consent form
- Purpose

1. What is your understanding of circumcision?
2. What is your own view and opinion on circumcision?
3. What do you know about the relationship between circumcision and HIV?
4. Trials have shown that circumcision reduces the rate of HIV infection from women to men by approximately 60%. What does this mean to you?
5. What does this mean for your relationship with others?
6. What does this mean you can and cannot do?
7. What does this mean to you in terms of condom use?

(VMMC adverts are presented to interviewee)

8. What does this advert tell you?
9. What does this mean for you?
10. What does this mean you can and cannot do?
11. What do you understand by ‘safer sex’?
12. How does the circumcision programme influence your understanding of ‘safer sex’?

Appendix 2

Interview Questionnaire: Semi-structured interviews with VMMC clinics

- Introduction
- Explaining and signing of consent form
- Purpose

1. Please explain the process that men undergo when they express interest in VMMC.
2. Please take me through the counselling process that men receive when they undergo circumcision.
3. Please highlight the benefits and limitations of the procedure.
4. To what extent do you tailor your message to men who have sex with men?

Appendix 3

Interview Questionnaire: Semi-structured interviews with policy implementers

- Introduction
- Explaining and signing of consent form
- Purpose

1. Who is leading the drive for circumcision internationally?
2. Who is leading the drive for circumcision locally?
3. Please explain the relationship between the Department of Health and organisations such as CHAPS and Brothers for Life.
4. Please explain how VMMC policy monitoring and evaluation takes place in South Africa
5. How do the outputs and outcomes re-influence the current policy?
6. How are the impacts on unintended groups evaluated and how are they considered in current policy?
7. What is the VMMC communication strategy in South Africa?
8. Who determines the current content of VMMC policy?
9. What are the objectives of VMMC policy in South Africa?
10. How have gay men been considered in the content of VMMC policy?
11. What are the objectives of VMMC public communication?
12. How are these objectives addressing gay men?
13. How is the content of public communication derived and how are unintended groups considered?

Appendix 4

INFORMATION SHEET AND CONSENT FORM[7]

Who I am
Hello, I am Deon Poovan. I am currently studying towards a Masters Degree in Management in Public and Development Management at the University of the Witwatersrand.

What I am doing
I am conducting research on Medical Male Circumcision and its impact on gay men. I am conducting a study to find out more about the perceptions and views of involved people

Your participation
I am asking that you allow me to conduct one interview with you about your knowledge, understandings and opinions. If you agree, I will ask you to participate in one interview for approximately one hour. I am also asking to give me permission to tape record the interview. I tape record interviews so that I can accurately record what is said.

Please understand that your participation is voluntary and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to go continue. If you do this there will also be no penalties and you will not be prejudiced in any way.

Confidentiality
Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of my university faculty (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

The information you provide will not be published unless you give your specific permission in writing at the end of this consent form. All identifying information will be kept in a locked file cabinet and will not be available to others. We will refer to you by a code number or pseudonym (another name) in any publication.

Risks/discomforts
At the present time, I do not see any risks in your participation. The risks associated with participation in this study are no greater than those encountered in daily life.

[7] Adapted from HRSC Generic Consent Form (HRSC, n.d.)

Benefits
There are no immediate benefits to you from participating in this study. However, this study will be extremely helpful to me in developing a research report that will add to current aspects and thoughts of Medical Male Circumcision.

If you would like to receive feedback on our study, I will record your phone number/email address on a separate sheet of paper and can send you the results of the study when it is completed sometime after July 2015.

Who to contact if you have been harmed or have any concerns
This research has been approved by the University of the Witwatersrand. If you any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the School of Governance at the University of Witwatersrand.

If you have concerns or questions about the research you may call my supervisor, Mr Murray Cairns, at +27 11 717 3689.

CONSENT

I hereby agree to participate in research on medical male circumcision and its impact on gay men. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

I understand that my participation will remain confidential.

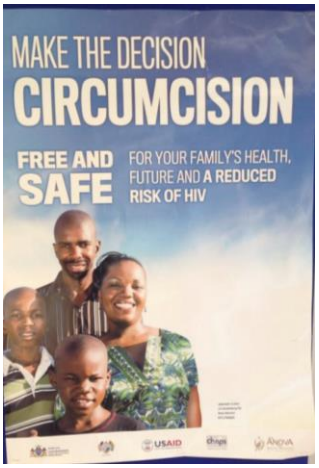
……..
Signature of participant Date:……..

I hereby agree to the tape-recording of my participation in the study.

……..
Signature of participant Date:……..

Appendix 5

Circumcision Poster



Picture taken of poster outside an East Rand factory's canteen.

Flipchart

Retrieved 10 September 2014 from http://www.brothersforlife.org/sites/default/files/medical_male_circumcision_flip_chart.pdf

Brochure:

Retrieved 10 September 2014 from http://www.brothersforlife.org/sites/default/files/medical_male_circumcision_brochure.pdf

Video 1

Retrieved 10 September 2014 from https://www.youtube.com/watch?v=JF-4trZP6fE

Video 2

Retrieved 10 September 2014 from https://www.youtube.com/watch?v=1Ti2t0S5vtk

Video 3

Retrieved 10 September 2014 from https://www.youtube.com/watch?v=NNtvdUhZaGc