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MAKING MEANING OF VOLUNTARY MEDICAL ADULT MALE CIRCUMCISION (VMAMC) IN THE CONTEXT OF HIV PREVENTION IN JOHANNESBURG, SOUTH AFRICA

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Supervisor: Professor Brett Bowman

A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, in fulfilment of the requirements for the degree of Doctor of Philosophy

Johannesburg, 2014

Abstract

Male circumcision (MC) serves a number of functions, which have traditional; aesthetic; and/or medical significance in South Africa. Recent studies have found that voluntary medical adult male circumcision (VMAMC) offers significant protection against HIV infection. Although the South African government has initiated a selective and staggered rollout of this HIV intervention, no empirical data are available on the meanings that key individuals attach to VMAMC. Such meanings are bound to the way that VMAMC will be received as a public health intervention. As such, this study aimed to develop a substantive grounded theory of how key stakeholders make meaning of VMAMC in the context of HIV prevention in South Africa to better understand the psychosocial factors that impact public health responses to this HIV intervention.

A Straussian grounded theory approach was utilised to analyse the repeated semi-structured interview data gathered from 30 adult male participants who live or work near the Alexandra Informal Settlement in Johannesburg, South Africa. These participants were from diverse racial, religious, and cultural backgrounds, each with their own unique practices regarding traditional circumcision or non-circumcision. The resulting grounded theory generated *tensions between tradition and medicine* as a core category. This category is comprised of three emerging sub-categories that impact VMAMC meanings, namely (1) *citizen rights and responsibilities in times of HIV,* (2) *men's health*, and (3) *the politics of implementation*. These categories are tensioned between *plurality and fusion,* to result in seemingly dual responses to the basic social problem of *performing masculinity* in the context of HIV prevention in South Africa. The overarching basic social process, *negotiating tensions between tradition and medicine* is driven by a perceived *crisis of medicalised modernity*. This crisis is made possible by an attempt to negotiate the meanings of traditional circumcisions that are most generally performed by community leaders and traditional healers at initiation schools in rural parts of South Africa to impart powerful masculine qualities to young men, against the health generating benefits of VMAMC when performed in clinical, surgical conditions by a medical doctor.

Despite public health based behavioural and biological interventions, HIV remains a pressing health burden in South Africa. While psycho-educational intervention programmes dominate the intervention landscape in South Africa, the importance of the meanings individuals attach to behavioural and body directed interventions has been frequently overlooked. This study, however; proposes that understanding the meanings attached to what appears to be a simple once-off body directed intervention is imperative to the development, roll-out, upscaling, monitoring and evaluation of VMAMC and all other HIV prevention strategies.

Keywords: Grounded Theory; HIV prevention; male circumcision; meaning making; South Africa.

Declaration

I, Lynlee Howard-Payne, declare that this thesis is my own unaided work. It is being submitted for the degree of Doctor of Philosophy in the University of the Witwatersrand, Johannesburg.

It has not been submitted before for any degree or examination at this or any other University.

_____

_____day of_____, 2014

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List of Acronyms & Initialisms

ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ASMR	Age-Standardised Mortality Rate
CADRE	Centre for AIDS Development, Research and Evaluation
CD4	Cluster of Differentiation-4
CI	Confidence Interval
DoH	Department of Health
FSW	Female Sex Worker
GBV	Gender-Based Violence
GT	Grounded Theory
HBM	Health Belief Model
HIC	High Income Country
HIV	Human Immunodeficiency Virus
HPTN	HIV Prevention Trials Network
IDU	Intravenous Drug User
LMIC	Low-Middle Income Country
MAMC	Medical Adult Male Circumcision
MC	Male Circumcision
MMAMC	Mandatory Medical Adult Male Circumcision
MSM	Men who have sex with men
MSW	Male Sex Worker
NDoH	National Department of Health
NGO	Non-Governmental Organization
NHI	National Health Insurance
NPH	New Public Health
PEPFAR	President's Emergency Plan for AIDS Relief
PHP	Public Health Psychology
PrEP	Pre-Exposure Prophylaxis
PSI	Psychological Society of Ireland
SABS	South African Bureau of Standards
SRH	Sexual and Reproductive Health

STI	Sexually Transmitted Infection
TB	Tuberculosis
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
Tdap	Tetanus, Diphtheria and Acellular Pertussis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMAMC	Voluntary Medical Adult Male Circumcision
WHO	World Health Organization

Chapter 1: Introduction

1.1. Background to the Study

South Africa's relatively young political democracy has been characterised by a drive towards social freedom and equality through reconciliation processes, national restoratiofn and its promotion as a 'rainbow nation' (Wagner, 2011; Woodrooffe, 2011; Woodward & Goldblatt, 2011). There remain, however; various key obstacles to making this a reality for all South Africans (Everatt, 2011; Mulligan, 2010; Todd, 2011; WHO, 2013). The Human Immunodeficiency Virus (HIV) features amongst these crucial challenges. The scale of its effects highlights the complexity inherent in disentangling psychological, biological and environmental variables when conceptualising risk management strategies that target sexual behaviour as part of its prevention (Abdool Karim & Abdool Karim, 2005; Mulligan, 2010).

Approximately 18% (six million people) of the South African population is infected with HIV. The 2010 Global Burden of Diseases, Injuries, and Risk Factors Study showed that the Age-Standardised Mortality Rate (ASMR) from Acquired Immune Deficiency Syndrome (AIDS) related illnesses has tripled since 1997 in South Africa (Wyk et al., 2013). By the end of 2010, six million people had died from AIDS-related illnesses in South Africa and two million children had been orphaned due to AIDS (Bozicevic, Riedner & Calleja, 2013; Global HIV/AIDS Response, 2011; Lozano et al., 2013; UNAIDS/WHO, 2013).

The global magnitude of the problem is evident in the formulation of the United Nations Development Programme's (UNDP) millennium development goals and the establishment of the United Nations programme on HIV/AIDS (UNAIDS), an organisation specifically aimed at developing public health based HIV prevention strategies. The latest UNAIDS goal is: ZERO discrimination, ZERO new HIV infections, and ZERO AIDS-related deaths, which it proposes can be reached by focusing research and funding on HIV prevention, treatment and the psychosocial causes and consequences of HIV and AIDS (UNAIDS, 2010). Until recently, the global community's response to the epidemic has typically been concentrated on managing the implications of existing infections by developing various methods of treating and caring for those who have been infected and affected by HIV (Global HIV/AIDS Response, 2011; UNAIDS/WHO, 2013).

These responses have been relatively successful in reducing the disease burden by up to 30% in areas in South Africa that have regular and easy access to HIV prophylactic interventions, such as those provided in the "HIV Prevention Trials Network (HPTN) 052 trial where antiretroviral therapy (ART) substantially lowers the probability of HIV transmission to the HIV-uninfected partner" (Tanser, Bärnighausen, Grapsa, Zaidi & Newell, 2013, p. 966).

Given this success, a significant share of the global HIV prevention and management effort is now focused on HIV prevention interventions (Global HIV/AIDS Response, 2011; UNAIDS, 2013; UNAIDS/WHO, 2013). This re-focus is perhaps most evident in the United States President's Emergency Fund for AIDS Relief (PEPFAR) petition for intensified efforts towards developing effective and sustainable HIV prevention programmes. The petition calls for the prioritisation of biopsychosocial and infrastructural elements related to HIV transmission. Voluntary medical adult male circumcision (VMAMC) has been identified as one such possible method of effective HIV prevention in low-middle income countries such as South Africa (Auvert et al., 2013; Mehta et al., 2013; Tobian & Gray, 2011; UNAIDS, 2010; UNAIDS/WHO, 2013).

Circumcision of the penis is, at least physically, the surgical removal of the male foreskin, which is the delicate skin tissue that covers the glans penis (Lagarde, Taljaard, Puren, Rain-Taljaard & Auvert, 2003). Male circumcision (MC) is one of the most common procedures (medical or otherwise) in the world, with 25 circumcisions performed every minute worldwide (Hammond, 1999; Weiss, Halperin, Bailey, Hayes, Schmid & Hankins, 2008). Some 15.3 million MCs occur annually throughout 23 traditional cultures located in Sub-Saharan and North Africa, the Muslim Middle East, the Jewish Diaspora, Aboriginal Australia, the Pacific Islands, and Southeast Asia, to name but a few (Denniston, Grassivaro-Gallo, Hodges, Milos & Viviani, 2006; Harris, 1974). Globally, approximately 30% of men are circumcised (Bhattacharjee, 2008; Denniston et al., 2006; Moses, Bailey & Ronald, 1998; Peltzer & Kanta, 2009).

At once a seemingly simple medical intervention on the male body, this intervention implies complex challenges at all levels of the biological, psychological and social dimensions that are assumed to undergird its prioritisation as a suitable HIV prevention strategy. When one considers the prevalence of MC globally one has to consider that MC carries separate but potentially overlapping medical, gender, cultural (or family tradition), religious, and aesthetic meanings for the individual who will be the targeted 'beneficiary' of a VMAMC-based HIV prevention intervention. When one considers the socio-cultural make up of South Africa, one cannot ignore the difficulties that reside within this diversity - a nation living under one legal system, directing one law of social engagement, that governs individuals originating from very distinct cultural and/or religious backgrounds that undoubtedly influences both individual and collective views of MC.

Considering the various biopsychosocial spaces that MC occupies, the way individuals attach meanings to VMAMC as an HIV prevention strategy is particularly complicated. MC in South Africa serves a number of functions, which have cultural, religious, aesthetic, and medical significance for the male individuals who undergo this procedure, as well as their friends, families and communities at large. A further predicament is the marriage of tradition and medicine through the practice of VMAMC for the purposes of HIV prevention. It is, therefore, conceivable that the meaning-making of MC (in these various forms) will be different to its meaning-making in the context of medicalised HIV prevention for adult men in South Africa, who either do or do not traditionally circumcise for cultural or religious reasons. By understanding the psychosocial factors involved in individuals' meaning-making of HIV preventative VMAMC, we can better understand, predict and navigate public health responses to the decisions that the individual will make with regard to the uptake of this HIV prevention intervention in South Africa.

While there have been a number of feasibility studies regarding the roll-out of VMAMC as a method of HIV prevention (Auvert et al., 2005; Auvert, et al., 2008; Kahn, Marseille & Auvert, 2006; Siegfried et al., 2003; Siegfried et al., 2005), as yet no single empirical study to identify and understand how individuals make meaning of VMAMC as an important node within this public health strategy has been undertaken. The current study seeks to address this important omission through the following aim and objectives.

1.2. Aim & Objectives

While a number of studies have been conducted within the realm of perceptions, attitudes, and beliefs regarding VMAMC (Mathew, 2012; Mkandawirea, 2014; Peltzer, Banyini, Simbayi & Kalichman, 2009), these studies have neglected to provide a nuanced account of VMAMC meaning-making (as I define it in this study) by key individual agents. As such, this study aimed to provide a grounded theory (GT) analysis of the factors involved in individual meaning-making of VMAMC as a means of HIV prevention. Although the South African government has initiated a selective and staggered roll-out of these programmes, no empirical data on the meanings that VMAMC holds for key individuals, which might impact the potential uptake of this public health intervention, are available. Rather, the research agenda that has informed this roll-out appears to be based on feasibility studies that have focused on the protective efficacy and economic scalability of programmatic VMAMC.

While important variables in programming, the ultimate uptake of the programme is dependent on individuals that may be regarded as key VMAMC stakeholders. This is because it is the factors involved in individual meaning-making of VMAMC as a primary HIV prevention intervention that are centrally important to the 'feasibility' of any programme and it is, therefore, a GT analysis of the way these factors inform the way that individuals attach to or 'make' meaning of VMAMC that forms the focus of this study.

Traditionally falling within the purview of health psychology, individual cognitions, schemas and meanings related to health and health behaviours, this sub-discipline has developed a number of invaluable models that can be used to predict the health behaviours that result from any particular public health strategy. Yet no such research has focused on these as they relate to VMAMC and a South African public health policy that utilises VMAMC as part of its comprehensive HIV prevention strategy. The resulting GT may be imperative in considering the viability and success of the national VMAMC roll-out as part of the Department of Health's HIV prevention strategy.

1.3. Statement of the Problem

Constructing or making meaning of a particular idea or issue is to establish a body of knowledge by synthesising relevant information within a specific context (Krauss, 2005; Novak, 1993). That is to say, meaning regarding a particular topic is made when data regarding this issue are considered and evaluated as being relevant or not (by the individual, within a particular context). This information is then utilised to give an understanding of the nuances and significance of this knowledge or practice. Thus, new understandings are associated with particularly unique issues through the process of meaning-making and the establishment of knowledge and/or practice.

In this study, I propose that individual meaning-making of a relatively new conceptualisation of practice, such as HIV prophylactic VMAMC, will impact upon the ways in which relevant benefactors and stakeholders will think about, and ultimately have bearing on, decision-making regarding the uptake of this HIV prevention strategy. I consider individual meaning-making to be complexly related to individual decision-making regarding particular health-related behaviours, which has particular implications for public health and HIV prevention strategies in South Africa.

An abounding tradition of health psychology and health behaviour theory, which will be elaborated upon later in this thesis, offers researchers several valuable theories that are considered in the development, implementation and evaluation of various public health strategies and policies. However, there are criticisms of these and their relevance in South Africa (Aarø, Flisher, Kaaya, Onya, Fuglesang, Klepp & Schaalma, 2006; Munro, Lewin, Swart & Volmink, 2007). For example, they have been largely developed in (and for application within) contexts that are adequately resourced (in terms of the financial, political, and social systems in place to address the issues related to HIV infection) in order to account for the issues that an individual might have to make meaning of when engaging with their health-related behaviours and HIV-risk assessment. Additionally, VMAMC cannot be considered a health-related behaviour, at least not in the traditional sense, as it is a once-off permanent body modification procedure rather than ongoing health behaviour, and each current health model relies on an individual making ongoing decisions about their health-related behaviours.

It will be shown in this thesis that existing health models do not accommodate for uniqueness of a once-off circumcision as a typical health behaviour and, more importantly for this study, these models cannot account for the critical psychological factors at play that drive individual meaning-making of VMAMC in the context of HIV prevention in South Africa. Without an understanding of the factors involved in individual meaning-making of VMAMC in the face of HIV prevention, these health models are limited in their account of why individuals might make the decisions that they do or would do regarding the uptake of this public health HIV prevention strategy.

While biomedical and anthropological accounts of MC are well documented, it is of particular interest to note that health psychology has not made a discernible impact in this area. This is particularly surprising as this sub-discipline has been used extensively to better understand behaviours related to or understood through the lens of individual health. MC is one of the most ancient and contentious cultural, religious, or biomedical practices. As such, MC has existed for centuries and been practiced by various people as a rite of passage, as a symbolic inscription of religious commitment, and as a collective health measure for preventing a host of diseases and infections that afflict males (Bhattacharjee, 2008; El-Hout & Khauli, 2007; Sheldon et al., 2012). The removal of the foreskin is both an intervention at the level of the body and the social, but when classed as an HIV prevention intervention, VMAMC both includes and extends beyond the biomedical or anthropological understandings of the body (and its rites) to include a host of psychosocial factors that influence individual meaning-making of VMAMC in the context of HIV prevention. These factors have yet to be systematically identified, described and theorised.

1.4. Rationale

Following international programmes (with some notable exceptions[1]), South Africa has implemented a number of different prevention interventions aimed at curbing the risk of HIV infection, containing viral transmissions, and ultimately eradicating the virus. Local

[1] For example, intravenous drug users (IDUs) are considered to be one of the populations at greatest risk of HIV infection in a number of high income countries (HICs). This is due to direct sharing and multiple person use of needles and/or syringes. Thus, HIV prevention interventions in such countries have implemented needle exchange programmes in an effort to reduce the spread of HIV amongst IDUs. On the other hand, given that the primary mode of contracting HIV in Africa is via sexual intercourse (particularly through penetrative peno-vaginal sex), South Africa has largely focused HIV prevention efforts on promoting safer-sex practices for people who engage in such sexual relations. Additionally, South Africa has not always followed international trends regarding HIV treatment and prevention. In 2006, the Minister of Health at the time promoted the use of African potatoes, beetroots, garlic and lemons for the treatment of HIV in favour of ARVs.

interventions have been and currently are underpinned by two (often overlapping) change-orientations, which must be understood in order to better appreciate the contextual drivers of VMAMC as a South African prevention intervention. The first is a broad approach to intervention guided by psychosocial perspectives to the development of culturally-sensitive, community-based education programmes with a focus on changing sexual behaviour, attitudes and norms (Mendelson, Mtshizana, Hani, Flisher, Mathews & Bekker, 2004).

The second draws on a strictly biomedical approach to HIV prevention through interventions on or in the body. A number of different global, continental and national studies have assessed the successes and limits of these programmes (Durantini, Mitchell, Earl, Gillette & Albarracín, 2006; Earl & Albarracín, 2007; Kirby, Laris & Rolleri, 2007; Vergidis & Falagas, 2009; Vergidis, Falagas & Hamer, 2009). Together, these studies have shown that intervention strategies aimed at HIV prevention are faced with multiple challenges.

Psycho-educational primed interventions are challenged by the very fact that the primary transmission mode of HIV in Africa is peno-vaginal sexual intercourse. Current estimates indicate that up to 90% of people infected with HIV contracted the virus via unprotected heterosexual intercourse (Boily, Baggaley, Wang, Masse, White, Hayes & Alary, 2009; Drain, Halperin, Hughes, Klausner & Bailey, 2006; Stine, 2008). This implies that its spread or containment will rely heavily on understandings of human sexuality, or sex, as they intersect with other social factors. This is no more apparent than in South Africa, where a 'one-size-fits-all' solution is complicated by the country being comprised of so many different cultural and religious groups, each with their own set of values regarding sexual behaviour, gender ideologies and understandings of health and disease.

Another formidable challenge, as predicted by studies of other health-risk behaviours (such as smoking cigarettes that can increase one's risk of lung and heart disease, or sunbathing which can cause skin cancer), is that engaging in risky behaviours is directly related to the perceived risk of the risk-taking individual (Stine, 2008; Weiss, Quigley & Hayes, 2000). This perceived risk in turn relies on a variable mix of knowledge and attitudes to the behaviour in question. Recent research has shown that when an individual does not perceive him or herself to be at risk of infection, they do not practice the necessary measures to reduce that risk (Howard-Payne, 2010; Howard-Payne & Kiguwa, 2008).

For example, Howard-Payne and Kiguwa (2008) showed that a large majority (60%) of young educated adults in urban areas of Gauteng, South Africa, do not perceive themselves to be at risk for HIV infection, regardless of the high-risk sexual practices in which they report to have engaged, and despite having high-levels of HIV transmission, prevention, and treatment knowledge. Such findings highlight the potential limitations of existing HIV prevention interventions that focus on replacing high-risk sexual practices with safer-sex practices, such as consistent and proper condom usage.

In strong contrast to an emphasis on direct attitudinal and behaviour change interventions, biomedical strategies have focused on HIV prevention through research into the production of a safe and effective vaccine; cervical barriers such as the diaphragm; therapy to suppress herpes simplex virus type II (the primary cause of genital herpes, which is a risk factor for acquiring and transmitting HIV); and microbicides that could be applied to the vagina or rectum (Steinbrook, 2006). Each of these medical technologies requires active and ongoing compliance and practice by the end-user. Human compliance to such medical regimes has been shown to be poor (Donovan & Blake, 1992; Hansson, Scherman & Löwhagen, 2004; Pech`ere, Hughes, Kardas & Cornaglia, 2007; Thomas, Burstin, O'Neil, Orav & Brennan, 1996; Trostle, 1988), so interventions that do not require ongoing monitoring through permanent modification of transmission vectors have been explored through VMAMC.

VMAMC has been shown to offer significant protection against HIV infection (measured as offering approximately 60% protection), leading key HIV prevention activists to call for its inclusion in HIV prevention strategies across the country (Milford, Smit, Beksinska & Ramkissoon, 2012). Research projects have subsequently attempted to establish the economic, logistical and infrastructural feasibility of such a roll-out (Auvert et al., 2008, Auvert et al., 2013; Kahn et al., 2006; Siegfried et al., 2003; Siegfried et al., 2005). However, there has yet to be an empirical, systematic study of how individual stakeholders make meaning of personal VMAMC in the context of HIV prevention. As such, this study sought to explore and understand the factors involved in such meaning-making so that these can be aligned in the national VMAMC policy currently being rolled out by the national Department of Health as part of its public health HIV prevention strategy.

Understanding the individual meaning-making features of VMAMC in the context of HIV prevention in South Africa, as implicated in decision-making and resulting health-related behaviours regarding HIV prevention and VMAMC, may illuminate the potentialities and problems for relevant stakeholders and/or beneficiaries of such a nationwide public health HIV intervention. Additionally, this study may contribute to the theoretical platform of health psychology in addressing HIV prevention within the public health system in South Africa. This study was thus guided by the research questions described below.

1.5. Research Questions

1. How do the intended beneficiaries and service providers make meaning of VMAMC as a means to HIV prevention in Johannesburg, South Africa?
2. What critical factors shape the meaning-making of VMAMC as a means to HIV prevention in Johannesburg, South Africa?
3. How might health psychology contribute to understanding and theorising these factors?

Given the paucity of theory, focus and empirical data associated with these questions, a GT approach was selected to respond to them. VMAMC does not exist in a contextual vacuum and no substantial theory of the ways meanings are made of it has been developed in the literature, thus this project was committed to the Straussian approach to GT (Charmaz, 2006; Melia, 1996). The Straussian approach was selected since, given my scholastic experience within the field of HIV prevention, a pre-determined paradigm system to theoretical framework construction was present (and is acknowledged later in the thesis) during the conceptualisation of the study, data collection, analysis and interpretation.

The research questions presented above were organically generated from the arguments presented in the following chapter, and were constructed so as to afford me the opportunity to develop a GT that provided overarching descriptive answers by developing a conceptual theoretical account of the factors involved in individual meaning-making of VMAMC in South Africa as part of a comprehensive HIV prevention strategy.

1.6. Considering the Literature

The researcher who embarks upon a study that follows a GT approach has to consider the controversial matter as to when and how the review of literature should be conducted. According to McGhee, Marland and Atkinson (2007), Glaser and Straus (the two originators of this approach) disagreed fundamentally on this important part of the methodological approach. Glaser insisted that a review of the literature only be conducted post data analysis, while Strauss (and Corbin) acknowledged that researchers cannot deny the impact of their previous experience and understanding of the literature related to their field of inquiry. Given that this study was concerned with the factors involved in individual meaning-making of HIV prophylactic VMAMC, I initially had to acquire a general understanding of meaning-making, which required that I orientate myself with meaning-making theory and meaning-making in the context of health psychology.

Additionally, so as to develop a doctoral proposal, I had to conduct at least a partial review of existing literature in the field of meaning-making and disease prevention. In doing so, I was able to confirm that the appreciation of meaning-making within the context of classic health psychology was somewhat lacking, therefore the location of this investigation was justified within a doctoral study so as to considerably contribute to academic scholarship and knowledge. In consideration of the above, and more importantly, based on the shared philosophical perspectives to GT (which are addressed further in *Chapter 3* reserved for *Research Methods*), I elected to follow the paradigm associated with the Straussian school of GT. This perspective allows the researcher to revisit the literature related to particular findings so as to enhance the interview data gathered (Strauss & Corbin, 1994). Thus, in an effort to limit foreclosure of theoretical sampling, I only engaged fully with the literature during the final stages of data coding and analysis so as to make certain that the generated theory was in fact grounded in the data. During this phase of the data analysis relevant literature was then reviewed and, using the constant comparative method, evaluated against the findings that started to emerge from the data.

This literature is introduced in the chapters related to the presentation of my results and the discussion thereof. By presenting and integrating this literature with my findings, I was able to reflect upon the ways in which the GT generated augments our current appreciation of individual stakeholder and benefactors' responses to novel HIV prevention methods in South Africa, such as VMAMC.

1.7. Outline of Thesis

Having provided an introduction to the project, describing its objectives and sketching the problem statement, the following pages outline the remaining seven chapters that constitute the thesis. *Chapter 2* is dedicated to outlining the reasons that support the need for public health policies to continue developing and implementing new ways of preventing HIV infection. This is achieved by describing the epidemiology of HIV while considering the essential biomedical and psychosocial implications of this pandemic.

In order to locate health psychology and the public health strategies and policies related to HIV preventative VMAMC, I consider meaning-making and its relevance to health and illness and offer a critical overview of the existing common HIV prevention strategies, both biomedical and psychosocial educational interventions, with a particular focus on the South African government's response to the HIV crisis. One such response includes the HIV preventative strategy that holds VMAMC at its core. Accordingly, I review the research available regarding the feasibility and acceptance studies related to the roll-out of this public health strategy, particularly in South Africa and other African countries.

The methodological underpinnings of Straussian GT approach utilised in this study are addressed in great detail in *Chapter 3*. The chapter then describes the various elements of my study's design, including the groups included in the sample, the data collection procedure and interview schedule, procedures for the coding and analysis of data gathered, as well as ethical considerations and my approach to researcher reflexivity.

In *Chapter 4*, I present my results and findings. In so doing, I provide evidence of the factors involved in individual meaning-making regarding VMAMC as a means of HIV prevention. Via the constant comparison method and theoretical sampling, I was able to generate a GT that was comprised of one core category, namely *tensions between tradition and medicine*. This core category intersected and interacted with three emerging sub-categories, namely (1) *citizen rights and responsibilities in times of HIV*, (2) *men's health*, and (3) *politics of implementation*, which are somewhat unique to this country. The properties and dimensions of each of these categories are unpacked and addressed in relation to the basic social process of *negotiating tensions between tradition and* medicine, as participants navigate the causal condition of *the crisis of medical modernity* with respect to *performances of masculinity* (as the basic social problem) that arises when making meaning of VMAMC for the purposes of HIV prevention.

In order to answer the research questions posed and generate a theoretical account of the phenomenon, *Chapter 5* considers the data gathered in relation to the existing theoretical landscape of individual meaning-making as it relates to health and disease, as well as existing health psychology theory that considers various health-related behaviours, with particular reference to HIV prevention in South Africa.

A review of this literature in consideration of my interview data highlighted the shortcomings of various existing theoretical positions in appreciating the role of individual meaning-making as implicated in health decisioning and related behavioural outcomes. This chapter also addresses the implications of my study by discussing the ways in which it might inform current and future VMAMC-based HIV prevention strategies. I consider the value of the new public health (NPH) approach and the role of public health psychology (PHP) within this philosophy, in addressing the issues raised by the GT generated. I argue that without considering the factors that seem to contour the way that key stakeholders make meaning of VMAMC as a public health HIV prevention strategy and policy, public health will remain grounded in economics and other considerations of logistical feasibilities, which overly rarefies densely complex psychosocial individual meaning-making factors.

I conclude my thesis in *Chapter 6* with a summary of the study's findings. The chapter outlines how, despite the critical concerns related to HIV, the overly reductive traditional public health approach to HIV prevention in South Africa may not adequately address the pandemic. This study highlights the urgency in considering and ultimately adopting theoretically innovative perspectives regarding the critical psychological issues that traditional public health policies consider in the development, roll-out, monitoring and evaluation of their future HIV prevention strategies. Given that this is the first study of its kind and that my recommendations call for a relatively radical evaluation of current public health policies regarding the national prevention of HIV, this chapter recommends a number of studies that should be conducted in the near future so that further evidence can be gathered to guide such evaluations and inspire alternative perspectives to the traditional public health policies embraced by those involved in HIV prevention in South Africa.

Chapter 2: VMAMC in the Context of HIV Prevention

2.1. Introduction

Studies have consistently shown that current global HIV prevention strategies, which include abstinence-only education programmes (Kirby, 2002), the promotion of consistent use of condoms (Jama Shai, Jewkes, Levin, Dunkle & Nduna, 2010), early diagnosis and treatment of sexually transmitted infections (STIs), and voluntary counselling and testing (VCT) (Uzochukwu, Uguru, Ezeoke, Onwujekwe & Sibeudu, 2011), have limitations. These limitations have led many experts to argue (Esparza, 2013; Frieden, Das-Douglas, Kellerman & Henning, 2005; Lurie & Wolfe, 2012; Manirankunda, Loos, Debackaere & Nöstlinger, 2012; Smith et al., 2010) for public health practitioners to consider the implementation of what many may consider to be radical strategies for HIV prevention. One such strategy is VMAMC. While recent studies have demonstrated stark differences in willingness to circumcise as a means to HIV prevention, no single study of the factors involved in individual meaning-making of VMAMC for HIV prevention has been undertaken. VMAMC is an intervention on the body of an individual as part of a public health drive towards preventing and managing a pandemic. To better contextualise this practice, this chapter attempts to describe and reflect on HIV prophylactic VMAMC within the epidemiology of HIV and its prevention.

2.2. The Transmission & Prevention of HIV

Our current inability to cure HIV adds to the complexity of its containment and management, which ultimately relies on its prevention and/or treatment. Thus, it is necessary to overview the ways in which HIV is transmitted and the various mechanisms available to prevent the acquisition of this virus. HIV is a retrovirus that compromises the functioning of the immune system by invading the host cell and commandeering the host's genetic material, relying on its reproductive mechanisms for a mass production of the virus, leaving the infected individual vulnerable to a variety of infections (Vacca, 2012).

Diminution of cluster of differentiation-4 (CD4) lymphocytes, which can be described using the analogy of the 'soldier cells' in the human body that attack invading units (such as the virus), is the trademark of HIV infection, and predicts an individual's risk for infection with opportunistic pathogens (Edelston, 1988; Schuitemaker & Miedema, 2000; Valdiserri, 1989; Waldby, 1996).

The distinction between HIV infections versus AIDS in general is noteworthy. Typically, it takes many years for HIV to weaken the body's immune system to the point of full-blown AIDS (Leach & Scoones, 2013; Sabatier, 1988). Common opportunistic diseases that would often occur at this point include tuberculosis (TB), weight loss associated with diarrhoea (Epprecht, 2013), herpes zoster, dementia, Kaposi' sarcoma and *pneumocystis carinii* pneumonia (Sabatier, 1988; Vacca, 2013). The progression of physical (and cognitive) deterioration from initial infection to the window period (the time between the acquisition of infection and serologic detectability) to full-blown AIDS depends on a host of factors (Kucirka et al., 2011).

More rapid HIV progression has been reported with behavioural and psychological factors, such as having unprotected sexual intercourse (with either a male or female partner) (Lane, Pettifor, Pascoe, Fiamma & Rees, 2006; Sanders et al., 2007), smoking (van Zyl Smit et al., 2010), poor nutrition (Liu et al., 2011), and depression (Carrico et al., 2011), however; not all studies confirm these findings (Hahn & Samet, 2010). The non-specific symptoms of primary HIV infection may make diagnosis (and resulting required treatment and lifestyle changes) a challenge for healthcare workers, as the patient may not be correctly identified (based on the range of symptoms and seemingly healthy physical appearance) as requiring an HIV test for confirmation of infection (Vacca, 2012).

HIV has been isolated from blood, seminal fluid, pre-ejaculate, vaginal secretions, cerebrospinal fluid, saliva, tears, and breast milk of infected individuals (Kane, Case, Kopaskie, Kozlova, MacDearmid, Chervonsky & Golovkina, 2011; Valdiserri, 1989). Viral concentrations in non-bloody urine, tears or saliva are comparatively low so these bodily fluids are highly unlikely sources of HIV transmission, while sexual contact is the most common route of HIV transmission (Kane et al., 2011; Waldby, 1996). HIV transmission (through non-sexual contact) can occur through transfusion with contaminated blood products, intravenous drug use (IDU), or occupational exposure (Kane et al., 2011).

Clear cases of transmission via oral sex do exist, however; these studies indicate that risk is comparatively low to other sexual practices (Vacca, 2012). Studies of transmission provide strong epidemiological confirmation that transmission of HIV occurs via peno-vaginal intercourse (Petrova, den Broek, Balzarini, Vanderleyden & Lebeer, 2013). This finding is of particular interest to this study, given that VMAMC is a biomedical intervention that reduces a man's risk of becoming infected with HIV during such sexual intercourse.

Global statistics show that approximately 80% of the people living with HIV or AIDS contracted HIV through peno-vaginal intercourse (UNAIDS, 2010; UNAIDS/WHO, 2013). Vaginal sex during menstruation may heighten the risk of transmission of HIV for the male if the female partner is infected with HIV (Lane et al., 2007). Given that this study is concerned with HIV prophylactic VMAMC (and considering that research has primarily reflected its protective properties against the transmission of HIV during peno-vaginal sexual intercourse) it is worthwhile comparing the estimated percentage of people in South Africa as infected via the various modes of HIV transmission. These estimates are reflected in table 1 below.

Table 1: Prevalence of HIV infection in Sub-Saharan Africa according to mode of HIV transmission

Mode of Transmission	Estimated Prevalence of HIV Infection
Receptive vaginal intercourse	80%
Receptive anal intercourse	7%
Mother-to-child transmission	11%
Receptive oral sex	1%
Blood transfusions	5-10%
Occupational exposure	4%
IDU	2%

Sourced from: UNAIDS/WHO (2013)

Due to the fact that sexual intercourse (peno-vaginal or peno-anal, depending on the country) is the major transmission route for HIV infection, eliminating sexual contact (abstinence) reduces the risk of becoming infected with HIV (Schuitemaker & Miedema, 2000). Abstinence, however; is neither a desirable nor practicable solution to the risk of infection (Petrova et al., 2012).

Given the importance of sexual transmission in the HIV epidemic, many HIV prevention strategies have focused on identifying and promoting safer-sex practices (Lane et al., 2007). As the name implies, these practices are thought to be 'safer' than other sexual practices in that they help reduce (but do not eradicate) the risk of transmitting HIV from one sexual partner to another (Vacca, 2012). These safer-sex practices include, in addition to VMAMC, getting tested for HIV to confirm whether respective partners require ART (Baeten et al., 2012); and using male or female condoms correctly and consistently during oral-penile sex (Page-Shafer et al., 2002), as well as peno-anal sex (Baggaley, White & Boily, 2010), and/or peno-vaginal sex (Clutterbuck et al., 2012). Additionally, risk of HIV infection can be reduced by practicing monogamy (Hageman, Dube, Mugurungi, Gavin, Hader & Louis, 2010); using dental dams during oral-vaginal (Richters & Clayton, 2010) and/or oral-anal sex (Coxon, Davies, Hunt, Weatherburn, McManus & Rees, 1992); and preventing other STIs that can increase the risk of acquiring HIV (Bernstein, Marcus, Nieri, Philip & Klausner, 2010).

Sexually active females can also reduce their risk of HIV infection by not practicing vaginal douching, which can remove healthy bacteria in the vagina that can protect the female from contracting HIV during peno-vaginal sex (Karim, Sibeko & Baxter, 2010). Furthermore, HIV infection can be prevented by using microbicides prior to sexual intercourse, as they can destroy viruses as they enter the body (Karim et al., 2010). Finally, the risk of HIV infection can also be reduced by limiting one's use of alcohol and drugs, which can impact on safer-sex decisioning and the risk of gender-based violence (GBV) and sexual assault (Baliunas, Rehm, Irving & Shuper, 2010).

While there are various existing public health policies regarding HIV prevention, as the source of the problem (the transmission of HIV through peno-vaginal intercourse) remains constant, advances and developments with regard to methods of prevention (such as VMAMC) require that new policies regarding HIV prevention be considered. As part of this imperative this study sought to extend the available VMAMC-evidence base by exploring the critical psychosocial factors involved in individual meaning-making of this HIV prevention intervention. As these are implicated in health decisioning and health-related behaviours, such information is important for policy makers when considering a range of HIV risk reduction and prevention strategies against the epidemiology of HIV globally and in South Africa.

2.3. The Epidemiology of HIV

Statistics on HIV prevalence and incidence are often dated even before being published, so these figures should always be regarded as best estimates. Nonetheless, UNAIDS/WHO (2013) estimated that 35.3 million (32.2-38.8 million) people worldwide were living with HIV at the end of 2012, and since its emergence, some 25 million people have lost their lives to AIDS-related illnesses. Approximately half of all new HIV infections worldwide occur among adolescents and young adults (Pépin, 2013; UNAIDS/WHO, 2013).

Despite the remarkable advances in basic virology and microbiology over the past several decades, HIV infection has developed into a worldwide pandemic, with tens of millions of people being infected and affected by the virus (Bozicevic et al., 2013; Global HIV/AIDS Response, 2011). Regional epidemiology of the HIV epidemic seems to differ most notably based on socioeconomic factors, for example the most heavily affected area in the world is Sub-Saharan Africa, with almost 23 million people infected with HIV (Bozicevic et al., 2013; Global HIV/AIDS Response, 2011; UNAIDS/WHO, 2013). As such, a summary of current epidemiological trends of HIV infection due to sexual intercourse in high income countries (HICs) and low-middle income countries (LMICs) is presented below. Given that this study is concerned with HIV acquisition via sexual intercourse (and its prevention for adult males through VMAMC), this summary primarily relates to trends in HIV infections acquired via sexual contact.

2.3.1. Epidemiology of HIV in HICs.

In their meta-review of epidemiological studies from 26 HICs, Sullivan, Jones and Baral (2014) found that HIV infection by male-to-female sexual intercourse has decreased over the past five years, while receptive anal sexual intercourse is the current primary mode of HIV acquisition in countries such as Australia, Austria, Canada, Denmark, Finland, France, Germany, Italy, Japan, Norway, Portugal, Spain, Sweden, Switzerland, the Netherlands, the UK and the US. Approximately 25% of the estimated three million HIV infections in these countries are due to male-to-male sexual intercourse (Chen et al., 2002; Sanders et al., 2007; Smith, Tapsoba, Peshu, Sanders & Jaffe, 2009; Vermund & Leigh-Brown, 2012).

Research has also consistently identified other social groups as being at particular risk for HIV infection in HICs, due either to their sexual practices or the socioeconomic conditions in which they live (the implication of which is a lack of access to various essential prevention resources) (Greener & Sarkar, 2010; Hargreaves et al., 2007; Sanders-Phillips, 2002). Globally, these groups include: (1) female sex workers (FSWs) (Elmore-Meegan, Conroy, Agala & Bernard, 2004) and (2) male sex workers (MSWs) (Geibel, Luchters, Kingola, Esu-Williams, Rinyiru & Tun, 2008) as they have multiple concurrent sexual relationships and perform transactional sex, and (3) IDUs (Carvajal, Estrada, Estrada & Jones-Rodriguez, 2011). The public health concern regarding these 'high-risk groups' (with the limited exception of IDUs) is that their sexual networks extend far beyond their immediate sexual peer groups and are associated with the epidemiology of HIV at the larger social level. For example sex workers may be at particular risk of sexual violence, or experience coercion to perform certain high-risk sexual acts (such as sexual intercourse without a condom) (Rhodes, Wagner, Strathdee, Shannon, Davidson & Bourgois, 2012; Shannon & Csete, 2010).

HIV prevention in HICs has largely relied on psycho-educational public health interventions in an effort to promote safer-sex practices among those who are considered to be 'at risk' for infection. Thus, while the epidemiology of HIV in HICs has largely been associated with particular population groups and related risk behaviours that facilitate HIV transmission such as men who have sex with men (MSM), the transmission of HIV in Sub-Saharan Africa is sustained by 'typical' heteronormative sexual risk behaviours in the general population (Baral & Phaswana-Mafuya, 2012). Thus peno-vaginal sexual intercourse remains the primary mode of contracting HIV in LMICs and public health interventions have had to rely on relatively different tactics in order to address this pandemic in such countries (UNAIDS/WHO, 2013).

2.3.2. Epidemiology of HIV in LMICs.

While the general reproductive age adult population remains the population at greatest risk of HIV infection in Sub-Saharan African, research has shown that the infection risk of HIV is still disproportionately concentrated in populations of MSM in LMICs, and so this group should also be represented in HIV prevention interventions and HIV-related research (Baral et al., 2012; Mills, Saidel, Magnani & Brown, 2004).

However, it should be noted that there is little compelling trial research that speaks to the relevance of VMAMC in reducing HIV acquisition for MSM or individuals who engage in other non-heteronormative sexual practices (Millett, Flores, Marks, Reed & Herbst, 2008). Thus, while VMAMC based HIV interventions may serve the larger 'at risk' population in LMICs, smaller groups that are at risk of infection, such as MSM, are often excluded from access to the resources and support offered through various sexual and reproductive health (SRH) and HIV prevention programmes that might reduce their risk of infection (Nguyen, Hein, Giang & Roger, 2008; Onyango-Ouma, Birungi & Geibel, 2005; Saavedra, Izazola-Licea & Beyrer, 2008; Sharlet, 2010; UN Report, 2010; Wade et al., 2005).

Many young adults engage in sexual intercourse with multiple partners and without 'protection', thus engaging in sexual behaviours that place them at high risk of STIs, including HIV (Kalichman, Rompa, Luke & Austin, 2002; UNAIDS/WHO, 2013). In Sub-Saharan Africa, sexually active young adults aged 15 to 35 years have some of the highest reported rates of STIs (Fortson, 2011; WHO, 2013). Young adults in this age group in South Africa currently have the highest HIV infection rates, so attention has (and should be) focused on how to reduce the spread of this disease amongst the country's youth (WHO, 2013). Several factors influence young people to engage in sexual activity such as changing hormones, emotional and physical (at the level of the sexual) needs and desires, peer pressure, and norms that support sexual risk-taking (Wilson & Koo, 2010).

In South Africa, black females aged 14-35 who engage in peno-vaginal sexual intercourse are considered to be at particularly high risk of HIV infection (UNAIDS/WHO, 2013). South Africa currently has the highest HIV prevalence in the world with approximately six million adults and children infected - an estimated 18% of the total population (Stine, 2008; UNAIDS, 2010; UNAIDS/WHO, 2013; WHO, 2013). UNAIDS/WHO (2013) reported that almost 23 million people, 65% of the total number of people infected with HIV, live in Sub-Saharan Africa, however; infection rates have started to stabilise in countries such as Zambia, Nigeria and Ethiopia. South Africa was not included on the list of 26 countries where HIV incidence amongst adults had decreased by 50% between 2001 and 2012. These figures point to the reality that HIV remains incurable and thus, while ART can assist those infected to live long and healthy lives, we cannot ignore the fact that access to and uptake of such therapy continues to be severely limited in large parts of the region. Efforts to address the spread of HIV in LMICs are often obscured by limited financial resources (Baral & Phaswana-Mafuya, 2012).

Independent economic development of these countries is largely compromised by the fact that there is a high burden of HIV infection among reproductive age adult females and males (who could contribute to the economic growth of their particular country), making donor resources from HICs (for psycho-educational prevention and treatment interventions) absolutely essential in the fight against HIV. Given ongoing donor contributions, sufficient resources dedicated to HIV surveillance, biomedical and psychosocial investigations, the development and implementation of socio-culturally and politically relevant prevention interventions, treatment and general health programmes, the achievement of an AIDS-free generation is a feasible objective (Fauci & Folkers, 2012). Nonetheless, the epidemiology of HIV in Africa confirms that the economics of HIV prevention and treatment are intricate and multi-faceted (UNAIDS/WHO, 2013), but that the scale of the problem warrants a public health approach to its prevention.

2.4. An Overview of Public Health Approaches & Policy

Winslow is cited in Koplan, Bond, Merson, Reddy, Rodriguez, Sewankambo and Wasserheit (2009, p. 1993) as defining public health provided by government as:

> The science and art of preventing diseases, prolonging life and promoting physical health through organised community efforts for the sanitation of the environment, the control of community infections, the education of individuals in principles of personal hygiene, the organisation of medical and nursing services for early diagnosis and preventive treatment of diseases, the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

Public health, as a medical sub-discipline, is invested in the health of the greater population through disease prevention rather than focused on curative medicine for the individual. Branches within the field of public health include occupational health, epidemiology and biomedical statistics, and psychosocial behavioural health (Friis & Sellers, 2013). As public health primarily focuses on the societal elements of the spreading or containment of disease, it echoes the complexity of the sociocultural, socio-political, and socio-economic factors that people engage with on a day-to-day basis.

Public health is deeply dependent on the active involvement of the population, as they respond (either in an obliging or obstructive manner) to particular health crises. "Public health is purchasable, as has been proved in the past when aroused public interest has stamped out plague after plague which once ravaged the population" (Paran, as cited in De Cocke, 2002, p. 67).

Public health policy can be regarded as the overarching gambit of perspectives in which various decisions are made by government concerning particular health issues (Buse, Mays & Walt, 2012). Policies are generated when decision-makers and stakeholders scientifically formulate, while considering a variety of competing interests and obstacles, strategic ways in which to accomplish particular population-health objectives. Such policies then undergo various forms of analysis so as to ensure that they are, and will continue to be, relevant and effective. Part of the research required for policy analysis concerns the feasibility of any public health intervention. VMAMC has been proposed as a cost-effective means to HIV prophylaxis in this context, however; this economic feasibility has yet to be tested against willingness to circumcise, which is predicated on the meaning that such a practice may hold for all the individuals concerned. Thus the section that follows provides an overview of current thinking on individual meaning-making in relation to health and illness.

2.5. An Overview of Meaning-Making

Many have argued that the evolution of human beings has resulted in a species that innately seeks to make meaning of their social world (Crotty, 1998). They do this by processing the properties of experience and then assigning significance to such properties. Thus definitions of meaning-making are often aligned with theories regarding the subjective perceptions the individual has of a particular issue. The conceptualisation of meaning-making generally refers to the strategy employed by the individual as he/she evaluates the significance of the particular issue, rather than simply acknowledging its properties (Cacioppo, Hawkley, Rickett & Masi, 2005). Meaning-making assists people in establishing and sustaining social connections and narratives by attributing importance to the various aspects of their lives. In fact, Cacioppa et al. (2005) suggested that the interrelatedness of meaning-making and sociality is the basis of what makes us human.

2.5.1. Meaning-making of good-health.

For this study the definition of good-health has been drawn rather widely, particularly in consideration of the multi-dimensional and dynamic systems involved in the multi-disciplinary constructions of health. As such I advocate for the Meikirch Model, and thus define good-health as "a dynamic state of wellbeing characterised by a physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility. If the potential is insufficient to satisfy these demands the state is disease" (Bircher & Wehkamp, 2011, p. 335). It is essential for this study to move beyond the theoretical conceptualisation of good-health to locate the relevance of meaning-making within this. There are three core elements that should be considered in the process of good-health meaning-making. Firstly, meaning of good-health is made when there is a personal sense of power or control over the general welfare of the individual (Singer, 2004). That is to say that the individual is able to assign meaning to their good-health when they feel that they have (at least some) control regarding their morbidity and mortality. Secondly, meaning is made when the individual believes that there are a number of goal processes related to their personal good-health (Folkman & Moskowitz, 2004; Stein, Folkman, Trabasso & Richards, 1997).

Lastly, good-health meaning-making has been associated with a personal sense of life-purpose (Coward, 1994; Reker, Peacock & Wong, 1987), which Park (2013) seems to consider as spirituality as she refers to a number of studies that support the claim that spirituality is a key variable for good-health and is a motivator for goal-generation in relation to a general sense of meaning in life (Aldwin, Park, Jeong & Nath, 2014; Holahan & Moos, 1987; Jordan, Masters, Hooker, Ruiz & Smith, 2013; Koenig, King & Carson, 2012; Matthews, Berrios, Darnell & Calhoun, 2006).

2.5.2. Meaning-making of illness.

Many researchers have investigated the theoretical premise that an effective method of behaviour modification resides within the induction of fear regarding illness and infection (Harris & Epton, 2010; Rogers, 1975; Witte & Allen, 2000). That is to say, individuals will adopt adaptive behaviours based on fear-arousal, in a linear fashion. Research has indicated that moderate (or 'medium') fear-initiation communication effectively results in behaviour modification.

The intention to modify behaviour is a consequence of both threat and coping appraisal strategies, whereby an individual will assess the perceived threat to their health (for the purposes of this thesis, HIV infection) while also considering the perceived coping responses available to manage the threat (for example consistent condom-usage and VMAMC).

According to McGinty, Goldenberg and Jacobsen (2012), threat appraisal operates on two levels, namely: (1) perceived vulnerability, and (2) perceived severity of the infection, whereby the induction of fear (at least indirectly) enhances both of these to result in protection motivation. The process of coping appraisal functions according to: (1) response-efficacy, which can be defined as an individual's belief in the adherence to behaviour change recommendations to actually result in the diminishing of the threat of HIV infection, and (2) self-efficacy.

Meaning-making of human health and general well-being has typically been under-researched, however; this area of study has become more prolific in recent years. Park (2013) proposed that meaning-making can influence the ways in which individuals manage various health crises, by mediating their decisioning and the ways in which they amend their health-related behaviours in order to overcome acquired illnesses or circumvent illness entirely. Meaning-making must therefore be understood as a fundamental feature of health decision-making, and thus should form a central target for study by health psychologists. However, this does not seem to be true in the case of VMAMC, as is described in the section that follows.

2.6. An Overview of Health Psychology

Health Psychology has a relatively short history, only emerging in Ireland during the 1980s with the establishment of the Psychological Society of Ireland (PSI) Health Psychology Special Interest Group (Weinman, Johnston, Molloy, French, Vedhara & Kapteim, 2011). This sub-discipline is primarily concerned with the study of the psychological and behavioural processes that are related to health, illness and healthcare (Hevey & Hickey, 2013). Additionally, by relying on empirical evidence, health psychologists are able to recommend improvements for healthcare policy and inform programmes based on health-related behaviours that promote well-being and prevent disease (Weinman et al., 2011).

While this study is concerned with the factors involved in individual meaning-making of HIV prophylactic VMAMC, choosing to undergo such a procedure (or not) is a health behaviour. Health-related behaviours can be defined as the sum of all endeavours that impact upon the individual's psychological, emotional, cognitive and physical condition (Forgas, 2013). There are essentially six categories of health-related behaviours (Sallis, Owen & Fisher, 2008; Quah, 2010) which are addressed below.

Preventative health behaviours are respected in cases when an individual, who believes himself or herself to be healthy, seeks to avert acquiring particular infections, diseases or ailments by practicing, for example, basic hygiene or the consistent use of condoms during sexual activities. Illness health behaviours prompt self-referral to a healthcare provider for screening/testing for illness by individuals, who perceive themselves to be experiencing some early symptoms of illness. Sick-role health behaviours arise when an individual, who believes that he/she is ill, seeks and receives a diagnosis as well as a course of action with regard to treatment so as to cure their illness. Compliance behaviour involves the adherence of the individual to the prescribed medical treatment, offered by the healthcare worker, for their particular diagnosis. Utilisation behaviours are followed when individuals make use of the various healthcare services available to them, for example free VCT for HIV, antenatal care, mobile clinics, immunisations, and so forth. Rehabilitation behaviours are undertaken so as to aid recovery (and prevent further disability if necessary) after a critical illness or injury, for example consulting with a physiotherapist or occupational therapist on a regular basis for a particular period of time (Quah, 2010).

The performance of various health behaviours is undergirded by the obvious but central assumption that individual human agents must act (or not act) towards or against 'health'. However, health psychology advocates that individual health behaviours are undertaken within a psychosocial-cultural space, which generates unique and deeply personal motivations, orientations, and constraints (Berke, Vernez-Moudon & Kang, 2014). Thus it has long been recognised that in order to develop a health-related intervention that produces reliable and continued behaviour changes for the prevention of HIV infection, an array of influential factors at the intrapersonal, interpersonal, community and societal levels must be considered throughout the research and interventions implemented (DiClemente et al., 2007; Sallis et al., 2008).

This notion acknowledges the network of causality that results in sexual risk-taking behaviours in relation to HIV infection, and in doing so, highlights that in addressing the public health crisis of the HIV pandemic, the proximal and distal factors that impact the individual's decision-making and uptake of safer-sex practices needs to be considered. However, a survey of existing literature did not yield any documented application of this model to the meaning-making of HIV preventative behaviours, especially novel behaviours such as once-off permanent body modification such as VMAMC.

2.6.1. The ecological model of health.

One may consider the ecological model of understanding health-related behaviours in relation to the classic theoretical framework developed by Bronfenbrenner (1979). According to Bronfenbrenner (1979), there are five levels at which mutual transactions occur between human beings and their environment - the Microsystem (in which idiosyncratic identities, characteristics, and cognitions develop within the individual); the Mesosystem (the context with which the individual interrelates); the Exosystem (the contexts or settings which the individual does not directly interact with, but which still impact the individual); the Macrosystem (which represents the greater social factors and cultural norms that impact the individual); and finally the Chronosystem (the trends of socio-environmental events and changes that occur over time).

It is important to note the complexity of an ecological framework as the individual can mutually interact with a number of levels concurrently, which can either inhibit or promote particular individual behaviours. In relation to health-related behaviours and the risk of HIV infection, one may consider the distal factors (such as those at the societal or community levels of influence) as impacting upon the proximal factors (for example interactions that occur at the interpersonal and intrapersonal levels of influence), which mutually impact upon each other as well as the individual, thereby resulting in the individual either being at high-risk of infection or being particularly resilient to such risk. Individuals are ultimately the agents of health behaviours and so any public health policy must be negotiated at this level. Often this fact is under-emphasised and so the psychology of health behaviours are not often the priority focus for primary prevention programmes, which privilege environmental change interventions.

A typical application of the ecological model to understanding HIV-risk and sexual risk-taking would require, for example, an understanding of the common sexual practices of the individual and their sexual partner(s), and then to consider those as they occur within their communities as well as the greater social context. An intervention that addresses each of these levels would afford researchers and practitioners the ability to identify a number of critical leverage sites for long-term behaviour change. A number of HIV preventions have sought to achieve this, however; as it has been argued previously, existing research has revealed that interventions aimed at changing sexual practices which are directed at the individual, particularly within the South African context, have been relatively unsuccessful (Durantini et al., 2006; Earl & Albarracín, 2007; Kirby et al., 2007; Vergidis & Falagas, 2009; Vergidis et al., 2009). For this reason there has been an increased focus on VMAMC as part of a comprehensive HIV prevention strategy.

Many psychological variables are often neglected in broad programmatic public-health based research because environmental and policy shifts have been shown to be more cost effective (Weinman et al., 2011). It is these often neglected variables that are prioritised for study in health psychology. In order to better develop public health policies, it is therefore important to appreciate the fundamental contributions that health psychology has made in understanding the interfaces between public health priorities and individual health behaviours.

Like many other sub-disciplines in psychology, many health psychologists emphasise the systemic nature of human life. In this way, health psychologists acknowledge that health behaviours are the outcome of a range of multiple factors at the intrapersonal, interpersonal, community and societal levels (DiClemente, Salazar & Crosby, 2007; Sallis et al., 2008). These levels are offered with respect for the fact that individuals within public health policies do not exist within a vacuum, and that various psychosocial factors account for the numerous potential outcomes regarding individuals and their preventative health behaviours.

This notion acknowledges the network of causality regarding sexual risk-taking behaviours with regard to HIV infection, and in doing so, highlights that in addressing the public health crisis of the HIV pandemic, the proximal and distal factors that impact the individual's uptake of safer-sex practices need to be considered of the kind that formed key targets for public health based interventions in South Africa. These interventions have taken particular form against the socio-political context in South Africa.

2.7. South Africa's Response to the HIV Pandemic

In order to better appreciate the way that public health interventions have taken shape in the HIV landscape and therefore the place and possibilities for making meaning of HIV and its prevention, I briefly outline South Africa's responses to the HIV pandemic below.

2.7.1. Towards the HIV vaccine.

Since the advent of modern medicine, with the exception of the provision of clean water, mandatory childhood immunisation against communicable and infectious diseases has been the most successful public health strategy implemented (Plotkin & Plotkin, 1999). Countless lives have been saved as people have been immunised against diseases such as diphtheria, pertussis (whooping cough), and measles (Shorvon & Berg, 2008), and diseases such as polio and smallpox have virtually been eradicated by vaccination programmes (Maldonado, 2002). Much like VMAMC, vaccines do not carry the same degree of limitations of other HIV prevention methods (for example sexual behaviour changes such as correct and consistent condom usage) (Koff et al., 2013). It is unsurprising then that such successful medical engineering has been considered by South African researchers in the fight against HIV in recent years (Choge et al., 2006; Cilliers, Patience, Pillay, Papathanasopoulos & Morris, 2004; Makgoba, Solomon & Tucker, 2002; Morris, Cilliers, Bredell, Phoswa & Martin, 2001, Williamson et al., 2003). While various HIV vaccines have been researched over the past 30 years, only three immunisation approaches have completed clinical trials on humans (Koff et al., 2013).

The first trial failed to prevent HIV acquisition in MSM and IDUs (Flynn, Forthal, Harro, Judson, Mayer & Para, 2005), while the second trial was unable to stimulate cellular immunity against the retrovirus in MSM (Buchbinder et al., 2008). It is interesting to note that in both of these trials, for reasons that remain obscure to researchers, there were more HIV infections among male participants who were uncircumcised than those who were circumcised (Koff et al., 2013). The final HIV vaccine, RV-144, was trialled in 2009 and was able to offer a fairly small initial protective effect (31% efficacy) for people at moderate risk of HIV infection practising peno-vaginal sexual intercourse (Robb et al., 2012).

In addition to a number of other HIV vaccines in development[2], a second generation of the RV-144 HIV vaccine is currently advancing towards clinical trialling and an exciting era in HIV immunisation seems to be underway. However, given the arduous and time consuming nature of vaccine development from conception to public availability, epidemiologists fear that the pandemic may outpace the response to HIV as it continues to be of grave health concern for particular communities in South Africa (Gupta et al., 2003; Newman, 2012; Quinn, 2008).

The efficacy of any disease prevention intervention is dependent upon public buy-in and acceptance (Shorvon & Berg, 2008). However, when it comes to the development, trialling and implementation of novel vaccines, the public is often apprehensive about the safety of such public health intervention strategies (Maldonado, 2002). Such fears can be substantiated by academic and public publications that claim that vaccines have been associated with particular developmental ailments, such as in the case of the MMR (the triple vaccine against measles, mumps and rubella) and the development of autism (Shorvon & Berg, 2008).

Despite reassurances from medical doctors, academics, and public health agents that the claims regarding the MMR[3] and autism are false, public trust in the value of the vaccine in relation to its potential risks seems to be compromised (Godlee, Smith & Marcovitch, 2010). Such instances of empirical impropriety can promote the general suspicion that the public (and sometimes the medical community) has regarding the roll-out of novel vaccinations. It might be anticipated that any new HIV vaccinations might be met with the same level of distrust and misgiving, particularly in cases where the functioning of vaccines are generally misunderstood (Maldonado, 2002).

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[2] HIV immunisation trials are being conducted on the following vaccines: AAV1-PG9, CDV and HIV Eng Immunogen vaccines (which are all in preclinical trial phases) as well as Ad35, Ad35 + Ad26, DNA/IL12/Ad35, and Sendai vaccines, which are at various phases of clinical trialling. While each vaccine varies on its immunisation functioning, after administration these vaccines aim to stimulate strong immunological responses to HIV in ways that are safe, well-tolerated and immunogenic in the study population in which it is tested.

[3] In May 2010, a panel of the General Medical Council, which regulates the medical profession in the UK banned the British doctor, who controversially drew a link between autism and MMR, from practicing medicine. The study, retracted by *The Lancet* in February 2011, linked the vaccine shots with the development of autism and bowel disorders. As a result, panicked parents failed to have their children vaccinated and the uptake rate for MMR, which had peaked at 92%, fell to a low of 81% in 2004. The transgressions listed by the panel include: (1) dishonesty about the paper itself; (2) undeclared conflicts of interest; and (3) ethical irregularities in how the children were recruited and managed during course of the research. The panel pointed out that the doctor's patent on an alternative to MMR called 'Transfer Factor' meant that he stood to gain financially by discrediting the triple vaccine. He was also appearing as an expert witness in a court action against the vaccine. Additionally, the doctor failed to mention any of this either to the hospital's research and ethics committee or to *The Lancet*.

This is magnified in the case of "herd immunity" (Stern & Markel, 2005, p. 617), where such public health interventions for infectious disease control are only successful when approximately 95% of the population must be vaccinated for protection to be afforded to the entire population. In such cases, vaccinations are mandated and thereby individual liberties, such as exemptions on philosophical or religious grounds, are threatened (Poland & Jacobson, 2001). In consideration of HIV-preventative VMAMC, some experts who are in the hub of HIV problem-solving research have called for relevant governments to consider drafting policies that will make MAMC a mandatory process as a drastic step to reduce the rate of HIV infections in those countries (Clark, Eisenman & Szapor, 2007; Schoen, 2007). In such a case, VMAMC would no longer be voluntary and would be mandatory medical adult male circumcision (MMAMC).

Needless to say, making a permanent modification to the body mandatory would have profound ethical, legal, social and political implications and such a recommendation would have to be extensively researched, as well as debated and negotiated amongst stakeholders and benefactors, prior to implementation (Kelly et al., 2012). Regardless of the issues concerning public buy-in and the success of immunisation public health interventions, vaccines remain incredibly effective mechanisms for disease control (Plotkin & Plotkin, 1999; Shorvon & Berg, 2008).

However, vaccination regime compliance remains a concern in the implementation of these interventions (May, 2005). The large majority of vaccinations require booster shots, for example vaccinations against influenza should be done yearly (Banach, Zhang, Factor & Calfee, 2013); a Tdap vaccine booster shot should be received every ten years to protect against tetanus, diphtheria, and pertussis (Thierry-Carstensen, Jordan, Uhlving, Dalby, Sørensen, Jensen & Heilmann, 2012); and booster shots are required for ongoing immunisation against spinal meningitis (Bishai, Champion, Steele & Thompson, 2011), pneumococcal infections (Ruiz-Palacios et al., 2013), and cervical cancer (Schwarz et al., 2011).

Studies have shown that even if people are receptive to vaccines for disease prevention, they tend to be non-compliant in re-visiting their healthcare provider to receive booster shots (Stampi, Ricci, Ruffilli & Zanetti, 2005). Unlike VMAMC, which does not require ongoing compliance regarding circumcision, the findings from the RV-144 HIV vaccine trial indicate that the vaccine was most effective during the twelve months post-immunisation with 60% efficacy at 95% confidence intervals (CI) 22-80, and thereafter efficacy declined sharply (Robb et al., 2012). Thus Robb and colleagues (2012) suggested that the efficacy of the RV-144 HIV vaccine trial would be improved with continued booster immunisation schedules.

One cannot deny the promising HIV prevention advancements that have resulted from local and worldwide efforts to develop an HIV vaccine. While we await the arrival of a safe and effective HIV vaccine, there have undoubtedly been other successful HIV prevention efforts. These can be seen in the plateau in HIV infection rates in certain parts of the world, even in Sub-Saharan Africa where infection rates were alarmingly high for several decades.

These efforts include ARV-based pre-exposure prophylaxis (PrEP) (Amico, Mansoor, Corneli, Torjesen & van der Straten, 2013); cervical barriers (Blanchard et al., 2011; Terris-Prestholt, Hanson, MacPhail, Vickerman, Rees & Watts, 2013); therapy to suppress other STIs that increase the risk of contracting HIV (Andrei et al., 2011; Tanton, Abu-Raddad & Weiss, 2011); as well as vaginal and/or rectal microbicide gels (Baeten et al., 2012; Frohlich et al., 2010). However, in cases where ongoing compliance is required, these are not without their limitations.

2.7.2. The politics undermining health.

The South African government (particularly during the period under the influence of publically-ousted ex-President Thabo Mbeki) has largely failed to present a united front on its approach regarding the fight against HIV and AIDS, resulting in a number of instances that have generated dismay and disorder amongst HIV prevention groups (Butler, 2005; Campbell & Mzaidume, 2002). In addition to incidents such as when former President Mbeki publically stated that HIV does not cause AIDS, and President Jacob Zuma, when charged with raping a woman who was infected with HIV (of which he was acquitted) claimed that he was not concerned about contracting HIV because he had taken a shower after the sexual encounter, there has been a long history of distrust between traditional medicine and 'western' medicine (de Andrade & Ross, 2005; Green & Makhubu, 1984; Liverpool, Alexander, Johnson, Ebba, Francis & Liverpool, 2004; Ogunniyi, 1988; Wireko & Béland, 2013).

In 1997, the democratically-elected government made funding available to research the efficacy of various traditional medicines, the findings of which were used to support the passing of the Traditional Health Practitioners Act in 2004 (Meissner, 2008; Sidley, 2004). However, at the same time, WHO raised concerns that there was still insufficient evidence to encourage its use in global health programmes and policies (Bullen, 2008; Smith, 2004).

The gap between these forms of healthcare was only widened in an incident involving the former Minister of Health, Dr. Manto Tshabalala-Msimang, who was an advocate of traditional medicine but was criticised for promoting unverified traditional medicines as alternatives to clinically-trialled ARVs (Amon, 2008; Nattrass, 2008). This was most notably reflected in her opening of the South African exhibition at the 2006 AIDS conference in Toronto, where the stand presented African potatoes, beetroot, garlic and lemon as methods for treating HIV infections, while the distinct absence of any ARVs was noted by the global media (Amon, 2008; Diethelm & McKee, 2009; Kapp, 2006; McGregor, 2009).

Some have argued that such positions allow for traditional and western treatments to be pitted against each other, ultimately undermining the value of empirical evidence that supports or rejects the value of treatments that reside in one camp or the other. This can result in communities neither trusting their DoH nor the HIV policies that such departments develop and implement. Despite the obvious value of the public health system, it is often poorly received and mistrusted by the communities that it seeks to serve (Agnarson, Masanja, Ekström, Eriksen, Tomson & Thorson, 2010; Culley, Zorland & Freire, 2010).

This may be due to the fact that there is a glaring disparity between what communities expect and what they are offered by public health outreach strategies. Communities most often seek curative care when they are ill, while public health has disease prevention as its chief health objective (Richardson, 2012). Without the community's clear understanding of the role and aims of the government when it comes to matters of public health, the bond of trust between government and its people can be compromised (Streefland, 2005). This bond of trust is essential as the state is entrusted with seeking to maintain the optimal health of its people, and the people in turn are entrusted with complying with public health guidelines and paying to maintain the public health service, typically through taxation. Thus, for the public health system to function efficiently, communities have to be both the recipients and advocates of the system.

2.8. Common Public Health Interventions for HIV Prevention

The prevention of HIV infection remains a global public health priority, as evidenced by annual international AIDS conferences that highlight novel biomedical and psychosocial research findings that can be considered in the development and implementation of various HIV prevention interventions (UNAIDS/WHO, 2013). Such interventions have been largely focused on two separate but related modes of intervention - psycho-educational and biomedical strategies.

2.8.1. Psycho-educational interventions.

Surveys of young people in various countries, including South Africa, consistently identify significant gaps in knowledge of HIV. These include misconceptions about causal transmission and prevention (Howard-Payne, 2010; Peltzer & Promtussananon, 2003). At the same time, these young people report widespread behaviours that place them at particularly high risk of HIV infection.

These include early participation in sexual activities, infrequent condom use, and multiple sexual partners (Kalichman et al., 2002). In response to this, those involved in various aspects of public health and disease prevention have sought to promote awareness of HIV by educating the youth in South Africa about the ways in which HIV is transmitted, as well as ways to prevent contracting HIV infection (Steinbrook, 2006). In addition to this biomedical educational focus, various programmes have sought to educate young men and women about the psychological and social impacts of HIV infection (Campbell & Mzaidume, 2002; Mendelson et al., 2004).

It has been suggested that peer education (in the form of members of local communities taking ownership of their particular HIV prevention strategy) is a route for successful South African HIV interventions (Campbell & Mzaidume, 2002), provided that there is a sufficient alliance between the various stakeholders of each of the macro and micro social structures of influence (Halperin et al., 2011). Such programmes propose a shift away from strictly biomedical understandings of HIV and AIDS (at the level of the individual) so as to incorporate broader community and social issues that impact upon the rate and mode of HIV infection (Campbell & Mzaidume, 2002; Jaworsky et al., 2013).

The primary challenge to the successful integration of these HIV educational initiatives with actually changing risky sexual practices is that engaging in risky behaviours is directly related to the perceived risk of the risk-taking individual (Abdool Karim & Abdool Karim, 2005; Mulligan, 2010; Peltzer & Promtussananon, 2003; Stine, 2008; Weiss et al., 2000). These biopsychosocial HIV prevention educational interventions attempt to change high-risk sexual practices by changing the way that people think about HIV in general, and the risk of HIV infection by debunking and deconstructing prevailing myths and stereotypes associated with HIV-risk as generated by the stigma of HIV (UNAIDS, 2010).

However, individuals tend to resist cognitively engaging with information that challenges their existing beliefs regarding HIV and their perceived personal risk of infection, and so continue to underestimate their HIV-risk and reject interventions that promote sexual behaviour change (like abstinence, being faithful to one sexual partner, or consistent condom usage). The perceived limitations of psychosocial educational interventions in generating dramatic changes in the ways in which people think about HIV and their personal risk of HIV infection, has often resulted in a great deal of resources being allocated towards developing biomedical interventions. VMAMC (at least seemingly) circumvent the social cognitive challenges presented by educational interventions in bringing about sexual behaviour changes on a wider scale.

2.8.2. Biomedical interventions.

Discovering and developing an effective HIV prevention mechanism has been the priority for medical science for the past several decades. The male condom is the most efficient method of HIV prevention used by sexually active individuals (UNAIDS/WHO, 2013). A meta-analysis in the United States found that the overall efficacy of condoms in reducing HIV transmission was 69% (Holmes, Levine & Weaver, 2004). Several laboratory experiments conducted to test the ability of latex condoms to provide an effective physical barrier against HIV have demonstrated a statistically significant negative association between condom use and risk of HIV infection (Davis & Weller, 1999; Pinkerton & Abramson, 1997; Weller & Davis, 2002). It is generally accepted by the medical and public health communities that, when used properly, latex condoms can significantly reduce the risk of sexual transmission of HIV (Holmes et al., 2004). However, condoms can fail to provide complete protection for a variety of reasons, including failure to use them consistently, failure to use them properly, condom breakage, and condom slippage (Tounkara et al., 2014).

The latest research in the area of novel HIV prevention methods has produced some highly valuable findings, which include progress with regard to the development of a safe and effective vaccine (Koff, 2010); cervical barriers such as the diaphragm (Matthews & Harrison, 2009); therapy to suppress herpes simplex virus type II, the primary cause of genital herpes which is a risk factor for acquiring and transmitting HIV (Glynn, Biraro & Weiss, 2009); and microbicides that could be applied to the vagina or rectum (McGowan, 2010). While each of these medical advances towards the elimination of HIV have had varying degrees of success in laboratory settings, the limitation of these interventions rest with empirical evidence that shows that human compliance with ongoing medical regimes is relatively poor (Donovan & Blake, 1992; Hansson Scherman & Löwhagen, 2004; Pech`ere et al., 2007; Thomas et al., 1996; Trostle, 1988).

In an effort to mitigate this phenomenon of non-compliance, efforts have been dedicated to searching for effective alternative HIV prevention interventions. As such, several studies have found that VMAMC reduces the risk of HIV infection in men practicing peno-vaginal intercourse (Auvert et al., 2013; Bhattacharjee, 2008; Gruskin, 2007; Mehta et al., 2013; Tobian & Gray, 2011; UNAIDS, 2010; UNAIDS/WHO, 2013).

As reflected in the epidemiology of HIV in Africa, 90% of adults acquire HIV via penetrative peno-vaginal intercourse (Bailey, Plummer & Moses, 2001; Stine, 2008). This finding has directed researchers' focus towards investigating the factors that may impact on the transmission of HIV for males by concentrating on the anatomical structure of the penis as being one possible modifiable vector of HIV infection in men.

2.9. Research on HIV Prophylactic Value of VMAMC

Biological studies have shown that the delicate tissue of the foreskin is vulnerable to microscopic lesions, which increases the risk of contracting HIV (Silverman, 2004). The foreskin also houses specialised Langerhans cells, which HIV and other pathogens can readily attach to (Auvert et al., 2013; Bhattacharjee, 2008; El-Hout & Khauli, 2007; Halperin & Bailey, 1999). Thus, by removing the foreskin, a man's risk of contracting HIV through peno-vaginal penetrative sexual intercourse will be reduced.

However, there is no evidence that VMAMC has any protective capacity for reducing the risk of HIV transmission from an infected male to his female partner, and research has yet to be conducted on the effectiveness of VMAMC in reducing the risk of HIV infection for MSM or men who practice peno-anal penetrative sex with their female partners. Some meta-analyses have, however; produced conflicting results with regard to the protective proportions of VMAMC against HIV infection, indicating that circumcised men might be at greater risk of HIV infection (De Vincenzi & Mertens, 1994; Van Howe, 1999; Van Howe & Storms, 2011).

Additionally, despite the number of studies conducted that have indicated that VMAMC may have a protective effect against HIV transmission for men who engage in peno-vaginal sexual practices, a number of studies have found this claim to be problematic (Boyle & Hill, 2011). Some report that this claim can only be made for men who engage in particularly high-risk sexual practices and not men in the general global population (Green, McAllister, Peterson & Travis, 2008; Morris et al., 2012), however; others indicate that any claims regarding the protective potential of VMAMC against the risk of HIV infection are based on flawed research methodologies that attribute causality to human anatomy rather than the complex factors which guide sexual behaviour for vulnerability to HIV infection (Dowsett & Couch, 2007; Van Howe, Cold & Storms, 2000).

The claim that that permanent surgical modification of a male's genitals will reduce his risk of HIV infection during heteronormative sexual practices rests, in part, on the belief that Langerhans cells (found in the mucosal tissue) are highly concentrated in the inner surface tissue of the foreskin and frenulum (Szabo & Short, 2000). Scientists, such as Fleiss, Hodges and Van Howe (1998), who challenge the validity of VMAMC as a method for reducing the risk of HIV infection for men who engage in hetero-normative sexual practices, do so in light of the claim that Szabo and Short (2000) failed to account for the comparative concentration of Langerhans cells in other parts of the penis (the glans, remnants of the foreskin, or scar tissue that develops as a result of medical circumcision). Without this data, selecting the foreskin and the frenulum as the most vulnerable locations of HIV entry and attachment is done based on conjecture rather than sound epidemiological research (Van Howe et al., 2000; Van Howe & Storms, 2011).

Until such time as this research can be undeniably confirmed and the exact mechanisms at play for reducing HIV transmission for the circumcised male are understood, VMAMC may be debated as a viable, ethical, and acceptable method of HIV prevention. Should randomised controlled trials undeniably confirm that VMAMC is a protective option; the South African government may have an obligation to implement VMAMC as the primary nation-wide strategy to prevent further HIV infections. However, the factors at play in the individual meaning-making of VMAMC as part of an HIV prevention strategy (by both experts and the public) will have to be better understood before a culturally-suitable programme can be developed that will address the numerous socio-cultural factors implied by VMAMC.

While research on the relationship between VMAMC and HIV is ongoing, and new contradictory studies appear almost weekly, mainly in medical journals, there is at least some consensus that VMAMC reduces one's risk of HIV infection. This reveals a number of possibilities for HIV prevention programmes in countries that have a high rate of HIV incidence and prevalence.

2.9.1. Evidence from risk reduction studies.

A number of independent global clinical trials have been conducted that indicate that circumcised men are less likely (odds ratio = 0.58; 95% confidence intervals: 0.36-0.96), over a 21-week longitudinal period, to contract HIV through peno-vaginal intercourse than intact men (Bonner, 2007; El-Hout & Khauli, 2007; Schoen, 2007; Siegfried et al., 2003; Williams et al., 2006).

Trial research in South Africa on VMAMC has shown that the practice yields some reduction in the risk of HIV infection by 60% (Auvert, Taljaard, Lagarde, Sobngwi-Tambekou, Sitta & Puren, 2005). The most well-known South African study regarding this claim is the "Orange Farm Trial" (an urban area close to Johannesburg) by Auvert and colleagues in 2005. The trial focused on the prevalence of HIV in adults practicing peno-vaginal sexual intercourse in Orange Farm where the HIV prevalence was relatively high (32%), and approximately 20% of the males in the region were circumcised by the age of 17. The researchers recruited healthy males between the ages of 18 and 24 who were uncircumcised but who were willing to undergo circumcision (n = 1538), and 1590 uncircumcised males who did not want to be circumcised. Over 90% of the sample was sexually experienced.

The intervention (of circumcising males who did not change their sexual behaviour versus uncircumcised males who remained as such and also did not change their sexual practices) found that medical circumcision results in partial protection against HIV infection. The obvious biases rest on the fact that the characteristics of the sexual partners could not be controlled for (Auvert et al., 2005). The evidence from such risk reduction studies has prompted two types of feasibility studies regarding the roll-out of a VMAMC-based HIV prevention intervention in South Africa. The first concerns the infrastructural feasibility of a national VMAMC roll-out. The second focuses on the acceptability or willingness of various people to 'participate' in VMAMC in one way or another.

2.9.2. Infrastructural and political feasibility.

A study by Auvert and colleagues (2008) estimated the financial and human resources that would be required for a South African national roll-out of VMAMC performed as part of an HIV prevention measure. As it has been estimated that the risk of HIV infection is reduced by 60% for males who have undergone VMAMC, at least two million new infections and 300 000 AIDS-related deaths could be prevented in Sub-Saharan Africa over the next decade (Auvert et al., 2008; Stine, 2008). Between the years 2023 and 2033, an additional four million new infections and three millions deaths could be prevented (Williams et al., 2006).

After developing a model (including costing, demography and HIV epidemiology) and investigating some 14 Sub-Saharan countries with low VMAMC (but high HIV prevalence), with the assumption that it would take five years to effectively implement such a programme, Auvert and colleagues (2008) found that the roll-out would cost less than it would cost to treat those who would become infected, yielding a net savings due to the reduced number of new HIV infections. Although it would require considerable funding and a high number of men willing to undergo such a procedure, it is believed that this investment would be justified not only by the financial resources saved as a result of the reduced rate of HIV incidence, but also as a result of other widely-claimed overall health benefits of VMAMC for males, suggesting that it would be a sustainable project in the long term (Auvert et al., 2008). However, cost-benefit evaluations are but one of many factors required in establishing programmatic feasibility.

2.9.3. Community acceptability of circumcision and willingness to circumcise.

Studies performed in African countries where MC is not regularly or traditionally performed (since all South African males would be targeted with this particular programme, not just those who currently practice circumcision or who have been statistically identified as being at high risk of HIV infection), show that there is a level of acceptance regarding VMAMC among healthcare practitioners as a public health intervention to combat the spread of HIV (Stine, 2008).

A meta-analysis of the acceptability of VMAMC as a procedure to reduce one's risk of HIV infection conducted by Westercamp and Bailey (2007) showed that the median proportion of uncircumcised men willing to become circumcised was 65% (range 29-87%), while approximately 70% of women would prefer circumcision for their partners or their sons and the same percentage of men would prefer circumcision for themselves or their sons.

Countries such as Zambia have helped raise awareness of the procedure's potential health benefits via mass media advertising and hospital newsletters. As a result of this media attention there has been an overwhelming response, with men coming from rural areas to the cities to have the procedure performed surgically (Stine, 2008). In Botswana, Kenya, South Africa and Swaziland, when men or women were asked about circumcision for their sons, more adults would agree to the procedure for their child than for their spouses or themselves. Approximately 75% of parents would seek circumcision for their son if it was safe, affordable and shown to be protective against HIV and STIs.

The meta-analysis showed that overall, 65% of uncircumcised men were willing to become circumcised for hygiene reasons and to reduce their risk of HIV and STIs. In rural areas, 51% of men were willing to be circumcised, while 77% of men in urban areas were willing to undergo circumcision. While such studies offer valuable indicators of uptake of VMAMC as a method of HIV prevention, these acceptability studies do not offer an account of why there may be a discrepancy in such decision endpoints. That is to say such studies are unable to detail the reasons as to why a man would undergo HIV-preventative VMAMC or not. My current study sought to address this by generating a theoretical account of the factors involved in individual meaning-making of such VMAMC by men who do and do not practice traditional circumcision in South Africa. This is unpacked further in the following section.

Despite the concerns and challenges to the implementation of VMAMC, the South African government continues to pursue this initiative, in light of its prophylactic evidence, as a method of HIV prevention. However, the success of any HIV prevention strategy depends on the social context in which it is implemented, as it has to be considered credible, culturally relevant, and practical by all the intervention stakeholders involved. For this reason, should VMAMC be considered a worthy intervention for implementation, the value and significance of MC needs to be considered beyond its value as a method of medicalised male body modification in an attempt to reduce the spread of HIV within the South African setting.

2.10. Existing MC practices: A Traditional Ritual & Rite of Passage

While definitions of tradition are varied across disciplines, often in an effort to best encapsulate the quintessence of what Quah (2010) refers to as the way of life blueprint, it could be said that tradition ultimately includes all social matters that reflect a collective's way of life. This allows perspectivistic spaces to exist whereby a nation, such as South Africa, is constituted of diverse groups that are distinctive in their ethnic origins, social practices, religious belief-systems and customs (Hulme, 2010; Swartz, 2013). Thus tradition plays a role in the beliefs, principles and conduct of culture, as well as the expression and practice of religion. Raday (2003) reminds us that understanding the symbols, practices and beliefs of a religion can play a critical role in making anthropological and psychological sense of a culture, and vice versa.

While the meanings, purposes and rituals of traditional MC for cultural and religious reasons are often very different, people typically hold a number of social identities at any given moment (Meyer, 2004). That is to say that while a young man in Johannesburg might identity himself as being Xhosa, he may equally identify himself as being Christian. In a country such as South Africa, where these social identities are often intertwined and inseparable from each other, it makes neither theoretical nor practice sense to discuss culture and religion as completely disconnected or mutually exclusive (Sasaki & Kim, 2011). Dover, Miner and Dowson (2007) suggested that religion be considered a separate, though interfacing, factor of culture. Thus an overview of traditional male circumcision for cultural and religious reasons is outlined on the following page.

In South Africa, 45% of males are circumcised (in the traditional fashion more so than for medical purposes) with considerable variation across its nine provinces (see table 2). These variations in the practice attest to the fact that circumcision has different geographical patterning, which often proxies for other types of differences such as language, culture and religion (Moses et al., 1998).

Table 2: Percentage of circumcised males per province in South Africa

South African Province	Percentage of circumcised males
Free State	71
Western Cape	68
Limpopo	48
Eastern Cape	44
Mpumalanga	36
Northern Cape	34
North West	33
Kwa-Zulu Natal	27
Gauteng	25

Sourced from: Department of Health (2013)

Cultural MC (along with other penile modifications) represents a context-bound, transitional, sacrificial practice of cutting or marking the penis to symbolise the shift from childhood to adulthood (Gluckman, 1968; Mbito & Malia, 2009; Peltzer & Kanta, 2009). Xhosa people view the foreskin as a cloak that hides the penis and when a boy comes of age (between the ages of 17 and 20 years), this 'cloak' is removed to expose the penis, representing his ownership of the powerful masculine phallus (Boddy, 1989; Crowley & Kesner, 1990).

It is with this masculinity that the young man is free to be the master of his life as he leaves the confines of the village to become a separate entity in the world. There is evidence of the ancient practice of MC in artefacts such as prehistoric carvings representing the circumcised penis (Angulo & García-Díez, 2009; Paige & Paige, 1981). Sacrifices by way of burning the circumcised foreskin to the Egyptian fertility god, Min, were thought to placate the heavens and promote fertility (Baldick, 1998). Theologians and anthropologists have considered that the biblical character, Abraham, may have revised this ritual to one that would require all Hebrew and Islamic males to be circumcised as an emblematic surrender of the male life force and reproductive power to their creator (Dunsmuir & Gordon, 1999; Douglas, 1970). Such rites, mandated by tradition, resist the ideology of the 'self-made man' and views MC as the inscription of God's name into the body (Wolfson, 2002).

Goldberg (1996) argued that the timing of religious MC (usually when the infant is a few days old) is of significant importance to the construction of family – the infant is united to his father by phallic appearance as well as to the religious orientation of the family. Paul (1996) offered a psychoanalytic perspective of religious MC, and anchored biblical circumcision to the oedipal dimensions of generational succession. The physical act of circumcision (dividing a single body into two parts) parallels the creation of women (Eve, in the story of creation in the biblical Old Testament book of Genesis) from the body of a genderless yet male-sexed creature (Adam).

Historically the practice of cultural MC in many African cultures was challenging for Christian missionaries, where the rite, in many ways, represented the primitive past (Aggleton, 2007). At the same time, however; religious MC carried a biblical endorsement from both Abraham and Jesus Christ (Massry, 2011; Silverman, 2004). After World War II, health orderlies introduced medical MC to Papua New Guinea. As a result, circumcision became associated locally with the medical hygiene practices of modern Europe. The rite, which for the missionaries was related to Christ's crucifixion and Christian purification, slowly became integrated into male initiation into manhood by the 1950s and 1960s (Silverman, 2004). This case highlights that MC can indeed serve various functions (biomedical/hygiene foci, religious and cultural rites) at the same time, implying that its use as an HIV preventative medical application in a South African setting could be understood alongside its other context-bound meanings.

However, medicalisation of the traditional practice of MC may have implications for that tradition and the practice of MC. In addition to the cultural significance that MC carries, its medicalisation and use against the risk of HIV infection for adult men has implications for the individual meaning-making of such an intervention for those who practice religious MC.

Theoretical accounts of circumcision based in culture or religion share health and lines of patriarchy as common underlying determinants. In both instances, circumcision appears to mark masculinity and play a role in the assumed hygiene of the circumcised group. These factors have been extensively studied in circumcising populations, but aside from historical and descriptive accounts, insights into the way these factors may feature in individual meaning-making of VMAMC in the context of HIV prevention are limited. Also, very little is known about why or how such apparently widespread belief-based practices anchor certain forms of patriarchy and hygiene in some groups, but not others.

2.11. Conclusion

In order to better describe and capture the individual meaning-making factors that frame VMAMC as a means to HIV prevention, the understanding of VMAMC as an intervention primarily focused on the physical body or as a socially symbolic practice must be supplemented by a greater focus on what meanings are attached to it by those that are key to its implementation as part of a public health HIV prevention strategy. By contextualising the global and local HIV landscape in which VMAMC is considered a possible means of infection prevention, this chapter has shown that the removal of the foreskin has implications that extend far beyond the biomedical or anthropological understandings of the body and its rites. These extend into psychological issues, religious, cultural understandings of MC, gender norms and human rights. Without careful consideration of these key factors in understanding the meanings of VMAMC for its practitioners and targets, economic feasibility will remain an insufficient motivation for rolling out VMAMC. Thus there has been an increased focus on VMAMC as part of a comprehensive HIV prevention strategy, but this cannot happen without a more in-depth understanding of the way that individuals ascribe meaning to the practice. I aim to contribute to this line of thinking by generating a data-embedded theory of the factors involved in such meaning-making.

Chapter 3: Research Methods

3.1. Introduction

While the preceding chapters have located my study within current understandings of HIV prevention, health psychology and meaning-making of MC and VMAMC, in this chapter I aim to account for the selection of GT as the approach used for data collection and analysis so as to fulfil the objectives of this study. In doing so, I outline the various conventions of GT research approaches so as to justify my selection of a Straussian GT approach to this study. GT, as a qualitative approach, will be outlined by providing a historical overview of its origins, its theoretical and philosophical assumptions, as well as foregrounding current issues and debates in the use of the method. Furthermore, I describe the study's sampling strategy, as well as the semi-structured interview schedules developed and utilised in the different forms and stages of sampling. The data collection methods selected for the study are discussed as a detailed description of the research procedure, and the data analysis process is presented.

3.2. The Selection of Research Methodology & Methods

Personal philosophies, the phenomenon investigated and the choice of methodology comprise the building-block of any systematic response to a research question. Morgan (1983) proposed five foundations that may be utilised when evaluating the potential utility of various research strategies. Firstly, the researcher can essentially amalgamate methods so as to capitalise on the unique strengths of these methods as well as to diminish their relevant weaknesses. Secondly, the researcher may aim to recognise a superlative approach (one that promotes epistemological supremacy), and thirdly, a contingency method (that one is able to evaluate a strategy by the efficacy of its paradigmatic assumptions) might be considered. Fourthly, the researcher might engage with a dialectic approach, which unites rival perspectives so as to develop a novel mode of understanding; or lastly, as a matter of practicality, the researcher may seek to embrace an approach that recognises that every existing strategy may have something of value to offer.

A failure to institute these foundations would lend itself to the notion that 'anything goes'. GT was chosen as an effective strategy for responding to the research questions after careful consideration of both its practical and philosophical value to the aims of this study, in that they are relevant to matters of methodology as well as method (Harry, Sturges & Klingner, 2005; Strauss & Corbin, 1998).

Deliberations of method were allied with the techniques to be utilised during data gathering and collection, which were considered to be comparatively superior when measured against various other methods (Bryman, 1984; Charmaz, 2006; Strauss & Corbin, 1990). For example, traditional narrative methods serve to offer descriptive accounts as to how people responded to particular events and how these events occurred, however; a GT approach yields an understanding of how and why people behave in particular ways in order to resolve certain problems. Therefore, such data collection methods afford the researcher opportunities to obtain nuanced descriptions and rich explanations regarding particular behaviours and meaning-making as the participants reflect upon their past actions, perceptions and views of reality (Banister, 2011; Carr et al., 2011; Silverman, 2013).

The GT approach was the most appropriate tool for exploring VMAMC meaning-making in the context of HIV prevention for several reasons. Firstly, the approach created a cognitive space that allowed me to orientate myself with the concepts and notions aligned with the area of study, while at the same time, acknowledge that the content and research findings reviewed (as with the development of the literature review), as well as the process of data gathering by conducting semi-structured interviews, would undoubtedly shape the theory that developed as a result of the study. Secondly, while VMAMC does not exist in a contextual vacuum, no substantial theory of the ways meanings are made of it has been developed in the literature. There are no hypotheses associated with this phenomenon, thus with the collection and analysis of novel data, I was able to adjust and refine a generated theory; a research process that diverged significantly from the quantitative convention of constructing and testing a hypothesis (which is traditionally not altered at any point of the quantitative research process). In other words, the phenomenon of interest was perfectly aligned to a reverse hypothesis as an outcome of the analysis, a central aim of the GT approach.

GT adopts a flexible research design devoid of an interest in typical hypothesis testing (Charmaz & McMullen, 2011; Tweed & Charmaz, 2012), rather seeking to have the research theory "emerge from the field in the course of the study" (Miles & Huberman, 1994, p.17). However, that is not to say that epistemological and technical principles can be confused into a hazy blur. Where GT is concerned, the selection of methodology and method is intertwined as there are two governing accounts of GT that are promoted (based on diverse methodological assumptions) due to the developments that have occurred in the area of GT since its original development by Glaser and Strauss (1965).

Despite the clear value and benefits of quantitative methodologies, there has been a steady cynical disillusionment with quantitative methods being considered as the superior (and only) approach to sound social sciences research (Downey & Ireland, 1979; Fineman & Mangham, 1983; Strauss & Corbin, 1990; Miles & Huberman, 1994; Silverman, 2013). An international trend shows that qualitative research is currently being accepted as an alternative to, rather than a subordinate of, quantitative approaches (Babbie & Mouton, 2001; Bryman, 2012; Strauss & Corbin, 1998).

3.3. GT in Health Psychology Research

Against the backdrop of the popularity of interpretative phenomenological analysis (as the primary methodology deployed for contextualising current debates, particularly in social psychology, between social cognition and discourse analysis) and the significance for health psychology (Smith, 1996), there is an increasing attraction to the utilisation of GT in research in the arena of health psychology. The GT approach has been found to be particularly useful in developing novel understandings of pharmacology and medicine, with special reference to the regulatory authorisation and promotion of innovative treatments of human illnesses (Michie, McDonald & Marteau, 1996; Pieyzsch, Shluzas, Pate-Cornell, Yock & Linehan, 2009; Tapon & Cadsby, 1996); coping with disease (Knott, Turnbull, Olver, & Winefield, 2011); ethics and informed consent (Seetharam & Zanotti, 2007). A number of HIV-related studies that have utilised the GT approach have been able to contribute significantly to the field of HIV prevention by verifying intervention provisions; and by developing and monitoring relatively innovative HIV education, prevention, and care interventions (Chakrapani, Newman & Shunmugam, 2008; Miller, Bangsberg, Tuller, Senkungu, Kawuma, Frongillo & Weiser, 2011; Rhodes et al., 2010).

While these studies are useful in identifying the constant and ever-evolving factors (and resulting relationships between factors) involved in one's decision (or ability) to consistently follow particular ongoing sexual practices related to HIV prevention, no study has been conducted that is able to account for the factors involved in individual meaning-making of a once-off permanent body modification procedure, such as VMAMC, in order to reduce one's risk of HIV infection.

Most current HIV prevention studies that utilise a GT method do so in order to evaluate existing HIV prevention and education framework interventions (that require ongoing sexual behaviour changes by their users in order to be considered successful or not). The effectiveness of VMAMC to reduce the risk of HIV infection, while still relatively debateable, is not the focus of this study, but rather this study seeks to give an account of the factors involved in individual meaning-making of a particular health-related behaviour (VMAMC) by way of a GT approach.

For the past several years, various authors (Fife-Schaw, 2011; Locke, 2004; Malson, 2010; Rogers, 1996; Rogers, 2011; Stiles, 2003; Youngson, 2009; Zea, Reisen & Díaz, 2003) have argued that health psychology, largely supported by findings from quantitative hypothetico-deductive research, has failed to establish a body of knowledge that fully captures the density, complexity and dynamism of health-related behaviours. Richer qualitative studies have since offered evidence that health-related behaviours are informed by knowledge, attitudes and perceptions of risk, as well as cultural and social (often informed by patriarchy) expectations and limitations on health behaviours and access to resources (Andersen, 1995; Berkman, Glass, Brissette & Seeman, 2000; Sallis et al., 2008; Traube, Holloway & Smith, 2011; Wakefield, Loken & Hornik, 2010). Health psychology research in the area of HIV is mostly dominated by hypothesis testing and model building, which generates several problems for theory building. In many cases not enough of the variance in multi-variate regression models could be explained (Betancourt, Meyers-Ohki, Charrow & Hansen, 2012; Bowling, 2009; Östlund, Kidd, Wengström & Rowa-Dewar, 2011; Traube et al., 2011).

In such cases, part of the problem may lie in premature statistical testing of theoretically-based arguments, that is, if the theories subjected to empirical research are problematic in their conception (due to a lack of theoretical input that can be supported by qualitative methodologies), it is not entirely surprising that the findings of these studies are not compelling (Britten, 2011; Bryman, 2012; Michie & Prestwich, 2010; Morse, 2010).

The GT approach adopted by this current study is able to address such limitations as it houses a relatively wide assortment of research methods and epistemological foundations, which a researcher can select from in order to match to the distinctiveness of the milieu of a research problem.

3.4. The Classic GT Approach

GT was conceptualised with the purpose of generating a novel theory by initiating a methodology that has the power to endure the research process, from the systematic collection of data through to the production of a multi-dimensional conceptual theory (Glaser, 1999; Glaser & Strauss, 1965; Harry et al., 2005; Strauss, 1987; Strauss & Corbin, 1997). Although it was originally proposed to be housed as a broad research method that would be pertinent in both quantitative and qualitative data systems, it has become progressively perceived and utilised as a purely qualitative research method (Glaser, 1999; Glaser & Strauss, 1965; Miller & Fredericks, 1999).

3.4.1. The origins of GT.

GT was developed by sociologists Anselm Strauss and Barney Glaser as an alternative to the prevailing research norms of the 1960s (Glaser & Strauss, 1965; Layder, 1982). Strauss, during his time as an academic and researcher at the University of Chicago, was influenced by the rationalist and interactionist works of R.E. Park, J. Dewey, G.H. Mead, E. Hughes, and H. Blumer (Oliver, 2012). Such scholars contributed to Strauss' perspective regarding the dominant research model of the time, which he saw as entailing the corroboration of existing, ungrounded prescribed theories derived by logico-deductive reasoning, or conjecture (Goulding, 1998).

Glaser, on the other hand, studied at Columbia University and was inspired by P. Lazarsfeld, who, at the time, was believed to be a visionary when it came to matters of quantitative research methods (Smith, 2001). During his involvement with various quantitative studies, Glaser felt that qualitative research methods, with regard to hypothesis testing as well as coding of data, lacked an unambiguous and methodical system of procedures for data analysis (Henwood & Pidgeon, 1992).

They developed GT as a means to "bridge the gap between the theoretically 'uninformed' empirical research and empirically 'uninformed' theory" as a response to "extreme empiricism" (Goulding, 1998, p. 51). Glaser and Strauss (1971) promoted the generation of compound theories in substantive and formal fields of investigation to be structured into more inclusive formal theories. This was in express contrast to the "monopolistic implications of logico-deductive theories, whose formulators claim there is only one theory for an area" (Glaser & Strauss, 1965, p. 35).

Subsequent to the development of their GT method, Glaser and Strauss were employed by the University of California, where they introduced GT to the Faculty of Nursing (Kools, McCarthy, Durham & Robrecht, 1996; Robrecht, 1995). During their work together at this time, Glaser and Strauss found that they differed on several key theoretical and philosophical assumptions regarding what they thought of as a "classical" GT approach. These fundamental differences resulted in the parting of ways for the originators of GT to yield two diverse schools of GT, namely (1) the Glaser school of GT, which operates within a post-positivist paradigm, and (2) the school of GT advocated by Strauss, who then united with Corbin to adopt a constructivist approach to GT (Annells, 1996; Mills, Bonner & Francis, 2006).

At first glance one might consider constructivism and constructionism as having similar meanings, however; there are critical differences between these two terminologies. Constructivism relies on the epistemological basis of critical and interpretative perspectives, which requires that the researcher adopts a subject-centred position (Scholl, 2013), while constructionism is located within a subject-object interdependent epistemology (Mantoura & Potvin, 2013). Based on a shared philosophical perspective to qualitative research (and GT in particular), I elected to follow the paradigm associated with the Straussian school of GT, which is contrasted, in detail, to the Glaserian school below.

Despite the technical criticism from authors that the Straussian school of GT is too rigidly programmed (Charmaz, 2006; Melia, 1996; Strauss & Corbin, 1990), it seems as though the heart of the split between Glaser and Strauss lies not in differences regarding the technical approach to GT, but rather in differences in philosophical perspectives (and the resultant ontological and epistemological stances, axiology, and methodological implications thereof) (Annells, 1996; Charmaz, 2006; Strauss & Corbin, 1990).

3.4.2. An overview of GT.

GT was designed in order to serve two key tasks; firstly, to function as a guard against theoretical stagnation and immobility via novel theory generation, and secondly, to institute an observation of field research as a source and locus of theoretical innovation so as to ground theoretical development in sound scientific data (Glaser & Strauss, 1965; Goulding, 1998; Harry et al., 2005; Layder, 1982; Strauss & Corbin, 1997).

Glaser and Strauss (1965) developed GT as they believed that the sufficiency of a theory relies on the research process that was utilised to derive it; they thus offered a methodology that could be applied to generate theory based upon the data that was collected. In other words this methodology was able to present a theory, which has its hypotheses and conceptualisation derived from data that was gathered, and is generated as the data is collected, coded and analysed (simultaneously) for the duration of the research process. This style of theory development, based on empirical investigation, would certify that the theory-product would be pertinent to the phenomenon being studied.

This approach to theory generation stood in stark opposition to the established logical-deductive perspectives, which Locke (1996) argued could be potentially biased as it may serve only to verify the validity of existing theory. Arguably this process is somewhat circular as a hypothesis is derived and informed by prevailing theory, which in turn informs methodological and analysis approaches, and will thus most likely generate findings that simply reflect back to the legitimacy of the informing theory. GT thus unambiguously abandons *a priori* theorising (which erects predetermined restrictions on the unearthing and expansion of theory) and is typified as a systematic process that is aligned with the area being investigated.

Strauss and Corbin (1994) argued that the GT approach differs from other methods of qualitative analysis due to its focus on theory generation and development, which can be either substantive or formal. A substantive theory is located in the research of a single content area, which involves the study of a particular phenomenon positioned in one specific situational setting, for example the factors involved in individual meaning-making of HIV prevention strategies such as VMAMC in Johannesburg, South Africa. On the other hand, a formal theory is related to a conceptual area and develops as a result of a single phenomenon being investigated under diverse conditions and situations, for example racism in HICs and LMICs.

3.4.3. Theoretical and philosophical assumptions.

GT is rooted in symbolic interactionism with an orientation towards understanding the meanings that people attach to particular events as well as the symbols used to communicate those meanings (Cockerham, 2013). Blumer (1980), who had influenced Strauss' philosophical approach to research, saw symbolic interactionism as being concerned with the intrapersonal features of human conduct.

Symbolic interactionism therefore considers the ways in which people characterise events, the ways in which they construct their reality, as well as the types of belief systems that are held, investigated and interpreted. Symbolic interactionism is based on Blumer's pragmatist perspective as he was particularly practical in his approach to problem-solving (Lüscher, 1990; McCarthy, 2012; Stryker, 2003). Symbolic interactionism is an especially useful theoretical position when studying meaning-making because:

> [It] was developed as an alternative account of social life that viewed society as a fluid and dynamic process of ongoing activity and varied reciprocating interactions. Symbolic interactionism, therefore, developed as a perspective that was concerned about the generation, persistence, and transformation of meaning and claimed that meaning could only be established through interaction with others. With whom, with what, and how one interacts becomes a major determinant in how one perceives and defines reality (Kendall, 1999, p. 744).

It is with these assumptions in mind that I decided to operate within symbolic interactionism, so as to be able to enter into the personal realities of the participants of this study in an attempt to determine, interpret and understand the symbolic meanings of objects, gestures or words utilised when engaging with the content material of this study (the factors involved in individual meaning-making of VMAMC for the purposes of HIV prevention in South Africa).

Two primary deviations in symbolic interactionism emerged as a result of Glaser and Strauss parting theoretical ways. Firstly, The Iowa School, which espoused the Glaserian positivist approach, and secondly, The Chicago School, which Strauss and Corbin saw as being humanistic, accentuating a *verstehen* perspective (where the researcher is more personally engaged in an attempt to better describe and understand the world as the participants perceive it to be, rather than from the position of the objectively detached observer).

This was selected as the approach that was to be utilised for my study in the data collection process (Goulding, 1998; Harry et al., 2005; Izzo, 2003; Layder, 1993; Strauss, 1987). Despite Strauss not overtly stating the assumptions fundamental to his approach to GT, his assumptions are intrinsic in his work and were made more explicit by his intellectual progeny (Corbin in particular). These can be summarised as being firstly, psychosocial developments direct and structure GT inquiry; secondly, collection and analysis of data occur and proceed concurrently; and thirdly, the research process, as well as its outcomes, are guided by the data as it is collected and analysed rather than by predetermined theoretical frameworks. Fourthly, this version of the GT approach triggers investigative processes and development of theory in favour of simple verification of existing theory. Fifthly, conceptual categories are (to the greatest extent possible) perfected, detailed and finalised through the process of theoretical sampling. Then, in addition to investigating human behaviour and social practices, GT aims to understand social experiences by housing the investigative outcome in theory generation. Lastly, GT analysis gradually results in further conceptual levels of analysis (Wolfswinkel, Furtmueller & Wilderom, 2011).

3.4.4. The Glaser-Strauss controversy.

The ontological implications for the differences in paradigms noted above resulted in the Glaserian approach adopting a critical realism position to answering questions regarding the nature of reality and what can be understood about that reality, while the Straussian approach is positioned in pragmatic relativism (Harry et al., 2005; Strauss & Corbin, 1990). Critical realism holds that reality can be seized to develop a GT that truly resides in the data (Mills, Chapman, Bonner & Francis, 2007). This is in stark contrast to the adoption of an ontological stance of relativism that says 'fact' is restricted in the established consensus of a particular period; a consensus that is founded in multiple outlooks regarding a certain phenomenon (Mills et al., 2007; Strauss & Corbin, 1990).

Strauss and Corbin (1994, p. 280) discussed the affiliation between theory, reality and truth by saying that "theories are embedded 'in history'... historical epochs, eras and moments are to be taken into account in the creation, judgment, revision and reformulation of theories". This particular position is presented as the foundation of the conditional matrix offered by Strauss and Corbin (1990), which is used as a tool for generating multiple viewpoints on a phenomenon as it surfaces from the data during collection and analysis (Charmaz, 2006).

Epistemological stances are dependent upon the paradigmatic assumptions regarding the relationship between the observer and what is being observed (Cutcliffe, 2000; Strauss & Corbin, 1990). GT, according to Glaser's approach, is contained by an epistemology of realism, where the findings are deemed to be revealed from within the data (Madill, Jordan & Shirley, 2000).

On the contrary, Strauss' approach is applied within an epistemology of contextualism, which holds that the findings are constructed by inter-subjective understandings of the phenomenon being investigated (Strauss & Corbin, 1990). The differences between these two schools of GT regarding philosophical, ontological and epistemological assumptions are mirrored by the dissimilarities in methodology, that is, the way in which the researcher approaches the phenomenon under investigation (Harry et al., 2005; Strauss & Corbin, 1990). The resulting methodological differences extend into the types of data that are gathered and analysed. The Glaserian school maintains a general approach (in line with the classical approach to GT) as it relies on both qualitative and quantitative data, while the Straussian approach primarily utilises a qualitative research method (to the exclusion of any quantitative data).

Glaser seems to hold a number of objections to the Straussian school of GT. One such objection concerns Strauss' conviction that the researcher can (and should) initiate the research enquiry with a predetermined research question in mind, which arises from the existing literature (Melia, 1996; Strauss & Corbin, 1990). The Glaserian approach follows research questions as they arise from the initial data analysis, and thus it is impossible for the researcher to enter the research field with any pre-set research questions. Another objection to the Straussian approach concerns the initial coding of data. While Glaser promotes initial coding through the comparison of occurrences with each other to reveal patterns and trends that will emerge as categories (Strauss & Corbin, 1990), Strauss embraces the open coding practice (to be addressed in greater detail later in this chapter), which includes the conceptualisation of solitary occurrences (Kendall, 1999; Strauss & Corbin, 1994).

However, perhaps the most profound difference between the approach promoted by Glaser and that of Strauss rests with the inclusion of axial coding in the Straussian school of GT (Charmaz, 2006; Kendall, 1999; Strauss & Corbin, 1990). In this process of coding, the researcher endeavours to reassemble the data through the use of a coding system (or paradigm model), which constitutes the phenomenon, its conditions, framework, effects, and action interface stratagem (Strauss & Corbin, 1990).

This process of Straussian data coding will be addressed in greater detail later in this chapter. Glaser contends that, under such coding circumstances, conceptualisation is not permitted the luxury of emerging freely but is rather artificially contained within a predetermined scheme (Burnard, 1991).

Glaser, therefore, maintains that the Straussian school of GT is at risk of generating inadequately integrated theoretical accounts for any particular phenomenon due to the researcher's fixation on operational processes involved with axial coding (Harry et al., 2005; Kendall, 1999; Strauss & Corbin, 1990). Axial coding is defined as the data analysis process whereby data is reassembled to highlight the linkages between the various categories of the GT (Strauss & Corbin, 1990). The value of axial coding is defended by the assertion that such a coding system will in fact aid the researcher in the investigation of a phenomenon, by offering a framework that can allow the researcher to contemplate the matters arising from the data in a more sophisticated, efficient and precise manner (Strauss & Corbin, 1990).

It has been proposed that axial coding be utilised in the pursuit of descriptive accounts of phenomena, while the Glaserian approach is best suited to the generation of theory (Locke, 1996). Glaser (1999) holds that the Straussian perspective is a separate type of qualitative method (he describes it as being able to generate nothing more than thorough conceptual descriptions of a phenomenon), as opposed to being a GT approach. However, even the critics of axial coding concede its value. For example, Kendall (1999) argued that without axial coding, she would not have been able to foster a multi-dimensional complexity of the main category being examined in her study of the experience of living in a family where a child had attention deficit hyperactivity disorder (ADHD).

This protracted debate has far-reaching implications for the operationalisation of the method (Mills et al., 2003; Wasserman, Clair & Wilson, 2009). In fact, a great deal of published work on GT calls for more explicit guidelines on how to actually conduct a GT analysis, a call that is answered, at least in part, by the Straussian school of GT (Cutcliffe, 2005; Harry et al., 2005; McGhee et al., 2007; Strauss & Corbin, 1990; Wimpenny & Gass, 2000). It is for these reasons that I considered a Straussian approach to GT analysis to be the most appropriate method of developing a conceptual understanding of the factors involved in individual meaning-making with regard to the use of VMAMC for the purposes of HIV containment in South Africa.

Additional Glaser-Strauss distinctions based on epistemology arose regarding the researcher's relationship with the data. Glaser advocates that (in accordance with classical GT) there should be independence between the researcher and the method, as the researcher is to maintain a neutral stance towards the data in respect for objectivity as it is understood by the post-positivist perspective.

Strauss, however; expects a subjective relationship to evolve between the researcher and the method as the researcher is to be active in the interrogation of the data as it is gathered and analysed (Annells, 1996; Locke, 1996). Glaser (1999) countered that GT's intention is to generate novel theory rather than (as he believes the Straussian approach tends to) to corroborate the researcher's preconceived understandings of the phenomenon.

Supporters of the Straussian approach claim, however; that the active role of the researcher allows him/her to rely on existing bases of knowledge that can guide the research process. This major difference in approach results in a methodological division in approaches to verification (Annells, 1996). Glaser (1999) recommended that verification of the emerging GT can only be performed via subsequent quantitative analyses that encapsulate 'the truth'. This sort of positivist and post-positivist assumptions related to verification (via any quantitative methods) are categorically discarded by the Straussian constructivist stance to knowledge formation (Mills et al., 2006; Strauss & Corbin, 1990).

Strauss and Corbin (1990) claimed that it is only through constant comparison and the capturing of multiple perspectives (located within a specific historical period and culture) that the theory can be verified. The final contrast between the Glaserian and Straussian approaches is rooted in the theoretical framework. Glaser relies on an emergent conceptual design while Strauss utilises a pre-determined paradigm system to theoretical framework construction (McGhee et al., 2007). Considering the fact that GT exists with the purpose of generating a theory, which is grounded in the data gathered, one must give pause to engage with the nature of theory and the types of theory that are products of a GT approach.

3.5. The Nature & Role of Theory

In addition to the consideration of the nature and types of theory within a GT approach, a discussion of the various criteria against which to assess the soundness of a theory is another important related requirement. It is also imperative to consider the role of current theory in the generation and expansion of a GT.

3.5.1. Types of theory.

A theory can be described as being comprised of reasonable associations that can uncover or link information and sets of ideas (Charmaz, 2006). Strauss (1999) proposed that a theory offers an account of a particular phenomenon in a manner through which there is a generalisation of unambiguous notions or concepts that can be scientifically measured.

This GT approach regards the resulting theory as having the framework of a simple "social process" (Goulding, 2002, p. 87). Aligned to this, Strauss and Corbin (1990) contended that in order to encapsulate the systematic process of theory development, the researcher must offer evidence of the evolution of occurrences by reporting on the reason for, and method of, action for the phenomenon under investigation. This should be achieved by outlining how the course of action interaction has altered, remained constant or degenerated (as well as offering plausible causal accounts for such courses of action).

It has been proposed that assorted types of theories ought to be distinguished according to several elements as an alternative to considering discrete levels of theory (Strauss, 1999). Strauss (1999) described a number of such elements (or dimensions), namely: (1) extent of generalisation, (2) capacity, (3) scale, (4) specificity, (5) theoretical intricacy and (6) theoretical relevance. The different types of theory that are of particular significance to GT include "theory bits" (Glaser, 1999, p. 843) and "grand theories" (Glaser & Strauss, 1965, p. 10). Glaser (1999) described ‘theory bits’ as a section of theory generated from a substantive theory that can be utilised to form parts of a future GT. He cautioned researchers, however; to approach the use of theory bits conscientiously as they have a restricted capacity to give an account of a convoluted and multi-dimensional social and intrapersonal reality (Glaser, 1999).

GT was originally designed (at least in part) as a response to the grand theory's stronghold in sociology during the 1960s, so as to allow one to differentiate between substantive theories (which are locally restrictive to a certain social issue, time, place and milieu) and formal, general theories (Creswell, 1994; Glaser & Strauss, 1965). Glaser and Strauss (1971, p. 33) reminded GT researchers that a formal (or general) theory is ideally constructed from a substantive theory, and that both formal and substantive theories are positioned within the "middle range" of theory types, that is to say that they rest on a continuum from common "minor working hypotheses" to "all-inclusive grand theories".

GT thus offers a researcher the capacity to develop a substantive theory (for empirical inquiry), with the long-term aim of using it to generate a formal theory (developed for conceptual social inquiry). This can be achieved by expanding the original research focus to include other populations, as is the case during theory elaboration, which builds on existing theory by way of qualitative case analysis (Vaughan, 1992), or to extend the area of research inquiry to include varying factors, conditions or contexts for further investigation (Oshansky, 1996).

3.5.1.1. The substantive theory.

A substantive theory is closely aligned with a specific area of investigation and is able to account for the phenomenon being studied, which can then be applied to other comparable situations. As per this study, the resulting substantive theory addresses the factors involved in individual meaning-making when an urban male in South Africa considers VMAMC for the purposes of reducing the risk of contracting HIV through sexual intercourse with a woman. This substantive theory might be valuable with a broader scope of application, such as South African patient meaning-making regarding other once-off medical procedures related to sexual activity and issues of reproduction, such as undergoing a vasectomy or having a full/partial hysterectomy, as well as the consideration of terminating a pregnancy.

Given this, I advocate the position that a GT approach maintains particular value when it is allied with existing theory within the research domain as opposed to being secluded from or opposed to the current theory (Harry et al., 2005). It is this alliance that allows for the augmentation of understanding and knowledge regarding the phenomenon being studied as a novel perspective on existing information is generated from the GT. Thus the final stages of the research process involve a literature review that underpins the presentation of the GT (Charmaz, 2006). As such, the role of existing theory in GT will now be addressed.

3.5.2. The role of existing theory.

Outlining the existing body of knowledge related to the area of inquiry serves dual functions. First is the promotion of theoretical sensitivity within the researcher, which is to say that the researcher has enhanced insight that will grant significance to the data via the separation of meaningful and less noteworthy information obtained through the research process (Strauss & Corbin, 1990).

Such processes, which include theoretical sensitivity through comparative practices, would compel the researcher to be analytical when engaging with content (words, phrases and/or sentences) that contains 'red flags' - statements that have definitive and over generalised claims (such as 'always', 'never', 'everyone'). These content cases should be noted and investigated further (to enhance the researcher's appreciation of the phenomenon but also to assess the validity of such claims). Secondly, by performing a literature review and developing theoretical sensitivity, the researcher will be able to better utilise the literature as a foundation in the process of conception development (Strauss & Corbin, 1998). The existing body of literature and theory informs abstraction in the generation of the surfacing of GT.

As much as existing theory plays a critical role in the development of a GT, so do the personal experiences and perspectives with which the researcher initiates the field of inquiry. These personal worldviews of the researcher must be held to scrutiny before they can be used to construct the analysis and interpretation of data gathered. For this reason I followed the suggestion made by Charmaz (2006) that a comprehensive review of the literature in the substantive field in which the phenomenon is positioned, be performed only after the point at which theoretical saturation of the GT is achieved. This is conducted so as to circumvent the internalisation of the perspectives proposed by scholars and authors of academic influence, which, if adopted, can result in the researcher entering the field of inquiry with preconceived notions that may be rigid and untouchable.

I was particularly vigilant for fear of adopting values, hypotheses and perspectives presented by authors who may have had greater gendered and cultural access to the ritual of MC, either directly or indirectly, than that possible for me, as a function of race, age, and gender and the implications these have on an ability to gain direct access to particular information and relevant male participants regarding, in particular, traditional South African MC.

Thus a comprehensive review of the literature and existing theory was delayed until such time as theoretical saturation was achieved. After this, I compared the findings to the existing substantive field so as to establish the significance of the resulting GT to the field of meaning-making in relation to the permanent, once-off body modification process of VMAMC for the purposes of HIV prevention in South Africa.

3.6. Developments & Challenges in GT

As with all methodologies, GT has undergone a number of developments since its initial conceptualisation and application (Charmaz, 2006; Strauss & Corbin, 1994). These include: (1) dimensional analysis by Schatzman (Charmaz, 2006; Kendall, 1999; Robrecht, 1995), (2) the iterative approach by Orton (1997) that amalgamated the conventionally inductive GT approach into a spiral inductive-deductive approach, and (3) the recommendation by Soulliere, Britt and Maines (2001) that conceptual modelling be incorporated into the GT process to serve as a resource for the researcher. These variations have developed as a result of GT's use in a diverse range of disciplines.

However, the concern is that while there is a growing body of literature born out of the GT approach, such publications have been criticised for their poor adherence to the original Glaser-Strauss GT method (Charmaz, 2014). Benoliel (1996, p. 413) conducted a review of 146 GT studies published between 1990 and 1994, and found that there were three clusters of GT. Firstly there was a "GT approach", which she considered to be research that relies upon interview data exclusively, but which lacks any identification of basic social processes. Secondly, "GT methods" was identified and described as engaging with GT as a research method without describing any actual research.

Finally she identified "GT research", which she described as research that concentrates on the psychosocial processes involved when individuals undergo substantial life changes, as well as the circumstances that directed such courses of events. As a result, GT research was considered to most closely resemble the original GT in aim and method because it was the only cluster that utilised aspects of theoretical sampling, constant comparison, compound comparisons between groups, and theoretical coding.

Similarly, it has been found that several original research studies published have made use of portions of the GT method without remaining devoted to the critical elements of the method (Becker, 1993). In this review, Becker (1993) found that GT researchers abandoned the underpinnings of GT research when they tended to, firstly, favour selective sampling rather than theoretical sampling; secondly, allow the focus of the study to surface from the data gathered; thirdly, use the incorrect theoretical perspective and also dismiss the constant comparison approach, whereby the researcher commits to the concurrent gathering and analysis of data; and lastly, rely on computer software programmes to ascertain core variables based on the frequency of their occurrence.

Additionally, six typical analytic errors (which includes the coding and analysis of data) in GT research have been widely discussed (Charmaz, 2014). Such errors imply that studies which claim to follow a GT analysis cannot technically be classified as such. These common analytic errors include, firstly, confusing and mixing qualitative methods of analysis, whereby the researcher compromises the canons of the GT approach by relying on techniques from other qualitative methods (most commonly that of phenomenology). Secondly, the researcher can undermine the fundamental tenets of GT, which is a phenomenon referred to as generational erosion (Charmaz, 2014). This essentially refers to the objections and critique that Glaser (1999) voiced with regard to the Straussian approach to GT.

Thirdly, the researcher may be guilty of prematurely closing categories, whereby the data is not adequately analysed and therefore lacks higher levels of analysis and consequent interpretation of the data. Fourthly, the researcher may make use of excessively generic labels, which can result in a descriptive account of the data rather than considering the conceptual processes that are specific to the context in which the phenomenon being investigated occurs (Charmaz, 1990). With the use of overly generic labelling of codes, the researcher is unable to adequately reflect on various emerging ideas, which would consequently guide the researcher in examining and reflecting upon the data in such a way so as to construct an analysis that is theoretically critical rather than simply descriptive.

The fifth analytical GT error, importing concepts, occurs when a researcher is unable to consider alternative concepts for the phenomenon being investigated as they cling to their discipline's preconceived notions and interpretations of the data. When this occurs the researcher "fails to provide an original and grounded interpretation" (Wilson & Hutchinson, 1996, p. 124). The final common analytical error, typology, is a form of methodological transgression, which speaks to a violation of the tenets of GT philosophical assumptions and general method. These errors are not uncontested in the final analysis, but it is important to highlight the theoretical tensions within the GT approach in order to appreciate the substantial range of differences between the many methods that are often elided as GT. The differences in the approaches towards GT by Glaser and Strauss outlined thus far remain the focus of most grounded theorists, as they defend the philosophical bases for and advocate for the utility of either approach (Annells, 1996; Charmaz, 2006; Madill et al., 2000). It was against this outline that the current research strategy was selected.

3.7. The GT Approach Adopted

The utilisation of GT is often classed as an empowering research approach as it considers the participants to be experts in relation to the area of investigation, as they offer their knowledge, experiences and perspectives (obtained in this case via multiple semi-structured interview sessions) that shaped the development of the GT (Fontana & Frey, 1994; Glaser, 1999; Glaser & Strauss, 1965; Strauss & Corbin, 1998). I explicitly acknowledge the gendered limitations on my access to and knowledge of the experience of MC (in any form), as well as my limited access to participants who would be able to provide essential details regarding this religious/traditional rite or medical procedure. Thus, at least on an ethical level, my gendered position lent real value to the expertise of the participants in that they provided the only mechanism through which I could engage with this phenomenon (Harry et al., 2005). This is particularly relevant given that no females accepted the invitation to be interviewed for this study (as originally conceptualised in the research proposal) thus the participants were all male. There was likewise important theoretical support for selecting GT, which is addressed below.

3.7.1. Theoretical support for Straussian approach.

The Straussian approach adopts a constructivist paradigm, which is positioned within a relativist ontology and contextualist epistemology, holding that the researcher is the principal instrument for investigation, where the data is interrogated and interpreted by the researcher to create an evanescent, novel and acceptable account of 'reality', which is advised by numerous perspectives (Annells, 1996; Charmaz, 2006; Locke, 1996; Madill et al., 2000). As the instrument of analysis it is important to reflexively interrogate the lenses that may have shaped my final analysis.

I have worked in the field of HIV prevention research and practice as both an academic and activist. This academic grounding has served to augment my theoretical sensitivity, but simultaneously placed me at risk of entering the research field with rigidly preconceived belief-systems regarding HIV prevention in South Africa. In order to account for such beliefs (and their potential impact on the research process and interpretation of findings), I kept a diary to track thoughts and theoretical influences so as to monitor my shaping of the research process and align such influences with my understanding of the data gathered.

Working for an NGO, I have conducted focus groups centred on better understanding HIV prevention in urban and rural South Africa[4]. Results from these groups revealed poor working conditions, and a lack of resources for HIV prevention had a profound impact on my views regarding the current HIV prevention strategies in South African communities that were most harshly affected by the HIV pandemic. I was further exposed to the context of HIV prevention in South Africa as a content researcher for a video on the role that VMAMC played in reducing the risk of HIV infection. Together these experiences shaped my interest in VMAMC.

My personal interest in the substantive area (as indicated above) in attempting to develop a theoretical account of the HIV prophylactic VMAMC meaning-making, may be interpreted as potentially compromising the strength of my analysis. However, Strauss and Corbin (1998) justified the significance of my experiences as adding meaning to the data gathered, and thus I felt encouraged to draw upon this experiential information when analysing and interpreting the data collected for this study, rather than denying its presence. However, this was not done wholesale. In order to offset the possible limits of this experiential bias on the way that the study and analyses were conducted, I relied on the feedback and input offered by the participants (regarding my understanding of the data) after various cycles of analyses, using their comments to preserve critical distance between my personal perceptions and the GT developed.

Another important preface concerns my attempts to uphold the principles of the Straussian GT approach followed. While interview data were the primary source of data coded and analysed in this study, other sources influenced (and essentially assisted) me in producing concepts for the generated theoretical factors that account for VMAMC meaning-making in the context of HIV infection. Such sources included, but were almost certainly not limited to, observations made by the fieldworker interviews about their interactions with participants as well as individuals who they approached and invited to participate in this study but ultimately declined to do so; and medical lectures and seminars that I attended on VMAMC and HIV. Such influences were recorded in a journal that I kept throughout the research process.

[4] The focus groups were conducted in Gauteng and Eastern Cape governmental hospitals and clinics in peri-urban locations such as: Khatlehong, Daveyton, Sebokeng, King Williamstown and Port Elizabeth; rural areas including: Tskane informal settlement in Brakpan, Refilwe informal settlement in Cullinan, East London and King Williamstown; as well as urban areas such as: Vanderbijl Park, Parktown in Johannesburg, Krugersdorp, Uitenhage, Laudium in Lenasia, Port Elizabeth, and East London.

3.7.2. Principles of Straussian GT.

Straussian GT holds that traditional scientific principles of rigour, namely: (1) theory-observation congruency, (2) generalisability, (3) reliability, (4) accuracy, and (5) authentication, should be addressed in a manner fitting the methodological needs of the study (Miller & Fredericks, 1999). Strauss and Corbin (1997) recommended that a sound GT should meet three key criteria.

Firstly, the data must be 'good' in that it is consistent, legitimate and plausible. Secondly, the research process must be considered to be sufficient, and lastly, there must be empirical support for the research findings. The following section is dedicated to outlining the required actions from me, as the researcher, in order to meet these three criteria so that the reader is well-positioned to assess the quality of this research.

3.7.3. Ensuring good data is obtained.

While Strauss and Corbin (1990) did not explicitly account for the ways in which sound data is produced, the general course of action for any credible qualitative study should be followed when conducting a GT. Following conceptualisation, familiarity with existing literature and sampling strategies, and ensuring the quality and integrity of interview generated data, are the next points of quality assurance in the research process.

3.7.3.1. Gathering quality interview data: Fieldworkers.

Researchers form a component of the world that they study and the data that they gather, thus grounded theories are developed and constructed "through past and present involvement with people, perspectives, and research practices" (Charmaz, 2006, p. 10). Argyris, Putnam and Smith (1985) stated that a general rule for generating sound quality data when conducting interviews is that there should be adequate characteristic criteria that should be met when selecting an interviewer (in this case factors including age, race, culture, gender, and multi-lingual proficiency were key criteria that had to be fulfilled, considering the sensitive nature of the research topic as addressed in previous chapters of this thesis). Given that acts and discussions of circumcision are traditionally the preserve of males, the participants were given the choice of being interviewed by myself (a white, English-speaking female) or by one of two fieldworkers (black, multi-lingual, young adult males). This afforded the participants the freedom to express themselves to an interviewer whom they felt most understood and respected the gender perspectives from which they were coming.

For example, only one male (out of the 60 adult males who I personally invited to participate in this study) accepted this invitation and agreed to be interviewed by me. Those who declined the invitation to participate in this study (or agreed to participate provided they could be interviewed by one of the fieldworkers) indicated that it was culturally and/or morally "inappropriate" for them to discuss any matters regarding circumcision with a woman (particularly one from a different race and cultural group). As such, I had to rely on fieldworkers to gather data for my doctoral study. The fieldworkers were far more successful in recruiting and interviewing participants with approximately one in every 15 adult males approached agreeing to participate in this study.

I recruited the two fieldworkers from a small pool of volunteer undergraduate students registered for Bachelor of Health Sciences degrees where a course in psychology (at various years of study) had been completed. After discussing the topic and what was required of the fieldworkers, I selected two of these student volunteers to conduct the interviews based on their particular interviewing and data recording skills, experience and availability to commit to the data collection process.

The fieldworkers were tasked with finding and setting up the interview sessions with the participants. I paid the fieldworkers from my personal funds at the recommended university rate for undergraduate fieldwork (after receiving an electronic version of the transcribed interview as well as the audio recording of the interview) for each interview conducted and transcribed.

Two fieldworkers conducted the majority of the interviews and thus, in order to generate quality interview data, it was necessary to ensure that the interview fieldworkers were competent in this method of data collection. I offered each interviewer some training on effectively conducting a semi-structured interview, as well as how to effectively keep writing notes during the interview (Frey & Oishi, 1995). The fieldworkers had also obtained some training in history-taking and communication with patients as part of their MBBCh (medicine and surgery) undergraduate degree, which was found to be a particularly valuable skill to possess for conducting interviews for this study (Seidman, 1991; Easton, McComish & Greenberg, 2000). The fieldworkers were also given a document that outlined the formatting and recording instructions to be followed (see Appendix J).

3.7.3.2. Challenges and benefits of fieldworkers.

There were a number of methodological and pragmatic implications related to relying on interview fieldworkers, for example, a great deal of time had to be dedicated to the training of these data collectors so as to ensure that there was a degree of uniformity to the data, which is typically compromised by interviewer and coding errors. Considering that I was not able to even meet the participants, I had to ensure that there was as much accuracy as possible in the recording of participant responses. As such, I spent innumerable hours reading the transcribed data while listening to the audio-recordings of the interviews. In the instance where the one interview was conducted in isiZulu, the second fieldworker was able to do this and confirm the accuracy of the transcribed interview.

While I believe that the fieldworkers received adequate training regarding the ways in which to make initial contact with potential participants (so as to maximise cooperation and legitimise the value of participating in this study), the fieldworkers reported difficulty in obtaining volunteer interviewees. This resulted in long periods of time when data could not be obtained and analysed.

Furthermore, fieldworkers may sometimes change the phrasing of a question on the interview schedule, which may distort the meaning of the intended question. There seem to be some instances in the dataset where this may have occurred, however; given the number of questions asked in the interviews, the fieldworkers were often able to clarify the meaning of such questions and obtain accurate information from the participants.

Another challenge to relying on the assistance of the fieldworkers was related to the use of probing questions during the interviews. There were a few cases (in reading the data transcripts) when a participant's response was not entirely clear to me, which could have been clarified if a probing item had been asked by the interviewer. However, in such instances I was able to meet with the interviewer to discuss such issues. It was found that my limited understanding of traditional MC was at the root cause of certain responses requiring clarification, which the interviewer was often able to provide during these meetings.

Overall, while I was satisfied with the quality of work produced by the fieldworkers, this process involved intense supervision to ensure that there was quality control and editing regarding the transcribing of the interviews. Additionally, as far as possible I had to supervise the control of sampling in an effort to ensure that the participants did in fact meet the sampling criteria for this study. This meant that the fieldworkers and I met regularly to discuss any concerns relating to the collection of data whereby further training could be provided to improve response rates, quality of interviewing and the class of interview data.

Bearing these limitations in mind, there were some methodological benefits to not acting as the primary interviewer in this study (Francis & Hemson, 2009). The fieldworkers shared a number of characteristics similar to the participants - they were from the same race, and sometimes tradition, as the participants from the general public; there was a shared language between a number of these participants; and they shared a similar educational experience to the student-doctor participants. Thus they were able to quickly establish a rapport with the majority of the participants, a critical element to acquiring data regarding such a personal, sensitive, and provocative research topic.

Furthermore, by giving the fieldworkers a semi-structured interview schedule, the fieldworkers were able to have a format from which to conduct the interview which was sufficiently flexible to allow the participant to volunteer information that I, considering my dissimilar personal background to the participants and the matter of traditional MC or VMAMC, might not have thought of to mention during the interview. This also meant that I was able to obtain data that was relatively removed from my strictly personal line of enquiry.

Additionally, since I have stated my educational and professional involvement with HIV prevention and sexual behaviour research, as well as my personal views on the matter, I found that I was able to access some of the participant-objectivity rarely afforded to qualitative researchers. I was thus unable to form an observationally-based personal opinion of the participants (except for the one participant who permitted me to interview him) and the analysis that followed the gathering of data was then largely free from potential personal biases that I otherwise might have developed.

3.7.4. The nature of interview data.

It is important to consider the fact that there are several orientations to the treatment of interview data. In an effort to minimise the number of interpretive errors that might occur during the analysis process, I was cautious in noting the type of interview data generated during each interview, as every type of interview data has varying value and thus required me to manage each differently (Goulding, 1998). Five such varying interview data types have been categorised; firstly, baseline data, which is information that would be consensually accepted as fact offered by the participant. Secondly there is interpreted data, which the participant offers as an interpreted account of a particular experience, and thirdly, proper-line data, which is additional information that a participant offers in support of his/her opinion or position regarding some aspect of the phenomenon under investigation.

Fourthly there is vague data, which is generated when the participant is either purposefully trying to mislead the interviewer through suppression or intentional deception, or when the participant is essentially hazy in their response to a certain interview item. Finally there is conceptual data, which is information that reflects the unsubstantiated opinions or views of the participants.

Under the analytic frame for this study, while noting that each participant within each sample group offered a unique account of their understanding and perspectives regarding traditional and medicalised MC in relation to HIV prevention in South Africa, the majority of the interview data gathered from the sample of adult males from the general public was interpreted or proper-line in nature, while the interview data gathered from the student-doctor group could be generally classified as baseline in nature.

Partington (2000) indicated that this is an important distinction because the information that participants provide during this method of data gathering could be reflective interpretations, perceptions or indirect accounts of past experiences (as is the case with the sample group of student-doctors who were asked to describe any relevant experiences that they had had with patients regarding VMAMC). Thus the transcripts from the sampled group of student-doctors interviewed were engaged with in a different manner from the information provided by the other two sample groups, who could, arguably, be more directly impacted upon by the roll-out of HIV prophylactic VMAMC.

The interviews conducted in this study were in some manner recursive conversations. It was through these conversations that I was able to extract any inconsistencies in my interpretation of previous interview data and share it with the participants (whereby they could reflect and comment) when they met with the fieldworkers for follow up interviews, so as to negotiate my interpretation of the data. However, the interpretation of data is a constant occurrence in the research process, in that it continues long after the interview has been terminated (Goulding, 1998).

It is for this reason that I required that the fieldworkers record the contact details for each participant, should it have been necessary to re-interview the participant so as to provide clarity on the interpretation of the interview data gathered previously. This was a relatively arduous process for me, the fieldworkers and the relevant participants, not only in terms of making themselves available for additional cycles of interviews, but also with regard to the demands of self-awareness and insight.

Additionally, there was an extraordinary degree of rapport and confidence that had to develop between each of these actors in the research process (Harry et al., 2005). The second criteria for assessing the quality of the GT is related to the research process, which should trace the GT back to the data gathered. I describe this in the section that follows.

3.7.5. Ensuring rigour in the research process.

In order for there to be a traceable link between the GT and the data used to construct it, the researcher must be able to offer a stream of evidence that can be tracked to assess the quality of the process utilised to generate the theory (Harry et al., 2005). Seven critical points may be used to ensure that this process has been sufficiently rigorous. These state that the way in which the original sample was selected, as well as the rationale supporting it, must be clear. Furthermore, the way that the primary categories emerged from the data analysis should be accounted for in some of the occurrences (as indicators) that directed the researcher to these primary categories.

Next, the ways in which the theoretical formulations directed the data collection process and the ways in which the theoretical sampling represented the categories must be well articulated. Then, the hypotheses (including the ways in which they were formulated and tested) concerning the conceptual relations should be noted.

Additionally, an account of any discrepancies between the hypotheses formulated and what was revealed in the data should be highlighted and accounted for. Finally, the researcher must provide a description of the manner (regarding difficulty and rate of collection) in which the core category was chosen, and also offer supporting justifications for this selection (Strauss & Corbin, 1990).

3.7.5.1. Confirming the empirical foundation of research findings.

It is essential that the researcher is able to prove that the findings and resulting theory are in fact located within the data gathered. Strauss and Corbin (1990) required that the researcher can provide such evidence by addressing the following criteria; firstly, the concepts must indeed be constructed from the data; secondly, there must be a relationship between the concepts; thirdly, there should be some dense conceptual bonds and the categories should be thoroughly developed; next, the theory should be constructed with some degree of variation in mind; fifthly, the theoretical interpretation should include a consideration of the conditions that may impact the phenomenon being investigated; sixthly, the process must be accounted for; and lastly, the theoretical results must be significant and meaningful to its context.

To summarise, in line with Strauss' (1999) model of GT, the researcher must develop theoretical sensitivity as early in the research process as possible, as it plays a particularly significant role at both the initiation and termination of the investigation process. Before the study begins, the researcher relies upon theoretical sensitivity to construct an orientation and flow for the research. This powerful reliance surfaces again during the final stages of the research in order to locate the implication of the emerging GT within the existing theoretical framework and knowledge regarding the phenomenon being examined.

In an effort to meet the criteria for confirming the empirical foundation of my findings, I elicited the participation of a number of individuals who engaged with the coding, analysis and interpretation of the data gathered for this study. One peer debriefer and a single peer auditor were involved in this process. The debriefer was a female sociologist who had a background in health and medicine and postgraduate supervision, with a particular focus on sexuality and HIV prevention within rural South African settings. This person offered invaluable input with regard to data coding and interpretation. The auditor was a male medical intern who monitored this process and offered feedback with regard to my interpretation of the data as being relevant to the most current developments within Gauteng public health debates and VMAMC strategies.

Furthermore, the fieldworkers were invaluable in assisting me with the development of the emerging categories of the GT of VMAMC meaning-making as they offered unique insights into the participants' narratives regarding traditional MC and VMAMC for HIV prevention. They also played a critical role in enhancing the trustworthiness of the study, as they invited the participants to read their transcripts and a summary of the analysis (which I provided to the fieldworkers) and comment on it. Any remarks, additional information and/or disagreements with the transcripts or summary of analysis were documented by the fieldworkers and reported to me so that they could be reintroduced into the analysis process for consideration (Strauss & Corbin, 1998).

With my ontological and epistemological philosophies clearly presented by the motivation to utilise the Straussian approach to GT, and the various concerns regarding Straussian GT addressed, it is now sensible to outline the research process that was followed in order to ensure that quality data was obtained, analysed and reported.

3.8. Contextualising the Sample

Gauteng Province was selected as the location for data collection, as recent statistics presented by the Department of Health (DoH), at the time when this research was conceptualised, show that the national prevalence average for HIV infection was 10%, which uniquely matches the average for Gauteng Province (UNAIDS/WHO, 2008). Statistics indicate that Gauteng has the lowest prevalence of MC yet has an HIV prevalence that matches the national average, making it a province suitable for investigation in relation to the aims of this study. The area selected (for snowball sampling of adult male participants from the general public), Alexandra Township, is the oldest informal settlement in Gauteng (established in 1905), is situated within the City of Johannesburg, and has an estimated population of some 390 000 individuals (Shapurjee & Charlton, 2013).

This node has encountered challenges such as high unemployment, rampant crime, infrastructure backlogs and limited job opportunities, all of which have proven to be factors relating to a high risk of HIV infection. The HIV pandemic in South Africa has negatively transformed the lives of many living in informal settlements and rural areas (Le Marcis & Ebrahim-Vally, 2005). The area also has a very high number of young people (aged 17-35 years); 32% unemployment; an average monthly income of approximately R1000; and a problematically low level of education, with 50% of the population over the age of 20 having no formal schooling (Susser, 2006).

Earlier studies with young men in this node demonstrated that significant numbers seem to simultaneously accept and reject hegemonic norms of masculinity, by negotiating and embracing unconventional perspectives of masculine gender identities (Langa, 2008). This, therefore, made this target population, which seems to represent the core of black, urban masculinity, one of interest in exploring the factors that influence meaning-making regarding VMAMC as a means of HIV prevention. These factors and the high influx of males (in relation to other informal settlements in Gauteng) were considered to make Alexandra a convenient and appropriate site that met the sampling needs of this study.

The inclusion of the sample groups (to be described below) was based on the understanding that these are the key people who may be impacted by the possible implementation of a VMAMC programme in an effort to reduce HIV infection rates in South Africa. The study relied primarily on a snowball sampling technique, as participants were asked to refer other individuals who they believed to meet the sampling criteria for this study (by way of supplying the fieldworkers with the names and contact details of such individuals), to obtain a final sample size of 30 participants.

3.9. The Participants

A sample of occurrences was collected from 35 in-depth interviews conducted over a 24-month period (between August 2010 and August 2012), where five participants were interviewed at least twice (approximately one to two weeks after the initial interview). After transcribing and coding of the initial interviews, analysis revealed some points for clarification as well as verification, so in line with the convention of GT, follow up interviews were conducted with particular participants as necessary.

There were 30 participants (aged between 18 and 64) in the sample, which consisted of two distinct groups of participants, namely: (1) 25 adult men from the general public in a large urban informal settlement in Johannesburg, Gauteng; and (2) five students in their final year of study for their MBBCh degree (Bachelors in Medicine and Surgery) from various South African medical schools, who were completing their clinical training at various public institutions in Johannesburg, South Africa. The demographic characteristics of the individual participants are reflected in table 3 on the following page. With approximately 50 interview-hours of interview data collected, I found the data to be sufficiently diverse (given the nature of the research topic) to support theoretical saturation and similar themes were presented during the latter interviews.

Table 3: Demographic Characteristics of the Sample

Participant	Marital Status	Age	Home Language	Highest Level of Education
1	Single	18	isiZulu	Grade 12
2	Single	21	isiZulu	1st year University
3	Single	18	isiZulu	Grade 11
4	Single	18	isiZulu	Grade 10
5	Single	18	isiZulu	Grade 11
6	Single	18	Sesotho	Grade 11
7	Single	18	isiXhosa	Grade 12
8	Single	18	isiZulu	Grade 11
9	Single	20	Xitsonga	Grade 12
10	Single	19	SiSwati	1st year University
11	Single	18	isiZulu	1st year University
12	Married	51	isiXhosa	Grade 10
13	Married	49	isiZulu	Grade 7
14	Single	24	isiXhosa	Grade 10
15	Married	52	Sesotho	Grade 10
16	Single	31	Pedi	Grade 12
17	Married	43	isiZulu	Grade 9
18	Married	61	isiZulu	Grade 8
19	Married	51	isiZulu	Grade 10
20	Single	34	isiZulu	Missing Data
21	Single	27	isiZulu	B.Tech
22	Married	64	isiZulu	Missing Data
23	Married	48	Pedi	Grade 10
24	Single	29	isiZulu	B.Tech
25	Single	22	SiSwati	B.Tech
26	Single	23	English	6th year MBBCH
27	Single	42	isiXhosa	6th year MBBCH
28	Single	35	isiXhosa	6th year MBBCH
29	Single	24	English	6th year MBBCH
30	Single	23	English	6th year MBBCH

3.9.1. Participants from the general public.

The group of adult male participants was comprised of 25 individuals, aged between 18 and 64, from relatively diverse backgrounds who lived in or near Alexandra Informal Settlement. The participants were asked what their home language was, which was relied upon as a proxy for traditional MC practices and thus had implications for the coding and analysis of data, whereby I believed that the factors involved in individual meaning-making of HIV prophylactic VMAMC may be influenced by the relationships that the participants may have with traditional MC.

These participants were either single or married; came from isiZulu, isiXhosa, SiSwati, Sesotho, Pedi, and Xitsonga backgrounds; had levels of education ranging from Grade 8 to first year University and technical diplomas; and the group was mixed in terms of the number of men who had children and those who did not.

The initial participants were approached as they neared the local taxi-rank, located near a community sports centre, KwaBhekilanga Sports Facility in Alexandra, and invited to participant in this study. This setting within the oldest informal settlement in Gauteng allowed for access to rich data regarding the factors that influence meaning-making of VMAMC as a method of HIV prevention in South Africa.

3.9.2. The student-doctor sample group.

Given that the fieldworkers were medical students themselves, and had relatively sound networks with professors, doctors, interns and other medical students, I relied on them to recruit and select up to ten medical students who were in their final year of undergraduate study to participate in this study. The fieldworkers relied on "word of mouth" recruitment techniques to inform their colleagues as to the nature of the study and what participation would entail. Although two female and ten male student-doctors made contact with the fieldworkers, showing an interest in participating, it is interesting to note that only five male student-doctors accepted this invitation. This, once again, speaks to the topic of traditional, religious, and medical MC in South Africa being considered the preserve of males, even by contemporary females within the medical profession.

The student-doctor sample group was included in this study so as to offer an additional dimension to the data gathered. This afforded me the opportunity to obtain insight into the most recent developments in VMAMC roll-out initiatives by the state, while investigating the position of those medical professionals who serve as mediators between the NDoH and the public. These participants were in the relatively strategic position of having personal, individual meanings of MC (as men from various cultural and religious backgrounds in South Africa), as well as being medical professionals who are tasked with promoting VMAMC as an HIV prevention intervention to their patients.

Only students who were in their final year of undergraduate study were sampled as they would have had the most experience with patient-care, while still being accountable to senior medical staff who would expect them to be fulfilling the state agenda by promoting VMAMC as a method of HIV prevention to their patients in public hospitals and clinics. The participants (aged 23-42) came from English and isiXhosa backgrounds, were all single, and had no children. I was particularly interested in considering the ways in which these participants were able to resolve (if any) tensions and conflicts that they may have had regarding their personal meanings of VMAMC in the face of the HIV pandemic and their professional agenda, as medical healthcare providers who are expected to reflect the directive from the NDoH that VMAMC should be included as part of a comprehensive HIV prevention strategy in South Africa.

3.10. The Interview Schedule

The most common form of collecting rich data on personal meaning-making (specifically here to be meaning-making of HIV and VMAMC) is to use one-on-one interviews (Boyd, Lo, Evans, Malvar, Apatira, Luce & White, 2010; Burnard, 1991; Carpiano, 2009; Courtenay, 2000; Sample & Kadleck; 2008; San Martin & Rodriguez del Bosque, 2008). The Straussian GT approach relies upon a list of interview questions that act as a guide for the interviewer (and the participants) rather than as standardised instruments where all questions are posed to all participants.

For this reason an initial semi-structured interview schedule was created, which was relatively different for the various sample groups so as to match the interview items with the types of knowledge and experiences that each group was likely to possess regarding MC, VMAMC and HIV prevention (See Appendix D, Appendix E, and Appendix F). The types of questions included on this initial interview schedule focused on the traditional cultural or religious relevance of MC to each participant, as well as general reactions to the use of VMAMC for HIV prevention in South Africa.

The interview schedule reserved for the group of medical students differed from the other schedules in that while it included items regarding their personal views of VMAMC, it primarily focused on the students' experiences with patients who had undergone medical or traditional MCs, their medical views regarding the current available HIV prevention strategies, their biomedical understanding of the value and/or risks of VMAMC in general.

Additional questions focussed on their views of public and private healthcare in South Africa, and their multi-cultural and human rights embedded training and medical meaning-making with regard to this permanent body modification for the claimed health benefits. Each interview was arranged to be conducted within a one hour period, however; interviews with participants who offered particular insight and responses to this topic lasted for approximately one to two hours.

As is the tradition in the Straussian GT approach, the subsequent interviews were based upon the analyses of the previous cycle of data collected. The fieldworkers also offered their particular insights and observations with participants to contribute to the development of the follow up interview schedule. The analysis resulted in a more focused set of interview items that were orientated towards uncovering who has decision-making power regarding the circumcising of male new-borns and young men (See Appendix D and Appendix E). Interview items were also aligned to elicit discussion on the relationships between MC (and VMAMC) and masculine sexuality, the endurance of pain and physical (and perhaps psychological) recovery, perceptions of HIV and risk of infection in relation to VMAMC, suggestions on how the Gauteng and perhaps the National Departments of Health could roll-out a successful HIV prevention strategy with VMAMC as its root focus, potential responses to partner requests for the participant to undergo a VMAMC, as well as potential responses to VMAMC for any male children that the participant may have.

Follow up interviews were conducted with participants who had been interviewed in the first cycle of data collection and who were available for further interview sessions. The various repeat interviews were first held with men from the general population. At the point that the interviews were finally conducted with the student-doctors, the emergent theory had become fairly clear and follow-up interviews with this sample consistently confirmed saturation. As all follow-up interview schedules were constructed on the basis of the analysis of data gathered in the previous interviews, I was able to provide the fieldworkers with a platform to probe the participants for clarity on information offered previously (to address any potential gaps in the developing theory), as well as to share the emerging themes with the participants so as to obtain verification, correction and/or comment on the analyses undertaken.

3.11. Data Collection Procedure

After ethical clearance for this study had been obtained from The University of the Witwatersrand Human Research Ethics Committee (Non-medical) – Protocol number H100 401 (See Appendix H), recruitment of adult male participants from the general public began. The fieldworkers and I visited the sampling site over several days and approached individuals as they either neared or exited the taxi rank and community centre. The student-doctor sample group participants were contacted via telephone or email by one of the two fieldworkers and were invited to be interviewed for the study.

These contact details were obtained as the fieldworkers were referred to particular individuals who met the sampling criteria for inclusion via their professional and academic medical network of students, professors and clinicians. During the invitation phase of data collection, each individual invitee was verbally briefed on the nature of the study as well as what their participation would entail. In cases where individuals accepted this invitation, contact details were exchanged and a time and place that was convenient to both the interviewer and the participant was negotiated for the interview to be conducted.

At each interview session, the participant was given the Participant Information Sheet (See Appendix A), which offered further information on the study, such as the ethical standards to which the study held itself as well as my contact details should participants have any questions pertaining to my study. Participants were also asked to sign an informed consent sheet (See Appendix B) that reflected their understanding of their rights and responsibilities as participants where the interview sessions were audio recorded (See Appendix C).

Each participant was also reminded that while VMAMC may be found to reduce the risk of HIV infection for sexually active heterosexual men, common safer-sex practices should continue to be followed (such as being faithful and consistently using condoms). At the conclusion of the interview the participant was given a pamphlet (see Appendix I) on HIV prevention and safer sex practices, which summarised the findings on VMAMC as offering protection against HIV infection (but that also reiterates the importance of safer sex practices as well as the fact that VMAMC does not result in one being invulnerable to HIV). As each interview was concluded, the fieldworkers kept the interview notes and audio recordings for transcription (which were saved on a portable flash drive and returned to me, along with the interview materials, for analysis).

Although Strauss and Corbin (1998) suggested that the researcher be discerning in transcribing the interview content (with only initial interviews transcribed in full so as to allow for a line-by-line analysis, and later interview transcriptions, which would be analysed in detail, being channelled by the emerging theory), I felt it necessary to have each interview transcribed in its entirety due to the fact that one interview was conducted entirely in a language that I did not speak or understand (and thus, it had to be translated from isiZulu to English). This was also done due to the limited active engagement that I was able to enjoy during the data collection process, with all but one participant choosing to be interviewed by one of the two interview fieldworkers (Harry et al., 2005).

3.12. Data Coding & Analysis

It should be noted at this stage that although the process of GT can appear to be linear, this is not necessarily so as the process must be systematic yet flexible. There is constant recursive examination of the data, whereby the researcher is to remain open to exploring the theoretical options that may arise during the data collection and coding phases of the research process. In line with GT research, the data was gathered and analysed concurrently (over the period of approximately two years). In order to better comprehend the GT process at this stage of the research, it is important to describe the various concepts for units of analysis as the theoretical factors involved in meaning-making regarding the uptake of HIV protective VMAMC emerge from the data sets collected. At the initial analysis codes are generated; these are considered the identifying anchors that highlight the key aspects of the data being gathered and analysed. When codes are compared and then clustered together (based on the similarity of their content), they are elevated to concepts.

As extensive groups of similar concepts are grouped together, categories are generated which are then used to construct a theory. For this study, the theory consists of various theoretical explanations as to the meanings that are attached to VMAMC in an effort to reduce risk of HIV infection. In order for codes to evolve into categories, which form the basis of this theoretical account of VMAMC meaning-making, the data undergoes various recursive coding and analytic processes (See Appendix G). Robson (1993) noted that there are two types of analysis during this cyclical process, both of which were performed in this study, namely: (1) formal analysis, which consists of theoretical sampling; and (2) informal analysis, which involves memo-writing through the constant comparative method.

3.12.1. Formal analysis: Theoretical sampling.

GT established theoretical sampling as a unique data collection and analysis type, whereby data gathering occurs simultaneously with its coding and analysis, which is guided by the emerging theory (Harry et al., 2005). This process commenced as I gathered initial data, in this case based on a broad set of semi-structured interview questions regarding general views about MC, VMAMC and the HIV pandemic in South Africa. This procedure allowed for the testing of the relevance of such interview questions (where they proved to be inappropriate they were replaced and re-tested) that became more intensely focused as the theory started to develop and as the data was categorised and a comparison of these categories was performed (Charmaz, 2006; Kvale, 1996). The initial research question, namely: "What are the individual meaning-making factors regarding VMAMC for the purposes of HIV prevention?", was presented in the form of an elaborated initial individual semi-structured interview schedule to adult and young males from Alexandra Township, where the data collected was transcribed and coded. This gave rise to tentative theoretical categories, which further informed more focused data collection rounds.

As a result there was a further refining of conceptual categories that were re-examined in relation to earlier data, where a particular theoretical category was adopted (Harry et al., 2005; Strauss & Corbin, 1998). This process was conducted until such time as there was sufficient integration of data from various rounds of data collection, and a sound theoretical model could be presented where the key factors that influence the meaning-making of VMAMC for the purposes of HIV prevention were outlined in a relational manner (Charmaz, 2014). In this study I had to contend with the absence of pre-set theoretical samples to be used in the generation of codes, concepts and categories, thus it was only at the conclusion of the research that the number and type of categories that were sampled could be identified (Charmaz, 2006; Harry et al., 2005). In order to cultivate the expansion of a category (to the greatest extent possible), an extensive and varied scope of concepts were included, with the limitation of the research aims brought to the fore. If one is cognisant of the inclusion of concepts one can directly manage the overview of the conceptual levels, and by having command over concept similarities and divergence, I was able to establish the identification of categories and their properties (Charmaz, 2014). The minimisation of concept divergence resulted in the identification of central category properties, while the converse assisted in the expansion of this instituted framework (Harry et al., 2005).

The two criteria used to guide theoretical sampling are basic in their conceptualisation but complex in their execution, namely: (1) theoretical purpose; and (2) relevance (Strauss & Corbin, 1990). Whether or not sampling should persist is resolved by the degree to which additional sampling would add value to the progression of the theory. This decision is informed by the emerging theoretical categories. I adopted the position held by Strauss and Corbin (1990) to conclude the sampling of certain concepts at the point when the category reached theoretical saturation, which occurred when the inclusion of supplementary data failed to further develop the properties of that category.

Strauss and Corbin (1990) also referenced the tendency for fresh categories to surface, even at the final stages of the research process, and recommended that such categories not be saturated. For this reason I focused further on the saturation (to the greatest extent possible) of the core theoretical categories.

3.12.2. Informal analysis: Memo writing and constant comparisons.

I engaged with the informal analysis at the initiation of the data gathering process (both during the actual interviews by asking clarifying or elaborating questions, and post-interviews through the process of memo writing), as I attempted to gain some understanding of the data obtained from the interviews conducted.

3.12.2.1. Memo writing.

Memo writing forms a crucial part of this process as it prompts the researcher to analyse the data and codes early in the research process, which is helpful when theoretical sampling is done to seek pertinent data to develop emerging theory (Charmaz, 2014). This process was largely driven by logic, and was informed by observations, reflections provided by the fieldworkers, as well as the summaries of concepts (which were verified by the participants during follow-up interviews with the fieldworkers) that had influenced me in some way or another during the coding and analysis process. During this process, theoretical links between categories were created and refined. I organised these during theoretical sorting, diagramming (which I found to be valuable for a providing visual representation of summarised key points raised from each interview and how these related to other interviews), and integrating of memos.

Memo writing occurring at this stage in the research process was highly conceptual as I sought to understand the magnitude and characteristics of the categories emerging from the data (Harry et al., 2005). The content of a number of these memoranda were included in the final structure of the GT.

3.12.2.2. Constant comparison method.

The GT data coding and analysis process for this study involved elaborating and refining the theoretical categories that emerged from the data (Charmaz, 2006). According to Strauss and Corbin (1990), categories can be considered as being of higher order, more abstract forms of codes or concepts, and are essentially the most credible conceptual explanation. Categories are established through the constant comparison method whereby all possible explanations for the data are considered, a hypothesis is formed for each potential account, and such hypotheses are empirically checked by re-examining the data.

The constant comparison method was conceptualised by Glaser and Strauss prior to the divergence of their schools of GT, and continued to be used by both Glaserian and Straussian grounded theorists after the institution of these separate schools. This was primarily due to its critical function (conjunction with theoretical sampling) in establishing "categories, properties, and hypotheses" that create the foundation of the developing theory (Glaser & Strauss, 1965, p. 101). Glaser and Strauss (1965) included four phases in this process: (1) incidents that are considered to be pertinent to each category are compared; (2) the categories and their properties are amalgamated; (3) the theory is bordered; and (4) the theory is finally reported. These four phases are addressed in detail below.

3.12.2.2.1. Comparison of incidents.

Two rules direct the process of comparing incidents, namely: (1) the researcher must compare the incident with previous incidents in the same and in other groups of the category, while coding the incident for a category; and (2) the researcher should stop coding at the point where a conflict in thinking develops, and should make a note of these thoughts in a memo.

GT places great emphasis on the importance of memo writing as it allows the researcher to chronicle any ideas, queries and objectives, and to delineate what may be obvious or embedded in the data collected (Charmaz, 2006). Such chronicling allowed me to conceptually digest the data gathered hitherto and to formulate a way forward for future data collection.

It is also suggested that a gamut of categories be constructed so as to allow the researcher to classify their scope, stipulations, significance and associations (Harry et al., 2005). Glaser and Strauss (1965) accounted for two forms of concepts that surface from the comparison of incidents, namely: (1) concepts that are extracted from the language or terminology used in the description of the process, behaviour or responses related to the research situation; and (2) those concepts that are established by the researcher in an attempt to account for and justify those processes, behaviours or responses. Although it was a challenging task, I tried to avoid prematurely privileging any particular set of categories before engaging fully with the data gathered.

3.12.2.2.2. Integration of categories.

The secondary phase of theory generation involved the integration of categories and their assigned properties (Charmaz, 2006). This occurred organically as theoretical sampling and analysis were performed simultaneously (where the collection of data was directed by the questions raised by the gaps in the theory as it was being generated).

3.12.2.2.3. Theory delimitation.

Once there is an integration of categories, the third phase of developing a theory includes the delimitation of the theory at two points, namely: (1) those of the theory, where the theory is adapted to elicit clarity by the removal of unrelated occurrences of knowledge as well as the expansion of those of value to the area of study; and (2) those of the categories, whereas the theory begins to surface, the number of categories are condensed in line with the delimitations of the theory (Harry et al., 2005). This reduction, as lesser sets of complex concepts emerged to yield a more prudent theory that was able to meet a wide scope of applicability, moved me to the final stage of theory development.

3.12.2.2.4. Writing the theory.

The GT culminated as I wrote the theory by satisfying three requirements, namely: (1) the framework must produce a systematic and logically substantive theory; (2) it has an obligation to be reflective of truth and accuracy (in terms of precisely reflecting the interview data); and (3) its final presentation should be considered practical by its audience (Charmaz, 2006).

This stage of theory generation was considered to be an integral part of the investigative process due to the additional insights, ultimately included in the final theory via the writing and rewriting of the theory refined as a result of the continued engagement with the data. This final process afforded me the opportunity to substantiate and explicate conjecture; address and resolve remaining problems; and ensure that the all concepts were comprehensive and clear in their presentations.

3.13. Forms of Data Coding

As proposed by Strauss and Corbin (1997), three forms of data coding were utilised (in both a simultaneous and interconnected fashion), namely: (1) open coding; (2) axial coding; and (3) selective coding. Towards the point of theoretical saturation, a conditional matrix was used to add supplementary understanding of the context in which the theory was grounded. These forms of analysis are discussed in the sections that follow.

3.13.1. Open coding.

Strauss and Corbin (1990) reported open coding as being the data analysis method whereby data is dissected, scrutinised, compared, conceptualised, and finally categorised. As recommended by these grounded theorists, I performed a line-by-line *in vivo* coding of the data for the first interview transcript generated from the discussion with a young man, which was relatively detailed and emotive with respect to the participant's response to the initial semi-structured interview schedule. I read this transcript carefully, underlined key words (as they related to the issues mentioned above), and wrote notes regarding my initial impressions in the margins of this transcript. I relied on key phrases (offered by the participant in his own words) to generate a summary that reflected an overall sense as to his understandings of religious, cultural and medical MC, the HIV pandemic and existing HIV prevention interventions in South Africa, as well as general sentiments regarding South African masculinity as related to the physical body, sexuality, patriarchy and continued cultural tradition, and the ability to withstand physical pain.

Two alternative key approaches could have been utilised during this categorising process, as proposed by Strauss and Corbin (1990). Firstly, a microscopic focus on a particular concept and the comparison of it to other concepts that arose during the labelling (coding) of the data, and the assessment of its connection (if any) to a similar phenomenon.

Secondly, the holistic approach that considers the complete data set to gain an understanding of the concepts. I utilised (at least initially) the holistic approach to categorise the data elements by constructing a summary of the first interview, and then shifted into a microscopic method when the next five interviews were analysed line-by-line, and thus initiated the coding process.

Once all the *in vivo* codes were generated, I listed and matched them with condensed code phrases that reflected the core ideas of what was offered by the participants. For Charmaz (1990), codes are mechanisms that are used to name, identify, categorise, assemble and organise the data collected. I relied on manual coding to code and organise the data. Once the codes generated had been listed, I reduced the number of codes by grouping similar codes together into clusters. The data components were compared for parallels, dissimilarities and uniformity of sentiment, so as to generate coded categories that were relevant to the theory emerging (Harry et al., 2005).

After code phrases were grouped together to form clusters, these clusters were reduced into meta-clusters, which were labelled. This was done as I determined the properties of the identified clusters and delineated the scope of these properties until such time as no novel information could be generated, that is to say that theoretical saturation had been reached (Strauss & Corbin, 1990). This was achieved by questioning the cause of a particular cluster, the timing of its occurrence, as well as the manner in which the cluster functions. It was in posing these self-directed questions that I gained further insight into the meaning-making of HIV preventative VMAMC in South Africa, and contributed to the transitioning process that generated the final theory.

This questioning process resulted in the connections between grouped codes coming to the fore, as some clusters shared properties of other clusters, while others contrasted in their property make up. The sharing of properties allowed me to integrate clusters into meta-clusters that could then be labelled. At this stage of the analysis I took to care to confirm that the labels were descriptive as well as conceptual (Goulding, 1998).

As such I revised the labelling process, as the stages where the labels being applied were too descriptive in nature and were lacking in conceptual consideration, for example, an initial label was noted as *fathers want their sons to look similar to them* was relabelled as *familial patriarchy*. This was later revised in further cycles of data analysis as categories were re-organised to better reflect the VMAMC meaning-making patterns in the data.

As the data analysis progresses, labels become concepts as a comparison of a particular incident is made with previous such incidents, followed by segregating it into as many conceivable codes as possible. As the frequency of this incident increases, comparing a new incident (with respective codes) would then result in the generation of concepts, and ultimately, the properties of the resulting categories (Charmaz, 2006).

I embraced the process of constant comparison-making to promote codes to a conceptual plane by outlining the conditions under which this concept occurred, offering an account for the incident as well as forecasting when it was likely to occur. This generated the foundation of the theory that materialised. Whether or not a code was elevated to a conceptual plane depended on its value in describing and accounting for a particular incident (Mills et al., 2006). I was able to evaluate such value by tracking the codes in further rounds of data collection, as well as by associating it to other conceptual categories (Charmaz, 2014; Harry et al., 2005).

Via the constant comparison method of analysis, concepts are grouped together to generate categories. Strauss and Corbin (1990) regarded categories as classifications of concepts, which emerge as concepts are compared with each other during the comparative phase of data analysis. During this phase there is constant comparison between groups of people within the area being investigated. In this study the groups of participants were men from the general public and student-doctors. This constant comparison technique enabled me to detect trends in the data as well as interactions between these trends. According to Strauss and Corbin (1990), categories must be considered higher order, more abstract forms of codes or concepts.

The next process in the open coding procedure requires the researcher to identify sub-categories, which are defined as the properties of categories that can be located along a dimensional range (Strauss & Corbin, 1990). For example, I identified data extracts that were related to the emerging category of *men's health* and sought to identify the different issues related to this category as well as their properties and dimensions. Initially, properties such as *masculinity*; *the* '*normal*' *male body*; *familial patriarchy*; *critical sensations of the penis*; *decision-making power*; as well as *risk and blame,* were identified and the dimensions of these properties were made. However, these were revised in further cycles of coding to better reflect the VMAMC meaning-making patterns within the data.

3.13.2. Axial coding.

For this study open coding generally preceded axial coding, which involved reassembling the data in a novel fashion whereby the different categories were linked in order to develop a GT (Strauss & Corbin, 1990). Axial coding occurs at a single category at a time and in doing so, the researcher is able to have that particular category at the centre of the analysis, thus highlighting its relationship to other categories (Harry et al., 2005). This process also plays a crucial role in the identification of the core category (Mills et al., 2006).

Axial coding comprises four discrete but synchronised actions: first, the conjectural relation of sub-categories to categories; second, the verification of these postulates alongside the data; third, the supplementary expansion of the emerging categories' properties; and lastly, the exploration of the variation in the phenomenon (Harry et al., 2005). Such efforts form a part of the axial coding process, and engaging with the data in this fashion enabled me to better appreciate the relationship between the different categories and their elements (Harry et al., 2005). Figure 1 below outlines this axial coding process.

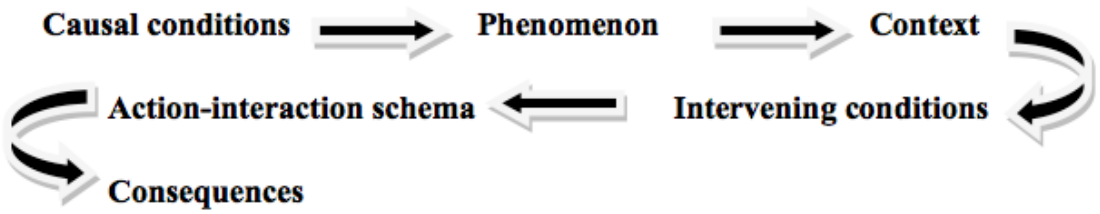

Figure 1. Schematic representation of the processes involved in axial coding

I engaged with this coding process by asking questions about the relationships that emerged through the constant comparison method. In order to test the theoretical explanations for the relationships that I started to develop, I relied upon the literature within various areas of public health, traditional and medical circumcision, as well as a number of key psychological theories of masculinity, so as to outline and compare the relationships among these categories.

In addition I sought to detail the emerging categories of the conditions that result in particular views of VMAMC in response the perceived risk of HIV infection, and to identify the contexts that shape meaning-making. Thus I had to engage with the action-interaction schemas by which VMAMC meaning-making is realised, and address the outcomes of these schemas, so as to yield a GT that is both detailed and specific.

For instance, the initial open code of *masculinity through traditional MC* was considered as being essentially connected with other open codes, while also being linked with higher order categories such as *men's health* and *tensions between tradition and medicine*. I did so by relating the concepts of *gender identity development* and *politics of MAMC* to *shifting notions of masculinity,* and positioning this within the emerging category of *men's health*. Later cycles of data analysis required me to re-categorise these concepts, which resulted in the final presentation of results detailed in *Chapter 4*.

I consistently reflected back upon the central phenomenon, the context in which it occurs, as well as the causal and intervening conditions that seemed to reflect the participants' meaning-making. For example, participants who considered themselves to be at low-risk for HIV infection had certain perceptions of existing HIV prevention interventions as being successful, and thus making HIV-preventative VMAMC a radical and unnecessary prevention strategy. Other participants who considered themselves or their communities to be at higher risk of infection felt that existing HIV prevention strategies were not effective enough in addressing the HIV pandemic, and so felt that VMAMC was a viable and indispensable intervention strategy.

Participants who had recently become sexually active were more concerned with their personal risk of HIV infection and were more open to considering the value of VMAMC in reducing their risk of infection than those participants who claimed to never have been sexually active. The same could be said for the participants of the adult male group who had young sons as compared to those participants who had no children. During open coding, such data extracts were labelled *favouring of traditional MC*, but this was reconsidered during axial coding as being related to the concept of *risk and blame.* It was noted that *the male body* and *patriarchy* were important with regard to *men's health* as intersected by *plurality and fusion*. This intervening condition was to prove centrally important to VMAMC meaning-making.

3.13.3. Selective coding.

Selective coding, the third sort of coding utilised in a GT approach, can be described as the practice of choosing the core category and methodically connecting it to the emerging categories whereby those connections are verified, further expanding on and then enhancing the underdeveloped categories (Harry et al., 2005).

Strauss and Corbin (1990) held that the core category is the pivotal theme of the data in which the other identified categories can be included. It has been argued that when data reflects a number of focal themes, there can be a number of core categories that can be identified (Strauss & Corbin, 1990). Given that two relatively discreet groups were included in the sample for this study, as well as the fact that multiple cultural perspectives regarding traditional MC were represented by the various participants, it is conceivable that several core categories could be identified during the selective coding of the data. However, as the Straussian approach to GT compels the researcher to select only one core phenomenon (Cutcliffe, 2005), while several significant phenomena were exposed during the construction of the themes, I continued to code and analyse the data until such time as a single core category emerged from the data, namely that of *tensions between tradition and medicine*.

I initiated the selective coding process by constructing a record of concepts (as produced through the axial coding process addressed previously) and developed them into an diagnostically discursive written theory by adhering to the following five actions: (1) explaining the emerging themes; (2) relating the sub-categories to the core category; (3) relating these categories at the level of their properties and dimensions; (4) validating those relationships using the data; and (5) augmenting sub-categories that require further attention and refining sub-categories to obtain precise and specific conceptual concretisation (Strauss & Corbin, 1998). Selective coding converts the relevant records (in the form of lists and schematics) into a discursive summary that describes the themes of the theory (which is outlined in the following chapter).

As noted above, while several significant phenomena emerged during the construction of the themes, the factors involved in individual meaning-making of HIV-preventative VMAMC were established as the phenomenon during the conceptualisation of the study, while three emerging sub-categories were identified. My objective was to place emphasis upon GTs that embody a basic social process and a basic social problem (Burnard, 1991), as well as to remain aligned with the aim of this study.

According to Wilson and Hutchinson (1996), the basic social process and basic social problem are issues shared by the individuals who participated in the study, but they may not have been overtly expressed by them. As grounded in the interview data, I found the basic social problem to be *performances of masculinity*, which resulted in the basic social process of participants having to *negotiate tensions between tradition and medicine*.

It was with this in mind that I repositioned the existing categories and their properties, a process guided by the configuration of trends monitored within the data. The consequence of exposing these patterns in the data is that the conditions of the theory's occurrence are augmented. In this study three patterns were recognised, and were labelled as *citizen rights and responsibilities in times of HIV, men's health* and *politics of implementation*. These are addressed in greater detail in the following chapter.

Data collection, from this point on, was directed towards substantiating the overall theory and the patterns of factors in individual meaning-making. This was performed as I surveyed the data to locate corroborating data, but at the same time, I considered data that was unusual or contradictory within the data. Participants were systematically offered the theory to invite their input (regarding its usefulness and applicability to their understanding of VMAMC) and given an appraisal of its development. The concluding cycle of interviews (for each group of participants) were directed towards gaining confirmatory insight into the interpretation of their accounts, and the theory was amended with this final data gathered.

Some concerns emerged from the final cycle of interviews, one of which was related to the defining features of *patriarchy*, which was more orientated towards the hypothetical scenarios generated by the line of the interview questions regarding the action of VMAMC for HIV prevention to men who have already undergone a traditional MC. Another concern was regarding the pessimism and negativity attached to the perceptions of public health and the NDoH in general, which may have corrupted the pattern of *the role of the state* and *autonomy and action* with regard to making health-decisions.

3.14. The Conditional Matrix

Strauss and Corbin (1990) conceived the conditional matrix as a technique that assists in cultivating an illustrative structure for the GT. It does so by methodically ascertaining and contemplating a broad scope of conditions and consequences (those that are intimately and/or vaguely related to the phenomenon under investigation) by tracing an occurrence through numerous planes of a matrix, essentially generating conditional pathways. Figure 2 below represents the levels of the conditional matrix.

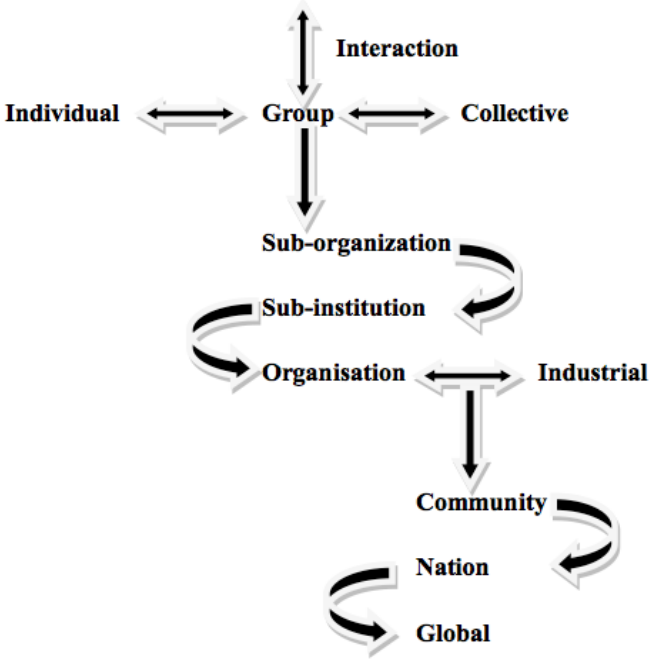

Figure 2. Levels of the conditional matrix

3.15. Theory Building & Refinement

As data coding and analysis progressed, the building of the GT became more focused as the number of categories were reduced via the constant comparison method. While there have been no studies of the way that individuals make meaning of VMAMC as an HIV prophylaxis, a number of other projects have attempted to isolate the role of meaning-making in a range of health related topics (Cacioppo et al., 2005; Courtenay, Merriam & Reeves, 1998; la Cour & Hvidt, 2010; Lee, Robin Cohen, Edgar, Laizner & Gagnon, 2006; Park, 2010; Park, Edmondson, Fenster & Blank, 2008; Singer, 2004; Wexler, DiFluvio & Burke, 2009). Several of these are GT-guided analyses.

While cognisant of the methodological imperatives of GT, these projects nonetheless openly ground themselves in disciplinary traditions. My focus on the factors involved in meaning-making in the context of VMAMC as a method of HIV prevention is itself rooted in a way of thinking about individual meaning-making agents and health. Loosely, this way of thinking and conceptualising problems falls within health psychology (as outlined in the previous chapter).

As a means to further contextualise the disciplinary orientation of the study, I had to research the assumptions, traditional foundations, frameworks and approaches of the discipline, and locate the phenomenon of my study within them. This was an arduous task as the topic under investigation spans a number of different disciplines, each with their own theory, traditions and merits. However, as the GT began to take form, the location of the factors involved in individual meaning-making of HIV-preventative VMAMC as a public health intervention in South Africa within fundamental health psychology theory, such as the ecological model regarding health-related behaviours, became apparent. The various theoretical positions within this model that could (at least partially) be utilised to inform the generation of efficient health-behaviour modification and infection prevention strategies were theoretically sampled and utilised in this study. During this phase of data analysis I found that these existing theories provided by health psychology offer, at least, a theoretical platform from which to consider why people select particular health behaviours (for example the selection of permanent body modification versus sexual behaviour changes), or why they behave in a particular way in relation to the risk of HIV infection.

During the axial coding phase of data analysis, *patriarchy* was initially set as a category and the theoretical perspective regarding gender and patriarchy was applied accordingly. In this structure *patriarchy* was considered to be the primary causal condition, with the intervening variables being *citizen rights and responsibilities in times of HIV*, *men's heath*, and *politics of implementation* recorded as the action-interaction strategies. Yet when this theory was tested against the data, I realised that *patriarchy* was an important but limiting feature of meaning-making as it did not consider other matters relating to *men's health*. Thus *patriarchy* was discarded as a core category, but included as a property that featured in the emerging sub-category *men's health*. This evolution of the GT reflects the philosophical underpinnings of the GT approach, as the researcher is required to re-visit the data to reconsider and re-test the emerging theories before finalising the GT as it relates to the aim of the study.

Memo-writing was retained throughout the research process as I noted any impressions and speculations in note form, which could be referred to during various cycles of data analysis and coding (Strauss & Corbin, 1998). I relied on this process to review all data within the structure of a novel GT. It is because of this process that I feel that the analytical framework is robust and that the GT generated is thoroughly related to the data gathered and analysed. As a result I was able to avoid the analytical error of typology (Wilson & Hutchinson, 1996).

Thus the initial application is remarkably different to the final GT presented. During the selective coding phase of data analysis, several significant concepts were exposed during the construction of the GT. After the second stage of open coding, *tensions between tradition and medicine* was selected as a core category in the phenomenon of the factors involved in individual meaning-making of VMAMC in the context of HIV prevention in South Africa. The GT analysis presented in the following chapter highlights the way in which the data gathered pivots around three sub-categories to the investigations of the factors involved in individual meaning-making of VMAMC for HIV prevention in South Africa. This was established as I attempted to lay emphasis upon GTs that embody a basic social process of participants having to *negotiate tensions between tradition and medicine* (Burnard, 1991), as well as to remain aligned with the objective of this study - to explore and account for the factors at play in the individual meaning-making regarding VMAMC for the purposes of HIV prevention.

Further analysis of this category involved identification of three emerging categories and the generation of their properties and dimensions. Thus sub-categories (1) *citizen rights and responsibilities in times of HIV;* (2) *men's health;* and (3) *politics of implementation*, emerged as being interacted with, and being intersected by, *plurality and fusion* regarding the basic social problem of *performances of masculinity*.

3.16. Ethical Considerations

Once ethical clearance had been obtained, I recruited and debriefed the fieldworkers on their duties in line with the expected ethical standards expected of human (non-medical) studies. Concerns regarding the confidentiality of data were one such ethical consideration, as various individuals had access to the audio-recordings of the interview sessions conducted.

The fieldworkers, my research supervisor, and myself, each had access to these recordings during the data collection and analysis process. The fieldworkers were informed that, in accepting payment for their fieldwork and data transcription duties for this study, they would be expected to assume responsibility for the safe-keeping of the audio-recordings, which were saved in a password protected mp3 file on a removable storage device, and the resulting transcriptions during the transcription of the interview data.

These fieldworkers were asked to sign a confidentiality clause that stated that they understood and accepted the terms of their employment and that they were to not disclose any data or findings to any person not involved directly with this study. As I was generally denied direct access to the participants during the interview sessions, the research fieldworkers were also extensively briefed on the expected procedures to be followed at each interview session so as to ensure as much consistency in the collection of data as possible.

There were no foreseen risks or direct benefits to the individuals participating in this study. It was, however; anticipated that the participants might experience some discomfort and anxiety when answering personal questions about their particular experiences (if relevant) of traditional or medical MC (adult or otherwise). In an attempt to mitigate this discomfort, the fieldworkers were particularly sensitive to these parts of the semi-structured interviews and did not directly initiate this line of questioning. For example, participants were not directly questioned as to whether or not they had undergone any form of MC; unless the participant offered such information the interviewer was not permitted to pursue a line of questioning related to such matters.

The participants were each given a copy of the participant information sheet and were required to sign the participant consent form to indicate that they understood the nature of the study and what their participation entailed. While the interviewer knew the participants' names, to ensure anonymity of the participants in the reporting of the data these were not documented on the notes used for data analysis, and participants were labelled according to the chronological order in which they were interviewed. Participants were offered refreshments during the interview session due to the anticipated length of each session. This was considered to be seen as a polite gesture to thank the participants for their valuable time and was thought to be neither coercive nor considered to be payment for their time.

The data obtained (audiotapes and written memos) from the interviews were digitised and saved on my personal computer as password protected files. The hard copies of the signed consent forms, which indicated participants' names and contact details, were destroyed after they were scanned and saved as password protected files on my private computer.

Due to the fact that the constructivist paradigm in which this study resides is based on the theoretical belief that reality is fluid, I acknowledge that I have an ethical and methodological obligation to acknowledge that my findings have been negotiated within particular cultural and social settings. Thus validity or truth cannot be grounded in any form of claimed objective reality. As such I sought to address the ethical validity of my study that is to say that I recognise the political and ethical considerations of the choices made throughout the research process. These include: (1) constant inquiry as to the benefit of the research to the target population (as outlined by the content of *Chapter 1*); (2) consideration for alternative interpretations and explanations of the findings than those constructed (to be addressed in *Chapter 4*); and (3) critically engaging with the theoretical offerings of the study as a mechanism to expand and augment the knowledge-base of the factors involved in individual meaning-making of novel public health interventions and policies, such as HIV preventative VMAMC, within psychological scholarship (as will be noted in *Chapter 4*).

3.17. Conclusion

This chapter has outlined the criteria for what constitutes as good GT analysis, as well as to substantiate the Straussian school of GT as the method of choice to best serve the aims of this study. Furthermore, the research approach was described in considerable detail to enable the reader to assess the quality of the research procedure and the ultimate value of the study's yield. The chapter also accounts for the ways in which the substantive theory generated (as presented in the following chapter) was informed by my personal world-views, in the hope that it may be regarded as trustworthy and of practical value to those involved in future HIV prevention initiatives in South Africa.

Chapter 4: Findings

4.1. Introduction

The preceding chapters of this thesis have described the conceptual foundations of the project, contextualised this study within the broader HIV and VMAMC landscape in South Africa, and detailed the research methodology that guided sampling, data collection and analysis. This chapter presents the factors involved in individual meaning-making of VMAMC, derived from local data, which are theoretically novel and may be useful in better understanding the complex overlays of meaning attached to VMAMC by individual key stakeholders in this national HIV prevention intervention.

4.2. Overview of the GT

The figure below represents an overview of the substantive GT generated.

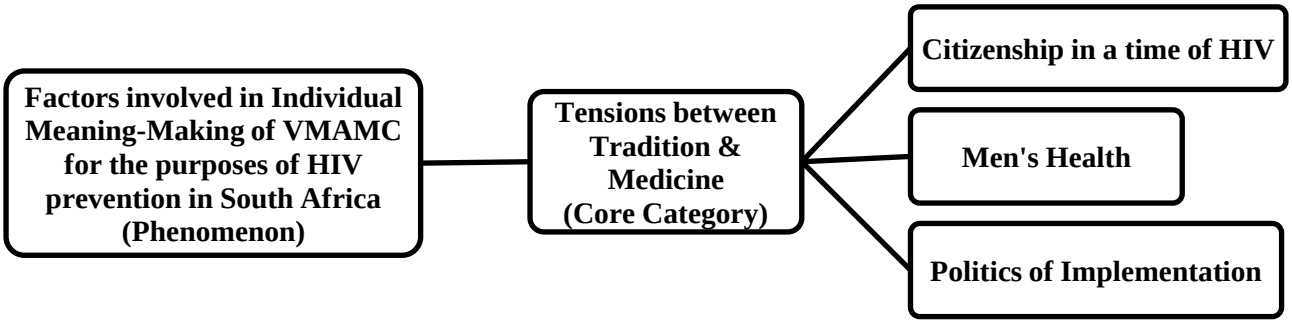

Figure 3. Overview Representation of Substantive GT

The data analysis revealed *tensions between tradition and medicine* as the single core category of this GT. Three sub-categories emerged during data coding and analysis, namely (1) *citizen rights and responsibilities in times of HIV*; (2) *men's health*; and (3) *politics of implementation*. It was found that these categories are intersected by *plurality and fusion* as it occurs within the basic social problem regarding *performances of masculinity* in the context of HIV prevention in South Africa.

The overarching basic social process, *negotiating tensions between tradition and medicine*, takes place within the causal condition of *the crisis of medicalised modernity*. The following section of this chapter elaborates on this GT as each of the emerging sub-categories is detailed in relation to their properties and dimensions, and how they intersect with the core category.

4.3. Citizen Rights & Responsibilities in Times of HIV

Citizen rights and responsibilities in times of HIV was found to be the first emerging category that constituted the core category (*tensions between tradition and medicine*) of this GT. Since VMAMC as a method of HIV prevention in South Africa is a public health intervention that is endorsed by the state, it was necessary to investigate if the perceptions of the South African government (in general) might impact the meaning-making of its preferred method for HIV prevention amongst its citizens. The data analysis showed that what VMAMC means in relation to the custodial role of the state against democratic participation within it, is also inflected by various understandings of the differences between medical and traditional MC.

VMAMC meaning-making is also related to the structure-agency debate, as participants consider their scope for behaviour end-points in relation to traditional norms regarding MC. It also emerged from the data that participant views regarding individual responsibility for personal health was a factor in VMAMC meaning-making, since it dictated whether or not they felt that they were capable of remaining HIV negative (or even should be held responsible for this). Thus, as a category, *citizen rights and responsibilities in times of HIV* has a number of properties and dimensions, which are comprehensively addressed on the pages that follow, while a visual representation of these is offered in Figure 4 on the following page.

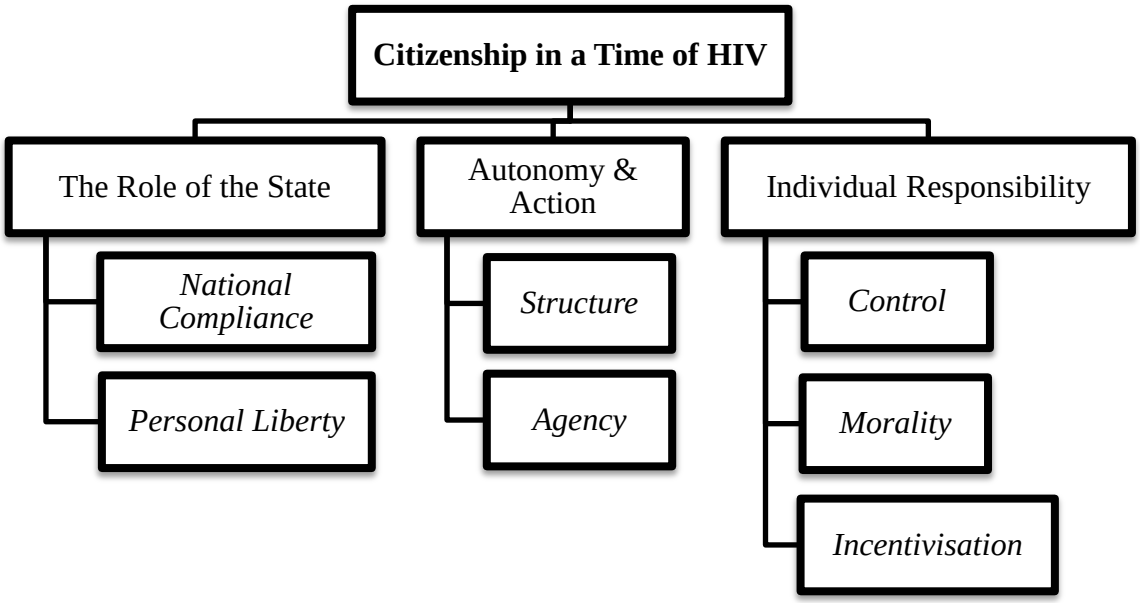

Figure 4. Properties and Dimensions of Citizen rights and responsibilities in times of HIV

4.3.1. The role of the state.

I was interested in participants' responses regarding the nature of 'voluntary' MAMC and how they might respond to the idea that someone might be able to impose this HIV intervention upon them. The South African government (as well as neighbouring governments)[5] has increased its public health messaging regarding MAMC as being its preferred method of HIV prevention (at least for the moment) as part of a comprehensive HIV prevention intervention. As such, the fieldworkers posed hypothetical questions to the participants regarding the privilege of the state with respect to MMAMC in a radical effort to reduce the spread of HIV in South Africa.

Here I was particularly interested in investigating where the rights of the individual (with regard to decision-making and uptake of this intervention) were legitimised or subordinated to the will of the state - in the case of hypothetical MMAMC in an effort to contain the spread of HIV in South Africa. Participants felt that the state could not impose MAMC upon them. P6 says, "*I don't think that people should be forced by the government.*"

[5] To view video content follow these URL links: www.youtube.com/watch?v=YBKo2x9p4iI; www.youtube.com/watch?v=SmUKlCW9BLw; www.youtube.com/watch?v=J-BCzkSJqKA; www.youtube.com/watch?v=tbkqnThpE4s; www.youtube.com/watch?v=FB7y15_IZxM; www.youtube.com/watch?v=o4zTZxSYhN4; www.youtube.com/watch?v=LabX_3raKoU

> *I do not think the government has the right to, like me I am scared to do that and I do not like people to force me to do that and I think that the government is doing that to us.* (P5)

However, P23 feels that the government has a right to pass policies that mandate body modification as a means to prevent HIV infection, "[...] *yes, people just need to understand, because this is for their own good so that they can be clean.*" Similarly, P20 says, "[...] *it is the government's right* [to implement MAMC for HIV prevention] *because by the end of day we will cry if the government does not do anything to help us fight the dilemma.*" P15 insists that rights of the individual are second to the good of the collective as "[...] *the government has rights to pass such policies because most people do not circumcise.*" Others stated this even more robustly:

> *To save the nation, you must protect everyone. So I think that there should to be a policy, as much as vaccination is a policy for everyone, it must be a policy; because the idea is not to interfere with the culture, it's about saving lives and making people live longer and happily. So I believe government must take it upon themselves to implement laws that are going to save lives. Even if you are a Xhosa, you are a Shangaan, you are a Venda, you are a Zulu, and you don't want to die young. And for us, as long as you are protecting the country, the country will sustain itself and stay healthy for a long, long time. So I think that it must be a government policy to save lives.* (P27)

I found that participants' responses often conflicted as they indicated that they either supported national compliance to governmental efforts for HIV prevention regarding a hypothetical mandating of MAMC, or they considered this hypothetical situation to be an imposition upon their personal liberties. Supportive data extracts are presented below.

4.3.1.1. National compliance.

Participants reflected on how they thought other South Africans might respond to the government imposing drastic policies regarding MAMC in an effort to reduce the spread of HIV in South Africa.

> [... many] *will agree with using* [mandatory] *male circumcision as a way of preventing HIV because they can see that a large number of people are getting infected and dying from HIV* [...] *it is for their own good.* (P19)

P12 also speaks to this when he says South Africans will embrace MMAMC for HIV prevention "[...] *because there are many people who are sick here so being circumcised might reduce that because keeping the foreskin is making them sick*." P13 says because of the severity of the HIV pandemic in South Africa, "[...] *the government has full right* [to institute MMAMC] *with the fact that people are dying from the disease* [...] *the government must force everyone so that we could lead a good life.*" P14 says that the government has a right to impose VMAMC as a mandatory policy, "[...] *people are getting wiped by this disease.*"

While MMAMC may be regarded radical, it would seem as though the participants felt that the severity of the HIV pandemic in South Africa warranted a revolutionary change in the state's approach to HIV prevention intervention. The data showed that the participants, from both traditionally circumcising and non-circumcising populations, were acutely aware of the severity of the matter in South Africa.

> [...] *as I'm speaking now, it is heart-breaking as young people who are in university when they finish after getting their degrees, they start working for only for one year and they die without enjoying their fortune of hard work.* (P13)

Here P13 reflects on HIV as impacting upon the individual's ability to participate in citizenship in South Africa, and calls on government to institute policies that will correct this matter. P12 supports the state making impositions upon the individual when it comes to preventing the spread of HIV, "[...] *yes he* [the government] *does have the right because it is saving the lives of the nation.*" Participants advocated for state paternalism since they believed that citizens are not able to make good health decisions for themselves:

> *I think that it came to the point when there's self-neglect. Immediately when there's self-neglect, that is detrimental to the person's life, the government must assist. As much as is done under Section 9 in the public hospitals: that a person cannot, in himself, be able to make decisions that are normal, the government can interfere. Also here, because if people cannot make decisions that will save them and make them productive, and make them live longer, then the government must come.* (P27)

Participants also referred to the HIV pandemic as impacting on young South Africans' ability to play active citizenship roles:

> [...] *it is important or the government to take initiative on this issue of male circumcision. If now you could go to a cemetery you will find more graves belonging to young people than old people because of HIV. The government should continue with the programme of male circumcision to reduce the number of young people infected so that young people and us would live longer like our great-grandparents.* (P14)

P19, who comes from a non-circumcising tradition, says "[...] *as I have said before that I would definitely go* [for HIV preventative VMAMC]. *If you were here* [from the government] *to take us for circumcision I was going to be the first one.*" P19 was not the only participant from a tradition that practices non-circumcising who indicated a willingness to undergo VMAMC. It would seem as though, at least for such participants, that VMAMC is regarded as a preferred method of HIV prevention.

Participants not only weighed in on the role of the state regarding VMAMC for HIV prevention purposes, but also on government playing a more prominent role in regulating traditionally performed MCs. In speaking to this, P2 says that "[...] *there were these bad circumcisions and stuff like that so government needs to take better control of this whole thing and start instituting safe and more hygienic ways of* [traditional] *circumcision.*" In saying this, P2 alludes to the notion that the state can have authority over culture and that biomedicine is prized over traditional practices. P1 also reflects that "*ja its bad man*" as he considers matters of safety and regulation of these traditional practices:

> *I think the government* [...] *needs to be more involved in this cultural circumcision thing to overcome that problem* [...] *In Eastern Cape whereby they usually say that initiation schools* [...] *we have initiates who* [...] *have died or are sick. The government needs to do something to overcome that.* (P1)

> *I think these botched circumcisions are due to people being greedy because some people are well trained traditionally to do circumcision in a traditional way. However, some people started abusing initiation schools and get a bunch of young men and promising them a proper circumcision, meanwhile they know they cannot do it properly. I think it needs to be more regulated and not just anyone can open an initiation school.* (P9)

Here P9 considers it the state's duty to protect citizens who practice traditional MC from those who might exploit cultural practices for financial gain. However, there seems to be a fine line between compliance with state regulations regarding traditional MC and the imposition of MMAMC upon men (particularly those who are opposed to any form of MC). This is addressed further in the following section.

4.3.1.2. Personal liberty.

As reflected above, P9 (coming from a traditionally non-circumcising background) does not see the state as being paternalistic, as he recommends that the government should regulate the practice of traditional MC since it does not infringe upon his personal liberties (because he does not practice traditional MC). At the same time, however; he objects to the state imposing MMAMC upon him personally:

> *It* [the government] *definitely doesn't* [have the right to make MAMC a mandatory public health HIV intervention] *because on the bill of rights there's a right there that* [...] *specifies each and every right that a human being has to what in making his own decisions. So I don't think the government could do anything there.* (P9)

However, participants considered the slippery-slope of states making unilateral impositions on its citizens regarding MMAMC:

> [...it] *might be tricky. They might as well pass a law that everyone must donate a kidney or you know what I mean. At some point someone must have autonomy for their own body. There is just no ways* [laughs]. (P30)

Participants reflected on the state's role to legislate individual human behaviour and anatomy modification for the benefit of population health. P4, despite being an advocate of VMAMC for HIV prevention, feels that the state cannot legislate health-behaviour in South Africa, "[...] *people are people, they will not listen to the government, and others will listen, others will not listen, government can't force people to have guidelines.*" Similarly P3 says, "*No, it should be a decision that one has to make personally. So the government doesn't have the right to persuade you to do something that you do not feel comfortable with.*"

> *No* [...] *that will be against the human rights, there is something called the right to privacy and dignity. It will be violation of one's rights. We just need to take responsibility to make sure that we take necessary procedures to prevent ourselves from getting infected.* (P11)

Participants seem to consider VMAMC for HIV prevention as being a personally viable alternative to existing HIV prevention efforts, that is, however;; until such time as it is contextualised as an imposition that compromises the decision-making power of the individual. That is to say that the meaning of VMAMC is that it is not a viable HIV prevention method when citizens believe that their ability to select or reject this prevention method has been annulled (by making this public health intervention mandatory).

Thus, while P1 acknowledges the severity of the HIV pandemic in South Africa and looks to the state to be responsive to this national health crisis, he says, "[...] *let government give us resources to do that but it needs to be the decision of the individual to take that step.*" Participants foresaw individual resistance as an inevitable response to perceived state paternalism:

> *I don't believe they* [the state] *have that right because I think; again, it should be an individual consideration. Forcing that* [medicalised circumcision] *on anybody is going to be adversely received, I think....then you'd get a whole group of people who are going to rebel and then you're basically at the starting board again with these people not doing what they want and still spreading HIV.* (P26)

Similarly, P7 (while advocating for the implementation of VMAMC public health interventions) says "[...] *each and every individual have their own thoughts, morals and values and they need to be respected*" and thus, the state should not make such impositions upon the individual. This data is interesting since P7 regards MMAMC as challenging his personal "*thoughts, morals and values*", however; he comes from a traditional background that dictates the ritualised circumcision of young men as a rite of passage. Throughout his interview P7 indicates that this 'mandatory' traditional practice should in fact be medicalised, yet he is opposed to the state instituting the same medical practice for the purposes of HIV prevention. This data extract speaks to the ways in which men regard imposed traditional practices that are performed medically as opposed to the same medical procedure being performed for medical reasons (such as HIV prevention).

Thus, in the face of the HIV pandemic and public health interventions, it would seem as though traditional structures impose certain restrictions on health decision-making and action. It emerged from the data that these limitations impact the degree of autonomy that participants believed they had in adopting various HIV preventative behaviours. This was found to be a vital factor in the meaning-making of VMAMC for HIV prevention. The ability of the individual participant to navigate their way between the dimensions of structure and agency in their meaning-making of VMAMC (in relation to traditional practices regarding MC) is addressed in the property of *autonomy and action* below.

4.3.2. Autonomy and action.

It emerged from the data that participants will consider their position on traditional structure and personal agency in decision-making and possible uptake of VMAMC in the meaning-making thereof. Some participants who practiced traditional MC saw any form of medical MC (and particularly VMAMC for HIV prevention) as challenging the traditional structures that subscribe particular meanings of masculinity to the practice of MC. For these participants, VMAMC was regarded as an intrusion on tradition and could not be accepted as a form of HIV prevention.

> […] *if you look in the cultural perspective, surely you're always going to get your parent might influence it* [the decision to undergo VMAMC or not], *like we said the parents haven't already done it* [MC] *when the kid was young, then you've got your spiritual leaders and cultural leaders and church goers who might influence* [decision-making] *but* […] *people will influence one way or another to say "yes, you must go do it".* (P30)

P9 believes that "*it* [VMAMC] *will degrade other people's cultures because it will simply add on cultural believes about HIV*." P4 predicts that the majority of South Africans will reject VMAMC if it challenges traditional structures since "*you have to follow your culture because; other things will go wrong if you do not follow your culture*." On the other hand, there were participants who acknowledged that VMAMC may exist beyond the realm of traditional structures (as it relates to the practice or non-practice of traditional MC), but that they felt that VMAMC should be regarded separately from these structures.

Some participants believe that the crisis of the HIV pandemic demands that citizens act autonomously from traditional structures if they limit the uptake of HIV prevention efforts like VMAMC:

> *I think that because when you do circumcision for traditional purposes they say that you are manly, meaning you are a man now.* [But] *at the end of the day, the person's life is more important than culture. It is a proper procedure to be circumcised at hospital because if you are circumcised traditionally there are higher chances of getting infected.* (P7)

> *You see, culture and religion, they are important but they have instances where they've stopped. We vaccinate every child in this country when he's born, to save lives. Save them from polio, to save them from all types of diseases. So this one* [VMAMC] *must also come in the same fashion, like the vaccine that is given to every child when its born because it doesn't cross religious, traditional or otherwise views. It* [VMAMC] *must be done in the same fashion because it saves lives. So cultural, religious, it is not important if we vaccinate children when they are born, we don't ask their culture or religion, we don't ask where they come from, we don't ask if they are wealthy, whatever, because we need to vaccinate them to prevent disease, to prevent them dying young.* (P27)

For the majority of the participants it would seem, at least on the surface, that structure and agency are regarded as discrete dimensions of autonomy and action. The implication of this seems to be that individuals may attribute absolute power to one or other of these poles in making-meaning of VMAMC (Gouws & Stasiulis, 2013). These dimensions are discussed below.

4.3.2.1. Structure.

For this study, I define structure as the social, historical and political contexts that dictate particular norms, customs and values as they relate to tradition. The data showed that traditional structures maintain a firm grasp on many individuals. P17 speaks to the structure of traditional practices when he says that, "[...] *in my culture you are forced to* [undergo traditional MC]." Even participants from non-circumcising backgrounds felt that men who come from cultures that mandate traditional MC should follow their tradition, since adherence to traditional structures is regarded as the fulfilment of a moral imperative.

For example, P2, who comes from a non-circumcising tradition, says that '*most of the cultures in South Africa support male circumcision so it's part of their culture, so it's the right thing to do*.' Participants regarded cultural and religious structures simultaneously impacting their meaning-making of VMAMC:

> *Well for cultural purposes some people have to do it but according to my religion I am not supposed to get circumcised. Some churches may be against it because it is chopping a part of your body.* (P3)

> [...] *we have known that in the Old Testament if you were not circumcised you were not allowed in heaven but in the New Testament all that changed. I think it* [autonomy regarding VMAMC decisioning and action] *will depend* [...] *some people will only want to have circumcision done for religious reasons and will never want that reason to change.* (P10)

Participants also reflected on the consequences of breaking away from tradition. P22, as a man from a traditionally non-circumcising population, recalls "*when I was a young boy my father told me that if I go there* [to initiation school for traditional MC] *and die, I am my own, because in our culture we do not go there* [to initiation school for traditional MC]." While P22 indicates during his interview that he would go for a medical MC to reduce his risk of HIV, he contradicts this claim as he continues to refer (throughout his interview) to the importance of maintaining traditional customs and adhering to their structures:

> *For me I think that male circumcision is a right thing as long as it will not be against someone's tradition because maybe in some culture some culture they do not believe in male circumcision* [...] *I don't have a problem with male circumcision as long as it does not interfere with your culture.* (P22)

P22 does not seem to consider that by undergoing a VMAMC for HIV prevention purposes he might be challenging his traditional structures (of non-circumcision), however; it is evident that adherence to traditional structure is a critical feature of VMAMC meaning-making. This is also echoed by several participants who insisted that they would come up against some resistance from their traditionally circumcising families if they opted for VMAMC rather than undergoing the procedure at a rural initiation school in the same tradition as their fathers and preceding generations:

> *I think that there must be a decrease of male circumcision for those who do it in terms of traditionally because the method they use there are more chances of getting infected. The safer way is to go to the hospital. I think they are unfair it is because it is not nice to force someone to use improper methods that will not reduce the risk of HIV transmission.* (P7)

P7 went on to say that traditionally circumcising families "[...] *will feel that their religions and traditions are brought down. I mean these methods they have been using it for ages and the medicine has developed in a rapid way.*" The imposition of traditional structures presupposes collectivism as P11 indicates that he was traditionally circumcised, "*I went for circumcision but it wasn't about the HIV. It was about me, my community and my family.*"

Thus, while some participants felt that the traditional structures regarding the practice or non-practice of MC impacted on their meaning-making of VMAMC for HIV prevention, a number of participants believed that they could consider VMAMC independently from their traditional structures and act autonomously.

4.3.2.2. Agency.

The fact that traditional structures have an impact on participants' ability to act autonomously with regard to decision-making and the uptake of VMAMC HIV interventions has important implications for public health policy makers and practitioners. The autonomy to negotiate the meaning gap of a medical modification to the body appears to be an important political process for individuals. Participants suggested that existing public health HIV prevention interventions that promote health behaviour modification have not considered this:

> [...condoms] *are not accessible, trying to get a condom if you are 16 years old it's free in your clinics but you go into your clinics who are staffed by the nurses who work in the community, so people judge you and they know that you and most of the condoms boxes are put right at the front at the reception desk, so if you walk in and you're 16 and aunt is sitting there in the waiting queue and want to grab condoms, it's definitely not going to work.* (P30)

Giddens (1976, p. 75) defined agency "as the stream of actual or contemplated causal interventions of corporeal beings in the ongoing process of events-in-the-world". Participants advocated for agency in decisioning and action regarding the state of their bodies in terms of VMAMC (in relation to existing traditional structures).

Despite their personal traditional structures that speak to customs and norms regarding the practice or non-practice of traditional MC, participants indicated that they would allow their sons to decide whether or not they wished to be circumcised (medically or traditionally) when they became adults. P10, despite personally not considering VMAMC to be a particularly favoured method of HIV prevention, says, "*I think it will be his* [the son's] *choice if he wants to if he thinks it's going to benefit him. It is his life anyway*."

Furthermore, participants indicated that they would make the decision to get circumcised or not, regardless of the traditional structures in place regarding the presence or absence of the foreskin (and method of removal in such cases) as it relates to a *performance of masculinity*. For example, P9 says that while MC has some "*religious and cultural value, I never thought it was something important*." The concept of agency is related to the notion of individual responsibility regarding health and illness. This is addressed in the property below.

4.3.3. Individual responsibility.

The participants reflected on how each individual citizen has a personal responsibility regarding HIV prevention in South Africa so as to curb the spread of infection. It would seem that participants who claimed a personal responsibility for their health and health behaviours assigned one of two meanings to this 'responsibility'. Participants regarded individual responsibility as taking control of one's health by practicing agency in decisioning and action regarding health-promoting behaviours. For example P11 says, "*We need to take responsibility to make sure that we take necessary procedures to prevent ourselves from getting infected.*" The participants regarded adherence to safer-sex practices as being related to taking a personal responsibility in the fight against HIV, but felt that not everyone in South Africa felt this way. Secondly, participants regarded individual responsibility as meaning a primary question regarding morality. As such, the dimensions of individual responsibility (particularly as they relate to the prevention of HIV) have become interlinked with personal control or morality (Douglas, 1992). These are unpacked below.

4.3.3.1. Control.

Participants, who considered personal responsibility for individual health and health behaviours as being related to *control*, often relayed this notion as they spoke to the physical body being their personal belonging. For example, P26 says, "*At some point someone must have autonomy for their own body.*"

P3 believes that no one can control one's personal health behaviours since "[...] *it's your body*", and while the foreskin has no traditional meanings for them personally (as it relates to a rite of passage), both P3 and P5 see that "[the foreskin] *its part of my body.*" P15 agrees, "*It's my body and my life.*" Others reflected the meaning of control as they spoke to causal responsibility, in the sense that one's good health or illness is determined fundamentally by personal choices regarding health behaviours:

> *I do support* [VMAMC] *it because it does help prevent HIV. They say that when you are circumcised you do not get diseases such as HIV, there is a possibility that you can get diseases, but when you are not circumcised there is a possibility that you can get HIV very easily.* (P5)

P18 feels that "*Some people don't care they just have sex with anyone without a condom. Some people are responsible and have safe sex.*" P11 considers how a large number of South Africans are not responsible regarding their sexual practices, "*people will just have sex like wild animals and not use condoms.*" He goes on to say that, "*We should actually think of the consequences and prevent HIV.*"

Participants spoke to personal responsibility for health in terms of liabilities or negative consequences of illness. These participants reflected on the impact of HIV on the country, communities, families, and the individual. They considered that the actions of one individual (by not adhering to various safer-sex practices) can incur a number of costs (including, but not limited to, medical and healthcare expenses), which can impact on a wider ecological network. P4, for example, believes that the potential pain of VMAMC is secondary to the consequences of infection, "*It's important we have to prevent HIV infection. Pain is just for a couple of minutes then it's gone and then after you can prevent HIV for the rest of your life*." P20 thinks about the consequences of unsafe-sex practices, "[...] *more people are sick and dying*", while P27 looks to education to inform the public of the consequences of HIV, "*Educate* [the public] *about humanity, risk, pain, suffering that the virus causes to humans*."

The outcome to meaning-making of personal responsibility in terms of the consequences of illness is that one may consider particular health behaviours as being the 'right' or 'wrong' thing to do. This has moral implications for the meaning-making of VMAMC in the face of HIV prevention.

4.3.3.2. Morality.

Participants referred to how the uptake of VMAMC would be the 'right' course of action:

> *Yes I would* [have my son undergo VMAMC] *because I don't want my son to be infected with HIV, I would advise him to do it because it is the right thing to do and they have done research that. They are sure that it will reduce the chances of contracting HIV.* (P4)

P2 considers people who adhere to safer-sex practices as having particular "*values*", and P24 speaks to the morality of the male citizen by saying, "*a real man makes the right decision and if circumcision means that he won't get HIV then, he must do it.*" P19 alludes not only to the morality of male citizens in opting for VMAMC for HIV prevention, but also casts aspersions on the morality of female citizens who have sexual intercourse with uncircumcised men when he says "*women prefer a circumcised penis* [...] *not those women who sleep around with every man.*" Although it is not overtly stated, there is also an undertone of blame assigned to the woman who becomes infected with HIV after having sexual intercourse with an intact man.

Similarly, the notion that the individual is responsible for their personal health and that this responsibility is attached to meanings of morality, can have implications related to blaming the infected individual for bringing about their own illness. For example, P20 believes that "*If people want to have fun only then they will get infected, get sick and die.*" As such, a number of participants reflected critically upon this matter to acknowledge that a broader social framework could impact upon the individual's ability to adhere to safer-sex practices. P14 looks to the state to take (at least partial) responsibility for his health, "*It is important or the government to take initiative on this issue of male circumcision.*" Yet participants indicated a sense of resistance to such interventions when they, as individual citizens, regarded their autonomy as being challenged by overtly medicalised public health interventions (Gostin, 1989).

Some participants raised an interesting point regarding the uptake of HIV prophylactic VMAMC and the social impact that this will have for intact men, such as P6 who said that "[...] *if you tell them* [boys and young men] *that you are circumcised, they say "let me see", I think they would tease one another for not being circumcised.*" P13 says "[...] *an individual must see that being not circumcised this days is very risky.*"

In this context, individual meaning-making of VMAMC is impacted upon by a concern of how others consider the presence or absence of the foreskin in relation to HIV preventative behaviours and the risk of HIV infection. Participants felt that if VMAMC were to be upscaled, the male who is uncircumcised (or not medically circumcised) may be regarded as being unconcerned with HIV, which is the current equivalent of a man who openly shares that he does not use condoms during sexual intercourse or has unprotected sex with multiple partners. Thus intact or traditionally circumcised men may be stigmatised as being at particular risk of HIV infection (or perhaps already be infected with HIV and/or other STIs):

> *I think it should not be used as a method of HIV prevention because it leads to certain stigmas and beliefs that are not going to work in terms of South Arica's problem with HIV/AIDS, it will create some form of stigma to people who are uncircumcised*. (P9)

> *Especially when you are going to be publicising the benefits, pros and cons of it. You tend to build this perception in people's mind that look circumcision is the way. It is like testing for AIDS, if you hear someone hasn't tested for the past four years. You tend to look at them in a funny way, it's possible that they might have it they are just afraid that if they test they going to find out that they have it, just confirm that it is. So it is going to have the same kind of stigma, look it's safer to have your foreskin cut off. If I ran to a guy in the bathroom and look at him and discover that he is not circumcised my perception of him will tend to change...*[to think of the man as] *uneducated, ignorant, this and that. A whole lot of negative things start coming.* (P25)

> *People* [...] *that are going to implicate ways of changing people's mind set about HIV should find a more subtle way not saying that if you are not circumcised you have a higher risk of getting infected with HIV, because that will cause some kind of stigmatisation to people who are not circumcised.* (P10)

While the state promotes VMAMC as its preferred method of HIV prevention in South Africa, some participants regarded the state as being paternalistic. However, they also indicated that the state might be able to encourage them to undergo HIV-preventative VMAMC, despite it not being their preferred method of HIV prevention. This involved the notion of incentivisation of health.

4.3.3.3. Incentivisation.

Participants essentially wanted incentivisation (in the form of money from DoH) in order for them to undergo HIV prophylactic VMAMC. For example, P18 states, "*I would want money, ja, give me money and I will go.*" P18 was asked to consider that it is unlikely that the state would have enough money to pay all men to have a VMAMC for HIV prevention purposes. He says "[...] a*ll the money that they spend on HIV and AIDS now, the things that do not work, they can rather give us money.*"

> [...] *money is the best because people love money; the government must continue with this programme if he sees that there are people who do not want to get circumcised, he must provide money as a form of incentive to compensate.* (P14)

However, not all of the participants felt that an incentivisation was necessary or even desirable. It is interesting to note, though, that most of the participants who did not require an incentive to consider undergoing HIV-preventative VMAMC had already indicated that they supported this public health strategy (or were at least willing to consider the possibility of doing so), indicating that this behaviour requires no compensation. Some participants were shocked at the notion that some participants wanted economic incentivisation:

> [...] *that is the mentality we have in South Africa, we have got perpetual sense of entitlement, due to the fact that of Apartheid. They got this mentality they are owed something by the government. South Africans are lazy generally as a nation, they are a lazy nation. So I would say any reason why someone would want any payment for circumcision causes, because it's self generally sense of entitlement that every person in South Africa has.* (P25)

Participants reflected some contradictions in their views regarding the incentivisation of health, as they considered the condition of their physical health to be their personal responsibility, while at the same time being enticed by the idea of receiving economic compensation from the state for taking on this responsibility. This might be considered as citizens wishing to be financially rewarded for VMAMC uptake. For example, while P13 believes that the individual should take responsibility for their health since "*it's your life not the government's life*", he believes that "[...] *if the government could give people something it will encourage them* [to go for VMAMC to reduce their risk of HIV infection]."

Similarly, P15 says "*the government has done enough for us, provided us with condoms and free HIV testing.*" Yet he then goes on to say, "*What they could do is give free medical aid.*" This statement alludes to recent developments regarding the National Health Insurance (NHI) in South Africa, which seeks to address socio-economic inequities regarding health as one of its key objectives. P16 believes that without compensation people will not support government impositions of body modification as a form of HIV prevention on its people. He feels that "[...] *people cannot be controlled because it is their bodies, but if there are incentives such money that would be provides by the government to compensate. It will encourage people to do male circumcision. They can give us money.*"

However, P21 seems offended by the idea, saying no to incentivisation, "[...] *because this is my life. I don't need government to convince me to take care of myself.*" Critically speaking, this incentivisation of health could be considered as understated coercion to have an individual behave in ways that are consistent with the state's interests. As P27 says, "[...] *giving incentives is a last resort. If you give incentives, you're not going to cover anyone. Other's will say "I don't want... my incentive is too small for me", because now you make people to be incentive-controlled.*" Participants spoke to the notion of incentivising VMAMC for HIV prevention for the public:

> [...] *while it seems like it's a good idea on paper, I don't think it's practical. I also just think that some people are so desperate that they'll do anything for money, and that's not a good motive to be circumcised. That's what concerns me.* (P26)

Participants noted that not only is economic compensation not feasible but it is also unethical:

> [...] *if a country can afford paying their citizens, then sure why not? In South African context that is definitely not going to work. I think you push like the medical benefit of it, the education* [but] *is that even ethical, to pay someone to cut them?* (P30)

This statement by P30 is one of particular interest since it epitomises the commercialisation of the citizen's body, as the foreskin becomes a commodity that can be purchased and sold during a time of HIV in South Africa. The data shows that there are a number of participants who find this to be offensive on a number of levels. P26 predicts that "[...] *in particular, the adult population might not take too kindly to being told that, you know, they should get circumcised.*"

P8 speaks quite passionately about his opposition to VMAMC by saying, "*I use contraceptives and I will know my status and have one partner. I know the method I'd have to use and stand my ground.*" Participants who share this position insist that their civil liberties (such as body integrity and autonomy of decisioning and action) cannot be sold or purchased. P25 asks facetiously, "[...] *I mean what is the price for a foreskin?*"

The underlying tension shaping meaning-making of VMAMC as part of a public health HIV intervention may (in part) be better understood in relation to the rhetoric regarding the male individual (given that this intervention targets adult males). This is not altogether surprising since there is a emergent interest in *men's health* among academics and clinicians involved in public health policy-making (de Visser & McDonnell, 2013; Gough, 2013; Griffith, 2012). *Men's health* is the next category that underpins the core category of *tensions between tradition and medicine,* which is discussed in the section that follows.

4.4. Men's Health

The emerging category of *men's health* is the second contextual condition that underpins the core category of this GT, *tensions between tradition and medicine,* in the meaning-making of HIV-preventative VMAMC. The participants reflected on this VMAMC HIV intervention in relation to their physical, psychosocial, sexual and reproductive health. As such, participants relied on cost-benefit assessments to remaining intact, being traditionally circumcised, being traditionally circumcised under medical conditions, or undergoing VMAMC for HIV prevention in order to create meaning of this HIV intervention. It emerged from the data analysis that the male body, as the target site of VMAMC for HIV prevention, and its relation to permanent surgical modification is a factor in VMAMC meaning-making. Unsurprisingly, the modification of the male body and patriarchy proved to be a critical feature of meaning-making of HIV-prophylactic VMAMC. Figure 5 on the following page outlines the properties and dimensions of the category *Men's Health*, and a discussion thereof follows.

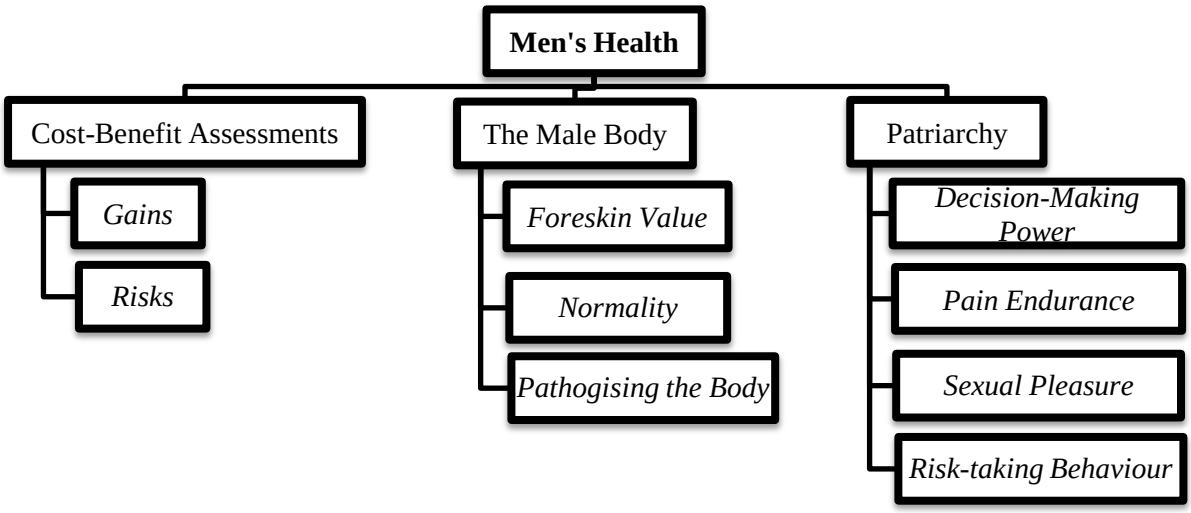

Figure 5. Properties and Dimensions of Men's Health

4.4.1. Cost-benefit assessments.

Throughout the interviews, participants compared the costs (risks) and benefits (gains) of penile modification by way of traditional or medical MC, as well as non-circumcision in some instances.

For example, participants assessed the risks and gains of VMAMC in the context of HIV prevention by saying:

> *Preventing HIV is important, but we must remember that this circumcising it does not prevent HIV infection but reduces the chances in fact by a smaller percentage; we shouldn't forget the numbers when we come to this and we should be more objective when answering this question. We must know that it is important to prevent HIV and remember that circumcision reduces the chances of getting infected by a smaller percentage.* (P9)

Thus, for this participant the cost of VMAMC does not justify the claimed benefits of HIV prevention, which is why he will not consider undergoing VMAMC:

> [...] *imagine just going through that pain, you might as well go for plastic surgery or facelift, I don't believe in doing something for just one reason. It would be a waste of my time and too much pain.* (P9)

Participants, most notably those who come from traditionally circumcising backgrounds, seemed to assess the perceived risks and benefits to VMAMC and then compare them to their perceptions of the risks and benefits to traditional MC, or no circumcision at all. P13 believes that the foreskin must be removed because it harbours bacteria and increases the risk of acquiring HIV. While being a proponent of traditional MC he says that, "*the circumcision done at hospital is safer than the one done at initiation schools.*" This is not unanticipated considering the long-standing debates on all forms of body modification, particularly those that relate to genital cutting and the male body.

However, as indicated in the previous sub-category of *citizen rights and responsibilities in times of HIV*, a large majority of the participants felt that MC (traditional or medical) had significant health benefits to an adult male and this was preferred to non-circumcision. The data analysis indicates, at least for a good number of both traditionally circumcising and non-circumcising participants, that the gains of foreskin removal exceeds the perceived risks thereof. These perceived gains are addressed in the following section.

4.4.1.1. Gains.

Most relevant to this study were the perceived benefits of VMAMC. P26 spoke to the medical benefits of VMAMC saying, "*I do believe that it prevents not only HIV, but a lot of the STIs as well.*" P26 goes on to reiterate this later in the interview, saying "[...] *the benefits aren't only going to be received for HIV infection rates; it's going to be received for a whole lot of diseases.*" Participant who do not traditionally circumcise made meaning of VMAMC in terms of safety and protection:

> [VMAMC] *has a meaning because it will make you safe and you will save your life because when you are circumcised because they have research that males who are circumcised have lesser chance of getting infected with HIV and those who are uncircumcised they have a greater chance of getting infected.* (P4)

The sample felt that there were hygienic benefits to the removal of the foreskin. Diseases that were regarded as being caused by poor hygiene were therefore considered to be prevented by medical or traditional MC. P28 speaks about encounters with patients, "*there are in the urology department cases that I have seen of people coming, even pimples on the skin itself so as I have said, it's very, very important for one to go for circumcision.*"

Furthermore, the participants (particularly those who have already been traditionally or medically circumcised) felt that circumcised men were better lovers:

> [...] *it is about sexual intercourse and women how they enjoy that type of motion and atmosphere when they are having sex with a circumcised person or uncircumcised one. I think roughly* [women] *will prefer a circumcised penis in terms of the pleasure in doing the sexual intercourse.* (P7)

However, P5 says that sexual performance and the ability to please one's partner is unrelated to the absence or presence of a foreskin, "*Most of the time when you are having sex, you have to do it right and it will depend whether you do it good. It will depend on the person*."

In addition to the endorsement for medical MC, there is support (by those who do and do not traditionally practice ritual circumcision) for MC's value for maintaining cultural traditions that have been passed along generations. For P1 it is important that his son follows their family's cultural traditional practices of non-circumcision, while P4 highlights that, as a man who comes from a circumcising tradition, "[...] *if we men do not follow our history then we cannot teach our sons to be real men too.*" Traditional circumcision suggests that the moral worth of cultural practices often seems to reside with foreskins and genital cuttings. Thus the risks of such traditional circumcisions were noted in the data, and were generally assessed as having greater risks than medical MC. These risks regarding non-circumcision, traditional MC and medical MC are unpacked below.

4.4.1.2. Risks.

Participants who indicated that they were generally opposed to all forms of MC, also indicated that they would at least consider undergoing a medical MC:

> *In general, I don't go with male circumcision because my culture doesn't go with it, there is nothing of male circumcision in my culture. But* [...] *I can take male circumcision done hospitally, then that one, I can take it.* (P1)

> [...] *it's not safe when you do it according to your culture because there are not enough medical instruments, I don't think it's good and it's not safe. I don't think those people at initiation school were professional enough and I wouldn't want to put myself at the same risk so it's one of the reasons of why I wouldn't do circumcision.* (P3)

P4 considers the risks of traditional MC, "*Yes I have heard those at the mountains. They do not use proper equipment for circumcising; they just use things they think are the best.*" Participants reflected on the risks associated with traditional MC practices and advocated for VMAMC:

> [...] *I think it's not done in a correct way because even with someone who does not have knowledge can perform circumcision on this young men. This is why young people die after coming back from initiation schools. It's heart-breaking, a better way is for this young men to be taken to hospitals/clinics for male circumcision because there are qualified doctors who can do this procedure safely.* (P13)

P25 heard something similar to this, "[...] *I know very much how the process works. In the bush for example the Xhosa, it's raw, even the guy cutting is usually drunk.*" Similarly, P15 "[...] *heard that about 15 to 30 boys had to have their penises amputated because they have been badly damaged from initiation school.*" P30 shares how he had a recent case "[...] *at Baragwaneth hospital. The guy had been traditionally circumcised and he came in, there were complications he has a phimosis and there was actual trauma to the actual penis.*"

Traditional cultural MC rituals have also been associated with an increase in the spread of HIV, particularly in cases where the same knife was used to circumcise all the initiates (Zavis, 2006):

> *It's not safe because you can get HIV when you do it cultural. They chop you with the same knife. The people were not professional because when they show us this things we get scared, that is the reasons why we are not circumcising.* (P5)

> [...] *there must be a course whereby a traditional surgeon would take and learn how to do the procedure correctly because there are many infections and must learn that once you use this blade to cut this person he must not use the same blade to cut another person.* (P21)

P21 goes on to say (with P10 concurring) that, "[...] *there should be more awareness and teach people who perform the procedure at initiation school.*" That is not to say, however; that there are no risks involved in medical MCs. Participants who had been medically circumcised as infants (and do not come from traditionally circumcising traditions), mentioned the potential risks of VMAMC:

> *Obviously, one of the greatest risks is the risk of infection. That would probably be a big deterrent into having it done. But if it's kept clean, and well dressed and looked after, that complication could be minimised greatly. And then other complications are obviously related to sort of bleeding.* (P26)

Despite the various perceived costs of traditional or medical MC, participants largely seemed to believe that circumcision (in any form) is better than non-circumcision. P21 says, "*I would say that sometimes the foreskin becomes painful. But if it is out* [removed] *then I do not think it is a problem. Generally I think it is good for someone to get circumcised*." The participants largely referred to the foreskin (or the intact penis) as "*dirty*", "*disgusting*", and "*weird*". Such negative views of the foreskin speak to the ways in which men regard their 'natural' bodies and the value that they assign to this part of their male anatomy. This is addressed in the property below.

4.4.2. The male body.

It emerged from the data that meanings of VMAMC in the context of HIV prevention are indivisible from broader traditional understandings of the male body, particularly the penis and the foreskin. Participant responses highlighted how it would be overly reductive to regard the foreskin from a biomedical perspective, given that it carries with it personal and collective meanings of manhood. Thus the data analysis showed that participants' perspectives regarding the value of the foreskin; what was to be regarded as its 'normal', 'natural' state; and how VMAMC may contribute to the pathologising of the male body, were critical dimensions in the meaning-making of VMAMC within the context of HIV prevention in South Africa.

4.4.2.1. Foreskin value.

When considering the meaning-making of VMAMC for HIV prevention, one cannot escape the consideration of the anatomy that is removed during such a circumcision. P5 considers the role of culture as imbuing the foreskin with meaning when he says of the foreskin, "[...] *it's just part of my body, but if I were a Xhosa it would have had a meaning.*" Similarly, P3 says "*According to me it's just a skin, its part of my body. Nothing else*." P25 regards the foreskin in an individualistic way saying, "*I believe your foreskin, you are born with it, it's yours, it's your belonging.*" However, participants considered the symbolic and relative value of the foreskin:

> *Some people say "I will not torture myself by removing it" and some say "I must remove it because it is harbouring germs and stuff". It is kind of a way an individual sees it as some people see it as something that is biologically there while other people see it as something vestigial something we do not need anymore. It all depends on an individual.* (P10)

P6 is opposed to all forms of MC, "*I believe that males should not be circumcised at all.*" P3 and P5, both coming from a traditionally non-circumcising population, insist that MC means "*chopping off your penis.*"

> [...long pause...] *because I will feel degraded personally I do not want someone to touch my private part. I will rather say no to sex or use other contraceptives that are proven to work like condoms. I would feel like I had been molested, touched and cut against my will.* (P8)

This anti-circumcision sentiment is absolute in particular interviews, with several participants being opposed to the routine neonatal medical MC of new-born boys since this is performed without proper informed consent. In this vein, P13 claims that he would have his son circumcised "*immediately after birth, when there is such law*", but almost a third of the participants indicated that they would not undergo VMAMC since they considered it to be a form of genital mutilation. This may be related to that fact that any form of MC is a permanent body modification procedure, which has implications for the state of the physical body as it cannot be reversed because the foreskin cannot be reattached.

The interview data alludes to VMAMC meaning-making as a result of the procedure not being able to be 'undone'. P30 reflects on the gravity of MC when he says, "[...] *the fact that you can't re-grow the skin...*" Much like tattoos, abortions, and hysterectomies, permanent body modification (particularly regarding the penis) carries enormous weight and consequence. Thus, permanent loss and perceived mutilation of the body can impose a host of individual meanings on VMAMC for HIV prevention. P30, since he was medically circumcised at birth, goes on to reflect on the possibility of his own loss, "*I would've liked it to know what it felt like...*". Such participants reflected on the anxieties that exist regarding the actual procedure of medical MC:

> [...] *you know if someone is holding a knife and a needle down there, you kind of know it's going to be painful one way or another. You going to freak out a bit. People just think of a knife and penis and those two things should never go together* [laughs]. (P30)

Considering the emphasis placed upon the penis as a symbol of the male form, any procedure that threatens the integrity of the penis may be viewed with general suspicion. P1 says, "*I can't say that I support it* [VMAMC] *because I've never seen any written evidence that says that male circumcision can prevent the risk of getting HIV*." P3, while being particularly opposed to the practice of traditional MC, is also hesitant to undergo a VMAMC for the purposes of HIV prevention as he says, "*I would* [go for VMAMC] *but not anytime soon because I still have my doubts and, I still have doubts about circumcising.*" If permanent loss of the foreskin and the resulting anxiety are meanings that are attached to VMAMC for HIV prevention, public health messaging may wish to address these concerns in order to ensure the successful upscaling of this intervention in South Africa.

Furthermore, public health practitioners may wish to consider the meaning-making of VMAMC, as participants addressed the relevance of the permanent change in the appearance of the penis after undergoing a traditional or medical MC. In considering the state of the male body, participants were asked if they thought that women preferred the appearance of a circumcised penis or an uncircumcised penis. Some participants seemed to have not considered what their female sexual partner(s) may think about the way that their penis looks, for example, P13 and P14 both laugh and admit, "*I don't have an idea!*", when asked if they think women have a preference between the circumcised and uncircumcised penis. In general, however; participants indicated a belief that the circumcised penis was more aesthetically pleasing to females:

> *Probably circumcised, I can imagine that. Actually one of my friend's moms has expressed* [her opinion]. *I remember her saying she found it* [the penis] *to look a lot better, so aesthetics was important. And that she, she just felt that it was a lot cleaner and that she preferred that to uncircumcised.* (P26)

> [...] *women usually appreciate a man with a circumcised penis. They just like a man without the foreskin because the dick does not really look appealing with foreskin... It must be removed so that the penis will look splendid.* (P15)

> *There are people* [women] *who had, I don't know what to call it; a fetish for a guy with no foreskin so I think for everything you find that there are people who would want and who wouldn't* [a man to be intact]. (P30)

However, P5 speaks to a circumcised penis as being the same as an uncircumcised penis, "*it doesn't matter because it is* [still] *a penis.*" On the other hand, for P15, the penis "[...] *looks really weird with the foreskin.*" Additionally, despite being opposed to traditional or VMAMC, some participants regarded the foreskin with disgust:

> *An uncircumcised penis has that wet stuff and it is disgusting because women sometimes like doing oral sex and with the foreskin it is disgusting but without the foreskin it is clean and disease free.* (P8)

Participants went as far as to imply that the male body only appeared to be representative of an adult man when the penis was circumcised. For example, P3 says that the circumcised penis "*makes it look like a man.*" This has implications for what men (and the broader South African society) regard as the 'normal' male body.

4.4.2.2. Normality.

Participants also offered other perceptions as they related to the 'normal' male body and MC. P26 indicates that he is circumcised and refers to this as his 'normal' state of being, "[...] *okay, I'm circumcised. So I don't really know what it's like to be uncircumcised, that's what I would've known. That's all I would've known.*"

P9 maintains that media can influence women's expectations of what a normal male body looks like when considering a woman's preference regarding a circumcised versus an intact penis. He says, "*I don't know whether women prefer a circumcised penis but in porn movies they always show a circumcised penis so I think women would prefer a circumcised penis.*" P27 concurs, "*the majority* [of women]*, because they are becoming conscious because of media, education and otherwise they always prefer circumcised men*." Participants showed that meanings of VMAMC are inextricably part of broader understandings of masculine 'normality', the ideal body, and body modification:

> [...] *it is also irritating especially during sexual intercourse. Some women feel that it is tickling and men feel degraded when the woman say that they are tickling them with the foreskin. So by removing it, they will feel manlier.* (P8)

> *Most of my girlfriends and ex-girlfriends have asked me why I haven't circumcised. And my response to that was that I don't think I am ready yet and they told me that I am a grown man and I need to show it. And my penis has to show that I have grown up.* (P3)

With similar meanings attached to what the 'normal' 'adult' male body should look like, public health messaging may need to consider these meanings and contemplate how the VMAMC intervention may legitimise or challenge what South African men believe to be representative of the 'normal' male form. Thus the upscaling of VMAMC as a form of permanent male body modification for the purposes of HIV prevention could contribute to the view that the foreskin is somehow naturally flawed, making its removal necessary.

4.4.2.3. Pathologising the body.

This notion is echoed by P24 "[...] *you have lowered your risk of getting infected, because when you shower you can clean yourself properly when you do not have the foreskin.*" For P4, "[...] *the foreskin has its own problems because it has diseases; it has HIV and like dirt and stuff. I think it is better to cut it off.*" The medicalisation of MC, which relies on discourse about it being a vector for health and disease, pathologises the male body, implying that it is somehow organically defective and reliant on medical intervention.

P17 believes that the foreskin must be removed because "[the foreskin] *traps dirt, especially for men who sleep around with many different women without using a condom. It traps all dirt that causes disease like STIs.*" This argument was relatively common across the data set and it speaks to men (from a range of cultures and generations) largely connoting natural bodily fluids (such as smegma) with the transmission of STIs and HIV. P18 speaks to this too by saying "*if the foreskin is not cut, it traps all the dirt, which causes sickness.*" P6 contradicts himself when he says that "[the foreskin] *must be removed to remove diseases*" since he initiates the interview by saying that he is opposed to any form of MC. Such sentiments were shared by participants regardless of traditional backgrounds concerning MC:

> [...] *the foreskin is not important because it traps dirt. Sometimes when you unfold the foreskin, you are welcomed by a pungent smell* [which] *is because of the dirt trapped and it makes one sick. When you have the foreskin after sexual intercourse, the dirt moves from the women's vagina and get trapped by the foreskin on the penis and it may make you sick.* (P19)

P20 believes that "*the foreskin traps dirt because when you unfold it you find whitish dirt* [...] *so the foreskin it's not important*" and P23 agrees, "*the foreskin is the one that traps dirt which may cause an individual to be infected. When you sleep with someone the dirt becomes trapped by the foreskin* [...] *its better when you do not have it.*" For P7, "*if you are not circumcised there are higher risks of contracting bacteria like when you urinate some of the bacteria get stuck to the foreskin.*"

Participants spoke from personal experiences as to the hygienic aspect to VMAMC:

> *I've just found it to be a lot cleaner; a lot more hygienic* [...] *I can definitely see the basis for the claims. I do believe that it prevents, not only HIV, but a lot of the STIs as well* [...sigh] *I personally believe that it's a lot more hygienic* [...] *I just feel like there isn't that excess amount of skin, which can harbour organisms.* (P26)

The dimensions of the property *the male body* show that depending on time and context, the circumcised penis may be viewed as a normal or abnormal aspect of the male body, which has implications for *patriarchy*. This property, as it relates to *men's health*, is discussed below.

4.4.3. Patriarchy.

The data showed that the participants largely located their VMAMC meaning-making within patriarchal perspectives regarding young men as independent decision-makers, who should endure and overcome physical pain, indulge in sexual pleasures, and be risk-takers (Mott & Roberts, 2014). These dimensions are addressed below.

4.4.3.1. Decision-making power.

Traditional MC has been the knowledge preserve of men, not only in rural areas where knowledge thereof is kept from those men who have not undergone the traditional rite, but from women collectively:

> [...] *you find that in some cultures as well being a man, you have to go through circumcision and you have to go through some traditional initiation stuff, which I do not know about because they are not allowed to talk about.* (P21)

P1 says "[...] *women do not know about these things man.*" Even P27 believes that "*Females, unfortunately so, they don't have interest in a male's penis. The shape or size; that's what is important to them.*" P25 says of traditional MC, "*It's not something to be talked about, that is the thing, especially to a woman.*" Given that women are so removed from traditional MC, I was intrigued by how this might compare to VMAMC for HIV prevention. Some of the participants from traditionally circumcising backgrounds as well as non-circumcising traditions indicated that their intimate female partners have no rights regarding decisioning for MC or VMAMC, and that it is considered culturally inappropriate for females to address the topic in its entirety[6].

These participants echoed the sentiment that women are not welcome in deciding on factors related to men's health, as P1 states, "*No women will tell us what to do*". P6 says "*I will rather take another woman, I will not accept it*", if his female sexual partner asked him to consider going to a VMAMC to reduce his risk of HIV infection. Likewise, P3 will "*not react in a good way because it's not for her to decide or to even recommend that. I am a man she doesn't need to tell me that.*"

> *My response will be negative, I will rather say no because I will be losing my value of being proudly man as I am now. I know that I would trust her in our relationship, it is not like I am sleeping around with different partners, and I am sleeping with her only. So I do not see any point of me circumcising to reduce the chances of getting infected. We are partners and we are in a relationship and trust each other.* (P8)

However, a number of participants indicated that their female partner could and should offer their input regarding decisioning and uptake of VMAMC for HIV prevention. P20 goes so far as to say that "*it's a bonus if your partner suggests such thing* [VMAMC for HIV prevention] *because this HIV, it's difficult to talk about, so if she brings it up, its better.*" Here P20 speaks to his female partner taking a leading role in *men's health*. Some participants shared that female partners should have some role to play in men's health:

[6] Therein resides an issue raised by this current study, whereby the target population for participation declined to be interviewed by me as they indicated that discussion and practice of MC, in any of its forms, was the preserve of males and could not be engaged with in the presence of a woman.

> *Yes if ever you have a partner who wants you to get circumcised you still have to consider your partner's opinion. You have to try and include the person in your life. That will be hard but it will depend on how I feel about MC and if my partner builds a good argument I will opt for it but if the argument is vague I don't know. But at the end everyone has to get circumcised.* (P11)

Thus it does seem as though women have some influence on men's health and as such, their role and inclusion in such matters will impact on individual meaning-making of HIV prophylactic VMAMC. While indicating that he would be receptive of input from his female sexual partner(s), P18 speaks to men being the gate-keepers of women's health since they have the potential to become infected with some STI and then in turn infect their intimate partner.

P18 says, "*I will agree* [to her request that I undergo VMAMC] *because I know she wants the best for me because as a man you will never know when that day you will cheat without condomising.*" As such, participants made reference to decision-making power for men as shaping what VMAMC (as a form of HIV prevention) may mean as a critical factor requiring negotiation within the space of an intimate sexual relationship:

> [...] *the individual will need advice from other people and his choice will be influenced by other people, for example if it is a grown man, a sexual partner may influence his decision* [female partners have] *a right to a certain extent to say that we need to take this kind of precautions because it is also her life involved. But the final say is on the individual.* (P10)

Much like many advocates of the state supporting VMAMC, participants who already support this public health intervention do not feel as though their female partners would be compromising their patriarchal power if their decisioning end-points are aligned to start off with. P4, who already indicated that he advocates HIV-preventative VMAMC, considers how he might respond to his female sexual partner asking him to undergo a VMAMC. "*I will not be that much surprised because she wants us to have a great life and she cares about me that I will not contract HIV.*" P14 regards the request of his female partner and says that, "*Yes I will do it because I will see that it is going to help me big time. She wants the best for me because this is our life.*"

P24 also says, "*When she tells me to go, I will do it.*" Even P5, despite not wanting to have a VMAMC, says that "*I will react in a good way because I have to satisfy my partner first of all and when my partner wants a thing I have to do that.*" P13 says "*it depends on when we talk about this issue, what evidence she gives me to encourage me to do so, but if it's her wish I will do it.*" Here, there is a consideration for the female partner's input to the extent that there will be an uptake of VMAMC despite it not being the man's personal preference. However, P26 notes that decision-making power should always reside with the man but that he should consider input from other significant people, "[...] *other people should have an opinion. They should be free to express their opinion, especially if they're involved, sexually, with someone because it's a two-way thing, really.*"

P7 says "*I'll accept her idea, if she sees that that is the only option I will go for it but I will first look at her conclusion whether she is correct or not.*" Here P7 indicates that he will not compromise his patriarchal power by substituting his female partner's opinion for his own, but will afford her opinion the consideration that he feels it deserves. However, when asked about decision-making power and the fact that women may be able to influence men's health, participants deferred to the relevance of tradition and patriarchy:

> *I've never thought of that, definitely it's another person who significant in that male's life that will pass comment but I also think that intervention, it's very much cultural based. Certain cultures were the man is still dominant I the relationship, if he doesn't want to use condoms whether the girl or lady asks to use condoms, it's not going to happen so I think the mainstream still lies with the guy, it's his decision whether a part of him it's going to be cut off or not but sure every but of extra influence is no harm in it.* (P30)

These patriarchal views regarding the limited decision-making power that women have regarding men's health is related to mechanisms through which masculinity can be proven via hegemonic practices and ideologies. One of the key elements that underpin hegemonic masculinity is the endurance of pain.

4.4.3.2. Pain endurance.

Participants reflected upon how enduring pain is inherent to hegemonic masculinity:

> *Pain is always there; even when you are working you experience pain. There is nothing that does not have pain even after eating too much you experience pain. Pain it's a minor thing, so men will not avoid pain. Avoiding pain is not important in this issue because pain is temporary while HIV is a life time disease, but with circumcision at hospital there is less pain.* (P19)

P15 speaks to the endurance of pain as being a critical feature of the entire experience of the rite of passage beyond just traditional MC, "[...] *at initiation school there are other things that we do, which are more painful than removing the foreskin.*"

The endurance of pain seems to be a function of hegemonic masculinity, regardless of cultural backgrounds. As P1, a participant from a non-circumcising background, says, "[...] *if a boy does not want to have it* [VMAMC] *done because of fearing his pain, he is not a man. He must not worry about the pain; it is what makes the man in him.*" For P7, hegemonic masculinity is demonstrated by overcoming fear of pain by embracing VMAMC as a HIV prevention intervention, "[...] *pain it is just that commotion for that certain period while HIV will last with you for the rest of your life.*"

> [...] *no one doesn't want to reduce the number of HIV infection in our country so they will do it* [undergo VMAMC despite fear of pain]. *It's important we have to prevent HIV infection. Pain is just for a couple of minutes then it's gone and then after you can prevent HIV for the rest of your life.* (P4)

P5 is one of the few participants who admits that the fear of pain is a consideration in meaning-making of VMAMC, saying that men would avoid VMAMC "[...] *because of the pain, I am scared of the pain*" even if they were aware of the HIV-preventative benefits of the procedure. P6 also reflects on this saying, "*I think pain is more important because you can think about what happened to you that day for the rest of your life.*"

Participants also considered this within the broader possibilities of the different experiences that constitute hegemonic masculinity:

> *I think it depends on people have a certain affinity to pain. Some might say that it will make me to be a man and some might say it is a waste of my time especially the recovery period. Again it is an individual question, it is what you see as the benefits of it and I don't think all men will be up for it.* (P9)

Included within the understandings of hegemonic masculinity is the experience of sexual pleasure. As such, the participants were asked to consider the possible impact that MC (traditional or medical) may have on their sexual pleasure. A number of participants indicated that this was something that every man would consider before undergoing a VMAMC for HIV prevention. *Sexual pleasure* as being a dimension of the property of *patriarchy* is discussed below.

4.4.3.3. Sexual pleasure.

Participants considered the foreskin as being a barrier to sexual pleasure since it limits stimulation and direct contact with the female partner's vagina. Thus, they believed that MC increases the level of sexual pleasure experienced by the man:

> [...] *there is nice penetration and the process of sex is nice. When you are circumcised you do not get the penis moving in and out of the foreskin, you get it moving all of it in and out of the woman's vagina during sex.* (P11)

At the same time, however; participants reflected on the importance of sexual pleasure to a man and the relevance of this to VMAMC meaning-making:

> *Definitely, I think that* [potential loss of sensitivity] *is the biggest hindrance or fact that is in a way of most people just going to get circumcision. For cultural or male circumcision medically it's the fact that the foreskin is a lot more sensitive so by losing it a lot of guys are worried.* (P30)

P26 indicated that this hesitation may be because men might be concerned that VMAMC could reduce their level of pleasure experienced during sexual intercourse, "[...] *I mean it stands to sort of reason that there are sort of nerve endings in the foreskin as well. I would imagine that it is a concern.*" P30 confirms this, "*It takes many, many, many years to breakdown stigmatise and the fact that sensation for foreskin, just the stigma involved around HIV.*" Some participants had heard the opposite to this belief that MC reduces the level of sexual pleasure experienced by a circumcised man, yet they remained wary of taking anecdotal evidence as ultimate truth when it comes to sexual pleasure:

> *Rumour has it that sex is more enjoyable when you having it with a circumcised person and also the person who is circumcised enjoys it. But we can't say that that it is the ultimate truth and we can't be sure because we have not read any research on such and we haven't read depth about it.* (P10)

P10 goes on to consider the relevance of non-circumcision to his father saying, "*I am born of an uncircumcised man and I do not think he has struggled in the sexual life*." P4, despite coming from a traditionally non-circumcising background (and the data does not reflect whether he is medically circumcised or not), advocates that VMAMC does not have implications for male sexual pleasure, "*no it is still the same thing even when you are circumcised you will have a normal sex life and after circumcision you penis will be normal.*"

P11, while choosing not to elaborate further as to whether or not this claim is made from personal experience, says of MC, "[...] *well it is nicer to have sex after circumcising. After circumcision your sex life improves.*" Yet P7 says, "*I think so for instance that for me personally if you are circumcised the pleasure is better.*" Similarly, P15 attests to this, "*as a circumcised man, since I did circumcision, sex is far different compared to before I had my foreskin removed. Now sex feels like heaven on earth.*"

P25, who is medically circumcised, goes as far as to say that, "*ja I mean I'm not too sure if you are aware but it actually allows your genitals to grow more than it would if you had the cap on* [the foreskin]." Furthermore he says, "*That basically is the selling card, it's actually the positioning strategy*" to have public health practitioners promote VMAMC as a mechanism to improve the sexual experiences of men. P27 seems to agree with this, "*It* [being circumcised] *makes me indulge more! And enjoy more!* [...] *this is my secret weapon* [points to genitals and laughs]." P27 goes on to say how patients that have been circumcised say, "*they have a new machine gun. So they want to use it to their extreme limit.*" It would seem as though, at least for men who are already circumcised, that sexual pleasure is greater after being circumcised.

Yet the narrative of P27 implies a higher risk of contracting HIV and other STIs for a man who seeks to maximise his sexual pleasure, regardless of the health consequences thereof. The complexities involved in *patriarchy* are evident in the data, particularly since the analysis shows that an expectation to participate in high-risk behaviours is considered a core component of *patriarchy*.

This highlights how by targeting *the male body* as a site for HIV prevention that men could be considered the primary vectors of HIV, and thus HIV would become regarded as 'a man's problem' and connote men as being at risk (and to blame) for HIV. This is addressed in the dimension below.

4.4.3.4. Risk-taking behaviours.

It has been argued that men's health (particularly as it relates to infections or disorders that are specifically associated with the penis and not the vagina) is understood as a product of men's behaviours (or *performances of masculinity* for the purposes of this study) (Dworkin, Hatcher, Colvin & Peacock, 2013; Evans, Frank, Oliffe & Gregory, 2011; Jewkes, Sikweyiya, Morrell & Dunkle, 2011; Stern & Buikema, 2013). That is to say men behave in ways that that place them at particular risk of illness and disease. That, together with common resistance to seeking healthcare (which can have a subsidiary effect of reduced opportunities for early detection of infections and cancers, treatment or even disease prevention), can result in men being perceived as being responsible for illness (Brenton, 2014). Participants alluded to this matter:

> [...] *after reading the paper you gave us* [the participant information sheet and the HIV prevention pamphlet] *I get it that why male circumcision must be done. The meaning is prevention against this disease because male circumcision will be a great help in reducing the chances of people, especially men, from getting infected.* (P13)

The data analysis revealed that the participants considered men as practicing high-risk sexual behaviours, which was why they thought that men should contemplate the uptake of VMAMC for HIV prevention. The view that *men's health* is underpinned by hegemonic masculinity that promotes high-risk taking can be further substantiated if people assess the culture of hegemonic masculinity in promoting risky sexual practices and engaging in other dangerous activities[7]. Participants reinforce this social perception of men as being natural risk-takers when it comes to sexual pleasure:

[7] As considered by South African insurance companies who charge women a lower premium since they are deemed to be less likely than men to claim for injury, disability or death (Cylus, Hartman, Washington, Andrews & Catlin, 2011).

> *Yes we are already getting excited about gel thing, there is that preventive gel. Most men wish that there could be spray that you could spray on and protects the both of you, so anything that seems like a cure or vastly effective preventing measure will automatically increase* [sexual risk-taking]. (P25)

P18 says that men cannot practice monogamy, "*without a doubt, it is in our nature to want sex, to want different women; it's how we were made.*" Similarly, P13 believes, "*men like playing it dangerously.*" Participants spoke to women's preference for the circumcised penis since it has connotations related to men's high-risk behaviours:

> *I think women should prefer a circumcise penis because women really want to reduce the number of HIV infection, men are very stubborn and we do not want to do that.* [Men are stubborn about] *this HIV stuff. Having to use those condoms and stuff, they* [men] *don't want to do that.* (P4)

The presentation of these properties within *men's health* shows that this category is a fundamental factor in the individual meaning-making of VMAMC in the context of HIV prevention. *Men's health* is embedded in strong patriarchal structures and institutions in South Africa. The meanings made of VMAMC cannot, therefore, be separated from both meanings of individual health and the health of these institutions. This tension between individual health needs and the mandates of public health was most summarily captured in the next category, *politics of implementation*, which constitutes the core category of the GT of individual meaning-making of HIV prophylactic VMAMC.

4.5. Politics of Implementation

Implementation of VMAMC as a HIV prevention strategy was a recurrent concern, with the participants indicating that the ways in which public health instituted the upscaling of this intervention would impact the way that they make meaning of it. Participants largely considered how various existing public health interventions have been implemented and extrapolated their experiences thereof to the implementation of VMAMC. A fundamental lack of trust for state healthcare underpinned this concern, as it emerged from the data that the participants made meaning of VMAMC in relation to their concerns that the existing public health infrastructure did not have the expertise and funding capacity to effectively upscale VMAMC.

The data analysis highlighted the critical role that awareness and knowledge of VMAMC played in the meaning-making thereof; participants felt that they did not have adequate information with respect to this intervention.

This resulted in a number of meanings being ascribed to VMAMC that were conflated with traditional MC, as well as VMAMC being understood as promoting high-risk sexual behaviours. It would seem as though such understandings of VMAMC might be addressed by the DoH adopting a more prominent role in public education regarding VMAMC.

Finally, it emerged from the data that participants made meaning of VMAMC in relation to their concerns regarding the role that their doctors will assume in the upscaling of this HIV intervention. Given that doctors assume a number of personal and professional identities at any particular moment, participants indicated that this would impact their understanding and meaning-making of VMAMC. Thus, in order to tackle these concerns, we have to understand how people make sense of existing disease prevention interventions so as to develop and implement VMAMC interventions that are aligned to this 'sense'.

As such, the category of *politics of implementation* emerged as the data addressed the way participants understood the political issues that impact the implementation of VMAMC and the many social challenges it faces in addressing HIV prevention in South Africa, but particularly an intervention related to VMAMC. Figure 6 outlines the properties and dimensions of this category, which are then unpacked on the following page.

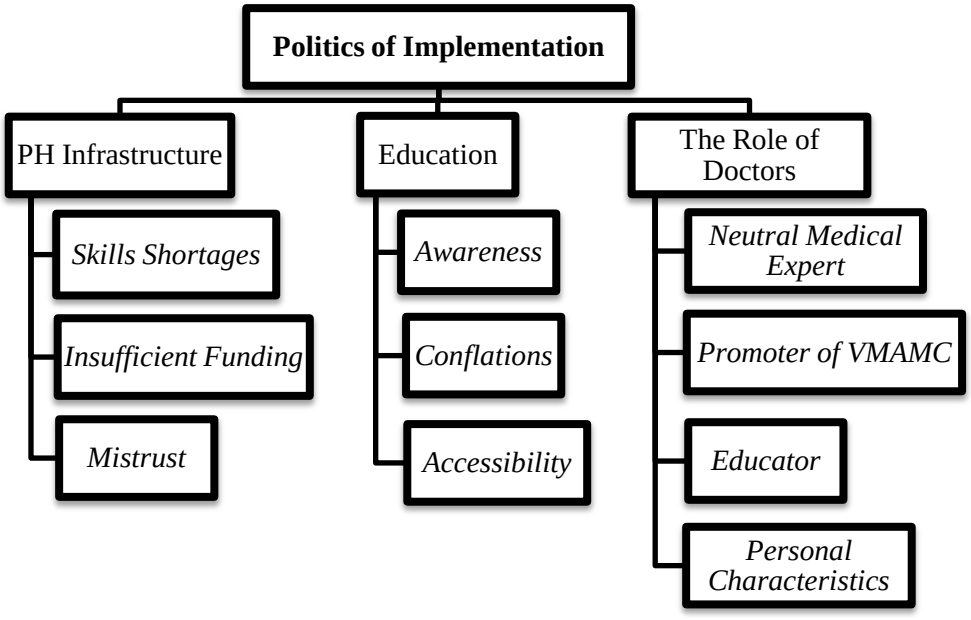

Figure 6. Properties and Dimensions of Politics of Implementation

4.5.1. Public health infrastructure.

As noted on the previous page, the participants were apprehensive about the existing public health infrastructure having the capacity to manage the various demands that accompany the upscaling of VMAMC. The participants identified these demands to include: (1) the scope of medical skill required to provide quality healthcare prior to, during, and after the surgery; and (2) sufficient funding available to attract and retain quality healthcare professionals to manage the various elements of such upscaling.

The concerns that the public health infrastructure would be unable to effectively manage the upscaling of VMAMC was underpinned by a general sense of mistrust in government to adequately develop and implement a public health intervention that would best serve the needs of the public. With such meanings attached to existing HIV interventions and state-provided medical care, there is a concern that similar meanings would be attached to VMAMC. The dimensions that constitute these meanings within the property of public health infrastructure are presented below.

4.5.1.1. Skills shortages.

Public health services are promoted and delivered by a number of skilled and unskilled health care personnel, including community and primary healthcare providers, doctors and surgeons, nurses and midwives. South Africa, although trailing behind its projected VMAMC uptake figures at this stage, remains committed to VMAMC. The participants reflected a concern regarding the NDoH's ability to adequately meet the demands of this intervention, worrying that the country is already under-resourced, under-staffed, and poorly managed in the public health sector. P30 says that the skills shortage in South Africa is an obstacle to a VMAMC roll-out, "*I don't think we have clinics and personnel who are staffed to actually perform the procedure.*" Thus, although being heavily promoted at the moment, the success of this programme largely depends on the preparedness of the public health system to adequately cater to the large number of males seeking this service.

Participants believed that the state would be unprepared and unable to offer VMAMC interventions that meet the global standards of good healthcare practices, resulting in participants then re-assessing their perceptions of risks that might be associated with VMAMC (as compared to those related to traditional MC).

The upscaling of VMAMC for HIV prevention requires a substantial increase in the number of qualified and skilled healthcare workers available and willing to meet this escalated demand for VMAMC, lest this targeted population consider non-clinical, potentially unsterile, and unsafe forms of MC as an alternative to VMAMC:

> [...] *you are then going to give rise to a lot of, sort of, illegal centres that are going to try and sort of promote* [VMAMC] *that then* [are] *not really sort of live up their claims and also not do such sterile medical procedures.* (P26)

Since there is an overall shortage of qualified medical staff to provide even basic health services to the public, it is not surprising that the provision of healthcare that is personally and collectively relevant to the diverse South African population may not be high on the DoH's list of priorities. This is an important challenge for some participants. P25 thinks that it will be difficult for the South African government to implement any public health interventions that require a collective acceptance in a diverse society, "[...] *it is a good idea to manage it and have it* [HIV pandemic] *controlled but at the end of the day, there are very many cultures in South Africa and the cultural diversity and values of our cultures*."

The concern that there are not enough skilled, culturally-competent healthcare workers to perform these VMAMCs resulted in the participants being wary of the implementation of such an intervention. Such meaning-making would have a bearing on the uptake of VMAMC if the public has a lack of confidence in the state to ensure that VMAMC procedures are performed by qualified healthcare providers. This is related to a core concern that participants had regarding DoH not having the funds available to adequately and successfully implement a HIV intervention that promotes VMAMC.

4.5.1.2. Insufficient funding.

The participants were worried that the DoH may not have the necessary funds available to implement VMAMC interventions in ways that would reflect the provision of quality healthcare services. The concern regarding health finance was alluded to by P30 as he considers the skills shortage as being related to a lack of funds to employ and retain the expertise of qualified medical staff. P24 believes that the state should consider the financial restraints experienced by public services and that MMAMC would be a possible solution to the long-term cost implications of the roll-out of other HIV treatment interventions.

He says that the state can "*decide how to spend tax-payers money on HIV care and so on so they can surely decide that this* [MMAMC] *would be cheaper and make it law.*" The public health sector was generally considered to be poorly resourced by the government and the participants believed that this shortcoming would influence the pace of uptake. For P30, "*with every intervention, people are very hesitant at first*' but that "*with enough time and enough explanation, it will get pushed through the masses and people will slowly start coming.*"

The belief that the state did not have sufficient funds to roll-out a VMAMC intervention that would meet basic standards of medical care was reflected in the participant responses regarding compensation for, and the incentivisation of, VMAMC. P25 considers this in relation to compensating men who undergo VMAMC, "*I mean the government doesn't even have the money and let's be honest, there is no money for them to give.*" The data indicates that this has not gone unnoticed by the public and is, therefore, a factor in the meaning-making of VMAMC. A number of participants seemed to believe that this HIV prevention intervention would not be provided for free by the state.

> [...] *but the problem is the price at the clinic the price is expensive. The problem is paying the money. Like now there is HIV testing that is provided at R25, if there is a place at such reasonable price, people will go for circumcision.* (P21)

In line with this belief, the participants spoke to free healthcare as being an incentive that would encourage them to take up VMAMC. P16 feels that the state should provide "[...] *free medication for male circumcision and free circumcision, because you pay to get circumcised.*" These statements are concerning, given that state hospitals and clinics are supposed to provide free healthcare to patients. Thus such perceptions of the public health system may be a contributing factor to the mistrust that seems to exist among the participants as they make meaning of VMAMC as a public health intervention. This is addressed further in the following dimension.

4.5.1.3. Mistrust.

The other obvious problem for the participants was the belief that there is widespread corruption in the health sector, which they held would undoubtedly influence public trust and impact uptake rates regarding VMAMC. Participants regarded the state and the DoH with suspicion:

> [...] *government have their interests, political interests and those political interests have certain attachments to certain socio-economic happenings within a country. So for country's economy to grow they will need certain social stability. The government have their own alterative motive for having this circumcision done. So government has an agenda that extends beyond caring for that individual.* (P25)

Similarly, P22 worries that government policies regarding VMAMC may only be developed to serve the cultural agenda of the president, "[...] *if it is according to the government, it will not work because look the previous president was Xhosa and now Zuma is Zulu so it means that every president will implement laws according to his culture*." Such views link the HIV prevention agenda with that of the state.

This, of course, has a long history that includes AIDS denialism under the Mbeki administration. More recently, the controversy surrounding President Zuma's HIV risk-taking behaviour, as well as the fact that he himself is a man from a traditionally non-circumcising isiZulu culture, means that many participants regarded the apparent objectivity of proposed VMAMC with suspicion.

Participants suggest that the increased media attention on botched traditional circumcisions at initiation schools may be part of a government-conspiracy in order to increase its position of socio-political control:

> *I was actually thinking because of the publicity about the botched circumcisions. It was actually a belief of mine that the government is trying to intercept the whole thing and trying to get control over it and manage it as their type of thing and regulate it.* (P25)

P25 reflects on this further, "[...] *the thing with the government, they will tend to want to control and manage the situation.*" This is complemented by the understanding of MC as a denaturalisation of the male body. P22 asks "[...] *if God created you this way why should you remove a part of your body?*"

Participants considered the political ramifications of allowing the state to perpetuate the notion of the naturally defective male body:

> *The government doesn't have the right to force people to do something to their bodies because some people regard their bodies as temple created by God. So to them the way God made them is the way they are going to stay. Then if you start telling them to cut a piece of their body they will ask question then saying that why were they created like that.* (P10)

Thus it would seem as though mistrust in the state and the DoH may result in the public making meaning of VMAMC in ways that reflect the perception that there is a socio-political agenda at play in the implementation of VMAMC for HIV prevention. This mistrust in DoH is further evidenced by P25, who regards the foreskin as being a carrier of disease. He equates the foreskin with free state-issued condoms, "[...] *you know it is like using the governments condoms basically, it has the same stigma as with foreskin that they have towards government's condoms*."

In this statement, P25 is referring primarily to the stigmatisation of the foreskin to say that an intact man will be regarded as being at high risk of HIV infection. He compares this 'high-risk' stigma to the way that the public regards state issued condoms (as either being ineffective protection against HIV or even increasing one's risk of infection). Thus P25 thinks that all DoH public health interventions should be mistrusted, ranging from novel interventions such as VMAMC, to longstanding HIV prevention interventions such as consistent and correct condom use.

The fact that the DoH is publicly endorsing VMAMC as a method of HIV prevention may have implications for the way the public makes meaning of such an intervention. However, several participants believed that education campaigns should be the central mechanism for addressing this mistrust. The participants believed that this responsibility ultimately rests with public health practitioners and the state.

4.5.2. Education.

The participants felt that there was a need for public education regarding HIV transmission and prevention in general, but specifically related to VMAMC. They felt that this would address some of the perceptions regarding the efficacy of VMAMC in preventing HIV and also inform the public as to ways in which this intervention would be implemented. This indicates that without this information the public would not be inclined to consider VMAMC as a viable method of HIV prevention.

P19 says he is encouraged to undergo HIV-preventative VMAMC by "*educational programmes for instances, the thing you are doing of telling us about circumcision surveys. After this, one would have more knowledge about male circumcision and will tell more people.*"

> *Definitely, it's like you going to get furthest with education. If people understand what the procedure involves if they understand the ultimate risks to it and the benefits that it's not just HIV. Ja, I think education, definitely education.* (P30)

Given the importance of education to the successful uptake of this HIV intervention, it was surprising that the interview data reflected a limited awareness of VMAMC. In fact, P1 remarked "*I've not heard something* [about VMAMC for HIV prevention]."

4.5.2.1. Awareness.

At the time of data collection, a surprising proportion of the participants were not familiar with VMAMC as a means to HIV prophylaxis. P1 reflects on how this lack of awareness has resulted in him regarding VMAMC in an unconstructive way. He says, "*Actually I can't say that I support it* [VMAMC] *because…I've never seen any written evidence that says that male circumcision can…prevent the risk of getting HIV.*" P20 says, "*...if I had the knowledge that when you circumcised...I would support the idea but now I'm clueless...*"

This sentiment, although unsurprising, is important since it implies that, at least at the most basic level, meaning-making of VMAMC as well as resultant decisioning and endpoint outcomes is related to an awareness of VMAMC. Thus meaning-making relies, at least initially, on a consciousness of the phenomenon to be understood and made meaning of. The participants were eager for guidance from government. According to P15, "[...] *most people do not circumcise because they don't understand the issue of circumcision, the benefits of circumcision. The* [governmental] *policies will clarify things.*" Yet it would seem that various state clinics and hospitals were not publicising this intervention in a meaningful way to the public. Participants from the student-doctor group indicated that they had not seen any campaigning of this public health intervention within public hospitals:

> [...] *honestly no, other than the articles that I read and just being involved with the healthcare system, that the only reason I know about it. I wouldn't say there is anything done inside the hospital, no.* (P30)

Participants also noted the general lack of awareness of this public health intervention beyond state healthcare facilities:

> [...] *the entire area of Johannesburg, the only place I have ever seen any mention on it or any sign in that, is on the route to Bara. There is one billboard that says male medical circumcision. If no one had seen it you wouldn't know that it's there. You wouldn't even know there is an option or clinics that you could go to.* (P30)

Similarly, P27 says, "*No, there's no vocality that has been made in any forums [at state clinics and hospitals] that I've attended about male circumcision. That's a little bit mute.*"

P26 also indicates that he has not noticed any particular DoH promotion of VMAMC for HIV prevention at the government institution where he is receiving his clinical training, "*So I'm currently at Bara and to my knowledge, no.*" Participants felt that public hospitals and clinics, as directed by the state, should be more vocal in raising awareness about this intervention:

> *I definitely think they need to back it more if they want to use it as a means to decrease the transmission rate. I feel like, with their backing and sort of educating people more on the benefits, they'll get more people volunteering to do so.* (P26)

The implication of this data is that while participants do not wish for the state to be paternalistic in its approach to public health and HIV prevention, the public does require some leadership from government regarding the containment of the pandemic. A lack of state visibility in the state-promotion of VMAMC for HIV prevention may impact the meaning-making of this intervention as perhaps being a prevention strategy that does not have the complete support of the state. Participants felt that education needs to extend beyond basic awareness of VMAMC-based HIV intervention in South Africa:

> *We do need to promote it more, but not just by a big billboard saying "get circumcised to prevent HIV" you know? I think we need to explain to people why that is...because I think just telling people "go get circumcised to prevent HIV" is not going to do anything because they don't understand.* (P26)

These participants also believed that parents should be targeted in these educational interventions regarding VMAMC:

> *Educating the parents, of all the cultures we have around the country and making sure people are aware of how important is HIV and how deadly it is to the youth of the country and from then having campaigns, symposiums, door-to-door, school visits, house-to-house, if necessary, if resources allow.* (P27)

> *I really think it all comes down, once again, to education and educating our children, especially from a very, very young age...and giving people all the facts and then allowing them to make an informed decision is really the best way. But ja, it definitely must be a choice that I think we need to get behind the facts more.* (P26)

However, several of the participants held that the lack of information that they had received was largely attributable to taboos regarding the discussion of sexual intercourse as the primary mode of HIV transmission in South Africa:

> *I think* [South Africans are] *very conservative in that aspect and it's been to our detriment and we have one of the highest HIV infection rates in the world...the more we educate people and do more public health promotion on it, the more accepted it's going to become. Sort of, more accepted as a norm it's going to become and we need to get over this thing where talking about sex and about genitals and about things like that is so taboo, because I really, really do think that we're living in an age where it's becoming more harmful to not talk about it.* (P26)

South Africa has a history of public sexual conservatism, however; there has been an increase in VMAMC-messaging through the media recently in the country and in other African countries. These campaigns should provide a medical perspective from which a wider range of meaning systems could be deployed by South Africans. This may be used to offset some alternative views that are not supported by public health evidence. P8, who comes from a non-circumcising background, says that he perceives traditional MC as increasing the risk of young men acquiring HIV, but then later conflates this perception of risk with VMAMC causing HIV itself. He says, "*I personally in the whole view of this issue, I think they* [South Africans] *should not agree* [to VMAMC] *due to that there is a high fluctuation of people getting infected.*" Given the general lack of awareness of the logic and effects of the use of VMAMC for HIV prevention, it is not surprising that there would be some conflations between VMAMC and traditional MC.

4.5.2.2. Conflations.

Conflations are evident in a number of participant interviews, for example P12 asserts that his support or rejection of VMAMC "*depends on where the procedure will be done, whether at hospitals or initiation schools.*" When the interviewer probes P12 on this matter by saying, "*If it was done at hospital... would you go for one?*" the participant simply shrugs his shoulders and does not offer a response.

This data extract could be interpreted in one of two ways: for P12, contemporary initiation schools that have adopted the medicalisation of traditional MC may represent these clinical conditions under which VMAMC would take place. Alternatively, P12 may not fully understand the medical nature of VMAMC, which should ultimately be performed under clinical conditions at a medical facility by qualified healthcare providers (which was not typical of the majority of traditional MCs performed in South Africa at the time that this 51 year old participant would have been circumcised). In the case of the latter interpretation, there is a conflation between traditional and medical MC. Participants also seemed to conflate the HIV protective benefits of VMAMC with traditional MC:

> *With me, it's different since I'm a Xhosa man; it is a must in our culture to be circumcised for cultural purposes as is part of manhood, not for HIV infection prevention. I think it's best for prevention because now, men will be killing two birds with one stone because they will be called real men, cultural status, and they will reduce their chances of getting infected.* (P15)

It would seem that this participant, who has already undergone a traditional MC, sees himself as protected against HIV regardless of whether his circumcision was performed traditionally or medically. There is little to no evidence, however; that speaks to traditional MCs having the same protective benefit of VMAMC against HIV. For men from traditionally circumcising backgrounds, this conflation seems to result in them having no motivation to uptake VMAMC.

As the interview with P12 progresses, he reflects further conflations regarding VMAMC for HIV prevention when he says that he would have a circumcision to reduce his risk of HIV infection "*because it will protect me* [against HIV infection]." During this interview, the interviewer confirms whether the participant is referring to a medical or traditional MC, to which the participant replies, "*no it must be the cultural way*." The interviewer engages with

this further by reminding P12 that "*the protective factor against HIV infection is only if it is done the medical way...*" and P12 insists that "*no it's the cultural.*" It would seem for P12 that the medicalisation of traditional MC or VMAMC have meanings that challenge the traditional meanings associated with the rite as a ritual that symbolises the passage of a young man into adulthood.

Later in the interview P12 supports the government in imposing mandatory MC upon its people in an attempt to control the HIV pandemic saying, "*male circumcision must continue and the government should enforce it and make it a law.*" However, when the interviewer clarifies that in that case the state would be imposing MAMC and not traditional MC, P12 responds, "*No, I said it must be cultural...cultural!*" P12 maintains his view that traditional MC, and not VMAMC, will be considered for HIV prevention, despite the interviewer trying to persuade him otherwise. This common conflation of VMAMC and traditional (non-medicalised) MC seems to impact on the meaning-making thereof, to the extent that men do not regard medical MC as necessary for HIV prevention. Furthermore, in the interview with P8, the interviewer engages with the idea regarding the role of the state in taking mandatory steps to prevent the spread of disease:

> [...] *yes because the government is the one that has 50% responsibility of making sure or insuring us from this kind of risks. The government has the right to make laws that say that this* [VMAMC] *must be stopped because male circumcision contributes to HIV infection.* (P8)

The interview is fraught with conflations of VMAMC and traditional MC as the interviewer tries to investigate why this participant would think this, despite there being no evidence that VMAMC increases the risk of HIV infection. The participant seems unable or unwilling to engage further with this issue. P7 indicates that he will not undergo a VMAMC since he does "*not think it is safe because the instruments that are used are not sterile*." However, when the interviewer reminds him that VMAMC is a medical procedure, P7 then says "*Then I support it because the materials that are used are sterilised and is done perfect and they prevent infection.*" P8 echoes this sentiment, "*It depends on the method used. If it is done traditionally, there are greater chances of getting infected but if it is done medically, like in hospital it is much safer*."

These responses highlight the stark contrasted meanings of VMAMC and traditional MC for participants who consider traditional MC to be a particularly risky practice. Thus it is critical that public health practitioners clearly inform the public as to the medical nature of VMAMC, so as to ensure that any conflations between VMAMC and traditional (non-medicalised) MC can be clarified. A number of the participants believed that public health education campaigns should be used to address such conflations:

> *If there could be people who go out there and explain the issue of the issue of male circumcision and its benefits in a clarifying way. When they could be educated they would make a logic decision because if you could look at the youth, they do not why they should be circumcised, they think it's just cultural.* (P20)

> *My viewing is that 60% of them* [men in South Africa] *will react positively and will agree if they are told the advantages and disadvantages of male circumcision to clarify things and then most of them will understand the issue of male circumcision.* (P15, after reading the literature provided to the participants by the interviewer regarding VMAMC)

In addition to the common conflations regarding VMAMC and traditional (non-medicalised) MC, participants referred to the general limitations of traditional public health education interventions in being adequately accessible to all in South Africa. It was believed that these limitations would ultimately impact on the ways in which people were able to make meaning of VMAMC. These concerns are outlined below.

4.5.2.3. Accessibility.

The interview data indicates that even though participants may have been aware of VMAMC for HIV prevention, they did not necessarily understand the mechanism thereof and certainly did not know how this intervention would be implemented.

Participants addressed how traditional public health education interventions have not adequately met the needs of the South African public:

> *Education campaigns hadn't been successful because they are not rolled out to everyone. They are targeted to people and they are not done over longer enough period and cost a lot of money, so there so many reasons why a lot of things fail and you can't change people's behaviour like overnight you know. It needs to*

> *come down more from parents and leaders in the community and things like that, they probably going to have a greater impact than some guy in a white coat from DoH coming in and giving you a lecture about something.* (P30)

Participants also considered that public health education may not always be accessible in the rural parts of South Africa. This is critical for P27 since he believes that this is where information regarding HIV is most desperately needed:

> [...] *there's an opinion that AIDS is a white man's disease that is among black people at large. The idea is to reduce the black population for white people to increase so that they can control the land as they've done before. Secondly, the campaigns have been directed to suburbs, areas of townships* [but] *areas of villages have not been penetrated that deep with knowledge and power. Especially in rural areas. Everyone you find in suburbs, he will trace his rural area somewhere... but when you go down there, they know nothing about that because you target only what you think is relevant to you or is easily accessible. To deal with this is a pandemic, you must go to the rural of the rural, to teach and make sure that they understand.* (P27)

Participants said that current public health interventions do not adequately cater for all cultural groups in South Africa, at the most basic level of language:

> *Just from my own personal experiences and having done projects in communities, one of the most important things I've found is that we need to cater for all language groups. Make sure that the information is always available in languages that they understand.* (P26)

In addition to the language barriers involved in public health education, P26 feels that the way in which information is presented to the public could improve their understanding of VMAMC for HIV prevention. He says, "[...] *what I have noticed, driving on my way to Bara - there's a very big billboard that does promote medical male circumcision for the prevention of HIV*." However, he seems to think that these sorts of educational campaigns are not particularly effective:

> *We need to put* [information] *in very succinct, easy-to-remember ways. Providing...concepts and words that they* [the public] *don't understand is what deters a lot of people, you know, and then they don't get the message. I think we need to be clearer and explain it in language that's easier to understand a lot of the time.* (P26)

Thus it seems as though a number of current education interventions regarding VMAMC have not addressed the *politics of implementation* (which seem to impact the meaning-making factors of VMAMC), but rather focussed on promoting some awareness that the intervention exists.

These findings highlight, once again, the complex nature of the development and successful implementation of an HIV prevention intervention that focuses on VMAMC. The following section unpacks the role that doctors may play within such processes since participants were anxious as to the ways in which VMAMC interventions may be implemented in South Africa.

4.5.3. The role of doctors.

Doctors occupy a unique position in the potential roll-out of VMAMC since they carry with them a number of simultaneous identities. They typically present themselves as medical experts, promoters of state endorsed health interventions and activists for disease prevention. However, they also carry with them their gendered, religious, cultural and personal identities, and as the data has shown, VMAMC for HIV prevention challenges each of these. Doctors, therefore, may have to negotiate these identities during consultation with their patients. Male doctors in particular may negotiate these identities differently in the case of HIV prophylactic VMAMC, since it will intersect their own personal views of tradition, medicine and masculinity.

Depending on how the doctor is able to negotiate these identities, he can at any particular moment be consulting with his patient in the role of a man, an individual with particular beliefs and cultural and traditional values, a father, or as a medical practitioner who seeks to prevent disease and promote wellbeing for his patients. Participants alluded to the fact that the role that the doctor assumes in the context of HIV-preventative VMAMC will impact on how such a practice will be made meaningful for them both personally and professionally.

4.5.3.1. Neutral medical expert.

The concern that doctors might allow their personal (traditionally-orientated) views regarding MC impact on the way in which they engage with issues of VMAMC and HIV prevention with each other and their patients, is one with far-reaching consequences. Participants from the student-doctor group claimed a 'neutral' role as future doctors in relation to HIV-preventative VMAMC:

> *I think my role would be to give people to knowledge and allow them to come to their own decision and conclusion. I don't think any way I'll have a right to enforce my opinion whether be my medical or professional opinion or personal opinion. I think with everyone you just provide them with information and hope that they make the right choice and obviously do the medical procedure itself.* (P30)

However, other student-doctor participants did not claim to be neutral on the matter of MC and this is made evident by the following interview extract:

> [...] *a fellow who came with a prepuce, that is a foreskin, that had a laceration. I said to him "look, this thing has a laceration, how long have you left it be?" He said: "for three weeks". I said, "But where did you get the laceration?" He said he was sleeping with his girlfriend who was a virgin. Then I said, "you know, you should have contacted assistance earlier in the clinic, this laceration would not have been this far. Secondly, you should have been circumcised, there wasn't going to be any laceration at all." So that is very important in my opinion to say that these people must be checked as early as possible, and then from there they must base it on that regard.* (P27)

It is not surprising that this participant would be promoting MC while consulting with his patients as he says that:

> *Alright, it is a fact, not my opinion, that it* [MC] *is a must. Males must be circumcised. Biblically it was done, traditionally it's been done. So, because I grew up in that tradition, I believe strongly that it must be done to every man.* (P27)

The notion that all medical professionals are somehow neutral regarding traditional and/or medical MC is misguided, particularly since it is often a polarising issue within both public and academic spheres. What is particularly interesting then in this case is how P27 makes meaning of VMAMC, given that he advocates so strongly for the maintenance of traditional MC practices:

> *I would definitely support it* [VMAMC for HIV prevention], *whole-heartedly as a medical person in the field who has seen how devastating it has been to our people. Although I know that there are cultural backgrounds of other nations that find such detachment of the skin to be irrelevant, we need to educate everyone because this is what saves lives and promotes people's lives.* (P27)

In this extract above, this participant seems to value VMAMC (in the context of the HIV pandemic) by underplaying the relevance of MC to non-circumcising traditions. He refers to the eleven official languages of South Africa as an indicator of the various traditional backgrounds that citizens typically identity with.

He ultimately identifies South African citizens according to race (as being either 'black' or 'white') and believes that black South Africans (regardless of tribal traditions regarding circumcision or non-circumcision) are undoubtedly in favour of VMAMC:

> [...] *we are having eleven languages. That also means we have eleven nations. My opinion seems to say that nine of them, which are black that know that it is a must practice. Whites, I'm not too sure about Afrikaners, they also know they must do the same. So I think that it will go well if it's put into action. I don't think there's much opposition to such initiatives that are supposed to save lives.* (P27)

Here this participant implies that tradition, in the face of HIV, should accede to medical interventions that may be perceived as challenging traditional structures and norms. Thus, he advocates that traditional MCs be performed medically:

> *If initiation school circumcisions are done by medical professionals, that it is safe and secure because I do it the medical way. Not the traditional way that seems to have complications in the long run. So for me, I really think that it is very, very good for us, as medical professionals, to go and help but not changing the traditional custom.* (P27)

Thus participants from the student-doctor group generally advocated for the medicalisation of MC, either as part of the traditional rite of passage or as a method of HIV prevention. This was essentially based on what they had been taught at medical school regarding the benefits of medical MC and the various risks related to the presence of the foreskin for the adult man.

4.5.3.2. Promoter of VMAMC

Since students in medicine are progressively acculturated to embrace the philosophies, practices, ideologies and culture of modern medicine, is was not entirely surprising that the participants from the student-doctor group felt a sense of duty to promote the public health intervention of VMAMC as a method of prevention of HIV infection. P26 feels that it is his duty, as a future doctor, to promote VMAMC for the purposes of HIV prevention. He says, "*as a South African doctor, I definitely would* [promote VMAMC for HIV prevention], *HIV is so prevalent in our society and I think we need to grasp onto any strategy that we can to try and reduce the load.*" Participants from the student-doctor group spoke to their role in promoting this public health intervention as they believed that they would encourage their patients (when relevant) to consider the option of VMAMC for HIV prevention:

> [...] *say if you were in urology department and young boys, teenagers guys are coming with STIs and still HIV negative or positive actually then I think it's good to start dropping the seed, mentioning it to them. I think that as a healthcare practitioner, the fact that your department of health is forcing it, I think it's something that you need to take on actively and do.* (P30)

> *My opinion seems to say that HIV is here to stay. It is a disease like any. We have many diseases that have been discovered in 1818, 1820... Mention influenza and others, so it's not going anywhere. So for safety of humankind, it* [MAMC] *must be compulsory, because we don't know which other disease is going to be coming after this one. This one, we've realised that for us to prevent it and attain a cure, we need to assist men by circumcising them.* (P27)

As such, P27 says, "*Definitely I would encourage a patient to undergo such a procedure* [VMAMC]. *To me, circumcision doesn't only prevent AIDS; it will prevent all types of diseases*."

Furthermore, the data indicated that doctors may, in their sense of duty to promote VMAMC (upon directives from NDoH), underplay the potential risks of VMAMC when consulting with patients. The data revealed this in a number of instances during interviews with the student-doctor group of participants:

> *There's no pain in circumcision, it's a myth that is being promoted by those who want this culture not to continue doing so. Yes, with the advances that we have now, circumcision is a smooth running process that doesn't cost a single pain.* (P27)

Even when the interviewer asks P27 about any potential post-operative pain during recovery, P27 says, "*No there is no pain there... none*." This participant also indicates that there are no risks involved in traditional or medical MC:

> *It* [MC] *is no longer a risk if people go for pre-term consultation, they are checked and analysed by qualified clinicians. By the time it is done, all the matters have been looked at and it's going to be a smooth procedure without pain, without complication. It has been proven to have 100% records of success, even with traditional people.* (P27)

In describing the potential risks of VMAMC, other student-doctor participants also minimised the consequences of a medical MC by comparing the risks to those related to traditional MCs:

> *I know often when those procedures are not done very well; or done amateur-ly by sort of non-medical professionals; then there's the great risk for bleeding. I mean those people can bleed to death. And then, basically, also genital mutilation and things like that.* (P26)

While P26 is accurate in his understanding that it has been shown that the potential risks are greater for a traditionally performed MC than for a medical MC this sort of messaging from doctors may impact the meaning of VMAMC for HIV prevention. Without perhaps intending to do so, such messages may be considered as challenging the meaning and value of traditional MC practices.

As indicated in the properties of *citizen rights and responsibilities in times of HIV* as well as *men's health*, such challenges to tradition may be met with resistance as men resolve that much more to uphold the meanings that they assign to traditional MC, by making meaning of VMAMC in ways that contrast, contradict and oppose the value of their traditional customs.

One way in which the participants felt that medical staff could remain 'neutral' in their encounters with patients and colleagues was if the healthcare professional was to take on the role of educator, sharing only 'the facts' regarding HIV transmission, prevention and VMAMC. The data, however; shows that the imparting of knowledge and 'fact' is often culturally-imbued, and discovering an ultimate 'truth' (even within the context of empirical evidence) is a challenging task.

4.5.3.3. VMAMC educators.

A number of the participants insisted that doctors should also be public health educators and inform their patients as to the risks and benefits of VMAMC for HIV prevention. This may very well be the expectation of policy makers, however; P30 indicates that doctors are not always able to talk with their patients, "*I have done circumcisions in Cape Town. Most of them were 15, 14 year old boys who came in, but there was no discussion with the patient. Patient just comes in and has it done.*" P25 was one of the few participants who indicated that he had heard about VMAMC for HIV prevention from his doctor after he thought that he had been exposed to HIV. However, doctors may not have the time or capacity to discuss VMAMC for HIV prevention purposes with their patients, given the limited health resources available to them at state hospitals and clinics:

> [...] *there is no discussion between the patient and the doctor. It's very much: "this is what you need to do, this is what we going to do for you; take this medication" and the patient leaves. There is no discussion about the actual traditional circumcision or education about it so that maybe he could educate his friends before they did it.* (P30)

Yet given his enthusiasm for traditional and medical MC, P27 says that he has taken the initiative in discussing VMAMC with his patients: "[...] *patient-to-patient dealing, that* [VMAMC] *is very, very, very well advertised.*" P30 feels that as the DoH is promoting this as a public health intervention, the success of the intervention would require active endorsement by the doctors and other healthcare workers.

This circumstance is noteworthy since this strategy relies on doctors moving beyond the realm of a neutral medical expert who simply relays the medical 'facts' to their patients, to discussing the protective nature of VMAMC against HIV infection, which is itself no longer a position of neutrality. Furthermore, when doctors do this with enthusiasm (inspired by their personal beliefs regarding the traditional and medical benefits of MC), they can be perceived by their patients as being coercive in forcing the state's agenda regarding VMAMC upon the patient. P3, P4, P6, P9, P10, P15, P19, and P21 all indicated that they did not want to feel as though someone (particularly those affiliated with government) was forcing them to undergo VMAMC.

As much as the participants spoke to the desire for medical professionals to present themselves and information regarding VMAMC in a factual and objective manner, it appears as though the personal characteristics of the doctor seem to be critical to the meaning-making, decisioning, and uptake of VMAMC. The participants indicated that should the doctor consulting with them be female or of a non-circumcising traditional background, they would not consider VMAMC in a constructive way. These matters are examined in the section below.

4.5.3.4. Personal characteristics.

Modern medicine operates on the theoretical assumption that doctors are able to treat all patients equally, regardless of social standing, gender or culture, however; studies have found this to be erroneous (Clair, Ritchey & Allman, 2014; Pawlikowska, Zhang, Griffiths, van Dalen & van der Vleuten, 2012).

The data showed that the participants were concerned with the characteristics of the doctor who would be attending to them in cases of VMAMC, since they felt that these characteristics would impact on their meaning-making of this intervention. As showed in the previous category (*men's health*), women played a limited role in traditional circumcision. It emerged from the data that as much as the gender of the doctor and patient may impact health meaning-making, decisioning and behaviour, the traditional backgrounds of the doctor may also influence VMAMC meaning-making in the context of HIV prevention.

When a doctor and patient share a traditional background, the interaction seems to be more sympathetic and collaborative than when there is no common traditional ground between them. Preference for the consultation or procedure to be performed by a male of the same traditional background may affect the ways in which meaning of HIV prophylactic VMAMC is made and may impact willingness and decisioning regarding the uptake of this intervention.

One of the primary oppositions to the Health Standards in Traditional Circumcision Act, according to Kepe (2010), is the involvement of uncircumcised people in medicalised MC. This condition speaks to the public regarding the traditional capacity of a doctor as being equal or more important than his role as a medical expert. That is to say that in the case of VMAMC and medicalised traditional MC, the medical expertise of the doctor may be less important than his traditional background and understanding of the traditional structures regarding the practice of MC as a rite of passage. Here Kepe (2010) implies that a skilled doctor who is not circumcised (particularly for traditional reasons) will be considered less favourably by the public than a healthcare provider who may be less skilled or less qualified if the latter has been traditionally circumcised.

For P12, the gender, 'culture' and status of the doctor performing the circumcision will prove crucial, "*I think it depends on who will approach me to encourage me and how they encourage me to go for male circumcision. It would have to be someone who is from my culture...and who has been circumcised...the right way.*" For this participant, the traditional way is "*the only way.*" However, this then eliminates entire groups of qualified people within the medical fraternity from participating in such interventions, based purely on the fact that they have not been traditionally circumcised themselves. Yet, P27 agrees with this suggestion: "[...] *preferably it must be done by doctors that have gone through the process*."

In summary, the sub-category of politics of implementation of VMAMC for HIV prevention speaks to data showing that meaning-making of this intervention is closely aligned with the actual implementation thereof. Constructive meaning-making of HIV prophylactic seems to depend on government being transparent regarding its political agenda, dedicating more money towards public health interventions, and hiring and retaining qualified medical staff to provide quality care to patients as they undergo VMAMCs.

Furthermore, educational interventions should seek to adequately inform the public as to the basic mechanisms involved in HIV-preventative VMAMC in ways that are meaningful and accessible. This may go some way to addressing the misperceptions regarding VMAMC that conflates its efficacy and conditions with that of traditional MC practices. Finally, public health practitioners should engage with the academic and pragmatic debates regarding the role of the doctor in the upscaling of this HIV intervention, particularly since the constructive meaning-making thereof challenges a host of constitutional and employment equity canons that are promoted within a democratic South Africa.

The data showed that the contextual conditions discussed above interact and intersect with *plurality and fusion* regarding the participants' masculinity and the ways in which this masculinity should be performed, particularly in relation to MC (traditional MC, medical MC or the non-practice of either). This is not surprising given that South Africans tend to be culturally plural, which impacts on the ways in which they regard masculinity and how they think they should behave in order to reflect this masculinity. This is addressed in the section that follows.

4.6. Plurality & Fusion: Interaction between the Contextual Conditions

The findings from data analysis thus far show that the dimensions (within the properties that define each of the three emerging sub-categories) are seemingly contradictory. For example, while participants understood citizenship as implicated in upholding individual liberties the practice or non-practice of MC, they simultaneously indicated that they would comply with the decisions of the state regarding VMAMC HIV prevention interventions. However, the data analysis showed that individual participants seemed to move between these two positions depending on the interview question and what it related to (for example sexuality, traditional rites of passage, or the role of their female partners in the upscaling of VMAMC). In order to account for this, the GT had to include a construct that traverses duality in order to address the seemingly contradictory nature of VMAMC meaning-making. I found *plurality and fusion* to be an appropriate mechanism to explain the movement between these seemingly dichotomous positions.

Plurality can be defined in a number of ways, however; for this study it is regarded simply as the legitimacy of diversity and inclusive understandings of a particular topic, which in this case, is meanings of VMAMC (Tsirogianni & Gaskell, 2011). Fusion is the process by which seemingly contradictory elements are connected to result in a complex unit (Martin & Sugarman, 2000). This *plurality and fusion* resulted from men considering a number of their masculine roles and the way in which these should or could be performed in relation to MC. For example, masculinity could revealed through undergoing the traditional rite of passage and/or as identifying as a responsible agent in the fight against HIV infection.

Figure 7 below represents how *plurality and fusion* interacts and intersects with each of the contextual conditions of the GT generated to underpin the basic social problem, *performances of masculinity*.

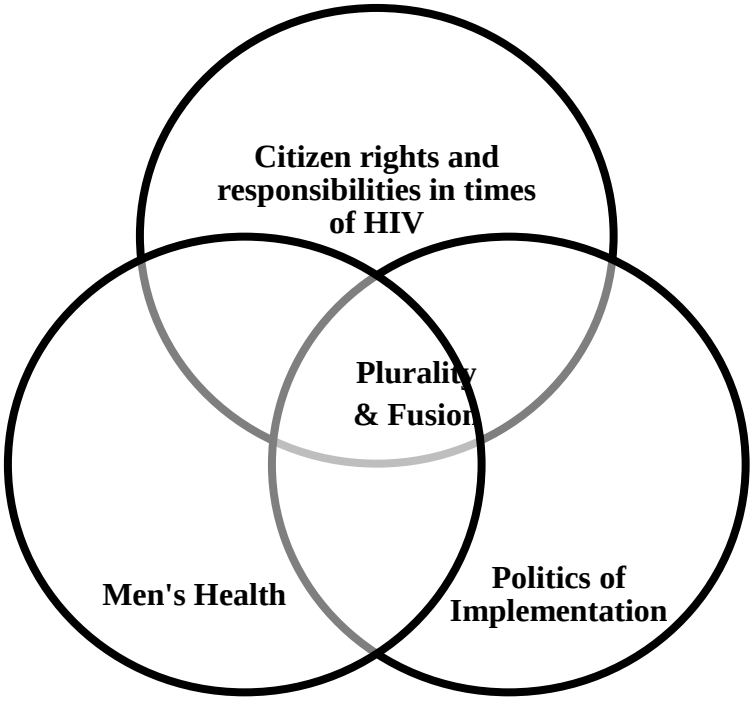

Figure 7. Pluralism interacting and intersecting the GT Contextual Conditions

4.6.1. Citizen rights and responsibilities in times of HIV.

Under this contextual condition, participants' views regarding what it meant to be a citizen (and more specifically a 'good' 'male' citizen) in South Africa during a time of HIV moved between and were at times reconciled at various points between two poles, for example structure and agency.

It emerged from the data that one's masculinity can be attained by defending individual liberties to make decisions autonomously from the state and/or by upholding the social structures legislated by government to contribute to the fight against HIV in South Africa. This seemingly contradictory positioning of the meaning of masculinity was critical in demonstrating the tensions between traditional and 'modern' forms of manhood when it came to considering circumcision and HIV prevention.

Participants regarded good male citizenship as embracing collectivistic ideologies, where there is a duty to cast aside their personal values and traditional customs to embrace any efforts that could contain the spread of HIV (such as VMAMC). P13 speaks to advocating for VMAMC for HIV prevention purposes, "*Yes I would go because it will be of great help in the reduction of my chances of getting infected*", so much so that he expects MAMC to be made mandatory by the state. However, he also feels that individual liberties (such as the freedom to maintain traditional practices (such as religious or cultural MC) should be defended.

P10 says that prevention of HIV is paramount, however; he also says good male citizenship is dependent on the protection of individual preferences regarding the state of the body and which HIV prevention interventions should be personally utilised in the face of HIV, as "*The government doesn't have the right to force people to do something to their bodies.*" Thus these views show that people can hold both individualistic and collectivistic ideologies regarding good male citizenship in South Africa, particularly in consideration of the HIV pandemic. Some participants said that government has the right to impose VMAMC as a mandatory public health intervention.

P2 says, "*I think it's not a problem considering that the majority of the South African population is infected with HIV so it's one of the steps being taken by government to cap this cycle of HIV infection in our country*." However, when the interviewer probes this further, P2 says that "*let government give us resources to do that but it needs to be the decision of the individual to take that step*." As the interviewer draws attention to this contradiction by saying, "*But if government makes these policies then they will be deciding for you...?*" P2 seems to take a stand by saying "*No they can't do that!*."

Additionally, the data analysis showed that these pluralised meanings of it meant to be a masculine citizen were dependent on the traditional background of the participant. For example, participants from non-circumcising traditions (because traditional MC plays no functional role in their sense of masculinity) did not see how medicalising the rite would cause any potential conflict for traditionally circumcising men. Such participants considered VMAMC as an intrusion upon their non-circumcising traditional structures, yet still thought:

> *Okay, yes South Africans most of them can agree* [with VMAMC] *because most of the South African cultures they do male circumcision, and another thing like when taking cultures like Xhosa whereby they use circumcision to as part of manhood to show their manhood so I think they can with go it.* (P1)

> *Most of the South African cultures select circumcision even before this research so ja no problem, it won't be any problem considering the fact that the western community just realized the important of circumcision so Africans had already been circumcising from long time ago so to them it won't make that much of a difference.* (P2)

P8 reports that most South Africans would be willing to undergo VMAMC "*because they have that belief that if you are circumcised, you are man enough and they believe that you will not be able to transfer blood if you sleep with someone*." Later in the interview, however; he says South Africans will not support the uptake of VMAMC for HIV prevention:

> [...] *because every religion has its own customs, history and beliefs of how the methods of conducting to be a man and how to reduce their chances of getting infected so by introducing that it will be changing their customs and so I don't think they will follow up on that.* (P8)

Thus P8 considers VMAMC to be a procedure that challenges masculinity, given that he comes from a non-circumcising traditional background. This has important consequences for the way in which public health messaging positions VMAMC in relation to masculinity for men who regard MC as a practice that is emasculating. P9 holds traditional MC in particularly high regard and does not question his masculine 'duty' in undergoing this rite, however; he is opposed to anyone dictating that he undergoes a VMAMC for HIV prevention.

He says "*each man owns his penis* [...] *and although circumcision is a decision involving many parties* [...] *but the most important decision is made by the person and the last choice or decision is made by the individual*." Ownership of the adult man's foreskin could therefore be said to be shared among the cultural patriarchal collective when it fulfils a traditional imperative, but shifts to become the property of the individual man when he feels that his personal liberties are under threat.

The complex cultural configuration set against the unique requirements of utilitarianism in a time of HIV complicated the way that the participants understood themselves as good male citizens in South Africa. These complications extended not just to the role of citizenship, but to the form and function of their male bodies and their health.

4.6.2. Men's health.

The participants provided multiple accounts of the impact any form of MC had on the way that they felt about themselves as men. *Plurality and fusion* of these accounts (regarding *performances of masculinity*) were further evidenced in the follow-up interviews with certain participants. In the follow-up interview with P4, the interviewer probes the statement made by P4 in his first interview that "[if] *you are circumcised you are not a real man*."

This claim is made almost certainly with his traditional background in mind since traditional MC is not a mark of adult masculinity for this participant. However, in this follow-up interview, the participant contradicts himself by saying "*I think we are all equal*." Later on in the same interview he goes on to speak about MC, "*Nowadays if you are not circumcised, boys think that you are not a man. If you are not circumcised, they don't think you are a real man*." He then indicates that he intends to undergo VMAMC for the purposes of HIV prevention. This may be because he has, in the interim, reconfigured his traditional background as it relates to a *performance of masculinity* (as a key agent in the fight against HIV, which is unpacked further as it relates to the basic social problem of this GT).

There was *plurality and fusion* underpinning the ways in which the participants regarded the value of their foreskins. P3 personally regards any form of MC as "*chopping off my penis*", yet can understand how "*In some cultures it's a way of showing that you have grown up, that now you have become a man.*" P25 does not regard the foreskin as being important "*because in any case you have to move it out of the way to get anything done* [during sexual intercourse]."

However, he is offended by the idea that any amount of money could compensate him for VMAMC for HIV prevention and that his foreskin can be commoditised, "*What amount do you offer and you go, "I'm going to give 'this much' for your foreskin", so it's a bizarre idea.*" *Plurality and fusion* is further evident in the perceived value of the foreskin for P25 when it comes to proxy decision-making regarding the circumcision of a boy or man. He says that his foreskin is not important to him and should be removed, however; the foreskin becomes symbolically important when the decision-making regarding its removal is in the hands of the state:

> [...] *if someone is going to come and all of a sudden say you can't have that, look you are not allowed to have that, it's like you can't have your middle finger, because you are going to use it wrong, so basically that's my logic. It is a part of me, my organ, it's my decision whether I want to have it or not.* (P25)

In addition to this, the participants negotiated *plurality and fusion* regarding traditional and biomedical parenthood in matters of *men's health*. For example, when it came to the rights of parents (fathers in particular) to act as proxy decision-makers on behalf of their male children regarding traditional or medical MC, participants who did not have children (particularly those from non-circumcising traditions) felt that parents did not have the right to decide whether or not their son would be circumcised.

Participants who do not traditionally practice MC said:

> [...] *there are some parents who make choices for their kids and they find that the decision is affecting the child in the future maybe in a bad way. They should rather sit down with the son and then tell him everything that he needs to know about male circumcision and then he will chose what best suits him based on his own understanding.* (P20)

P20 indicated previously in his interview that he would have his son medically circumcised to reduce his risk of becoming infected with HIV. Furthermore, he says of state mandated MAMC, "*It is the government's right* [to mandate MAMC] *because by the end of day we will cry if the government does not do anything to help us fight the dilemma.*"

Participants who were parents (particularly those from circumcising traditions) felt that as fathers, they did have this right. P27 feels strongly about having his son medically circumcised, "*With me, it's a culture. I was born in it* [traditional MC]. *As a medical professional, I've seen it save lives, so definitely, he'll have to go through the knife, like it or not*." However, at the same time, he believed that "*it must be the parents that just do what is best for the child. Not enforcing it. It's not forced, its being done correctly so, in assisting him to become a human being that lives longer and be productive*."

Plurality and fusion in proxy VMAMC decision-making was interesting since it highlighted how a number of participants felt that they (as fathers) had the right to impose medical MC for HIV prevention on their sons to prevent them from being infected with HIV, while at the same time not wishing to undergo the procedure themselves.

P5 says that he would have his son circumcised, "*I will make my son to circumcise at an early age so that in future I will prevent him not to get HIV and diseases*" since he believed that children under the age of 18 should abide by their parents' decisions. But in considering himself for VMAMC he says, "*I have my own doubts, I do not see the use of circumcising now.*" This data is important for public health since it indicates that the traditions of circumcision and non-circumcision are markers of feasibility for VMAMC-based HIV interventions, at least for current generations of adult men in South Africa.

Traditionally non-circumcising participants echoed the same views regarding father-son resemblance and traditional practices. As P1 states, "*I'm a very cultural person, I'd like that my son follow my culture also so for that reason I won't consider to take my son to circumcise.*" However, P1 indicates that he would have his son medically circumcised to reduce the son's risk of HIV. Yet, when it comes to maintaining tradition, he says, "[...] *every parent would like to do things like they would like to follow the culture. And culturally we know that a child needs to perform all the rituals that were performed and done by both parents.*" For P6 (who does not practice traditional MC), VMAMC might disrupt tradition and patriarchy because for "*some parents it will be difficult because they are not used to the situation of circumcising*", however; he reports that he would permit his son to decide whether or not he would undergo VMAMC for HIV prevention. However, P18 says "*I will force my son to go for circumcision*", yet at the same time he regards VMAMC as intruding on his traditional non-circumcising practices: "*I will not go because there will be a major conflict with my culture because originally we do not practice male circumcision.*"

Participants, especially those who already had children, saw themselves as powerful parental conduits when it came to making decisions regarding their child's body:

> *Parents have the right because if they do not put the word on their children they become out of control and they do stuff and don't make anything from their parents. Parents have the right because they are able to control their children at an early age. The child will grow up and see that he is circumcised and he will be told the reason why he was circumcised.* (P15)

In such cases, the foreskin seems to the property of the father (who does not traditionally practice MC and is himself still intact), but at the same time he has ownership of his son's foreskin. This has implications for possible public health messaging regarding that is 'eligible' for HIV-preventative VMAMC. On the other hand, P16 says "*As I have said I will not go against my culture* [by undergoing VMAMC]", yet he says that he will allow his son to make the decision for himself regarding VMAMC, "[...] *when he grows up, I will give him a choice when he is old enough to decide for himself whether he wants to be circumcised or not.*" P18 says, "*I will force my son to go for* [medical] *circumcision because I want him to be safe from all hurt and pain*", yet he also says:

> *I think as a parent you have a right but you should not force a child to be circumcised or not but rather sit down with the child and explain the dilemma and state the consequences whether they are beneficial or not of male circumcision.* (P18)

The participants also reported multiple and at times fused beliefs about the role of women in men's health and how their presence or absence impacted on the participants' sense and *performance of masculinity*. For some participants, by having their female sexual partners weighing in on their uptake of the intervention, they felt that their masculinity would be compromised so they would have to respond in ways that reclaimed their sense of masculinity. At the same time they also welcomed input from their partners as they indicated that doing so was a testament to their masculinity. P30 advocates for the inclusion of women (as sexual partners) in the decision-making regarding VMAMC for the purposes of HIV prevention.

At the same time, however; he considers how this would impact his sense of masculinity personally:

> *I think for any guy the fact that you going to be taking a knife or injection or anything near my penis. It's going to be an issue so I don't think most guys are just going to be like "cool she wants me to get it done to prevent HIV". Condoms are really good viable option you know and if you are a person who is acceptable to using condoms why must I go have things chopped away, so I think a lot of people will protest for that fact. So I probably wouldn't* [go for VMAMC if female partner requested such]. (P30)

It is not surprising that the majority of statements themed *plurality and fusion* emerged within the contextual condition of *men's health* as this condition encompassed issues such as the male body and patriarchy, both of which impact views regarding *performances of masculinity* separately from VMAMC for HIV prevention, but are amplified that much more within the context of a public health intervention that targets men (and their penises in particular) in an effort to address the prevention of HIV in South Africa. It is now necessary to consider *plurality and fuson* as underpinning *performances of masculinity* in relation to the *politics of implementation* of this intervention.

4.6.3. Politics of implementation.

Negotiating meanings between the poles of *plurality and fusion* was evident in concerns related to the ways in which VMAMC may actually be implemented, and this impacted on the ways in which masculinity could be performed in relation to this HIV intervention. Participants wanted VMAMC to be implemented in ways that were meaningful to all male citizens (or inhabitants) of South Africa. However, they also needed the intervention to have personal relevance to them as individuals with unique circumcising traditions. The pragmatic difficulty of this was emphasised by participants who felt that all traditional backgrounds should be considered by the NDoH in the upscaling of VMAMC. P28 says, "*If the government can come up, mix up with the traditional groups, talk with them and put up a protocol and say this is the way this should be done for prevention and control of infections.*"

> *Everyone has their own opinion and own practises, you are going to find that people are not going to be having the same view on the matter. There will be conflicts around religious people but if everyone gets circumcised in the hospital I don't think that there is going to be much a problem. But if they use their original or ancient ways of circumcising like initiation school. That is where the ideas will clash.* (P1)

Participant spoke to the necessity for psycho-educational interventions to explain why he (as a man) should consider undergoing VMAMC as a method for preventing HIV, but contradictorily, they believe that the general public should be misled into believing that VMAMC is not as effective in protecting men (who practice peno-vaginal sexual intercourse) from HIV as what the research has found it to be.

For example, P10 indicates that education is required to "*try to get rid of the myths and untrue acts*" regarding HIV, but the these programmes should be deceptive and "*shouldn't just tell people* [about the true protective nature of VMAMC] *and let people run with the idea because it is going to end up doing more harm than good*." As this interview extract from P10 shows, participants were concerned that the implementation of VMAMC would encourage sexual risk-taking behaviours among men who might then feel invulnerable to HIV and other STIs. For example, P11 is concerned that with the implementation of VMAMC "*people will just have sex like wild animals and not use condoms...* "

However, when the interviewer shares his concern with the participant that South Africans are already practicing high-risk sexual behaviours (with sexual risk increasing over the past few years), "*But research shows that people are not using condoms consistently anyway...*", P11 maintains that condom usage and other prevention interventions should be favoured over VMAMC, "*No... but... they must.*"

Furthermore, this ambivalence (highlighted predominantly by the participants from the student-doctor group) regarding the role of the medical doctors in the implementation of VMAMC. The participants indicated that doctors should be neutral medical experts, however; by the nature of their active promotion of VMAMC for HIV prevention as advocated by the NDoH, doctors would be endorsing VMAMC over traditional MC to their patients. For example, when asked if he thought that maintaining traditional customs was more than or equally as important as embracing medical developments that alter those customs, such as VMAMC for HIV prevention, P30 said that:

> *I would say no, it* [tradition] *shouldn't be more important* [than medical HIV prevention interventions]. *From a biomedical side of things, the fact that you can decrease the risk of transmission and have a greater impacts on health of population that for me obviously going to be more important.*

During his interview, P30 acknowledges the importance of traditional practices, "[...] *looking at an individual obviously you can't exclude their cultural beliefs, when you can't say it's more important. I think maybe they need to be hand in hand.*" P30 is not unique in his proposal that traditional-medical MC hybrids (which will be discussed in greater detail shortly) underpin a pragmatic solution to the tensions between traditional MC practices and the introduction of VMAMC for HIV prevention. However, P30 indicates that he does not subscribe to any traditional practices regarding MC and goes on to say, "[...] *as long as at the end of the day the guys are getting circumcised. Who really cares you know?* [laughs]."

This latter comment seems to diminish the traditional values of MC by implying that the values related to the practice of traditional and medical MC can be conflated, since the outcome (a removed foreskin) is the same for both. Thus while he indicates that he will be neutral in his interactions with patients in the future, he may directly or indirectly share this conflated view of MC with his patients in the future, and in so doing, promote VMAMC in ways that devalue the traditional background of a patient, which could be met with individual resistance to this public health intervention. This is critical in light of statements such as those made by P9, who says that "*it states on the Constitution that you have the right to dignity and culture. It will not be dignifying for some people. In some cultures circumcision may be seen as the loss of dignity.*"

Thus far, the results chapter has argued that *plurality and fusion* was the intersecting and interacting variable of these contextual conditions at the point of *performances of masculinity*. This point was found to be the basic social problem within the GT generated to attend to the phenomenon of individual meaning-making of HIV prophylactic VMAMC. As such, the following section of this chapter will provide further substantiation of the *plurality and fusion* underlying the basic social problem, whereby participants contemplated the various ways in which they could attain and reveal their hegemonic masculinity within the phenomenon of HIV-preventative VMAMC in South Africa.

4.7. The Basic Social Problem: Performances of Masculinity

Masculinity, and how VMAMC may impact on the ways which the participants regarded their masculinity (as well as how they thought others would perceive them), proved to be a critical feature of the analysis. As such, the *performance of masculinity* is presented as the basic social problem. Considering the pluralistic setting of South Africa, P25 indicates that there is no absolute correct way to perform masculinity, "*what is the norm when it comes to masculinity? Is there a norm? There isn't...really.*"

The data showed that the participants felt that there were a number of ways in which they could perform their masculinity, for example some participants spoke to *performances of masculinity* based on culturally-mandated behaviour:

> [...] *that is upon cultural values, I think it doesn't make any difference. I mean it is up to you whether you follow to do circumcision or not. It is just being stereotyped... It all falls under the cultural aspect. If those people with a certain mind-set that if you have removed your foreskin, you are a man.* (P7)

Yet P7 goes on to highlight how masculinity is related to traditional MC in ways that inherently exclude the uptake of VMAMC as a *performance of masculinity*, "*when you do circumcision for traditional purposes they say that you are manly meaning you are a man now but when you do it for traditional reasons only*."

For these participants, *performances of masculinity* seem to be constructed around robust physical health, risk-taking, aggression and traditional MC. For P11, who supports only traditional MC, "[...] *kids are dying trying to be men. The harsh conditions there, there people there must change their practises but not actually change it but rather modify it into a safe one.*" P1 notes that masculinity is not bound to circumcision in particular, but is rather culturally-determined by saying that, "*It's not the circumcision; it is what the culture says it is. Culture says that makes you a man.*" P2 feels the same way, saying "*it's just a matter of being circumcised or not being circumcised. But I think it's a manner of religion and culture.*" This is no more apparent than in South Africa where hegemonic masculinity is performed through traditional MC, whereby young men are expected to endure and overcome physical pain as they symbolically mark their bodies to shift from boyhood into manhood. However, participants reflected on how traditional MC does not necessarily yield true adult masculinity:

> [...] *what is happening now you find that in the Xhosa culture when the boys come back from initiation school for circumcision they behave like hooligans and bully everyone in the house. You find that before they went to initiation school they used to help around with the house chores like washing dad's car but when they come back they are totally different. When you ask them to do this they start complaining and they start smoking and drinking at home and I don't think it makes you a man. Your actions let's say your responsibilities. You must know that as a man you must do that.* (P21)

> [...] *the youngsters after they are back from initiation school, when they come back they become disobedient and do not listen to their parents. It is about people doing this wrong and they say that "I'm coming from initiation school and now I can do anything". And they say "I can smoke in front of my father". That thing makes us to lose some respect. When this guys come from there you can't tell them anything. Going there, it is just a waste of time.* (P22)

Thus P22 considers that masculinity is not gained from the practice of traditional MC, nor from the initiation rituals performed during the rite of passage, while P6 elaborates on the differences between traditionally circumcised men and those who come from a non-circumcising tradition: "*uncircumcised men are more powerful than circumcised men because you can recognise an uncircumcised man easily through their behaviour.*" This participant comes from a non-circumcising background and is deeply opposed to traditional MC, and states that he would not undergo VMAMC at any time. For this participant, MC (in any form) is regarded as compromising patriarchal power and hegemonic masculinity.

For some of those participants who do not practice MC, the rite carries no significance as a *performance of masculinity*. P1 reflects, "*Oh to me, it* [MC] *doesn't have any meaning because there is no difference between like, I see no difference between circumcised guy and the uncircumcised guy because I think their job is the same.*" Here P1 refers to masculinity being related to men performing a particular role or function rather than the state of the penis in relation to MC.

Participants from non-circumcising backgrounds considered *performances of masculinity* as being unrelated to genital cutting and more to do with a man's ability to contribute to heteronormative citizenship:

If an uncircumcised man has a house, wife and children, and a circumcised man have the same things. I think it has to be about how you satisfy a woman [sexually] *and how you represent yourself in the community. I think the whole important to men about removing the skin is having that vuvuzela* [instrument that makes a loud noise] *in your mind that tells you that you have circumcised and you are a man now.* (P8)

Circumcision doesn't define manhood at all. Masculinity these days has a totally new definition. In the olden days you had to go to the mountains and struggle for a long time. There are many successful men that we look up to that are not circumcised... the modern man cannot be defined on his penis or foreskin. He needs to show masculine qualities of being a good provider and so on. (P10)

Participants reflected on how modernity has altered traditional *performances of masculinity*:

I think it is just the traditional thing, something that has been in the history something that has been valued and it is brought to the 21st century it becomes a confused issue. People are more liberal. It is very convoluted because what made you a man then is not what makes you a man now. Now its money, big house, nice car and not the foreskin and circumcision. (P9)

Participants considered traditional constructions of masculinity in terms of the heteronormative agenda:

Women would seek men for their survival qualities and men would women for their reproductive qualities. In terms of being masculine, it should be someone who is able to provide for my wife, plant seed, be able to take care of our young. Foreskin or not...I can still ensure that all those things are seen too. So whether you have your foreskin or not, doesn't have anything to do with masculinity. (P25)

I think they [men] *are all the same; it is the matter of your personality whether you are a man. Whether you are circumcised or not, it is still the same thing, it is just how you view life, people around you and how you socialise; I think that what determines what a lesser man is.* (P11)

P11 does, however; mention that socialisation regarding hegemonic masculinity is part of traditional MC:

> *In the past, it was always about going to initiation school. In initiation school you get to leant about manhood, how to treat people, women, you get to learn about the society and socialising and that is what makes you to be a man. Being circumcised is just part of the process.* (P11)

Participants from non-circumcising traditions did not see circumcision as a *performance of masculinity*, but rather regard masculinity as an adherence to other typical hegemonic characteristics and behaviours:

> [...] *we have seen uncircumcised men who are more matured than those who are circumcised, and we have seen those who are circumcised behaving like lunatics. So it* [circumcision] *doesn't have any significance, it's all about mental maturation it's not about circumcising.* (P13)

> *No I don't think circumcision will define someone as a man; man is defined by his choices and what he stands for. A man who is circumcised and a man who...is not circumcised can both make bad choices, and act in a not manly way and not take full responsibility.* (P9)

For P25, masculinity is measurable in the context of one's ability to attract a female sexual partner. This, for him, is unmistakeably related to the presence or absence of a foreskin, since he thinks that women are less likely to select an intact man as a sexual partner. He says, "[...] *some women will tell you straight that "I don't have sex with a man with foreskin at all, condom or not, I don't care". It's dirty because it collects things and what not*." Thus for some men VMAMC may be selected not as a measure for actually preventing HIV infection, but rather as a way to increase the likelihood of successfully finding a sexual partner.

In considering their possible responses to their intimate female partner requesting them to consider undergoing VMAMC for HIV prevention, P8 says "*my response will be negative, I will rather say no because I will be losing my value of being proudly man as I am now*." P15 considers his position on the role of women in men's health saying, "*for me it will be something new for men. I will argue on that one with her because it's my body and my life.*

She can't really tell me that I need to be circumcised." Here P15 indicates that a female partner offering input regarding men's health would be novel and unexpected.

Despite claiming to not subscribing to any prescriptive norms regarding *performances of masculinity*, P25 responds in an almost stereotypical male way when he says that, "[...] *being a man, I would say no* [to his female partner suggesting that he undergo a VMAMC for HIV prevention purposes] *because pride and what not*."

Higher conceptual levels of *performances of masculinity* in the data coding and analysis revealed two dichotomous mechanisms that were favoured in the performance thereof in relation to VMAMC for HIV prevention. There were: 1) adopting active agency in the fight against HIV in South Africa; and 2) the *performance of masculinity* in the maintenance of traditional practices. For these participants, meaning is attached to the way that VMAMC either buffers or diminishes masculinity and manhood. These are outlined below.

4.7.1. HIV-fighting agent.

Reporting taking on the role of an active agent in the fight against HIV in South Africa was a common occurence across the data set. For example, when asked if circumcised men or intact men were more masculine, P13 seems to have assessed *performances of masculinity* that are aligned with VMAMC and HIV prevention when he says "*according to the information I have gained, circumcised men are better off than uncircumcised men in terms of being at risk of getting infected with HIV, with the reason that there are diseases especially STDs that uncircumcised men get.*" P15 regards VMAMC for HIV prevention as having value as a *performance of masculinity*, "[after having a VMAMC] *you will see yourself as man enough and at a lower risk of getting infected*."

P23 also equates masculinity with being an agent of disease prevention when he says, "*I think those who are circumcised are more of men because they are safe from diseases*." Likewise, P24 assigns meaning to VMAMC in ways that highlight his masculinity, "*a real man makes the right decision and if circumcision means that he won't get HIV then, he must do it*." In follow-up interviews, after having a chance to read the pamphlets regarding the research on HIV prevention and VMAMC, participants often reconsidered personal and traditional meanings of VMAMC and tended to speak about VMAMC in a more positive way than in the initial interview:

> *Different cultures, most cultures will go with this whole circumcision thing because as I said that earlier time that most South African cultures go with circumcision. And most Zulus must do this circumcision, which tells us that they do announce circumcision as a possible way of reducing HIV/AIDS.* (P1)

In this case, when individuals are perceived as placing the needs of the many above their own, the collective (most often the community directly involved) may recognise this and reward the actions of this individual with increased social standing and influence in the community. Throughout his interview, P4 seems to have high regard for VMAMC-based public health intervention for HIV prevention. He says that "*Yes I would* [undergo VMAMC] *because I want to save our country; I want to reduce the number of HIV infection in our country*." It seems as though he has adopted the role of HIV prevention-agent and that, at least for him, this offers him a new way of performing masculinity (since he would not have been able to achieve masculinity through traditional MC, which is in opposition to his non-circumcising traditional structures).

While being opposed to all forms of MC and insisting that he will not undergo VMAMC for HIV prevention purposes, P6 says, "*We need to take care of our country to reduce the number of HIV infection by getting circumcised*." It would seem as though, while not wanting to participate in VMAMC interventions himself, he feels that he is part of the collective of men who he regards of caretakers of South Africa by undergoing this HIV prevention intervention. P14 makes constructive meaning of VMAMC in relation to his ability to fulfil his role within his family, "*I don't see anyone who does not want to live an elongated life with his family. This disease affects everyone in South Africa*."

In the case of HIV prevention through VMAMC, the state relies on education strategies to shift the responsibility of public health onto the individual by speaking to the agency of the individual and how it is in their best interests to promote their personal health by actively supporting disease prevention strategies. Participants compared HIV-preventative behaviours to lifestyle behaviours to prevent other diseases:

> *If you have diabetes, you have risks of the same opportunistic infections that you going to get in HIV. You're going to lose your feet;* [...] *get erectile dysfunction;* [...] *lose your eyes. You're going to die from HIV as much as you can die of diabetes if you don't look after yourself. You can't force people to look after themselves; it's not anyone's job but yourself to look after yourself.* (P29)

However, other participants felt that some South Africans may not be adequately acknowledging the gravity of HIV pandemic:

> *I think we're becoming hyper-acute of the HIV pandemic but we still aren't taking it seriously enough and I'm not sure that many people will go out and say "let me get circumcised because I don't want to transmit HIV", whereas when it's done for cultural or religious purposes, they often don't really have a choice or they're embracing that choice quite openly.* (P26)

This data extract is critical to understanding VMAMC meaning-making in the context of HIV prevention. Here P26 believes that VMAMC will not be a priority for men in South Africa, given that HIV prevention is not a primary concern and that traditional MC will continue to trend over VMAMC. This is unpacked further in the following section.

4.7.2. The prioritisation and maintenance of tradition.

In the data extract above, P26 thinks that traditional MC will continue to be practiced (more than VMAMC) due to two reasons. The first relates to autonomy and action, whereby he believes that in consideration of traditional MC, men are not able to act with agency against traditional structures. This may be due to the resistance that they might come up against from their families and communities if they attempt to favour VMAMC over the practice of traditional MC as a rite of passage. The second reason for the preference of traditional MC over VMAMC is the maintenance of tradition. Here P26 indicates that men will willingly embrace traditional practices and wish to adhere to these traditional structures rather than change these practices to slant towards medical philosophies regarding the body and disease prevention. For example, P9 says, "*I think it* [MC] *will have more value to have it for cultural or religious reasons than for HIV prevention.*"

Participants who came from a circumcising tradition generally regarded this as more important than VMAMC for HIV prevention:

> *Protection as you has said before you still need condoms to practise safer sex because it is not 100% safe. If you do circumcision for cultural or religious purposes it's a good thing and it actually boost you morally and your self-esteem. People around you tend to view you in a respectable way.* (P1)

I believe that P26 is speaking to the inability of VMAMC to compete with traditional MC practices that have longstanding historical, social, cultural, and personal significance to the men who come from traditionally circumcising backgrounds. The data indicates that this plays a crucial role in VMAMC meaning-making, which should be considered by those involved in public health as this HIV intervention moves towards upscaling throughout South Africa.

For participants who come from a traditionally circumcising background, failure to perform one's masculinity through traditional MC results in the perception that such an individual is not a real man, regardless of his age and social standing. P19 reflects on this when he says, "*we are all equal but in some cultures when you are not circumcised you are not considered a man, you are considered a boy.*" P17 highlights the importance traditional MC, "*the meaning to me its manhood because after initiation school you are treated like a men and you can do things done by older males.*"

The importance of maintaining tradition regarding traditional MC or non-MC was noted across the dataset. P4 speaks to the importance of adhering to traditional practices of penile modifications (to circumcise or not circumcise) as it informs masculinity and patriarchy, "*if us men do not follow our history, then we cannot teach our sons to be real men too. It would be bad man.*"

As a self-identified Xhosa man, for P15 hegemonic masculinity is attained through traditional MC: "*to me, it's a manhood stage, besides anything. If you want to be man you have to be circumcised in my culture*." After the interview this participant spoke to this again briefly when he told the interviewer that a boy who rejects traditional MC practices is not welcome to visit the homelands because of his uncircumcised state, nor will he be allowed to marry a Xhosa woman since he cannot negotiate *lobola* (payment of wealth bride) with her family, as he is not a man (Ansell, 2001). P20 confirms this, "[...] *in some cultures like Xhosa when you are uncircumcised no matter how old you are or have any kids, you are a boy*."

Furthermore, the importance of maintaining tradition was noted throughout the dataset as participants tended to show regard for each other's traditional practices, despite such customs being considerably different from their own. Although not necessarily wanting to undergo any form of MC himself, P9 respects the cultural value of traditional MC, "*I am ok with male circumcision since it is part of people's traditions all over the world*."

The participants indicated that the introduction of VMAMC challenged a man's ability to maintain his traditional practices regarding MC or non-MC. P18, who says that he is Zulu, insists that traditional MC is not practiced in his culture and that he will not go for a VMAMC to reduce his risk of HIV in case "*people might think that I did it for culture, and that would be wrong, so...*[shrugs]."

The notion of cultural identity and the significance of the present or absent foreskin is one of interest, considering that traditional practices and norms are subject to an evolution of their own. Other Zulu men reflected on how traditional MC is not part of their modern culture but how it used to be practiced hundreds of years ago. P4 says, "*I think all cultures do support male circumcision because when we grow up as boys we used to go to the mountains and then the elders will do the circumcision on us themselves*."

However, P16 considers how other Zulu men may react to VMAMC since they do not currently practice any form of MC, "*in my culture we don't practise male circumcision so for them it will be difficult to digest such issue and hence they will react in a negative way*."

Thus, in accounting for the basic social problem regarding *performances of masculinity*, the data showed that two (competing) actions were central to them being able to feel, and show others, their masculinity. These two key actions (uptaking VMAMC for HIV prevention or rejecting VMAMC in favour of maintaining traditional MC or non-MC practices) rival each other and are, therefore, the basis of the core category of this GT (*tensions between tradition and medicine*). The data showed that participants sought to negotiate these tensions, which constitutes the basic social process of this GT.

The section that follows addresses the basic social process, which includes an analysis of relevant data regarding participant responses about the maintenance of the traditional practices and customs embraced by their families, while at the same time having to consider novel medical innovations that can help South Africans in the fight against the HIV pandemic.

4.8. The Basic Social Process: Negotiating Tensions between Tradition & Medicine

Public health interventions do not exist within a vacuum, as they exist at the intersection of socio-political history, religious rites, customs, cultural and social norms. *Negotiating tensions between tradition and medicine* (as catalysed by *pluralism* within the *performance of masculinity*) was identified as the basic social process in this GT.

Contextual conditions, as described earlier in this chapter, influence the basic social problem of *performances of masculinity,* and reactions to the basic social problem ultimately influenced the ways in which participants believed that masculinity should be performed when considering the HIV pandemic in South Africa as well as an adherence to traditional practices. Participants often took an initial stance on traditional or medical MC relatively early in the interview:

> *I don't have a problem with* [medical] *male circumcision as long as it does not interfere with your culture...It is right for preventing* [HIV] *as long as it doesn't undermine other people's traditions and cultures. I do not see a problem if people will still be able to continue following their culture.* (P22)

Other participants felt that HIV should be prevented at all costs and supported the implementation of VMAMC for HIV prevention:

> *I would say that culture has been there for a long time. They have done it* [MC] *as a culture for cultural purposes and they've done it for religious purposes. Then now it's time for everyone to do it for health purposes. It's the basic thing; it's like a need to almost everyone these days because circumcision helps one.* (P28)

The data showed that this basic social process, while most notably critical for participants who practice traditional MC, was also relevant to all participants, as non-circumcision is, in itself, also a traditional custom. The participants, regardless of age, culture and level of education, clearly articulated some of the tensions that are salient in the medicalisation of a typically traditional (cultural or religious) ritual for South African men. In order to better appreciate the relevance of tradition to this basic social process, I found it essential to address the meanings related to traditional MC and non-MC practices.

4.8.1. The relevance of tradition.

MC has been traditionally been constructed as an act of cultural transition, whereby the cutting or marking of the male body symbolises the shift from childhood to adulthood (Kepe, 2010). Tradition has ways of conferring hegemonic masculinity, which is typically done through initiation rites such as traditional MC. This is, of course, culturally-bound, as P8, who is from a non-circumcising tradition says, "*I will feel less of a man if I am circumcised*." Other participants who also came from non-circumcising traditions felt similarly:

> *I don't think being circumcised makes you any different, I don't think less of them* [other men] *if I do find out that they are or they aren't* [traditionally circumcised]. *And the same applies to my patients that I've seen are circumcised, it really makes no difference to me.* (P26)

Each of the participants commented on a culturally-sensitive respect for the value of traditional MC, even those who have not been traditionally circumcised:

> [...] *it's basically manhood, it's making you a man, you would stand the pain, stand infection, the environment you live in the bush. You are eating food that hangs off a tree, burnt on a fire. You are not supposed to drink water because it promotes urinating movements and what not, so all these different dynamics add up to make you a man and it's all gruelling.* (P25)

Participants reflected on this, saying that it is the process of traditional MC as being part of the rite of passage (and not a stand-alone act in itself) that carries the value regarding masculinity:

> *It's probably the process they go through, I can imagine. You know, like, the cultural differences. I know it's a lot more than not having a foreskin. I think it's sort of the rite of passage that they go through. So it's probably more the experience than not having a foreskin.* (P26)

> [It is] *all about being a man. At initiation school they put you under harsh conditions, whereby you can see that here I can take full responsibility. The lessons that we get change us and after coming back from the initiation school you come back as a changed person.* (P11)

> [...] *being circumcised is part of manhood in our culture that is the basic importance. In initiation school they teach you about self-discipline, self-respect and respect, which is the basic importance of being a man.* (P15)

However, P25, who was medically and not traditionally circumcised, speaks to genital cuttings as having limitations regarding hegemonic masculinity (so as to attract a sexual partner) for the benefit of others, "[...] *if you chose to concern yourself about your foreskin, you going to work with a chip on your shoulder and you are the only person who knows whether you have a foreskin or not*."

P26, who also comes from a culture that does not traditionally circumcise, says, "*if you take people at face value, I mean the people walking around, you can't tell whether they're circumcised or not.*" However, participants who identified themselves as isiZulu did not practice traditional MC, which has implications for VMAMC uptake:

> [...] *it* [uptake] *will depend on where they are situated for instances people in Eastern Cape, Umtata, will select* [VMAMC] *because they are already practising it as part of culture while in Kwa-Zulu Natal they might not because Zulu people don't practise male circumcision* [but] *they will select it if the advantages and disadvantages of circumcision are explained to them in a clarifying manner.* (P18)

Given the importance of tradition to the participants, the fieldworkers probed them as to their positions regarding the HIV pandemic and medical mechanisms that could stem and reverse the rate of infection in South Africa, and how this weighs up against their existing traditional customs.

These probing interview questions often compelled participants to try to resolve the tension that exists between tradition and medicine, as they see the medicalisation of MC as legitimate in the face of the risks associated with traditional MC. This was attempted in a number of ways, one being the marriage between VMAMC and the traditional practice of MC as some hybrid-type intervention.

4.8.2. The traditional-medical hybrid of MC.

Participants saw a resolution as they suggested that medical MC can be a mechanism that traverses the basic social process:

> *Everyone has their own opinion and own practises, you are going to find that people are not going to be having the same view on the matter. There will be conflicts around religious people but if everyone gets circumcised in the hospital I don't think that there is going to be much a problem. But if they use their original or ancient ways of circumcising like initiation school. That is where the ideas will clash.* (P11)

> [...] *it* [VMAMC] *won't be any problem considering the fact that the Western community just realized the importance of circumcision, so Africans had already been circumcising from long time ago so to them it won't make that much of a difference* [if traditional and medical MC were combined]. (P2)

> [...] *different cultures and religions will agree with using* [medical] *male circumcision as a way of preventing HIV because they can see that a large number of people are getting infected and dying from HIV. They will also understand because most cultures and religions still practice the culture of male circumcision and those who don't* [practice traditional MC] *will understand because is for their own good.* (P19)

P13 feels the same as he says "*yes it will take away such perceptions of saying that a man who is circumcised* [traditionally] *is more of a man than the one who is not, because it causes conflict within a lot of cultures*."

It should be noted, however; that participants seek to have the traditional ritual remain the same, but simply to have the actual circumcision performed by a medical practitioner. It is important to note that these participants do not refer to VMAMC for the purposes of HIV prevention in particular, but rather the medicalisation of the traditional rite. Participants reported an increase in traditional circumcisions taking place under medical conditions.

> [...] *in terms of the African culture that we mostly see in the hospitals now*. [...] *I think obviously if there is going to be a collaboration between them you going to have a better outcome. I do think that traditional rites of passage, traditional healers that perform it should be trained in some way and there should be a health practitioner purely because of the fact that we know that they mess up and things go wrong, so to prevent those. I think it's better and just by having a health practitioner there and helping with it, you are not obstructing or interfering with the cultural aspect of going through your right of passage. At the end of the day the kid is still get a circumcision and he still would have done before culturally to get to that point.* (P30)

> *Those people who perform male circumcision at initiation school they are not taught properly how to cut the skin in the safest way. People just do it for the money. What I suggest that people who wants to do male circumcision for traditional or cultural reasons during the procedure of cutting the foreskin there should be a doctor present to supervise to ensure safety of this young men...at least they could be provided with equipment that is safe and sterile.* (P19)

> *Most people still believe in their culture, it would be much wiser if we could try teaching those traditional surgeons and those who take care of the boys at initiation school, it the modern medicine coming together with traditional medicine trying to increase the knowledge they have to deal with such issues.* (P10)

While the proposal of a traditional-medical hybrid approach to VMAMC for HIV prevention may appear to relieve the tensions between traditional and medical MC, further analysis of this issue indicates that the process of pain, the conditions of circumcision, and the timing, are critical factors that need to be considered in order to consider the possibility of this hybrid intervention.

4.8.2.1. The process of pain.

Participants who traditionally circumcise indicated a desire for the rite to be medicalised:

> *If one goes to the hospital there is no pain but if you go to the bush pain, there is a lot of pain there in the bush; there is a lot of pain!! I would say that they must introduce the medical guys over there* [laughs] *to treat people over there because it's not well for people. I don't know how to put it because if you can just feel pain and knowing that there is nothing to do about it and you there, seeing that there is only one person standing there looking at you and telling you that this is the way of becoming a man. It is not the right thing. I think that there must be other ways, because there is a lot of pain there!* (P28)

However, the participants were often unable to reconcile the tension that exists with respect to the value of traditional MC being characterised by the endurance of pain during the genital cutting, versus this pain being largely absent during a VMAMC procedure. Since pain endurance is a relatively large component of traditional MC, it is tensioned against medical MC since the initiate should feel no pain during the medical procedure.

Student-doctor participants noted that patients should not be concerned about experiencing pain as a result of a medical MC:

> [...] *analgesics work really well* [laughs] *so in terms of that much pain no, when we use KZN you know the boys didn't actually feel anything other than pin prick when it first came in. I mean, you give them plenty of analgesics afterwards. I don't that will really… it's like saying that a woman shouldn't give birth because there is pain involved in it, that shouldn't be a factor I think.* (P30)

However, some participants spoke to the value of the entire initiation process (not just the circumcision itself) in testing the initiates' ability to withstand pain. P11 shares that, '*Yes it is all about being a man. At initiation school they put you under harsh conditions, whereby you can see that here I can take full responsibility. The lessons that we get the change us and after coming back from the initiation school you come back as a changed person.*' Thus the process of pain may be an issue that can be circumvented, making the proposed traditional-medical hybrid for VMAMC a possibility. Yet there are other conditions of these seemingly contradictory circumcision practices that need to be considered.

4.8.2.2. Conditions of circumcision.

The conditions required to ensure the protective value of VMAMC are considerably different to those that constitute the conditions of a traditional MC. For example, medical MCs are performed on individuals, while traditional MCs are performed on a group of young men. P22 refers to this, "*You find that when you grow up male circumcision is a way of showing your manhood. Like in Xhosa people, you find that you are a group of boys all being circumcised in the mountains*." Furthermore, medical MCs involve the participation of a number of qualified healthcare personnel, regardless of gender and traditional backgrounds. On the other hand, traditional MCs distinctly exclude the participation of men who have not undergone a traditional African circumcision. In order for traditional-medical MC hybrids to be feasible, one or both of the positions will be required to alter the conditions under which their MCs are performed.

Considering the inability of the medical profession to compromise its conditions of surgery and the unlikelihood of longstanding patriarchy in traditional MC to change, the viability of this proposed hybrid becomes improbable. This viability is also made questionable by the consideration of the timing of traditional MC versus medical MC (and particularly VMAMC for HIV prevention).

4.8.2.3. Timing.

A number of the participants felt that medical MCs should be performed on younger children. A student-doctor participant considered a discussion regarding the timing of medical MC and informed consent that he had with his medical peers:

> [...] *where people were talking about should male medical circumcision be done at birth or later. There is a lot of discussion about people who are circumcised were done when were really young, so they don't really have a choice in it or, for them it's just done, it is what it is.* (P30)

Another student-doctor participant also wondered about informed consent and if he would have made a different decision regarding circumcision if he had been afforded the opportunity (since he was circumcised as an infant). The matter of timing and informed consent are raised as issues here:

> [...] *sometimes I do wonder if I had a decision, what I would choose. So now, I'd like to still think I'd choose to be circumcised. But, well I think parents do have more of a right. I don't know so much that if the decision should only rest with them. But, I mean, then you'd have to wait until the child to get a bit older, then memories are involved, it's a tough one.* (P26)

Nonetheless, P26 speaks to how it might be better to circumcise South African males when they are infants, "*I think it's obviously better when done earlier* [there are] *less memories of the trauma, less pain perception*." He goes on to reflect on hearing from those who have been circumcised as adults enduring much pain and discomfort:

> *Some of the people that I've heard of that got circumcised later on report it as being very painful and obviously they were more acutely aware of that pain and the memory involved with that as opposed to those that had it as a young child or just after birth.* (P26)

P26 goes on to say that the fact that this intervention would target adult men is problematic, "*So I do think it would be a big deterrent and that's something that needs to be looked at. I mean nobody really wants to have sore genitals*." P28 also advocates for this intervention being performed earlier but more so because it should be done prior to sexual debut:

> *circumcision has to be done as for my culture* [...] *we do it at the age of 17, which is as far as I am concerned, circumcision is supposed to be done at a very earlier age because of the prevention it has*.

Nonetheless, while the medical profession tends to promote neonatal MC, medical MC for the purposes of HIV prevention has only been proposed to target adult males and is voluntary by nature, which implies informed consent. However, it could seem as though the issue of timing remains a concern for the proposed traditional-medical hybrid for VMAMC interventions. This is because the timing of traditional MC (even if it is medicalised) does not coincide with the timing required for VMAMC to be effective against HIV infection. Participants reflected on the matter of timing regarding VMAMC, sexual debut and risk of HIV infection:

> *I think that it's a two-fold problem because it's not the circumcision that is a problem; it's the fact that people are sexually active earlier. So an intervention probably be focused more at not having teenagers doing sex at 10, 12, 13 years of age. Medically I don't think they are psychologically prepared for the consequences they come with it but in reality they are doing it. So pushing circumcision to an early age. You know you got to weigh up is that person having an informed consent when they say let's do the circumcision? Whether it's medical or whether is a cultural aspect. So I think anything younger than 14 is starting to become a bit too young to. You know the intervention needs to be focused on the other ways also if you look at rates of HIV infection is not prominent in those age groups. It's very much your 18 to your 22, 27s that have the highest rate at the moment, So keeping in still at your 18, 17 age group currently where it is it will still work I think.* (P30)

During the interview with P21, the interviewer made the participant aware that there is not enough evidence to show that performing medical MC at an earlier age is effective in reducing the risk of HIV infection. P21 realised then that the timing of traditional MC does not overlap with the age at which VMAMCs are performed.

P21 noted this as a difficulty in presenting a traditional-medical hybrid approach to VMAMC, "*ja it's difficult, if we leave it too late, the boy could be infected already by the time he goes when he is older*."

> [...] *you will find that at this time most of the youth who are sexually active they are not circumcised because they haven't arrived to the age whereby they can be able to go the initiation school to get circumcised. That means that they will be at high risk of getting infected if they are doing circumcision for cultural purposes. It will be wise for us to get circumcised at an early age. If it would be possible for culture to change the way they do male circumcision... like instead of waiting for the child to turn 18 to take them for circumcision... I think they should take the child for circumcision as soon as they hit puberty, when you start developing feelings for girls.* (P21)

P12 considers the timing of traditional versus medical MC in relation to the average age of sexual debut in South Africa, saying that "*it depends on how clean the person's blood is because some people before they go to initiation school they sleep around and they get infected, when they are there they infect others through the process of cutting the foreskin*."

Tradition (within culture and religion) is a critical feature within South African society, whereby the performance of traditional rituals is seen as a way to preserve personal and collective identities within the context of medicalised modernity. However, the data shows that traditional practices are not impervious to change. A number of the participants referred to a time when traditional MC was part of the rite of passage for a young man as he becomes initiated into manhood:

> *I know that we have many cultures in South Africa, the way I know it male circumcision was initiated in the Bible ages ago. So some cultures like Xhosa chose to continue practising the culture of male circumcision but other cultures like Zulu put an end to it. The reason why male circumcision stopped in some cultures especially Zulu was due to the war during Apartheid. But male circumcision was generally common thing.* (P13)

> *In my village, in Matatiela, we have seen many* [Zulu] *people crossing from Zululand coming to Xhosaland in Matatiela, coming to do circumcision. Although they have not yet pronounced themselves that they accept it, but Zulus are crossing to come and do that* [traditional MC]. (P27)

P27 adds that people from non-circumcising traditions will amend their practices regarding traditional MC if this change is endorsed by their leaders, "*Maybe if they* [Zulu people] *say that their king must do it* [traditional MC], *maybe it will be simple and accepted, and then everyone will do it. Until the king is doing it, the problem is there* [laughs]." P28 also says, "*There are guys friends of mine who once said that when the king pronounced the fact that everyone should circumcised, they said if he can do it, they will follow him*."

This is remarkable since it speaks to the ability of traditional structures to change and evolve over time (particularly if this change is advocated by traditional leaders). In consideration of HIV prevention in South Africa, it may be of particular relevance for public health practitioners to encourage traditional leaders to buy into the protective nature of VMAMC, thus relying on these leaders to promote changes in traditional structures regarding traditional MC or traditional non-MC to make meaning of VMAMC in a constructive way during the upscaling of this HIV prevention intervention. Participants suggested that traditional leaders need to be educated about VMAMC:

> *We need to educate traditional leaders. We need to educate isibonda* [villagers], *isinduna* [leaders], *ichiefs* [chiefs], *all who are at that level to mention about this* [VMAMC], *that this* [VMAMC] *is happening. But the culture, because it* [tradition] *has changed now, it seems, according to me even traditional leaders, they are also going to school, so they are well aware of the developments there. It doesn't mean that because you are a traditional leader, you don't go to school. They are well-educated as well, so it becomes easier to implement it more because they are also educated as well that they can implement such strategies.* (P27)

P19 believes that if Zulu men started to practice MC it would be "[...] *basically returning to our ancient cultural practises. Everyone was practising male circumcision ages ago during the time of Shaka. Some cultures decided to stop because they afraid that they would attack while they were there at initiation school*." On the other hand, P20 says that he would have his son medically circumcised to reduce his risk of HIV infection in the future because, "[...] *we could return back to the time of our ancestors to practise our cultures*."

The participant is reminded by the interviewer that the procedure would be under medical and not traditional conditions. As a significant proportion of participants from non-circumcising traditions spoke favourably about restoring ancient traditional MC to their traditional customs, this may be something worthwhile to consider in public health messaging regarding VMAMC. P24 says of VMAMC for Zulu men, "*we will be returning to our heritage and culture, which was practiced ages ago. Circumcision is not a modern thing*." This sentiment is an important one since it introduces a new way of considering VMAMC for members of the public who do not currently practice traditional MC. Core tensions seem to arise when participants consider VMAMC as a 'modern' concept that challenges tradition. If public health messaging can present VMAMC as something that is not necessarily 'modern' but rather more closely related to historical traditional practices, the public may make meaning of VMAMC as an intervention that does not necessarily stand in opposition to their traditional practices.

While the rituals may shift with social, economic, or political trends, the tradition of MC seeks to continue the privilege of males and masculinity over females and their values, meanings and culture. This is at odds with modernity, particularly in urban areas of South Africa. This predicament was identified as the underlying causal condition of the GT, and as such, *the crisis of medicalised modernity* is addressed in the section that follows.

4.9. Causal Condition: The Crisis of Medicalised Modernity

As previously stated, the participants indirectly referred to modernity as being the underlying cause of the tensions that exist between tradition and medicine. There was either a general longing for what P2 refers to as "*the olden days*", where traditional structures were untouched by modernity, or the participants spoke about modernity as improving various aspects of their daily lives. With modernity there has been a strong focus on the relevance of medicine in improving the everyday lives of people (since it generally increases longevity and overall well-being). For example, P13 considers the introduction of medicalised traditional MC as preventing critical injuries and deaths of young initiates who are going through the traditional rite of passage into adulthood. For the purposes of this study, medicalised modernity is defined as the modernisation or the gradual progression of a society from 'pre-modern' to 'traditional' and finally a 'modern' state, whereby medical science has played a key role in this social development.

Although this definition may appear to locate medicalised modernity as a linear structure, it does not preclude the theoretical and practical understanding of a developmental condition that occurs in a non-linear fashion. Thus the increasingly feature role that medicine seems to play in society emerged as the causal factor for the tensions between tradition and medicine in considering HIV-prophylactic VMAMC meaning-making, as participants reflect on the focus on the male body as a site for disease prevention (via permanent surgical modification).

During modernisation there is increasing focus upon medicine within capitalism, urbanisation, globalisation, industrialisation, secularisation and rationalisation (Larouche & Potvin, 2013). Regardless of the individual participant's position regarding tradition or modernity, almost all the participants noted that the advent of HIV has compelled them to consider medical interventions that do not neatly adhere to their traditional practices and customs. As such, the key example of medicalised modernity for this study is the medicalisation of traditional circumcision, but also the medicalisation of MC (VMAMC for HIV prevention) in ways that are seemingly contradictory in meaning to those ascribed to the traditional African rite of passage. The participants referred to how traditional practices (such as MC) have become increasing medicalised and how citizens would generally approve of medical public health interventions in consideration of the HIV pandemic:

> [...] *they* [South Africans] *will agree* [with VMAMC] *because the methods that are used at the hospital are 99.9% accurate in terms of preventing HIV and AIDS. There is no other African who wants to contribute to the population infected. We must use every alternative that we have medically to fight HIV.* (P7)

P2 comments on how traditional MC has become medicalised by saying "[...] *I think it's just an indication that society has moved from doing things the olden way, you see in the olden days the community used to have a person who specialised in circumcision*." P4 believes that modifications to the body should be medicalised, "*I think they* [traditional MC practices] *should stop. Those circumcising at the mountains...they should support circumcision that is performed at the hospital, because it is safer*."

The participants reflected on how modernity has impacted traditional structures related to masculinity, parenting, intimate relationships, personal identity, and most relevant to this study, health and disease prevention. For example, participants referred to how modernity has altered traditional meanings of masculinity and the performance thereof:

> *I think it* [circumcision] *is just the traditional thing, something that has been in the history something that has been valued and it is brought to the 21st century it becomes a confused issue. People are more liberal. It* [*performances of masculinity*] *is very convoluted because what made you a man then is not what makes you a man now. Now its money, big house, nice car... and not the foreskin and circumcision.* (P9)

> *Due to modernisation it is turned into various different things. I have to have the biggest car, the biggest house, I have to have social proof, I have to be respected amongst people, I have to present leadership qualities. At the end of the day that influences the woman's perception of my masculinity, at the end of the day, that is what masculinity about, attracting a woman.* (P25)

Participants considered how medicalised modernity has changed the ways in which boys and men think about their bodies (in particular the penis):

> *I think the whole culture where we are shifting toward people's genitalia and private areas are their own, the fact that even kids shouldn't bath together, siblings like that, it's a cultural change, and we are trying to protect people because of the rate of paedophiles and things that are out there. We are trying to protect kids so much that people are almost internalising everything, they don't discuss their private areas in general. I think that's the biggest problem. People are not open about it.*' (P30)

Modernity was alluded to in the interview data as participants considered the urbanisation of various parts of the country. Here participants reflected on how modernity has widened the tradition-modern gap between people residing in rural and urban areas of South Africa. Participants spoke about the differences between traditional MC for those who live in urban and rural areas:

> *It's all about culture and where you are located for instance if you grew up in townships and you know that your father did not go for circumcision, you will not go either. In some culture some do it and some don't. For example; us moshweshwes, we don't do it because we grew up in townships. Just like me my father never told me that he did it so I never did it, and I never force my kids to do it will be their choice when they grow up.* (P16)

> *I think again it's going to be different whether you're in an urban environment or rural environment. Rural environments tend to be more traditional and traditional reasons would be stronger than the medical ones but in a city like Johannesburg where everything is like cosmopolitan a lot of people are losing their traditions.* (P29)

Here P29 highlights that during urbanisation, tradition seems to recede to make way for medicalised modernity. He went on to say that traditional structures have already buckled under the strain of medicalised modernity, and that the reasons underpinning MC in South Africa will primarily be medical "*as long as its offered widely enough and advertised widely enough, then I think it will catch up, it will work*." Participants addressed the 'inevitability' of medicalised modernity filtering into traditional practices:

> *Yes, you see when it was done, I was young, and I was a rural boy. I've learnt through the traditional way. But now that I'm medically orientated knowing matters of hygiene will need to be improved, that's number one. Number two, it must be done by a qualified person, because in the past, yes we have qualified people, traditionally, but you know they cannot produce anything that is a certificate or otherwise. But if it's done by a medical doctor, there's always recourse for a person that could be have been harmed in the process.* (P27)

> *If a person has been harmed in the process, he can always know that he can go the legal route and the doctor can be sued and he'd have to pay it. But, the way it was done previously, it was that there was no guaranteed security that if someone has done it wrongly, then he'll have to pay for the damages that could've been caused. Especially now that in our time, we see so many people that have lost their penises because of the old way of doing things.* (P27)

The participants often referred to western medicine when they spoke to medicalised MC. The *crisis of medicalised modernity* may thus reside in the understanding that medicine is a 'western' concept, which (for at least some participants) implies non-African or anti-African. For example, P1 refers to traditional MC and medical MC as being "*the western way*." P2 says that, "*the Western community just realised the important of circumcision so Africans had already been circumcising from long time ago*."

Modernity is often regarded as being part of westernisation, as a number of western institutions (such as modern medicine) are introduced to 'traditional' societies, where the adoption thereof either does not make sense in the existing culture or is viewed with general suspicion and fear. Some participants spoke to the fact that some members of the public may reject any medical HIV prevention strategy because of this. P1 says, "*Actually I can't say that I support it because I've never seen any written evidence that says that male circumcision can prevent the risk of getting HIV*."

This statement indicates that the public requires proof and scientific evidence that supports public health claims of VMAMC preventing HIV. However, given the longstanding historical significance of traditional practices regarding MC or non-MC, men seem satisfied to rely on anecdotal evidence from their communities, families, and peers regarding the value of maintaining such traditional practices. P7 indicates that, "*I think they will feel that their religions and traditions are brought down. I mean these methods they have been using it for ages and the medicine has developed in a rapid way*." Public health practitioners may need to bear this in mind as they introduce a novel HIV intervention to a public that holds time-honoured meanings of traditional MC (or non-MC) that VMAMC seems to contest.

Participants felt that people from traditionally circumcising backgrounds would make meaning of VMAMC for the purposes of HIV prevention as an intervention designed to further compromise the significance of their traditional practices:

> [...] *the moment any medical connotation is attached to it* [male circumcision], *it loses itself intensity and its value* [...] *the people who actually do it, they are old fashioned* [...] *once they hear something that has to do with medicine, they just automatically switch off and they are not interested.* (P25)

> *In the olden days, all the religions used to practise MC* [...] *In the Old Testament, if you were not circumcised, you were not allowed in heaven but in the New Testament all that changed. Some people will only want to have circumcision done for religious reasons and will never want that reason to change.* (P10)

However, with the increasing medicalisation of society, medical MC (or at least the medicalisation of the traditional rite) was regarded particularly favourably. P7 says of medical MCs, "*the methods that are used at the hospital are 99.9% accurate in terms of preventing HIV and AIDS*."

Participants referred to the reports of botched traditional circumcisions as they considered regulation of traditional practices through medicalised modernity:

> *I think to a certain level control is necessary because if you look at the traditional healers they also have governing body now because of various crimes they can commit. It is necessary to get cultural circumcision managed but not as hands on as government normally does.* (P25)

> *I also believe that culturally is the best but* [...] *it needs to be improved because of the hygiene. There is no hygiene at all and* [...] *one is not supposed to drink water for a certain period of time, that's dehydration. Now that I am clear of such things I don't think it's the right thing* [...] *So, that's why I am saying if ever they might involve the department of health on the circumcision while it's being done culturally, but they must also involve the department of health.* (P28)

In an effort to counter the impact of medicalised modernity on tradition, some participants indicated that their sons would have no choice but to adhere to the participants' traditional practices regarding MC:

> [...] *you go through the cultural way it's not only initiations; there are so many things that are taught to the person to make him into a young man. So he'll* [my son] *have to go* [be circumcised] *that way. But cultural way must be improved upon by involving qualified people to assist. But cultural way is the best. Not the hospital way*. (P27)

This statement shows *the crisis of medicalised modernity* for P27 since he so strongly advocates for the medicalisation of traditional MC (as well as VMAMC for HIV prevention), however; he will insist that his son continue the practice of his traditional customs, which seems to be more important than disease prevention (in the form of VMAMC).

South African efforts (particularly in the Eastern Cape where the majority of traditional MCs are performed) to integrate VMAMC with traditional MC, such as introducing the Tara Klamp (a VMAMC instrument that significantly reduces the risk of penile amputation) into the ritual of cultural MC, have been largely unsuccessful due to the lack of support for its utilisation by traditional leaders (Kepe, 2010; Peltzer & Kanta, 2009).

In fact, participants considered the recent increase in botched traditional MCs as being a sign of medicalised modernity:

> *I think it's just an indication that society has moved from doing things the olden way you see in the olden days the community used to have a person who specialised in circumcision. There were no incidences where there were these bad circumcisions and stuff like that so government needs to take better control of this whole thing and start instituting safe and more hygienic ways of circumcision.* (P2)

> *Well when you see what is happening at some initiation schools, it is a very cruel and heart breaking issue. This did not happen during the time of our ancestors because the person, who used to perform the procedure, cutting of foreskin, was trained and also experienced. I have heard that about 15 to 30 boys had to have their penises amputated because they have been badly damaged from initiation school.* (P15)

Traditional MC remains discordant within dominant western traditions (such as medicalised modernity), even for those that embrace MC in its medicalised form (R´oheim, 1942). Participants reflected on medicalised modernity within tradition:

> *I suspect that people are still quite traditional and...they won't...I don't know, I suppose it's a toss-up between the tradionality, not wanting to turn circumcision into a medical procedure as opposed to a traditional procedure but at the same time people are scared of HIV and if you tell someone that this can decrease your chances of getting HIV, I think it will probably be quite a successful programme. I think, I think people will react positively to it.* (P29)

> *Preventing HIV it is our main goal and we are trying by all means to make sure to keep the numbers minimum and which is kind of difficult. We try to incorporate as many things as possible but it is not going to make everything better it has to be a process in which people learn and know that what this is all about and know that percentage it is not that high of them reducing their chances of getting infected.* (P10)

> *I agree that circumcision is important, but it needs medical intervention. The way it was done before, it was traditional without consulting the western way of life. Now, for us to save lives, we need to involve the western-trained people: doctors, nurses, especially those, so importantly so, all those who have gone through the same process. So take the same people that are qualified, who have done the traditional way, to be the one assisting there, and then it will improve the life of the humankind in South Africa.* (P27)

Participants reported on the various benefits of medicalised modernity, and proposed that VMAMC be integrated with the other traditional customs that act as a rite of passage for young men into adulthood:

> *What's important is that the government and the traditional surgeons, the ones at initiation schools, should sit down and state their differences concerning this issue in such a way that the procedure of circumcising is performed at hospital by a doctor then after the recovery from the surgery the child is then taken to initiation school where he will be taught. Because the circumcision done at hospital is safer than the one done at initiation schools* [...] *there it is cold, unhygienic and they use the same instruments for every young men and also the traditional medicine that is given to them it's not safe some of them.* (P13)

> *I think at initiation school there should be someone to supervise the procedure to ensure safety since people insist on doing male circumcision at initiation school. People at initiation school should agree to work with doctors hand in hand.* (P20)

> *Government should be involved 100% in male circumcision and the teaching of inkatha and ingcibi, the people that are responsible for the surgery itself in the bush. Those guys need to be educated thoroughly. The ways of living in the bush is not appropriate, we have to teach those guys how to do the things to avoid infections because the only thing that is killing people there is infection. Control infection nothing else.* (P28)

Yet, participants also considered the tensions between traditional and medical MC:

> *I think it's going to be received with mixed feelings. And also, I think the cultural differences are also going to play an important role, you know. Some groups will readily welcome it. Some… not so much.* (P26)

> [VMAMC] *is right thing to do but the way that it's been done. If the government can come up, mix up with the traditional groups, talk with them and put up a protocol and say this is the way this should be done for prevention and control of infections because what we are seeing today, it's exactly what is quite detrimental to the lives of our kids. So many people are dying* [...] *because of the process the way it's done is no longer safe at all* [...] *you might find that they will be cut the glans itself instead of cutting only the prepuce. So that's why I'm saying putting the control all by the government and ingcebi should be trained, they should know how to use this thing. In our place, one knife was used, they will simply wipe it without sterilising it, they wipe it and then cut the person next to you, which is for me there is no control and prevention for infection in the whole programme but it's truly need by each and every other male guy to be circumcised.* (P28)

However, participants also considered the gap between tradition and medicalised modernity as shrinking:

> *I do know that traditional healers in Limpopo, Mpumalanga areas are becoming more and more involved with the medical community. I know there is a traditional healers association that is formed that considers itself to be just another arm of medicine and the idea is that traditional healers should have his place and a medical doctor have his place and they should be able to work together that is the idea. There is still a lot of animosity between the two groups of people obviously but it's getting there. I do think it can be brought in.* (P29)

Given the difficulties with managing the crisis of medicalised modernity, participants thought that successful implementation of VMAMC should start targeting children, who may be more willing to embrace medicalised modernity over tradition:

> *So get to the kids while they are still young, start explaining to them, start building that belief in the, like how they took out the whole racism belief, its total impossible to get rid of it from the older generation. It's the kids who can't tell the difference between a black person and a white person and from that level onward we get a better generation and a more tolerant generation of each other so same method will work for circumcision* [for] *HIV and AIDS. I reckon more resources should be thrown towards the kids... because most of adults are dying of AIDS anyway.* (P25)

As noted previously, a number of participants proposed a traditional-medical hybrid approach to VMAMC:

> *Most people still believe in their culture, it would be much wiser if we could try teaching those traditional surgeons and those who take care of the boys at initiation school, it the modern medicine coming together with traditional medicine trying to increase the knowledge they have to deal with such issues.* (P10)

However, in analysing the conditions that underpin the basic social process of negotiating tensions between tradition and medicine, it was found that this may not be a pragmatic or ideological solution to these tensions.

In an effort to manage the causal condition (*the crisis of medicalised modernity*) of the basic social process, participants employed both explicit and implicit emotion-based strategies. In addressing these strategies, public health workers may be better equipped to manage the tensions that arise when implementing the systematic medicalisation of a traditional rite, which carries a unique significance for the individuals who practice this traditional ritual, as well as VMAMC for HIV prevention.

It emerged from the data that participants relied on explicit strategies to manage the tensions generated by the crisis of medicalised modernity, by indicating that existing HIV prevention strategies were sufficient to address the HIV pandemic in South Africa. As such, VMAMC was considered to be unnecessary intervention, given that the participants believed that the A-B-C approach to HIV prevention was adequate and did not require the inclusion of VMAMC. By overvaluing existing HIV prevention interventions, participants were able to circumvent the tensions brought about by *the crisis of medicalised modernity* in the consideration of HIV prophylactic VMAMC.

4.9.1. Explicit strategies: Overvaluing existing HIV interventions.

Some of the participants confessed that while there are some conditions that merit paternalism, the context of HIV-preventative VMAMC was not considered to be such an occasion.

These participants, who largely opposed HIV-preventative VMAMC, continually referred back to the value of current HIV prevention strategies implemented in South Africa:

> *No I wouldn't go for VMAMC because it lies to yourself that because okay as I'm standing now I need to know to prevent myself from getting HIV there are ways of not getting of preventing HIV that we know that have been proven to be correct – 100% so I can only use the 100% ways of what preventing HIV and AIDS.* [...] *like abstaining and everything and then all of those ja*. (P1)

> *Most men think that when they are circumcised they are safe from HIV and then tend not to use condoms, in that way male circumcision is misleading men. The best way is to use condoms to be safe from HIV even if you are circumcised.* (P15)[...] *it means that when you come back you are not going to use other measures. So it is best to put that at back of your head or sub-conscious and know that it will help, but if you are going to use it as an excuse not to use protection then it will not help.* (P11)

P2 says something similar as he considers the personal uptake of HIV-preventative VMAMC, "*nah not really I wouldn't go through that process just because of I want to reduce the risk if getting of contracting HIV. There's condoms, there's abstaining...*" Similarly P8 says he will not undergo VMAMC, "*I will be bound to use contraception*." P6 says that he would not go for a VMAMC to reduce his risk of HIV infection saying, "*no because I don't only believe in circumcising* [...] *they must use condoms rather*." When the interviewer questioned this participant about the possible limitations of this, since research has shown that condom compliance in South Africa is somewhat inconsistent, the participant only responded with a shrug.

In assessments regarding the value of VMAMC for HIV prevention in relation to existing HIV prevention efforts, there are a number of conditions that would swing the outcome in favour of the benefits of VMAMC. To name only two: (1) if the prevention intervention was 100% effective; and (2) there were no other prevention methods available. The participants below considered that neither of these conditions is met, which is why the public may continue to favour existing HIV prevention interventions:

> *I think if we were talking about the fact that circumcising leads to 100% decrease risk of HIV transmission then government will have a role in legislating it, but the fact that condoms are a viable option, a really good option even when circumcised you still need to use condoms, then I don't think there is, just no ways.* (P30)

> *Well I support medical adult male circumcision... but as a way of preventing HIV transmission, I do not think they should put it in that way. Actually they should encourage people to circumcise but making it for preventing, I do not think it is a good idea, well... I don't know... maybe it is a good thing.* (P11)

When probed on this resistance to VMAMC for HIV prevention, P11 says "*because when you say that it prevents HIV then people will just have sex like wild animals and not use condoms...*". When the interviewer indicated that condoms are not currently being used consistently regardless of this public health intervention, which is why it is necessary to consider other modes of prevention such as VMAMC, P11 simply says, "*No... but... they must* [use condoms]."

Participants seemed to favour existing HIV prevention efforts because they were concerned that South African men may be encouraged to increase their sexual risk-taking after undergoing a VMAMC:

> [...] *those that are circumcised must still be informed yet that it is not the end of the day. It's just the beginning of the process. Next to it, condomise. Next to it, have one partner. Next to it, have one woman that you'll say is yours and not having multiple partners as you'd like.* (P27)

Participants believed that harm may be realised in the perception that once a man has been circumcised, he is no longer vulnerable to HIV infection. Participants explained why they would not have their son medically circumcised:

> *Because if he grows with mentality that "now I am circumcised so that means I can have sex like hell because I know that I am on the safer side" so by then he will be contracting HIV because he has a negative mentality that he wouldn't contract any virus. I will teach how to defend him on this issue that he must contraceptives because if I make him circumcise he will say that dad is giving me the licence to have sex because I'm on the safer side.* (P8)

This may be attributed to the education campaign that was launched prior to the launching of the public health endeavour, which did not promote VMAMC as a 'natural condom' (Bonner, 2001; Lagarde et al., 2003). The interviewer tried to engage on this with P8 by saying, "*but I think that some research done overseas says that if you do medical circumcision...also educate people to still use condoms... that they don't practice riskier sex-practices...*"

This only makes P8 laugh as he says, "*ja no we must educate ja...but if we must use condoms anyway then why bother being circumcised?*" The interviewer tries to pursue this thought by speaking to the fact that, as things currently stand, condoms are not used consistently by the public. P8 maintains that only condoms are necessary in the fight against HIV. Participants propose deliberately misleading the public as to the amount of protection that VMAMC offers in the prevention of HIV in order to limit the extent of sexual risk-taking:

> *Hide the fact that is 60% reduce it to 50% or 40% make it seem like look without your foreskin you are safer but not 100% safe. Because 60% will ring a bell in someone's mind that is 100%* [protection against HIV infection]. (P25)

P10 also worries that the public will not be able to moderate their sexual behaviour upon hearing of the protection against HIV offered by VMAMC. He says, "*When a certain principle or fact it is introduced, people start having stories and myths before it is even clarified after many years so...*" In order to counter this, he suggests that:

> [...] *they* [public health practitioners and government] *shouldn't exaggerate what it* [VMAMC] *can do but what they can do is they have to be moderate, the way the tell people about it so that they can try to get rid of the myths and untrue acts that come with it, because when they say it reduces in some people minds it say that your chances of getting HIV go away. They have to be careful on how they moderate this, they shouldn't just tell people and let people run with the idea because it is going to end up doing more harm than good.* (P10)

Education campaigns are received in context and thus can never be meaning-free. Such campaigns should, therefore, carefully consider how similar messaging can be received in contrasting ways. Participants who had been medically circumcised considered their circumcisions as having prevented them from contracting HIV:

> *I have been in a situation where I have been exposed and luckily I got through because of circumcision. I really do believe that it's effective compared to someone that is not in the same situation* [medically circumcised] *would have found themselves in a difficult situation.* (P25)

On the other hand, P8 cannot see how VMAMC can protect one against HIV since "*even if the foreskin is removed it is still unsafe. When you have... sex with someone...there will be an exchange of something*."

Those who regard HIV-preventative VMAMC dubiously contend that offering the public such a procedure while informing them that their risk for infection is reduced, will simply result in an increase of high-risk behaviour as individuals will believe that that they are immune to the disease after the procedure (Hodges, Svoboda & Van Howe, 2002).

This concern was echoed by P2, "*I think that many people who are circumcised would more or less start behaving riskly. They wouldn't use condoms because they think that the risk of contracting HIV is lower when you are circumcised*." P6 agrees that "*male circumcision will promote unsafe sex*." The issue is succinctly summarised below:

> [...] *I think a lot of people will then begin to use it as an excuse to sleep around and say "well, look, I'm circumcised. I'm not actually spreading HIV". So that's why, while I do believe that it's a good strategy, they do need to emphasise that it can't be used alone and it needs to be used in collaboration with safe sex practices.* (P26)

Some participants felt that VMAMC would only be regarded favourably if it was integrated into existing public health interventions:

> [...] *so it shouldn't be the main focus to say that male circumcision stops HIV or stops the contraction of HIV just has to go hand in hand with instilling values in people to start using condoms more and ja not rely on circumcision only.* (P2)

> *Yes, yes I support the idea* [of HIV-preventative MC] *greatly. I think it*'s *how we can contribute to reducing the chances of people from getting infected, but we should not only depend on male circumcision only we should also use other methods of eradiating this disease like using condoms.* (P13)

Participants supported the use of VMAMC for the purposes of HIV prevention in South Africa, provided it is implemented as part of a comprehensive HIV prevention strategy:

> *I do think there is definitely some value to the claim that it will prevent HIV. But again it can't...just be used alone as a means to prevent. And I just think though they need to be able to follow through if they want to use it as a means, you know, just saying that "it should be done" isn't enough. They need to provide the means to do it as well.* (P26)

There was only one participant who overtly valued VMAMC as circumventing a number of the limitations regarding existing HIV prevention strategies in South Africa:

> [...] *you cannot change how people behave that cannot be a focus of your strategy, I cannot expect my patient to behave differently, and I can discuss with them the need for behaviour change. I need to assume the patients, people are going to keep having sex with numerous partners and often I need to assume rape is a reality in this country. I need to assume that people don't really think about looking after themselves until it's too late.* (P29)

However, this participant does not advocate for VMAMC to the exclusion of existing HIV prevention interventions:

> *I think in this country especially we need to just do about whatever we can to curb the spread of HIV but I think it's important for people to understand that circumcision is not the be all end all. It's known to reduce the risk; it doesn't negate the risks so condoms still need to be number one I think. I think male circumcision is important and should be offered everywhere to everyone but I don't think it should be relied upon.* (P29)

Thus, despite a rather clear indication that current HIV prevention strategies were not sufficiently addressing the issue of potential risk of HIV infection for the general South African public, participants who were opposed to undergoing VMAMCs to reduce their personal risk of infection indicated that the current prevention strategies were adequate for their prevention of HIV infection. P10 favours existing HIV interventions over VMAMC saying, "[...] *there are other means of protection, which really work, if used properly and proper care is taken and certain consideration are made before two people indulge*."

The participants of this study who belonged to a cultural or religious group that does not typically practice MC were generally opposed to relying upon VMAMC, and indicated that they would reject the implementation of such an HIV prevention intervention. Given that VMAMC is a form of genital cutting, which is not practiced in Zulu culture, P16 decided that he would not undergo a VMAMC for HIV prevention, "[...] *as I have said I will not go against my culture, I will rather you use a condom every time I have sex*."

P23 feels that the onus is on the individual to appreciate the value of VMAMC-based interventions, "[...] *most people will love it* [VMAMC for HIV prevention] *if only they could think out of the box*." However, P15 feels that men who come from non-circumcising traditions may resist the implementation of VMAMC more than men from traditionally circumcising backgrounds, "[...] *for the cultures that do not practise male circumcision have to be open mind and consider the risk of not being circumcised that they have a higher risk of getting infected*."

Research has shown, however; that individuals tend to remain attached to their ways of thinking, even in the face of disconfirming evidence. This was found to be the case as the participants employed implicit strategies to manage the matter of *the crisis of medicalised modernity* and the resulting tensions between tradition and medicine, which were more subtle than the participants' accounts of explicit strategies.

4.9.2. Implicit strategies: Othering.

The data indicated that the participants, in an effort to manage the crisis of medicalised modernity, made meaning of VMAMC in relation to HIV-risk. That is to say that those who were opposed to VMAMC indicated that they were not at risk of HIV and thus, this intervention was not necessary for their consideration. These participants tended to indicate that while they were not at risk, others were.

Participants offered reasons that underpin HIV-risk assessments in ways that confirm an individual's invulnerability to HIV:

> [...] *it's unconscious ignorance and what men tell them. You know we believe what we want to believe in* [...] *based on our paradigms and what influences us basically you know with social dynamics* [...] *it's one of those perceptions that just develop based on nothing really.* (P25)

Essentially the data showed that participants rely on the process of *othering* to limit the potential inevitability of having to consider VMAMC as a necessary HIV prevention strategy in South Africa. Participants implied that VMAMC-based public health interventions are worthwhile in the fight against HIV:

> *I don't think it's a bad thing, they should relate to that because it's a way of helping people like making a future for the next generation, if there are many diseases in the future. Doing this research will actually help a lot of people according to my opinion, because now people have a chance to actually, first of all there are people who didn't know about circumcision and how it helps people now since they do. I think everyone should go out and do it.* (P3)

> *I do support* [VMAMC] *because it does help prevent HIV. They say that when you are circumcised you do not get diseases such as HIV, there is a possibility that you can get diseases, but when you are not circumcised there is a possibility that you can get HIV very easily.* (P5)

However, these same participants felt that this intervention is of value to other South Africans, but that it would not be relevant to them personally:

> *Well, since it does reduce the spread of HIV* [...] *I think it's a good thing somehow but then people like me* [...] *I don't think I will be getting circumcised soon*[...] *I do support it because it helps reduce the spread of HIV, but there are these...*[long pause]. *For me, I don't think I will do it, but it's a good thing, a good idea.* (P3)

> *I do not see the use of circumcising because I don't usually sleep around...Circumcision, I don't think I am ready because I do not see the use of me circumcising* [...] *I don't see the purpose.* (P5)

When asked if other South Africans would favour the uptake of this public health intervention, P3 says, '*Ja most people would, not everyone. Me being myself I am not ready to do it and there are people who have the same mentality as me, I don't think everyone will agree.*' P5 echoes this when he says '*Yes they would agree because many people in South Africa don't want to get HIV, I don't think they will disagree with male circumcision because they are scared. They wouldn't disagree with male circumcision.*'

Across the dataset it was noted that only the promiscuous 'other' would have to consider VMAMC. For example, P20 says that "*if people want to have fun only* [have unprotected sex with multiple partners] *then they will get infected, get sick and die*." This has critical implications for the way in which people make meaning of VMAMC.

For example, VMAMC can in itself be stigmatised as only being necessary for those who are at risk of infection. In responding to a female partner asking the participant to consider having VMAMC for HIV prevention purposes:

> *It would be something that I'd have to negotiate with her. I'd want to question why she wanted me to get one, if she thought I was being unfaithful or if she was maybe cheating. It would make me think many things about the quality of my relationship.* (P9)

P10 highlights this stigmatisation when he says "*God says that it must be one man and one woman, so my partner would not ask me to do that. We must be faithful to our partners*." By saying this, P10 implies that partners cannot discuss VMAMC with each other without the insinuation of sexual infidelity or promiscuity. P22 also alludes to this, "[...] *maybe she is been going around and seeing someone who has been circumcised*." Participants indicated that such a discussion would be met with suspicion:

> [...] *let's say you have a wife and you are not circumcised and your wife keeps on nagging you that you should be circumcised because she is afraid that you might get diseases if you don't. We will talk about it first and sit down and ask her the question why all of the sudden, it will also depend how long we have been together.* (P21)

This stigmatisation is an issue that may impact the way in which men make meaning of VMAMC, which could ultimately have a bearing on the uptake of this HIV intervention. Since notions of risk and danger are used interchangeably in the data set, meanings seem to be attached to beliefs regarding who is 'dangerous', who is 'safe', and who should be socially perceived as compromising other people's health and safety.

The concern here is that research has shown that people in South Africa do not perceive themselves to be at risk for HIV infection, regardless of the high-risk sexual practices in which they report to have engaged, and despite having high levels of HIV transmission, prevention, and treatment knowledge:

> [...] *as people, we do not know how to take care of ourselves. Some people don't care they just have sex with anyone without a condom. Some people are responsible and have safe sex. I think male circumcision is right it will protect everyone.* (P18)

This perception of personal invulnerability to HIV infection has largely been associated with risk assessment of other people, from other social groups (Thompson & Kumar, 2011). This '*othering*' is alluded to by P21, who reflects on how this notion influences his way of thinking of VMAMC, "[...] *it is difficult because maybe you should not have to have the circumcision* [...] *let us say that you are married and you and your partner you both know your status and you both do not sleep around*." One participant predicts how his future sexual relationship(s) would not require him to consider undergoing VMAMC to prevent HIV infection:

> *I know that I would trust her in our relationship, it is not like I am sleeping around with different partners, and I am sleeping with her only. So I do not season any point of me circumcising to reduce the chances of getting infected. We are partners and we are in a relationship and trust each other.* (P18)

Participants illustrated this anchor of 'the other' in relation to the public's risk-assessments in relation to VMAMC:

> *Ja because I think that everything, it's like people who smoke you tell than that it's bad for them, they continue smoking you know. It's that degree of what is a chance of me getting the disease and someone who is religious at using condoms and doesn't sleep around why must he lose the pleasure effect and be circumcised for what reason?* [It] *definitely plays a role for people.* (P30)

Social depictions of the virus, as well as who is considered to be at risk of infection, may assist individuals in projecting their fears of infection onto an 'other' - someone who is 'not me'. P3 says that he "*wouldn't suggest that*" any sons that he may have in the future be circumcised to lower their risk of HIV infection. He speaks about VMAMC being necessary for the 'other' who is sexually promiscuous:

> *Well until I see that as he grows up the kind of person that he is, if he is the kind of person who sleeps around with every girl like he is some kind of "player". I would recommend that.* (P3)

P9 echoes this saying, "*I will rather spend my energy teaching my son to protect himself if he is going to be sexually active. I'll do the A-B-C principle and I'll rather let him go as his personal choice*." P18 agrees, "[...] *it depends on how we take care of ourselves, some people are promiscuous while others are not* [...] *so those who are promiscuous, it would be important for HIV prevention because they are more susceptible to being infected*."

This image of 'otherness' may offer some comfort to those who exploit it to negate their fear of HIV, for the reason that it connotes they will be spared from infection so there is little or no accountability for their sexual behaviours regarding HIV infection. This finding is of particular interest to this study since it reminds researchers and other involved in public health that there are a host of psychosocial factors at play in the understanding of HIV-risk and people's responses to this perceived risk in considering the various HIV prevention interventions available to them. These psychosocial factors in turn impact how people make meaning of these interventions, which may influence the uptake thereof.

4.10. Conclusion

This chapter presented the findings of this constructivist GT study regarding the factors involved in individual meaning-making of HIV prophylactic VMAMC in South Africa. As advocated by Strauss and Corbin (1994) in their approach to GT research, the concepts of this GT were inductively derived from the interview data gathered and clustered together in a higher order analyses to form categories. The linkages between these categories were investigated and addressed, which was the basis for the substantive theory that emerged from the meaning-making perspectives of key agents of this HIV prevention strategy. The following chapter discusses this theory of VMAMC meaning-making by unpacking the various elements of the GT in relation to existing literature and frameworks.

Chapter 5: Discussion of Findings

5.1. Introduction

The aim of this study was to generate a substantive GT that accounted for the factors involved in individual meaning-making of HIV prophylactic VMAMC in South Africa. *Chapter 4* presented the analysis of the interview data that this theory relied upon for its development. This chapter constructs an account of these findings in relation to relevant literature to unpack this theory. The chapter begins with a summary of the GT, followed by a discussion of each element of the GT (including the contextual conditions that constituted the core category; the interacting and intersecting variables; the causal condition (and its explicit and implicit strategies); as well as the basic social problem and the basic social process). The chapter then situates the significance of this study in relation to the existing literature through a discussion the factors involved in individual meaning-making of VMAMC in the context of HIV prevention.

5.2. Summary of GT

As shown in the previous chapter, the GT analysis revealed one core category, *tensions between tradition and medicine,* which was constituted by three emerging sub-categories, namely (1) *citizen rights and responsibilities in times of HIV*; (2) *men's health*; and (3) *politics of implementation*. The properties and dimensions of each of these sub-categories are considered in this chapter as they intersect and interact with *plurality and fusion* regarding the basic social problem in the context of HIV prevention in South Africa. The basic social problem identified in this GT was *performances of masculinity,* which underpinned the basic social process, *negotiating tensions between tradition and medicine*. The basic social process was found to be driven by *the crisis of medicalised modernity,* which was managed by the explicit strategy of *overvaluing existing HIV prevention strategies,* and implicitly via the process of *othering*.

This meant that since assessments regarding personal risk of HIV infection were made in ways that limit the necessity for VMAMC, participants were able to (partially) avoid the tensions that are generated by this HIV prevention strategy. The data analysis that exposed the contextual conditions of this GT (the three emerging categories) underpinned the core category of this GT, *tensions between tradition and medicine*.

These conditions, as well as their individual and combined effect on the meaning-making of HIV prophylactic VMAMC, are discussed in the following section in relation to existing literature that was theoretically sampled during data coding and analysis regarding the phenomenon of VMAMC meaning-making.

5.3. Unpacking the Contextual Conditions

The three emerging categories of this GT were contextual issues that underpin VMAMC meaning-making, since they reflect a specific set of conditions that intersect at a certain time and point (which were identified as the occurrence of *plurality and fusion*) to give rise to meanings of VMAMC that are unique to men who are beneficiaries and stakeholders in this intervention. Relevant literature is integrated into the discussion of each condition to locate its relevance to existing knowledge.

5.3.1. Citizen rights and responsibilities in times of HIV.

This emerging category included a number of properties and dimensions that impacted the meaning-making of HIV-preventative VMAMC and was salient across the various theoretical frameworks. HIV-preventative VMAMC meaning-making is considered to be significantly implicated in the role that the state plays, as participants held government partially responsible for protecting its citizens against the HIV pandemic, yet they also felt a level of individual responsibility in monitoring their own personal health behaviours with some degree of autonomy.

There has typically been a relatively tense relationship between government and the individual regarding national compliance and personal liberty regarding the uptake of public health interventions (Bambra, Fox & Scott-Samuel, 2005). This is because the individual (particularly those from LMICs) generally looks to the state to take responsibility for his or her welfare, which requires the state to make decisions that impact individual citizens as part of the collective, while at the same time not infringing upon the individual citizen's right to practice and enjoy their personal liberties (Mechanic, 2013). Like many other epidemics, the arrival of HIV and the necessity to contain its spread means that as the state has had to contend with ethical and practical debates regarding the degree to which it can legitimately impose upon individual liberties for the 'common good', and the point at which protecting the welfare of the collective becomes a ruse for corroding basic civil rights (for example circumcising a traditionally non-circumcising male).

The literature shows that in times of social crises and fear, such as during outbreaks of plagues or threats of bio-warfare and bio-terrorism, citizens are often more willing than usual to have their personal preferences and freedoms restricted by the state if it is perceived to result in improved general safety and health (Laurin, Kay, Proudfoot & Fitzsimons, 2013). The data supported the premises of this fundamental tenet of social contract theory (Scott, 2007) since a number of participants, despite their personal preferences regarding traditional MC or the practice of non-circumcision in its entirety, felt that the state should exercise its might in imposing mandatory MAMC, particularly in light of HIV prevalence in South Africa.

The severity of the threat of HIV thus evokes the core values of public health (Bayer & Colgrove, 2002). At the height of the HIV epidemic in the 1990s, when HIV prevalence was on the rise globally and there were a high number of AIDS-related deaths (since ART was still in various phases of research and development), a number of international governments considered several extreme interventions to limit the extent of the epidemic, including a state of quarantine where people infected with HIV and full-blown AIDS would be isolated from the general public (Bayer, 1991; Bollinger, Tripathy & Quinn, 1995; Gostin, 1989). Such extreme proposals for early containment of HIV, while largely voided as other more viable prevention and treatment options became available (Hansen & Groce, 2001), raised some philosophical debates regarding the role of the state in disease prevention.

It has been proposed that public health interventions embody and support the notion that the protection of society should be prioritised over the personal liberties of the individuals that constitute the collective. In consulting the limited body of literature regarding meaning-making theory, it was found that the dimensions of these properties could be understood in relation to the conceptualisation of health as an expression of a procedural social engagement. That is to say that there is a tension between the individual and the social environment as the ultimate determinants of health and illness (Alderman, Hipgrave & Jimenez-Soto, 2013; Smith, 1996). This is because the lines between the individual citizen's rights and responsibilities to others in the prevention of HIV can be indistinct.

Psycho-educationally informed HIV interventions have tended to focus strongly on discourses of individual responsibility for disease prevention (Gilmore, Savell & Collin, 2011; Mechanic, 2013). However, it could then be argued (as in the ecological model of health) that HIV-preventative VMAMC as a public health intervention makes an intrusion on the individual citizen and implicitly highlights how the individual (and in this case, the individual male body) has the potential to affect the health of others (most directly his sexual partner) (Bernier & Clavier, 2011).

According to Knowles (as cited in Minkler, 1999, p. 122), the individual has to make "the primary critical choice [to] change his personal bad habits or quit complaining. He can either remain the problem or become the solution to it". However, public health and public health policy have long since considered the controversies related to the problem of whether the individual is responsible for personal health behaviours, or if society (as understood within the larger ecological framework) is to be held responsible (Baron et al., 2014; McLeroy, Bibeau, Steckler & Glanz, 1988; Minkler, 1999; Sallis et al., 2008).

More pertinent to this study, however; is addressing the contested meanings of personal responsibility for health in understanding the meanings of VMAMC. The participants indicated that they had control over their own bodies and had to take ownership of the decisions that they made about their sexual practices and VMAMC (in relation to HIV prevention), however; some participants noted that broader socio-environmental factors played some role in health behaviour outcomes and could not limit their reflections on individual risk of HIV infection as being purely the responsibility of the individual.

The student-doctors in particular referred to the need for public health to be cognisant of a broader vision of HIV prevention that includes the social limitations to adopting safer-sex practices (such as social constructions of hegemonic masculinity that encourage sexual risk-taking). However, the participants referred to individual citizens as having agency in making purposive health decisions and behaving accordingly. Theoretical advocates of agency in health studies regard the individual as freely volunteering health action. That is to say that an individual citizen is fully aware of the justifications for her/his actions and can foresee the consequences thereof.

Yet structuralists believe that health behaviour is a product of particular environmental conditions (Ansell, 2014). According to this perspective, one would say that the participants have no freedom in VMAMC meaning-making and that their responses regarding this are merely reproductions of traditional structures that impact their thinking of VMAMC and HIV prevention.

Participants, who indicated that they would personally undergo VMAMC to reduce their risk of HIV infection, said that they would do so even if it had implications for their adherence to traditional structures regarding the practice or non-practice of MC. However, in cases where religious or cultural doctrines are followed dogmatically, it is evident that to challenge tradition by acting autonomously and deviating from cultural or religious structures, is to potentially face punitive measures such as being rejected or disowned by your family. For these participants, the gap between the structure of traditional norms (as they relate to traditional MC) and the ability to act as an autonomous agent in preventing the acquisition of HIV by undergoing a VMAMC, is a critical factor in the individual making meaning of HIV prophylactic VMAMC.

For example, P29 (who says that he is Jewish) has to contend with religious tradition, where MC is a part of the Jewish tradition because God gave Abraham a commandment to circumcise his male children in Genesis 17:10-14. He indicated in his interview that his family's religious structures would largely exclude his (and other Jewish men's) participation in VMAMC since they are typically circumcised a few days after birth. Adherence to Jewish MC is often crucial to Jewish families since circumcision is seen as a sign of the covenant between God and the Jewish people and "any uncircumcised male, who has not been circumcised in the flesh, will be cut off from his people; he has broken my covenant" (Genesis 17:14).

Studies support individual agency in determining personal health behaviours and related outcomes (Prestwich, Sniehotta, Whittington, Dombrowski, Rogers & Michie, 2014; Reilly, Rowley, Luke, Doyle, Ritte, O'Shea & Brown, 2014), and such evidence is compelling for the argument that individual control is a dominant element to determining personal health status. If one accepts that individuals have control over their health outcomes, then these individuals are held responsible in making the 'right' choice.

Thus the meaning-making of VMAMC seemed to be lodged as a moral problem for many of the participants in this study. However, I advocate that the morality of individual health decisions is only contextually meaningful. That is to say that participation or non-participation in VMAMC can only be considered moral or immoral within very specific local contexts that warrant particular and fine-grained analysis.

While a very limited number of people would dispute that individuals have at least some responsibility for their personal health outcomes, there are social and political consequences to overstating individual responsibility to the exclusion of other critical social factors in determining the prevention of HIV. This overstatement is perhaps one of the most forceful critiques of traditional public health and health theory.

It is problematic to consider the individual citizen as being responsible for their personal health within the context of HIV prevention, for example placing the responsibility of public health upon the individual (regarding decisioning and action) may allow for them to feel that their compliance with public health initiatives can be purchased through the incentivisation of health. The need to be compensated for undergoing VMAMC for HIV prevention needs to be investigated further to clarify what these participants felt exactly they needed to be compensated for. There could be a need to be compensated for infringement upon one's individual liberties by having to participate in a public health intervention, for having to forfeit traditional custom to undergo a medical version of the procedure, or for having to modify a part of one's body. Such views imply that national compliance may be purchased, even if VMAMC runs against the structural norm of non-medical MC or individuals that are themselves opposed to the practice of any form of MC.

The data suggest that the incentivisation of health through economic compensation may be met with a backlash as individuals attempt to reassert their civil liberties by actively resisting HIV-preventative VMAMC, which could result in the failure of the intervention (Braveman, Egerter & Williams, 2011). A collective unwillingness that resists the uptake of VMAMC may ultimately offset the potential long-term benefit of this procedure in the fight against HIV in South Africa (Bogart et al., 2011).

In its report on the global AIDS epidemic, UNAIDS (2013) indicated that by the end of 2012, South Africa had only reached 20% of its target for the number of men set to undergo VMAMC by 2015. This can be compared to Kenya, where during the same period (from 2007 to 2012) it had reached 63% of its 2015 target. Thus public health systems will certainly have to consider these meanings in the potential upscaling of the VMAMC intervention.

To summarise, the category of *citizen rights and responsibilities in times of HIV*, in this GT, is characterised by the theoretical positions that underpin VMAMC meaning-making in relation to the historical tensions between the roles of the state; autonomy and action; and individual responsibility in the promotion of health and therefore prevention of HIV in South Africa. Thus, *citizen rights and responsibilities in times of HIV* (in both the broad and narrower senses) should be considered a critical category of individual-meaning of HIV-preventative VMAMC. This should be flagged as one the driving forces behind the success or failure of any related public health intervention. Individual citizens exercise their own resistances or accessions to the mandates of health behaviour strategies circumscribed by the state. Understanding this means that recourse in public health messaging may be necessary, but certainly not sufficient, in shifting individual responsibilities and orientations to VMAMC, because evidence cannot be extricated from the lenses of those that receive it. This is nowhere more obvious than in the contextual condition of *men's health*.

5.3.2. Men's health.

Men's health and illness is considered to be typically related to male-oriented risk factors, either psychological, social, physiological, or environmental, and so require uniquely male-oriented health interventions to promote health and well-being for the individual and the collective (Shabsigh, 2013). The WHO has advocated for gender mainstreaming of its public health interventions, however; arguably women have benefited more from this innovation than men (Ravindran & Kelkar-Khambete, 2008; Rodin, 2013; Vlassoff & Moreno, 2002). A historical limitation to men's health was the identification of men as a homogenous collective, which excluded the consideration of men as individuals that come from different traditional backgrounds and thus, may have unique preferences for the state of their bodies in relation to what may be considered good-health. Contemporary concerns for men's health seek to remedy this limitation. Studies on VMAMC, such as this current study, represent a crucial point for advancing this trend.

This emerging category highlighted how participants made meaning of HIV prophylactic VMAMC as being the outcome of assessments that weighed up how MC (and non-MC) impacted physical appearance, health and illness, sexuality, and masculine identity. As the participants make meaning of VMAMC for HIV prevention they consider non-circumcision, traditional MC and medical MC as having risks and benefits to men (psychosocially) and their health.

There were conflicting findings on the perceived risks and benefits of MC on men's health in the literature that were reflected in this study. Participants regarded traditional and medical MC (including VMAMC for HIV prevention) as being able to assist in preventing many health-related problems (including penile cancer, STIs, and dermatological conditions) later on in males' lives. The student-doctor participants also considered, unlike preventative vaccinations which often require follow-up booster shots that the positive effects of medical MC do not subside over time (Schoen, 2007). Furthermore, the participants referred to MC (in particular that which occurs as part of the traditional rite of passage) as making them look and feel like 'men'.

They spoke to the social gains of traditional MC as increasing their social positions, since the people in their families and communities regarded them more highly after undergoing this rite. This has patriarchal implications for the upscaling of VMAMC for HIV prevention and is an issue that was identified as underscoring the basic social process. However, it could be argued that patriarchy may also subjugate men as it forces men to adopt traditional *performances of masculinity* (such as traditional MC) since, according to some participants, failure to participate in these rites would result in ridicule by those who are circumcised.

For example, even when the '*inkwenkwe*' (meaning 'uncircumcised boy') become adults they are not supposed to mix with the 'real men'. The consequence to this is then that men who undergo VMAMC rather than traditional MC may be regarded as not being 'real men' by their communities. As such VMAMC may be understood as being a HIV intervention that infantilises adult men and compromises their masculinity.

Participants who oppose traditional circumcision insist that the perceived cultural benefits that might be gained through the rite do not compensate for the various complications that can result from this procedure, especially if performed under non-sterile conditions as traditional circumcisions are (Morgan, 1998; Pieretti, Goldstein & Pieretti-Vanmarcke, 2010; Rhinehart, 1999; Weiss, Larke, Halperin & Schenker, 2010).

All of the participants noted that the procedure of MC, particularly that of traditional (non-medicalised) MC, carried particular risks for physical well-being. Participants noted some of the consequences that research has also listed for MC, such as pain, bleeding and risk of infection, necrosis, penile amputation and rupture of internal organs and death (Ahmed, Mbibi, Dawam & Kalayi, 1999; Bailey, Egesah & Rosenberg, 2008; Bhattacharjee, 2008; Lagarde et al., 2003; Mogotlane, Ntlangulela & Ogunbanjo, 2004; Renshaw, 2003; Wilcken, Keil & Dick, 2010).

It would seem as though the participants regard traditional MC as being a particularly risky practice, and since the participants appear to conflate traditional MC with VMAMC, this meaning may be attached to VMAMC. This could impact the uptake of this intervention should it be upscaled to a nationwide roll-out for HIV prevention. With these consequences attached to the current participants' meanings of VMAMC, it is unsurprising that participants from non-circumcising traditions indicated some reservations regarding the uptake of VMAMC. Should this intervention be upscaled to a nationwide roll-out, which would seek to include the participation of men who do not practice traditional MC, public health messaging might need to address these health and safety concerns to highlight the sterile, medical, surgical conditions under which VMAMCs should be performed.

Participants, most certainly those from non-circumcising traditions, indicated some concerns about the psychological consequences of undergoing VMAMC. The literature reviewed following the data analysis shows that the development of psychological consequences to MC seem to be largely subject to the traditional norms regarding the ideal body-type, as well as whether or not the male who is circumcised belongs to a community that practices traditional MC (Corduk, Unlu, Sarioglu-Buke, Buber, Savran & Zencir, 2013). The aesthetic value of the male body, and particularly the penis as being uncircumcised or circumcised, proved to be critical in meanings attached to the psychology of the male body and the penis.

The participants referred to the intact penis as being ugly, which then implies that for these participants, VMAMC fulfils a cosmetic imperative whereby men undergo this procedure in order to 'improve' the appearance of the penis. Here VMAMC is made to mean that the natural penis is somehow inferior, ugly, or abnormal in comparison to the surgically altered penis. This has implications for perceptions of the male body in relation to being 'normal' regarding having a circumcised or intact penis.

The participants alluded to VMAMC as a mechanism that further pathologises the male body as being naturally defective (in the sense that the foreskin increases the risk of a man becoming infected with HIV). Narratives within the interviews on the foreskin were aligned to images of dirt, which mirrors a number of studies that found that many people worldwide believe that the circumcised penis is 'cleaner' and 'more hygienic', as one does not have an exterior barrier (the foreskin) restricting one's ability to thoroughly wash the shaft of the penis (Collier, 2012; Kwena, Bukusi, Gorbach, Sharma, Sang & Holmes, 2010; Walker, 2014).

Apparently the participants have largely subscribed to the belief that the foreskin is inherently flawed and should be removed (through traditional or medical MC). Mass psycho-educational public health efforts may have contributed to the growing phenomenon of prevalent beliefs that the human body is essentially defective and in need of medical intervention by healthcare professionals. Given that this is the meaning that men have made of their foreskins, this has profound implications for the meaning-making of VMAMC. Should VMAMC be upscaled to a primary HIV prevention intervention across South Africa, public health practitioners may wish to consider their VMAMC messaging in ways that do not confound such meanings of the naturally defective male body.

The patriarchal underpinnings of MC as they relate to *men's health* were amply evident in the data. Many argue that the reason older boys are traditionally circumcised is because they have the ability to self-monitor and preserve the secrets of MC when they return to their communities after initiation (Deacon & Thomson, 2012). Typically, a son is not permitted to bath or be seen naked by his mother after undergoing a traditional MC and a wife is to remain ignorant of how her husband's circumcised penis looks.

With only one exception, participants did not refer to mothers when considering parents as proxy decision-makers regarding the circumcision of sons. Most of the circumcised (traditionally or medically) participants consider the involvement of family but they single out male relatives. This has implications for the roll-out of the VMAMC-based intervention in the context of single mother (or female guardian) households, if females are regarded as having no decision-making power within the context of VMAMC as an extension of patriarchy into modern public health interventions.

Even in instances where participants described their intimate relations as essentially equal, the fact that the female partner is seldom permitted to comment on the matter of the physical state of her partner's penis was particular interesting, since her personal health is inherently linked to the degree of risk he has regarding his susceptibility to HIV infection. The implication of this is that males can be considered as the gatekeepers of women's health (while women remain passive recipients of male decisioning), as men decide whether or not to undergo HIV preventative VMAMC, which may impact on her risk of HIV infection.

Furthermore, when considering the implementation of VMAMC for HIV prevention, the participants seemed particularly concerned with the political implications thereof. That is to say that they are concerned with conceptions of who will be impacted upon by the upscaling of VMAMC, when this might be implemented, and the ways in which this might be achieved. Public health structures are understood, in this case, as directing and dispensing HIV interventions that determine who is likely to benefit and who is likely to be disadvantaged as a result of the upscaling of HIV-preventative VMAMC. The impact of the final sub-category, *politics of implementation* of VMAMC, is discussed in the following section.

5.3.3. Politics of implementation.

While HIV prevention strategies are considered to be more critical than ever (Bongaarts, 2010; Kelly et al., 2012), novel HIV prevention interventions, which include the development of the HIV vaccine, microbicide trials, and VMAMC, have been met with several psychosocial and healthcare system obstacles. These include inadequate procurement structures, unaccountable public service delivery systems, ineffective supervision of healthcare workers or programmes, as well as profound deficiencies in financial resources and trained, competent healthcare personnel (Dovlo, 2005; Ngoasong, 2009; Schneider, Blaauw, Gilson, Chabikuli & Goudge, 2006; Zachariah et al., 2009).

These have resulted in the substantial setbacks considering the reduction of new HIV infections in Africa (Lie, Emanuel & Grady, 2006; Tanser, Bärnighausen, Cooke & Newell, 2009). Nonetheless, many African researchers, healthcare and government workers, and various NGOs remain committed to addressing the HIV pandemic in South Africa by considering the ways in which to develop and implement effective public health policies and practices focused on HIV prevention, including that of VMAMC.

The participants generally reflected on how years of poor facility maintenance, underfunding, understaffing and general mismanagement have resulted in the deterioration of the essential physical infrastructure of the public health system, making the fight against the HIV pandemic that much more challenging (Karim, Churchyard, Karim & Lawn, 2009). The participants even considered how, considering these circumstances of public health care provision in South Africa, the public had to pay for healthcare at state health facilities.

This is concerning for two reasons: (1) either the public is largely uninformed about free healthcare at public facilities (which could mean that people avoid seeking healthcare if they believe that they might not have enough money to receive adequate care), or (2) there are certain public hospitals or clinics that are allegedly corrupt as they are charging patients for healthcare that should be provided for free.

Either way, this has implications for the way that individuals make meaning of VMAMC for HIV prevention; because they are unlikely to consider the procedure if they believe that public health care is beyond their economic reach. Further research should determine whether these misconceptions or the perceived corruption act as barriers to the uptake of VMAMC. This is an opportune moment for this research as it has direct implications for the way that the state develops and implements National Health Insurance (NHI).

Perhaps even more concerning was the finding that even if government had sufficient funding to successfully upscale the roll-out of VMAMC for HIV prevention, the participants did not trust government to implement this intervention in ways that reflect the greatest interests of the public regarding HIV prevention. These perceptions were grounded in the state's limited success in protecting young initiates from the dangers of traditional MC. Since the participants largely conflated the meanings of traditional MC and VMAMC, the same risks attributed to inefficiency were attached to state-run VMAMC.

In an effort to address the risks associated with traditional MC, the DoH in the Eastern Cape, since recording "2262 hospital admissions, 115 deaths and 208 genital amputations for circumcisions between 2001 and 2006", established the "Application of Health Standards in Traditional Circumcision Act No. 6 of 2001" (Peltzer, Nqeketo, Petros & Kanta, 2008, p. 66), which legislates that traditional surgeons have to be lawfully recognised by the health department in order to perform such procedures.

However, participants did not seem to be familiar with the Circumcision Act and did not believe that government was being active enough in protecting initiates' health and safety during this traditional rite of passage. This might be because, despite the introduction of this Act, the media continues to report on instances of botched traditional MCs.

This matter requires further investigation, as if acts are passed by state health departments but are seen as not being effectively implemented, this could have an impact on how individuals make meaning of VMAMC as a state-endorsed public health HIV prevention strategy. The public may not believe that the welfare policies and regulations established by DoH will not be enforced in VMAMC (as may be the case for traditional MC) and so HIV-preventative VMAMC will continue to be considered as risky as traditional MC, which will impact on the decisioning and uptake of this public health intervention.

Should individuals who traditionally practice non-circumcision be particularly concerned about the potential biopsychosocial consequences of undergoing a VMAMC, they may be primed to pay particular attention to news reports regarding botched circumcisions. This, combined with the perception that the state does not enforce the acts implemented to protect its citizens, might result in VMAMC implying that the risk outweighs the personal HIV preventative benefits of undergoing such a procedure.

Furthermore, participants indicated that all public health HIV interventions should be mistrusted (including state-issued condoms) since they were regarded as being of a particularly poor quality. This perception could be a result of instances in South Africa, as stated by Moszynski (2007, p. 957), where tens of millions of "defective, locally manufactured condoms were recalled from circulation" in August 2007, and then again in October 2007, which "resulted in widespread panic and a political scandal".

Parker (as cited in Moszynski, 2007), who was the director of the Centre for AIDS Development, Research and Evaluation (CADRE) at the time of the events, felt that the standing of public health had been disgraced as a result of corruption within the South African Bureau of Standards (SABS), where a testing manager had received bribes from the manufacturers in order to approve defective condoms for distribution. It would seem as though, for some participants, the reputation of the public health treatment of HIV remains discredited.

Despite this, participants considered education to be at the core of shifting these potentially distrustful perceptions of VMAMC. Without more information regarding VMAMC being communicated to the public in a way that is accessible, and in ways that address the various concerns that the public may have regarding its implementation, VMAMC may continue to be conflated with traditional MC. Furthermore, the participants were concerned that without this essential information, the public may regard VMAMC as the silver bullet to HIV prevention and so may understand VMAMC as a mechanism that will allow an increase in sexual risk-taking behaviour.

Participants felt that doctors were well positioned to act as educators and promoters of VMAMC for HIV prevention. However, this was only considered to be effective in cases when the doctor was seen as being from the same traditional background as the patient. Knowledge transfer was only considered to be effective through 'matching' patient and doctor, yet clearly this would not be possible in a national roll-out of VMAMC.

This is concerning because participants felt that if VMAMC information were to be communicated to them by a doctor who was of a different traditional background to them, they would either outright reject such a method of HIV prevention or they would have to accommodate relatively foreign ways of thinking (Shehadeh, McCoy, Rubens, Batra, Renfrew & Winter, 2012). The latter would require some political manoeuvring as the NDoH crusades to popularise policies that match the VMAMC agenda in South Africa. This political element to education can have a profound influence on the success or collapse of a national prevention policy.

What may not have been considered for the upscaling of VMAMC is that some doctors may be personally opposed to VMAMC. As with abortions in South African, healthcare providers are not obligated to perform (or even assist in) an abortion if they are opposed (for any number of reasons) to doing so (Ngwena, 2003). While they are legally and ethically obliged to provide lifesaving care to a patient, who may be related to an emergency as a result of an abortion, health workers may decline to perform a legal abortion (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). They are, however; required to inform the patient as to her rights and then refer her to another healthcare worker or to a facility that will perform the abortion (Hodes, 2013). Similarly, not all doctors will be promoters of VMAMC and may thus not be required to perform such surgeries.

The successful upscaling of VMAMC-based HIV prevention interventions would be dependent upon the findings of this study that accounts for the meanings of VMAMC, which are rooted in existing traditional, biomedical, aesthetic and personal-identity factors. To summarise, this category highlights how VMAMC meaning-making is related particularly to the conditions of implementation, more so that the actual act of circumcision itself.

The previous chapter presented findings that indicate that the contextual conditions interact and intersect with the *plurality and fusion* of *performances of masculinity*. The section that follows discusses these.

5.4. The Interacting & Intersecting Variable: Plurality & Fusion

Initially, I found it exceedingly difficult to code and analyse the preliminary data since participants seemed to make meaning of VMAMC and other key concepts (masculinity, medicine, and tradition, for example) in one particular way, but then responded to the same issue in a seemingly contradictory way at a later point in the interview. At first I believed that this was because the participants may not have understood the interview questions or may not have been aware of the logistics involved in VMAMC for HIV prevention. The latter proved to be true but only to a certain extent, as the data gathered from the final interviews conducted with the participants from the student-doctor sample group (as well as a number of other participants from the general public) seemed to be exceptionally familiar with this HIV prevention intervention.

During the coding and analysis of the initial interviews I made note of these 'contradictions', and asked the interviewer assistants to conduct follow-up and subsequent interviews with probing questions to encourage the participants to acknowledge and resolve the meaning of VMAMC in a clear way. This was significant because in the interviews that followed, almost without fail, the participant did not seem to be able to answer these probing questions. In reviewing the entire dataset it occurred to me that this inability to resolve these 'contradictions' seemed to reside more in the fact that the participants did not seem to see these contradictions in the way that I did, as at least for a large proportion of the sample there was no contradiction in meaning-making. Rather it seemed as though participants relied on negotiating the *plurality and fusion* of various meanings of VMAMC and how these might impact *performances of masculinity*.

This may be the reason for participants, at any given time, holding a number of different (often competing) views and meanings of VMAMC and related matters, in ways that caused no obvious conflict within the participant.

Meaning-making theory with cognitive leaning is often used to explain so-called 'contradictions' in thinking. Biases are generated when information about the social world is processed in ways that protect the individual from evidence that refutes positive personal beliefs and rather focuses on information that verifies the existence of such positive self-regard (Baker, Leon & Collins, 2011). Such theories would hold that men from traditionally circumcising backgrounds tended to process information regarding VMAMC in ways that uphold their masculinity through a reconfiguration of traditional MC (or modernised medical MC) performed as a means to rightful citizenship. On the other hand, men from backgrounds where men are not traditionally circumcised processed VMAMC information in ways that preserved their understanding of masculinity that is not attached to ritualised MC. Here the meaning of VMAMC is attached to the way that circumcision either buffers or diminishes masculinity and manhood.

Plurality and fusion is an underlying variable to the contextual conditions of this GT because in post-traditional societies, individuals are no longer bound to a singular tradition nor are they constrained to one traditionally-endorsed *performance of masculinity*.

5.4.1. Citizen rights and responsibilities in times of HIV.

Citizenship is complex since it is culturally-dependent and evolves with changes in particular social formations, but essentially refers to the necessary connections between people of a society at a particular place in time (Stevenson, 2002). In this study, citizenship is built on a number of (often oppositional) points on several conceptual continuums, such as personal liberty and national compliance; structure and agency; and rights and responsibilities (in the prevention of HIV). The apparent oppositionality of these dimensions is challenged by participants who give the impression of simultaneously having often conflicting or contradictory views regarding what they believe constitutes good male citizenship. Under this contextual condition, one's masculinity can be attained by defending individual liberties to make decisions autonomously from the state, while masculinity can also simultaneously be expressed by upholding the structures legislated by government to contribute to the fight against HIV in South Africa.

Plurality and fusion traverses the meaning gaps crafted by these seemingly oppositional understandings of citizenship. This negotiation of complexity is characteristic of modern societies that straddle the urban and rural and the traditional and contemporary (Giddens, 1995). Postmodernism compels us to acknowledge that citizenship is located within an increasingly unstable traditional structure that can easily accommodate the diverse experiences of modern South African life (Watson, 2014).

Plurality and fusion of *performances of masculinity* within *citizen rights and responsibilities in times of HIV* can be considered in relation to number of related theoretical perspectives, for example interactionism (Bourdieu, 2000), interpretativism (Weber, 2009), structuration (Giddens, 1984), post-modernism (Fedor, 2014), and post-structuralism (McLaughlin, 2013). These highlight how the concepts of personal liberty, agency, and rights, which I label as individualism, national compliance, structure, and responsibility (labelled as collectivism), are reciprocally dependent and inherently related to each other in underpinning good male citizenship. Collectivism is preoccupied with the dimension of obligations, duties, and belonging regarding citizenship, while individualism is concerned with the civic, political and social rights of citizenship (Scott, 2007). While collectivism is evident in the data, it is unable to account for the spaces of individualised ambivalence and ambiguity that the participants simultaneously occupy. More generally, this sort of fragmented experience of modern living is able to make sense of both the place of tradition and modernity, often at the same time and in relation to a position on a health decision such as VMAMC for HIV prevention.

In concert with others who advocate post-modern theory, this GT highlights that through *plurality and fusion*, citizens are contextualised by their psychosocial milieu but they are not helplessly bound to it (Dunn & Castro, 2012; Watson, 2014). In saying this, it is essential to consider the interview data as representing not merely a neat separation of the traditional from the modern but a complex intersection thereof. Thus it is not viable to expect participants to hold the extreme position of either pure individualism or absolute collectivism in their meaning-making of VMAMC for HIV prevention. Theoretical frameworks, including deconstruction (Brogan, 1988; Derrida, 1997), logocentrism (Van der Heiden, 2011), post-structuralism (Kleppe, 2013), and phenomenology (Kelly, 2014), advocate that meaning is perpetually delayed because it is never finalised as truth is ever-changing.

The interview data highlights how meaning-making is subjective and not necessarily rational. Participants were able to hold contradictory meanings of VMAMC, whereby one meaning could be activated at a particular time and context, with a different meaning at a different time and context. The introduction of VMAMC to the South African public encourages thinking and meaning-making that relies on *plurality and fusion* in order to make sense of this HIV intervention. These theoretical frameworks address our limitations in being able to interpret novel phenomena (such as HIV-preventative VMAMC), which can be used to explain the *plurality and fusion* underpinning the responses from the participants regarding VMAMC meaning-making in relation to *performances of masculinity*.

To summarise, HIV prophylactic VMAMC may challenge traditional *performances of masculinity*, which may have implications for meaning-making as this public health intervention stands in juxtaposition to traditional MC. Traditional MC is understood as fulfilling collectivist ideologies regarding masculinity, while VMAMC may force traditionally circumcising citizens to accept that their circumcision is a modern practice that individuates them from such traditions. However, it could be that VMAMC, by virtue of its motivation to serve the common good (over and above the objectives of the individual), may be accommodated into traditional African circumcising structures specifically and men's health more generally.

5.4.2. Men's health.

Plurality and fusion was the central tension underlying how the men described the foreskin. They reflected on how it is a natural part of the male body, while at the same time being a site for disease, dirt and infection. Participants see VMAMC as a mechanism that further pathologises the male body, while also being a procedure that makes them more masculine. Similarly, the participants regard MC (as a *performance of masculinity*) as a rite that culturally celebrates the shifting of a boy into manhood (or religiously marks his body in symbolic submission to his creator), however; it can also, and sometimes simultaneously, be understood as a mutilation of the body and condemnable transgression of human rights, (Denniston et al., 2006; Grund & Hennink, 2012; Mshana, Wambura, Mwanga, Mosha, Mosha & Changalucha, 2011; Westercamp, Agot, Ndinya-Achola & Bailey, 2012).

The sheer number of groups that exist to show their opposition to the practice of traditional and/or medical MC speaks to the depth of emotion and passion related to the abolishment of this practice[8]. They are not alone, with many cultural commentators comparing 'circumcisers' to abortionists. They are also regularly ridiculed as being perverts, sadists, or even Nazis (Booker, 2013), largely echoing the reasons offered by participants who claimed that they would not undergo VMAMC even if it were to reduce their risk of HIV infection because it can be compared to rape or sexual abuse (Cromie & Kelleher, 1993; Svoboda, 2013).

This type of meaning of VMAMC as being a form of genital mutilation was relatively common among participants from non-circumcising traditions. Although a large proportion of the South African male population practices some form of traditional MC, there is a substantial number of men for whom any form of genital cutting is a foreign and cruel concept. This is something to be considered during public health messaging during the potential upscaling of VMAMC in South Africa.

Thus *plurality and fusion* in the data shows that meanings of VMAMC in the context of HIV prevention cannot be separated from wider culture understandings and meanings of the male body. The male body cannot be reduced to any sort of biological essence since foreskins are facts of personal and collective significance, where, depending on one's heritage or personal perspective, the foreskin has been made culturally or biologically significant. Rather, it is an object of contestation and cultural debate.

South Africa is a society that is constituted of elements of both individualist and collectivist perspectives (Babones & Babcicky, 2010; Nafstad, Blakar, Botchway, Bruer, Filkukova & Rand-Hendriksen, 2013). The seemingly contradictory positioning regarding *performances of masculinity* was evidenced as participants considered traditional and 'modern' forms of manhood when it came to making meaning of VMAMC.

[8] The following is but a partial list of some of these groups that exist at present: D.O.C. (Circumcision Doctors Opposing Circumcision); In Memory of the Sexually Mutilated Child; INTACT (Infants Need to Avoid Trauma); UNCIRC (Uncircumcising Information and Resources Centre); NOHARMM (National Organization to Halt the Abuse and Routine Mutilation of Males); MUSIC (Musicians United to Stop Involuntary Circumcision); Mothers Against Circumcision; OUCH (Outlaw Unnecessary Circumcision in Hospitals); S.I.C. Society (Stop Infant Circumcision Society); as well as ARC (Attorneys for the Rights of the Child).

Considering the history of Johannesburg and its development into a cosmopolitan city, where most of its inhabitants migrated from rural areas to its centre in search of employment and resources, it is not surprising that a good number of its residents maintain ties with their rural 'homelands'. In Johannesburg, people are confronted with social interactions and environments that are vastly different to those in their homelands, and these urban experiences require these individuals to be flexible in their responses in order to be considered socially 'competent' (Tierney, 2014). Participants reflected on the notion that people adhere to a code of masculine conduct when they visit their rural homelands that is remarkably different to their way of life in the city where they reside. Navigating these rural and urban masculine identities seems to require a reliance on *plurality and fusion*, as individuals are often compelled to adapt their individual meaning-making strategies to the context in which they are located at particular moments.

That is to say that an individual may reject the traditional norms in his private life to embrace modernity and urbanised *performances of masculinity*, while adopting such norms as part of his public life (Faist, 2000; Vaughan & Arbaci, 2011; Ward, 2013). This could explain why the participants could not always identify the 'contradictions' that they presented in their responses that reflect both an advocacy and rejection of VMAMC. However, participants did highlight the difficulty of maintaining their traditional customs when living within a large metropolitan city like Johannesburg. It was noted that it was particularly difficult to maintain traditional values and practices in wealthy urban areas than in rural areas, where communities are more homogenous than in the cities.

Additionally, the matter of *plurality and fusion* was evident in the interview data as it relates to patriarchy and ownership of the foreskin. Bloch (2004) highlighted the patriarchal nature of traditional MC as a rite that represents a political oath in certain societies. In Xhosa traditional MC, a father (or male guardian) expresses his devotion to the community by commending his son's reproductive promise to elder kinsmen and fraternity, thereby renewing group unity (Mercier & Fageant, 1998). Traditional MC embodies the nuances of symbolic classification and the forming of structural relationships of activities to label group membership (Gluckman, 1968; La Fontaine, 1985; Mehta, 1996; R´oheim 1942; Spencer, 1965; Turner, 1967; Van Gennep, 1909; Warner, 1958).

In South Africa foreskin ownership collides with traditional epistemologies in which foreskins have importance that expand beyond the individual's physical rights into cultural identity (Talle, 1993). One has to question who in fact owns the foreskin, since in the case of traditional MC it does not seem to be the individual's intrinsic property, as his male identity (and all related personal and social benefits thereof) depends on him parting with it. This 'foreskin ownership' is then undoubtedly inseparable from how men make meaning of VMAMC. The dataset reflected *plurality and fusion* regarding ownership of the foreskin in the face of patriarchy. Almost all of the participants indicated that they had ownership of their bodies, but that their sons could not take ownership of their own foreskins, both in terms medicine and tradition. These participants would wish for their sons' genitalia to resemble their own and for the familial tradition of MC (or non-MC) to be continued for the generations that follow.

The concern that arises as a result of parents (particularly fathers) having decision-making power regarding the traditional or medical circumcisions of their sons is that agency in decisioning and action regarding VMAMC are no longer present by the time that the son reaches adulthood. This has implications for the upscaling of VMAMC for HIV prevention, since there will be a substantial number of young men in every generation who will be unable to participate in this intervention even if they wished to, because they will have already previously been medically or traditionally circumcised at the insistence of their fathers.

In summary, the *plurality and fusion* of men's health shows that social constructions of hegemonic masculinity (as they are related to MC practices) are not unchallengeable. The practice of traditional MC is currently considered to be less popular in some communities (Dave, Johnson, Fenton, Mercer, Erens & Wellings, 2003), while in others it remains an essential ritual that is imperative to personal masculine identity and patriarchy (El-Hout & Khauli, 2007). While the practise and popularity of MC has evolved over time, the traditional rite remains a male-only event whereby initiates have no (or limited) interaction with females (Kepe, 2010; Marck, 1997; Mavundla et al., 2009; Mbito & Malia, 2008). This was found to be a critical factor in VMAMC meaning-making, as participants revealed *plurality and fusion* in their responses to the inclusion of women in the implementation of VMAMC for HIV prevention. This is discussed in the section that follows.

5.4.3. Politics of implementation.

In order to address (at least in part) the issues identified in the public health system as obstructing HIV prevention efforts in South Africa, WHO (2011) proposed the utilisation of task-shifting. Task-shifting is a cost effective mechanism which includes the reasonable reallocation of work amongst healthcare teams so that less specialised staff are delegated to fulfilling particular medical roles, so as to make more qualified healthcare providers available to perform more complicated clinical tasks (Chang, Serwadda, Quinn, Wawer, Gray & Reynolds, 2013; Ezechi, Gab-Okafor, Ostergren & Pettersson, 2013). HIV related task-shifting has been successfully implemented in several Sub-Saharan African countries (Chang et al., 2013; Ezechi et al., 2013; Lehmann, Van Damme, Barten & Sanders, 2009; Pollock, Love, Steffes, Thompson, Mellinger & Haisch, 2011). For example in Kenya, nurses and trained clinical officers have successfully performed VMAMC surgeries (WHO, 2011).

However, the patriarchal traditions related to traditional MC intersect with the strong history of patriarchy in medicine, whereby doctors are typically considered to be men while women tend to occupy 'lesser' positions within the medical profession. In South Africa, nursing remains a predominantly female profession (Berman, 2012; Bracken, Messing, Campbell, La Flair & Kub, 2010; Mavundla, Netswera, Bottoman & Toth, 2009; Pillay, 2010). This sort of segregation within the medical profession may have a negative impact on the ways in which men regard women (and the ways in which women regard themselves), by imposing and legitimising patriarchy within the practice of medicine, and by extension, matters that relate to public health.

This has implications for the implementation of VMAMC in areas where task-shifting may be required. The fact that participants never once considered that a consulting physician or surgeon could be a female, speak volumes as to the conditions under which they expect VMAMC to be performed. The participants did not address the matter of female healthcare professionals directly, however; whenever they spoke about a doctor discussing VMAMC with them or actually performing the procedure, they always referred to the doctor as a man or used the pronoun 'he'. Such concerns were certainly related to patriarchy in the longstanding practice of traditional MC, and this was thus conflated with how this historical position regarding the exclusion of women from all matters related to MC would be challenged by VMAMC.

The data raised important questions regarding the space that women can occupy (professionally) within the practice of medicine, which is not as 'gender neutral' as it is assumed to be. Given this gendering, it is not surprising that the very possibility of female doctors being involved in the delivery of VMAMC was considered important by the participants. According to Chief Patakile Holomisa (who is the President of the Congress of Traditional Leaders of South Africa), "women should not be fiddling with penises of males" (Kepe, 2010, p. 732). However, at the same time, the South African Department of Health is dedicated, in line with the Employment Equity Act (Mathur-Helm, 2005), to non-prejudiced and non-discriminatory ideals with regard to the employment of a qualified individual based on their race, gender, sexual orientation, and religious beliefs.

One must then consider that this public health intervention will be impacted by the patriarchal tension that arises when the success of South African VMAMC HIV prevention strategies seems to rest on the distinct absence of female healthcare professionals, administrators, monitoring and evaluation researchers, and intervention promoters or educators, while simultaneously upholding the social principles of gender equity and empowerment in post-Apartheid South Africa. Yet the inclusion of women in medicine and healthcare may very well be a challenge to the uptake of VMAMC for the purposes of HIV prevention, especially since traditional forms of MC forbid the inclusion of women.

To conclude, the intersecting and interacting variable of *plurality and fusion* in this GT offers a feasible account of how seemingly contradictory approaches co-exist (as presented within the properties and dimensions of *citizen rights and responsibilities in times of HIV*, *men's health*, and *politics of implementation*) when participants make meaning of VMAMC for HIV prophylaxis. This is evident in the causal condition of the *crisis of medicalised modernity* (discussed on the next page) underlining this GT as individuals contend with how modernity intersects with 'tradition' as a means to restructure masculinity, which is an important site for meaning-making.

5.5. The Causal Condition: Crisis of Medicalised Modernity

Having defined medicalised modernity in the previous chapter, it is necessary to consider the theoretical frameworks that may account for this causal condition at it occurs in this study. The theoretical frameworks that have attempted to account for the various demographical and epistemological shifts that accompanied modernity are vast, but essentially consider that 'traditional' societies, typically with the aid of more urbanised and industrialised counties, have the capacity to (over time) modernise their social and cultural structures (Schifirneț, 2012). Participants referred to this as they alluded to the tensions that exist between rural and urbanised accounts of masculinity, HIV prevention, and medicine. Participants reflected on this crisis as they indicated that they, as individuals, had the ability to enhance themselves and alter their society, primarily by critically reviewing their understanding of science, technology, economics, as well as their religious and cultural beliefs.

Furthermore, the participants alluded to the contested process whereby non-medical issues are seen to have become medicalised[9], for example child-birth, death, weight-loss, and MC, which are now commonly done in clinical settings (Conrad, 2013; Huber et al., 2011). It is primarily contested because it implies that some experiences can reside in the medical domain and others cannot (Ballard & Elston, 2005). According to Morgan (1998), for medicalised modernity to firmly appropriate otherwise 'non-medical' practices, the conceptualisation of the object to be medicalised requires the development of theories and paradigms.

Medicalised modernity seems to operate at a number of ecological levels. For example, traditionally non-medicalised practices are medicalised at the macro-level through institutionalisation. This relies on a systematic alliance between various disciplines. It emerged from the data that the medicalisation of traditional MC or VMAMC for HIV prevention becomes legitimised through buy-in from the legal system, private and public medical aids, pharmaceuticals, academic hospitals, NGOs, and the NDoH. Thus institutionalisation compels citizens to acknowledge the authority of medical understandings of the male body and how it requires modification in order to prevent HIV infection.

[9] For example, something as common as travel requires that individuals produce inoculation certificates for inspection by immigration officials (such as yellow fever) should they be visiting an area where there is a high risk of disease contraction.

The findings presented in the previous chapter showed that participants feared that a formal institutionalisation of MC could witness the male body (understood as being inherently defective and pathological) being used as a leverage site for socio-political control.

5.5.1. Socio-political control of citizens through medicalised modernity.

Participants referred to a growing risk that there could be an increase in social and political control masquerading as the preservation of health (Morgan, 1998; Zola, 1979). The severity of the HIV pandemic in South Africa legitimises interpreting traditional practices through a medical lens. Zola (1975) claimed that as citizens subscribe to this perspective by medicalising traditional MC and advocating VMAMC for HIV prevention, they knowingly or unknowingly promote the utilisation of medical science for the purposes of social-political control. This, he stated, is possible because the state (through the public health system) is able to cloak itself with technical impartiality and benevolent scientific processes, resulting in a more enthusiastic and 'rational' public acceptance of this medical practice of permanent genital modification (Davis, 1973; Zola, 1975).

Traditional MC has a long history of being medically appropriated. For example in the 1890s, English physicians recommended that the Jewish rite be performed under clinical surgical conditions by neonatal surgeons (Carpenter, 2010). According to Gollagher (2000), these physicians considered Jewish circumcisions to be archaic, dirty and unsafe. At the same time, these physicians asserted that being uncircumcised was associated with masturbation and psychological (as well as physical and mental) disorders such as insanity, neurosis, pubescent turmoil, female sexual aloofness, epilepsy, nymphomania, blindness, hair growth on the palms of the hands and soles of the feet, as well as the diagnosis of hysteria (Aggleton, 2007; Darby, 2003; Hodges, 2005).

They believed that intact males found masturbation more pleasurable and thus may be more prone to self-stimulation. By severing a sensitive portion of the penis, many exponents of medicalised MC argued that young boys' hands would not be tempted into masturbatory pleasures (Alouf, 2005; Darby, 2003). Young English boys were therefore medically circumcised during the late 1800s as a prophylaxis to masturbation. This practice was maintained into the early 1900s, with the Royal College of Surgeons endorsing medical MC in *On Circumcision as Preventative of Masturbation* (1891) and *Circumcision, It's Advantages and How to Perform It* (1893). During this time, many have argued that MC was medicalised so as to regulate sexuality and morality.

Participants' views that the state was attempting to control its citizens in the face of the HIV pandemic highlight a stark contrast between the current government administrations (under President Jacob Zuma) as compared with the Mbeki administration[10]. Furthermore, participants referred to the traditional background of the country's president as they considered VMAMC as being a form of socio-political control. President Zuma is a Zulu man and thus comes from a non-circumcising tradition, yet he has publically stated that he endorses the implementation of this medical intervention and has encouraged all adult men to undergo VMAMC for HIV prevention. Participants believed that should future elected presidents belong to traditionally circumcising cultures or religions, they are likely to withdraw such endorsements for HIV-preventative VMAMC in favour of traditional (potentially non-medicalised) MC practices.

Therefore VMAMC was understood as being an intervention that would be implemented to comply with the personal agenda of the presidency rather than as a HIV prevention strategy that is in the best interests of the populace. However, the medicalisation of traditional MC and HIV prophylactic VMAMC speak to a movement away from traditional MC practices in contemporary times. Medicalised modernity then generated a sense of crisis for those who were expected to maintain traditional customs related to MC, since it was seen as challenging traditional structures.

5.5.2. The corrosion of tradition.

While some participants indicated that there can be no doubt that tradition often overrides medical justifications for VMAMC, other participants considered medicine to be the most highly regarded and significant form of knowledge required in addressing the HIV pandemic. From this perspective, medical bodies become dominant as they are permitted to retain or reject traditional paradigms of MC, and in so doing, traditional values and customs become medically appropriated. Proponents of modernity claim that maintaining tradition without critically reviewing its purpose, social value, consequences and outcomes, is detrimental to society's development (Dirlik, 2003). Thus modernity leaves little space for traditional beliefs or customs as rationalism, critical thought, urbanisation and industrialisation take hold. Therefore it is not surprising that the participants elided medical MC with traditional practices, for example ritualised genital cutting and penile modifications.

[10] The Mbeki regime was criticised worldwide for its stance on the link between HIV and AIDS, the banning of ART distribution in state hospitals, as well as an overall delayed response to the HIV pandemic in South Africa (Kalichman, 2014).

Medicalised modernity in the health sector is regarded as the transitioning of societies from 'traditional' views of health and illness to 'modern' perspectives. It has been argued that medicalised modernity is not simply the introduction of 'western' medical practices at the expense of, for example, African traditions (Pratt, 2012), however; socio-political events such as colonisation and Apartheid with its legacy in South Africa were driven by western ideologies that compromised African traditions, identity, independence and autonomy (Baronov, 2010). Thus while modernisation theorists claim that medicalised modernity is erroneously conflated with westernisation, colonialists did in fact seek to westernise African tribes.

This may also explain why, despite VMAMC and medicalised traditional MC posing fewer health risks than traditional MC, some participants insisted that having the ritual performed under medical conditions (as opposed to in rural initiation schools by untrained traditional healers) would impinge on the traditional value of the rite, and therefore opposed the implementation of VMAMC (Mayatula & Mavundla, 1997; Mavundla et al., 2010; Mbito & Malia, 2009; Meissner & Buso, 2007). Ballard and Elston (2005) noted that while medicine's jurisdiction has extended itself beyond the realm of health and disease by intruding on society, the public (as healthcare consumers) can either embrace or resist the medicalisation of society. For those who oppose the medicalisation of traditional rites, VMAMC means the corrosion of tradition.

A number of studies have found that medical interventions have been resisted on traditional grounds despite their benefits to the public (Chatters, 2000; Jackson & Scambler, 2007; McKinlay & Marceau, 2000). Such interventions may include the amputation of an infected organ or body part, repudiation of organ donation, or refusing to perform an autopsy on the deceased, all of which are related to religious and cultural beliefs that the body must remain intact for the after-life, as well as the refusal of blood transfusions or organ transplants due to the belief that the 'soul' resides in the living tissue and fluids of the body. Thus belief-systems play a role in HIV prophylactic VMAMC meaning-making, and will need to be considered should South Africa remain committed to the upscaling of this public health intervention as part of the UNAIDS agenda for HIV prevention (UNAIDS, 2013).

As such, if VMAMC is regarded as a challenge to the belief systems of particular religious and/or cultural groups within the South African population, public health practitioners may need to be aware that such groups may resist the uptake of VMAMC as a HIV prevention intervention.

The *crisis of medicalised modernity* has an effect of the post-traditional order whereby one can embrace tradition as well as medicalised modernity, since for some participants they are not seen to be mutually exclusive. So as much as the data speaks to participants being either traditional or modern, further analysis shows that this binary conceptualisation is often blurred in practice. Participants who welcomed medicalised modernity believed that that medical MC will be used as part of the traditional rite of passage for their sons (when they assumingly 'come of age'), yet cling to tradition in the sense that their sons will have no voice in this decision and that this structure of tradition will be forced upon them.

Park (2013) argued that meanings are "discrepancy-based" as they allow for the perceived discrepancies that people have of their situational and global meanings, which can generate distress. That is to say that people may have an assessed meaning of a certain matter, which they then consider to be at odds with their global meaning (their general beliefs about the world). According to Park (2013, p. 40), global meaning is the "individuals' general orienting systems and view of many situations", while situational meaning is limited to a particular occurrence and involves three phases: (1) the preliminary assessment of the relevant issue, (2) a reconsideration of global meanings, and (3) the conclusion of these phases.

In the case of the causal condition of the *crisis of medicalised modernity*, participants in this study seemed to initially locate VMAMC for HIV prevention within the meanings that they assigned to traditional MC. Depending on whether or not meanings of traditional MC were aligned with the meanings of VMAMC, individuals then reconsidered their meanings of traditional MC in relation to the severity of the HIV pandemic. If they were unable to resolve or reconsider the meanings that they had assigned to traditional MC, they remained in a state of crisis. In order to manage this crisis, individuals then have to change their situational meanings of VMAMC to no longer challenge their global meanings of traditional MC by relying on explicit or implicit strategies.

5.5.3. Strategies for VMAMC meaning-making.

Park (2013) proposed that people tend to favour homeostatic conditions and so will attempt to diminish this discrepancy to resolve any distress. This resolution can occur via two primary strategies: (1) problem-focused; and (2) emotion-based (Benson, 2010). Meaning of VMAMC is made within the context of a causal condition such as *the crisis of medical modernity* while relying on emotion-based strategies through accommodation (the amending of general belief systems to better align situational with global meanings) or assimilation, which is the easier of these two cognitive processes as it allows the individual to adjust their appraised situational meaning to unite with existing global meanings (Park, 2013).

5.5.3.1. Implicit strategies.

Participants who were opposed to VMAMC (or who were unable to marry their global meanings of traditional MC with their initial situational meanings of VMAMC) relied on a host of knowledge systems to make it so that VMAMC for HIV prevention was not necessary or relevant to them as individuals. In such cases, participants indicated that the state should upscale VMAMC for HIV prevention in South Africa given the severity of the pandemic. However, the data analysis revealed that participants were largely referring to the necessity of VMAMC uptake by 'other' men who they considered to be at particular risk of infection.

HIV has been constructed as a concern for 'the other' in countless ways. Conceptions of HIV, since its emergence, have been anchored using categories of 'the other' that have a long history: the homosexual, the drug addict, and the sexually promiscuous (Aggleton, Rivers & Warwick, 1993; Thompson & Kumar, 2011). In a similar vein, the participants often attributed HIV-risk to sexual promiscuity.

They believed that promiscuous men (or men who were married to unfaithful women) should take up VMAMC since they were at high-risk of infection. None of the participants identified themselves as being sexually promiscuous or having female sexual partners who were capable of infidelity. For this reason HIV prophylactic VMAMC was understood as being a method of HIV prevention for 'other', vulnerable men.

This *othering* occurs as people seek to make meaning of HIV and HIV-risk (Baban & Craciun, 2007; Durantini, Mitchell, Earl, Gillette & Albarracín, 2006; Kaler, 2004; Kirby, Laris & Rolleri, 2007; Riley & Baah-Odoom, 2010). Research has shown that individuals underestimate their personal risk of infection by relying on beliefs and biases within the context of a social crisis (like the HIV pandemic) (Howard-Payne, 2010; Howard-Payne & Kiguwa, 2008; Stine, 2008; Weiss et al., 2000).

This is the key theoretical challenge to a number of HIV prevention interventions, as perception of risk is a critical factor in inspiring people to modify their health-related behaviours (such as adopting safer-sex practices). The fear of HIV infection generates a host of self-protective mechanisms, whereby individuals underestimate their risk of infection (despite acknowledging particularly high-risk sexual behaviours) and so reject preventative behaviours. In underestimating their risk of infection, participants seemed to overestimate others' risks. Participants relied on the process of *othering* to limit the personal relevance of VMAMC as a necessary HIV prevention strategy in South Africa.

Participants indicated that they would consider men who underwent VMAMC as being sexually promiscuous. Despite psycho-educational interventions that seek to dispel the myth that only homosexuals, IDUs, and/or people who are sexually promiscuous can contract HIV (Jones, Baker, Gelaude, King & Jemmott, 2013; Spiegel, 2004; Wechsberg, Luseno, Lam, Parry & Morojele, 2006), social cognitive theory proposes that human beings rarely amend existing biases (Gaertner & Dovidio, 2014; Rendell, Fogarty, Hoppitt, Morgan, Webster & Laland, 2011). Even in the face of disconfirming evidence, people often cling to their existing beliefs regarding HIV-risk, and these were relied upon in the meaning-making of VMAMC as being a personally irrelevant HIV intervention. This meaning was substantiated by participants reflecting on the value of existing efforts that made VMAMC a redundant method of HIV prevention.

5.5.3.2. Explicit strategies.

Participants, in their evaluation of the personal relevance of VMAMC, indicated that they relied on existing safer-sex practices to prevent HIV. They believed that, for them personally, VMAMC was a radical and unnecessary intervention. For these participants, VMAMC was radical in relation to the use of condoms.

Without evidence that indisputably proves that the health benefits outweigh the risks, VMAMC will continue to be regarded as an intervention that carries too many biomedical consequences to warrant it as a primary method of HIV prevention, and thus the public may regard existing interventions in favour of it. However, research has found that South Africans are not adopting these safer-sex practices, at least not on a consist basis or in the correct manner (UNAIDS, 2013).

In an effort to distance oneself from the stigmatisation of VMAMC, participants may take recourse to mis-cognitions. These are the products of economised information processing, whereby in order to maximise the amount of information that can be processed, information that simply confirms what people already believe to be true about the social world is retained in favour of adjusting long-standing world views by considering contradicting evidence for such views (Park, 2013).

Participants seemed to do this as they proposed that VMAMC may eventually be regarded as a legitimate form of HIV prevention, such as condoms have become, but that this intervention is only likely to be accepted by the younger generations who are able to manage *the crisis of medicalised modernity*. Participants spoke to targeting the youth with education interventions, as the older generations may be too set in their ways of medical and traditional MC to have the two procedures co-exist. Although this implies that the current adult male population is largely removed from potential participation in VMAMC, the participants' suggestion that psycho-educational public health interventions should target boy children to prepare them for the uptake of this public health intervention when they reach adulthood is perhaps a solution to the basic social process and thus should be explored further.

Existing HIV interventions were further favoured over VMAMC as participants believed that VMAMC would in fact encourage sexual risk-taking and consequently increase the spread of HIV in South Africa. The participants felt that the public would not be capable of monitoring their sexual practices if they believed that undergoing a MAMC would significantly decrease their risk of HIV. They suggested that educational programmes should mislead the public by saying that the protective factor of VMAMC was not as high as 60%. However, public health interventions which are endorsed by the government that intentionally mislead the targeted beneficiaries of HIV-preventative VMAMC may only serve to further stimulate mistrust of the state and its public health interventions.

As in other studies (Bonner, 2001; Halperin, 1999), participants were sensitive to the possibility that VMAMC-centred HIV interventions might, tragically, substitute other efforts such as condom-use and education to encourage behaviour modifications. The participants proposed that the successful upscaling of VMAMC in South Africa would depend on public health integrating this intervention into existing HIV prevention interventions. Education campaigns should therefore also link sexual behaviour modifications, which include the consistent and correct adherence to safer-sex practices, to VMAMC.

To conclude, the findings relating to the causal condition of this GT remind researchers, once again, that while South African public health policy-makers often have to satisfy a host of 'conditions' set by global public health policies in order to receive essential funding to be able to develop and implement HIV prevention policies, such 'conditions' often collide with the various socio-cultural elements of the unique South African population.

While global policies remain focused on addressing the public health issue of HIV prevention, they may fail to adequately consider the significant issues that arise from the *crisis of medical modernity* within the South African context. Having detailed this causal condition, the section that follows explores the basic social problem, *performances of masculinity*, which seemed to organise the data.

5.6. The Basic Social Problem: Performances of Masculinity

Understandings of what constitutes masculinity are not unanimous nor is it immutable, since it is socially constructed to reflect a particular social context (Levant, 2011). A historical account of South African masculinity must take account of traditional patriarchy, colonialism, as well as racial and tribal oppression (Carton, 2002; Connell, 2005). As such, while I note the significance of considering masculinity within local and universal contexts, this study focuses on the interpretation of the data as it converges on the ways in which the participants from my sample make meaning of VMAMC in relation to their *performances of masculinity*.

The participants considered *performances of masculinity* in relation to a number of typical hegemonic characteristics and behaviours, for example being a good provider for one's family, attracting a suitable sexual mate, and conducting oneself with honour.

For these participants, hegemonic masculinity was revealed through behaviours that were not limited to the prioritisation of traditional practices relating to MC or non-MC, however; they noted that there was a degree of masculinity attached to the ways in which others regarded them as men, and this was undeniably related to penile cutting practices.

The participants felt that others would regard them as being particularly masculine if they adopted one of two roles: firstly, they could be regarded as being an active masculine agent in the fight against HIV; or secondly, they could be perceived as being masculine as they maintain and prioritise traditional practices relating to MC. In both cases it would seem as though these *performances of masculinity* are aligned with being a protector of the people, either through HIV prevention or maintaining traditional values and customs.

Performances of masculinity are culturally-bound as they are related to the presence or absence of the foreskin, as well as the method, timing, and context of its removal. It has been stressed that the traditional rite of MC typically demands that the man endure physical pain, isolation, as well as various tests of hegemonic masculinity (Beidelman, 1997), while it appears that gender and ideology often are central to traditional and medical MC. For some African cosmologies, male bodies need postpartum modifications to achieve complete 'wholeness' (Silverman, 2004). Although this is a concept foreign to many, under these ideologies masculinity is not universally complete upon birth. Participants who prioritise traditional MC practices over VMAMC are doing so in the belief that they are defending their historical rights to attain masculinity through traditional practices that cannot be changed to accommodate medical HIV interventions.

For Xhosa men in South Africa, the rite is typically regarded as a vital component of the initiation of pubescent boy into manhood and masculinity (Mavandla et al., 2009; Vincent, 2008). During this initiation, the boys are isolated with other initiates for a defined period of time within an initiation school. The initiation typically consists of cultural 'indoctrination' in the form of various intricate rituals, abstinence from sex and particular foods and/or fluids, tests of physical strength and masculinity, and the MC is performed by the *ingcibi* - the traditional surgeon (Peltzer & Kanta, 2009). This ritual is performed in groups of up to 20 boys at a time, where these boys live together for approximately three months in the rural Eastern Cape as they undertake the conversion from boy to man.

It seems as though, given the dissimilar conditions under which medical MC for traditional purposes and VMAMC for HIV prevention must occur, men who subscribe (willingly or otherwise) to traditional MC or non-MC may find themselves reluctant to take up this potentially prescribed form of HIV prevention.

Furthermore, men who regard any form of MC as compromising their traditional identities which are related to remaining intact, may also find that they are unable to participate in this HIV intervention. For example a number of the Zulu participants indicated that they could not undergo VMAMC for HIV prevention in case people then believed that they had been traditionally circumcised and mistakenly identified them as being Xhosa or Pedi rather than Zulu. However, the Zulu King, Goodwill Zwelithini, recently endorsed the introduction of MC into Zulu culture by way of VMAMC in an effort to address the HIV pandemic (Decoteau, 2013). This highlights the potential of VMAMC being introduced as a traditional practice that is aligned with meanings of masculinity in the adoption of both HIV-fighting agent as well as maintaining traditional MC practices.

An issue that might not have been widely considered regarding the implementation of HIV prophylactic VMAMC relates to traditional practices regarding MC or non-circumcision, which is critical to *performances of masculinity*. The tension that exists due to the introduction of VMAMC as a public health HIV prevention strategy in South Africa since it currently challenges meanings of traditional MC or non-MC was identified as being the basic social process in this GT, as participants sought to make meaning of VMAMC by negotiating the tensions that exist between tradition and medicine. This is unpacked further below.

5.7. The Basic Social Process

As noted above, the traditional ritual that includes MC is seen as bestowing the initiate with qualities, protection and identity that cannot be attained from modern medicine. While modern medicine acknowledges the role of non-physical aspects of the human experience (as the psyche) in causing illness (as in psychosomatic illness) or influencing the outcome of treatments (the placebo effect), it does not lay emphasis on features (such as the soul). Traditional medicine, on the other hand, provides holistic treatment to the individual as it considers the physical body and non-physical body as being the cause of illness. This could be the appeal as Street, Ngcobo, Mbatha and Gqaleni (2012) estimated that 80% of the South African population consults with traditional systems of health.

Traditional medicine maintains that AIDS is caused by HIV, but it also upholds that HIV infection is punishment for the youth rejecting traditional norms and breaking traditional taboos (Ogunmefun, Gilbert & Schatz, 2011). In a multi-cultural South Africa, however; it is not unusual for a person to blend a traditional and medical understanding of illness. It is the treatment or prevention of illness that causes friction between tradition and medicine, since medical interventions can sometimes intrude on other traditional norms in order to prevent or treat a particular illness. This has been the case with VMAMC, which is encased in a context marked by *plurality and fusion*. The role of tradition in generating meanings of VMAMC is articulated in the ways in which people think, speak, interact with, value, and practice MC.

Each participant spoke to the importance of tradition - even those who indicated that they did not maintain any particular traditional African values or practices (most notably within the interview data from the younger participants). Nonetheless, each participant was aware of the particular meanings and rituals regarding traditional MC, as well as other culturally-specific customs that are performed at particular times in an individual's life such as at birth, coming of age, marriage and death, and observed these customs to varying degrees.

Since tradition is not meaningful on its own but rather as performed within a familial context, this has implications for VMAMC for HIV prevention since this links the foreskin (and the way it is removed - or not removed) to traditional affiliations. However, the participants proposed that VMAMC could be successfully integrated into traditional MC practices simply by having the rite medicalised. The point for concern within the South African context, however; is not regarding the capacity for MC to eventually become widely accepted as both a medically- and traditionally-valued practice, but rather with regard to the medical versus traditional value of the practice in relation to its use against the spread of HIV. Therefore the underlying *tensions between tradition and medicine* are not limited to the *crisis of medicalised modernity,* but rather rests within the seemingly irreconcilable differences between MC performed as part of tradition (whether it be under medical conditions or not), and the conditions under which VMAMC would be performed in order to meet its public health-based imperatives for HIV prevention.

5.7.1. Impossibilities of traditional-VMAMC hybrids.

Almost all of the participants suggested a hybrid of traditional MC and VMAMC as a way of navigating the tensions generated by the introduction of this HIV prevention strategy. This propensity towards hybridity, in consideration of ambivalence (Naum, 2012), post-modernism and globalisation (Whitty & Biberman, 2012), multiculturalism (Modood & Dobbernack, 2011), and post-colonialism (Yousfi, 2014), speaks to meanings of VMAMC being a product of a number of experiences regarding traditional MC and medicine. This implies that it is entirely normal for the majority of participants to join conflicting concepts together in an effort to minimise their differences. While the participants proposed a hybrid of traditional and medical MC as a pragmatic way of overcoming the tensions between tradition and medicine, the process of pain, conditions, and the timing of the VMAMC proved that a marriage between tradition and medicine in the form of the proposed hybrid would not be entirely uncomplicated.

5.7.1.1. The process of pain.

While student-doctor participants who came from traditionally circumcising backgrounds believed in the maintenance of tradition, they supported the medicalisation of the traditional practice. This was because they believed that medicalised MC does not involve any pain and that there was little to no risk involved in the procedure. Given this support of medicalised MC, it was unsurprising that they also suggested the traditional-medical hybrid approach to VMAMC for HIV prevention as a way of bridging the tensions between tradition and medicine.

Yet each of these participants had themselves been traditionally circumcised, not under any medical conditions and certainly not with HIV prevention in mind, which is why they may not have anticipated some of the practical and ideological impracticalities related to this proposed hybrid.

The previous chapter highlighted how medical MC would challenge the meaning of traditional circumcision in relation to the endurance of pain. This tension is relieved to an extent since participants from traditionally circumcising backgrounds say that tests regarding pain endurance exist in other parts of the initiation process as well, which means that its absence from the MC component of the tradition is made more bearable.

Pain endurance as an element of hegemonic masculinity for traditionally circumcising participants is not necessarily at odds with medical MC as well as VMAMC for HIV prevention, since this intervention would be conducted under similar medical conditions whereby pain is not experienced during the procedure. Yet there are other conditions that underpin the cultural or religious relevance of a traditional MC that seem to be at odds with the conditions required to ensure that VMAMC will adequately reduce a man's risk of acquiring HIV during peno-vaginal sex.

5.7.1.2. Conditions of circumcision.

Traditional MC is principally a communal practice whereby the intact male initiate would be joined by 20 other young men to be circumcised as a rite of passage. VMAMC for the purposes of HIV prevention, on the other hand, is performed on an individual adult man while he is in an operating room. The initiate being circumcised would traditionally expect the absence of any women, however; the men undergoing the HIV-preventative VMAMC would have to anticipate that the procedure might be performed by a female healthcare worker (possibly the anaesthetist, surgeon, post-op doctor, and/or nurse), even if he is likely to be more at ease with a male healthcare worker considering the nature of the procedure (Jerant, Bertakis, Fenton, Tancredi & Franks, 2011; Levinson & Lurie, 2004). There does not seem to be a resolution for these *tensions between tradition and medicine* for the conditions under which these procedures are performed.

5.7.1.3. Timing.

Some participants, most notably from the student-doctor group, understood medical MC as having long-term health benefits, saying that it is a 'simple' procedure and, if performed shortly after birth, the infant recovers quickly enough to limit the amount of physical and psychological trauma that may be experienced (Ahmad, Goel, Pandey, Goel, Parashar & Bhatnagar, 2013; Blank et al., 2012; Grunau & Tu, 2007; Schoen & Fischell, 1991). However, the matter of consent is raised if one considers performing MC at an early age. Furthermore, it should be noted that the HIV prevention intervention does not propose to perform circumcisions on new-born males but rather the intervention relies on the participation of consenting adult men. The fact that this student-doctor believes that neo-natal medical MC is "better" than adult MC, introduces a new set of meanings to VMAMC as being a potentially risky procedure given the age of adult men who participate in its uptake.

Moreover, the proposed age for VMAMC does not correspond to the age at which traditional MCs are performed. Participants indicated that they would support MCs taking place under surgical (rather than traditional) conditions, but that they should occur at the traditionally-determined time of when young men are between 17 and 20 years old, and are ready to be welcomed into manhood by their culture. Research has found that by the time these young men undergo such a circumcision they are already sexually active and thus at risk for HIV infection (Harrison, Cleland, Gouws & Frohlich, 2005). In order to be of medical and HIV preventative relevance, VMAMC may have to be performed prior to sexual debut.

Thus not only does the timing of the traditional ritual seem to impact upon masculinity, but the nuances of the rite (for example those who are permitted to take part and be involved in the ceremony, the geographical location of the circumcision, and the method of incision) are significantly different for a VMAMC as opposed to a traditional MC. These discordant conditions remain a point of contention amongst the South African population. These are likely be key factors in how the public *resolve tensions between tradition and medicine*, which will ultimately be a feature in the meaning-making of VMAMC for the purposes of HIV prevention.

It is important to note the difference between the medicalisation of traditional MC and VMAMC for HIV prevention purposes. The medicalisation of traditional MC also generates tensions between tradition and medicine, which seem to only be further exacerbated within the context of HIV prophylactic VMAMC. Traditional MC has largely already been medicalised by the Health Standards in Traditional Circumcision Act, which was vociferously contested. Men were significantly opposed to the fact that the bill does not exclude the participation of women (mothers, aunts, sisters or grandmothers, as well as female medical personnel) from the ritual, and the requirement of the bill that a medical officer to oversee all ritual circumcisions was accepted (although begrudgingly so), on the provision that this officer was a 'black man only' (Kepe, 2010). Additionally, public response suggested that rather than the contemporary medical instruments approved by the bill for use during the traditional MC, a 'sterilized assegai' (which the initiate should supply himself at the time of his circumcision) should be used so as to maintain the sense of tradition that is considered to be critical to the purpose of the traditional MC (Kepe, 2010).

It is unlikely that all the conditions as stated above by the public could be met in the upscaling of VMAMC, as they would largely undermine the efficacy of the HIV prevention intervention. Furthermore, they undercut socio-political strategies that progress South Africa to being an ever more equal society that does not discriminate against people based on gender, race, religion, sexual orientation and creed. As long as the conditions of traditional MC and VMAMC for the purposes of HIV prevention remain so dissimilar, beneficiaries who come from a traditionally circumcising culture or religion may have irreconcilably conflicted meanings of HIV-preventative VMAMC. Indeed, reconciling these perspectives required negotiating some of the lynchpins of identity for many of the participants, and this formed the basic social process identified by the theory.

5.8. Addressing the Basic Social Process

The complexity of individual VMAMC meaning-making is highlighted as a result of the conditional matrix data analysis. In line with the ecological model of health, it was identified that VMAMC meaning-making occurs at various levels within two perspectives: (1) the person-centred; and (2) the situation-centred perspectives.

The person-centred perspective includes VMAMC meaning-making that results from intra-personal and interpersonal factors. This GT of VMAMC meaning-making is rooted within understandings of masculinity. That is to say that the way that individual men feel about themselves as male citizens, as well as how others perceive these men and their masculinity, impacts the meanings of HIV prophylactic VMAMC. If a participant believed that he would be considered by others as being especially masculine for maintaining traditional MC practices in favour of VMAMC, he regarded VMAMC as a threat to tradition and as an intervention that is a potentially unnecessary adjunct to existing HIV prevention interventions. Conversely, if the participant believed that he would be perceived by others as being particularly masculine by undergoing VMAMC, then this would be favoured as the way to perform masculinity, since VMAMC meant that the man could take on the role of protector by being an active agent in the fight against HIV. This aspect to the GT is important as it is the means by which participants in this study sought to control and minimise the tensions that arise between tradition and medicine in the context of HIV prevention in relation to their masculinity.

In the situation-centred perspective, VMAMC meanings manifest at a societal level, both national and international, as well as a community level. While the participants largely regarded the individual as being solely responsible for the prevention of HIV and the uptake of VMAMC, it is important to consider that such meanings and decisions cannot be evacuated from local contexts. A number of studies have shown that particular environmental factors may have a greater influence on individual health-related behaviours regarding HIV prevention than individual characteristics (Latkin, German, Vlahov & Galea, 2013; Mustanski, Byck, Newcomb, Henry, Bolland & Dick, 2013; Sallis et al., 2008; Stock, Peterson, Gibbons & Gerrard, 2013; Traube et al., 2011).

Individuals are influenced in countless ways by their interpersonal interactions, the socio-environment, as well as social and traditional norms about sexual and reproductive health and practices (DiClemente et al., 2007). VMAMC meaning-making manifests at a national level by the South African government's stance on VMAMC for the purposes of HIV prevention, as well as the existing national HIV prevention interventions that are available to the public. VMAMC meaning-making is positioned at the international level as debates rage on regarding the human rights deliberations, informed consent, as well as the maintenance and continuing of gender ideologies associated with traditional MC and patriarchy. VMAMC meaning-making is located at the level of community, as it is largely informed by the communal practice of ritual circumcision where young men (in groups of up to 300 individuals) gather in a rural-based initiation school to undergo training and tests of manhood.

5.8.1. Relevance of existing theory to VMAMC meaning-making.

The GT of VMAMC meaning-making should be considered in relation to various individual health theories (broadly classified as being motivational-, multi-stage-, or behavioural enactment-based), which imply that knowledge about HIV transmission and modes of prevention would be the foundation that would bring about infection-avoidant behaviours as individuals seek to reduce their risk of infection. However, such theories cannot fully accommodate the place of meaning-making of public health interventions. These are outlined below in relation to the second research question posed in *Chapter 1* - How might health psychology contribute to understanding and theorising these factors?

5.8.1.1. Motivational models.

This variant of health psychology theory looks to motivational models to predict health-related behaviours at specific moments in time, while illuminating the factors that influence these behaviours (Orbell, 2007). These models include the Health Belief Model (HBM) (Adler, Kegeles & Genevro, 1992; Deci & Ryan, 2000; Kaler, 2004; Rosenstock, Strecher & Becker, 1988); the Theory of Reasoned Action (TRA) (Ajzen & Fisbein, 1980; Van Dyk, 2003); and the Theory of Planned Behaviour (TPB) (Van Dyk, 2003).

Each of these models proposes that individuals make reasonable and systematic use of available information in determining how they choose to respond to certain health crises. However, this study shows that since *plurality and fusion* underpins VMAMC meaning-making, such meanings are contingent and dynamic and are influenced by a host of factors that are not grounded in rationality. As such, health decisioning and action endpoints responses to HIV (and VMAMC) are neither necessarily 'reasonable' nor 'systematic'. This poses considerable threats to these models in predicting circumcising behaviours.

Nonetheless, in addition to considering the importance of social norms, these models offer a comprehensive theoretical explanation of the associations between the constructs of beliefs (or attitudes), intentions and health-related behaviour for the individual (Fishbein & Ajzen, 1975). TRA, for example, proposes that individuals make reasonable and systematic use of available information in determining how they choose to respond to certain health crises (Ajzen & Fishbein, 1980).

Under these theories behaviour is directed by two stages, namely: (1) the individual's behaviour is determined by their intention to act (or not to act) depending on their attitude towards the intended behaviour; and (2) the pressure of social or traditional norms determines the individual's behaviour. This second stage of the TRA model is of particular interest in considering responses from participants regarding autonomy and action, since traditional MC is largely practiced by young South African men who, willingly or otherwise, fulfil the social imperative of maintaining the traditions of their particular cultural and/or religious group.

Similarly, TPB considers the importance of perceived behavioural control, which can be defined as the scope of ability that an individual believes they have with regard to practicing a particular health-related behaviour, as a predictor of health-related behaviours (Fishbein & Ajzen, 1975). The underpinnings of this model are similar to Bandura's concept of self-efficacy, as individuals are more likely to embrace a change in behaviours over which they believe they have control. This perceived behavioural control can be guided by knowledge, competencies, personality, assertiveness, and emotions (internal factors); the implementation of health-behaviour changes; opportunities to maintain these changes; access to resources; as well as structural traditional norms that impose particular roles and associated behaviours for women and men (external factors).

In other words, the perceived presence or deficiency of resources (both internal and external) and opportunities, as well as self-efficacy, can all determine the degree of perceived behavioural control of an individual. The premise of TPB also rests upon that notion that beliefs or attitudes, which reside within the individual but are often generated both within the interpersonal sphere and socio-cultural structures, are the primary motivators of an intention to practice certain health-related behaviours.

The practice of traditional MC maintains familial and traditional customs that bestow adult masculinity upon initiates. While rejecting tradition as the motivation behind MC implies some level of autonomy in relation to VMAMC, this reframing could result in a young man selecting VMAMC (rather than traditional MC, medicalised or otherwise) being infantilised by his peers, family and community. A number of participants felt that when younger generations of men act autonomously they are perceived to have severed ties with their 'homelands', which has particularly negative consequences for the ways in which that young man's family is viewed by the rest of the community.

What seems to be a core concern for the value of these theories to understanding meanings of VMAMC, are that they were developed to consider health and health behaviours for individuals within relatively homogenous populations, yet South Africa cannot be considered such a population. It is thus difficult (without being able to account for the individuality of VMAMC meaning-making) to rely solely on these models to understand circumcising behaviours.

Importantly, these models seem to speak more to an understanding of people's responses to disease (and risk of disease), rather than them being able to address the responses to the public health intervention implemented to promote related preventative behaviours. That is to say that these models are useful in being able to predict whether or not someone would think it necessary to adopt preventative behaviours to reduce their risk of HIV infection, but the models do not consider the meanings attached to such risk as embodied in public health directed behaviours, such as VMAMC, which impact health decisioning and preventative behaviour. For example, these models may account for why an individual engages in risky sexual practices but they do not account for how the meanings attached to VMAMC, may promote or resist the uptake of this intervention.

Perhaps more significantly, these health models operate according formulaically. Such predictive equations position each individual at a particular location upon a "continuum of action likelihood" (Baban & Craciun, 2007, p. 53), and thus these models are considered to be clustered together as "continuum theories" (Weinstein et al., 1998, p. 291). Ideally, health-behaviour modification interventions that are anchored in these health models function with the primary aim of shifting target individuals across this continuum towards a high probability of health-behaviour adoption (Manderson, 2002). Thus, while theoretically effective, they are unable to account for the fact that HIV prophylactic VMAMC is not an ongoing behaviour as it is a once-off body modification procedure. As such, it could be argued that, overtime, a man could be moved towards considering and ultimately adopting VMAMC However, the reverse is an impossibility.

VMAMC may be likened to permanent and largely irreversible modifications to the body, such as removal of key reproductive organs by men and women for sterilisation purposes; emergency procedures to remove infected organs (appendectomies, cholecystectomies, tonsillectomies); termination of pregnancies; pre-emptive surgical interventions to remove tissue proven by various genetic testing to be at high risk for cancer (amputation of vital limb tissue to remove tumours, mastectomy for breast cancer, gastrectomy for stomach cancer, hysterectomy for uterine myoma) (Aida, Baba, Yamakura, Taga, Fukuda & Shimoji, 1999); permanent cosmetic/aesthetic procedures (permanent make-up and hair removal, tattooing, body piercing and scarification, cosmetic dentistry); reconstructive surgeries as well as gender reassignment procedures.

While VMAMC would be classified as a preventative health-related behaviour, it is somewhat unique in the sense that it is not ongoing health behaviour, making the utility of various theories and health models within traditional health psychology sorely limited.

The motivational models also account for the role of particular emotions in determining the behavioural outcome in certain situational contexts. However, the data showed that VMAMC as a procedure that has permanent body consequences to future health-related behaviour decisioning is a complex act, and thus the meaning-making thereof does not readily fit into these health models. Therefore, while these models collectively address the various behavioural options available to individuals when choosing a sexual practice at any given time, namely abstinence, sex with a condom, or unprotected sex, they are unable to address the impact of VMAMC with regard to ongoing sexual practices. As such, VMAMC is uniquely related to consequent sexual risk-taking and these theories are unable to account for this relationship.

The motivational models listed above share the theoretical premise that health-behaviour modification comes about as a result of an active decision-making process, whereby the consequent gains and costs of undertaking a certain health-behaviour are cognitively appraised before the behaviour is adopted. While this assumption is useful in predicting some health behaviours, these models do not address the composite psychosocial issues that impact on *meanings* of the health behaviours or the public health interventions that promote and deliver health interventions, which is a precursor to health decisioning and behaviour outcomes.

There is a theory amongst this grouping, however; that may be useful in attempting to understand health decisioning and behaviour in relation to the basic social process of this GT. Developed by Bagozzi (1992), goal theory extends motivational models of health behaviour to include the consideration of the influence of goal intentions and effort (or 'trying') on behaviour modification. According to Bagozzi (1993), goal intentions are formed on the back of existing attitudes, subjective norms, and goal efficacy (as they relate to the process of the behaviour change as well as the perceived probability of success or failure of adopting the desired behaviour). Three evaluations are made once goal intention has been generated, which select the channels of obtaining the proposed goal.

These include: (1) self-confidence; (2) the probability of goal attainment; and (3) perceived pleasantness or unpleasantness of the attainment process. Goal intention, subsequently, determines 'trying', which is defined as the actions that initiate and regulate the fundamental processes that result in goal attainment. 'Trying' operates according to three courses of action, namely: (1) decision-making with regard to the means of action; (2) preparing and regulating the goal-orientated behaviour, which are a function of implementation intentions; and (3) preservation of commitment to that behaviour, which echoes the cognitive processes required for the maintenance or disregard of the goal commitment.

While further investigation is required to gauge the value of this model for application in health psychology, its resonance with the proposed GT of this study cannot be overlooked. The inclusion of goal efficacy and the first course of action ('trying') in this model are of particular interest, as they consider critical individual processes involved in meaning-making. However, as with the majority of health behaviour models, a great deal of this theory was developed to account for the maintenance of, or disengagement from, a behaviour (Armitage & Conner, 2000; Bandura, 2005), implying that its relevance and applicability is more aligned to typical health behaviours that require continued practice and adherence to the ongoing behaviour, which a once-off VMAMC for HIV prevention purposes cannot be considered to be.

Motivational health models are referred to as stage theories (Weinstein, Rothman & Sutton, 1998) and hold that health-behaviour has a complexity that a singular predictive formula is unable to adequately address when developing an intervention aimed at modifying particular health-behaviours. These stage theories consider the various perceived benefits and barriers that an individual might have to confront at each of these different stages, clearly VMAMC for HIV prevention cannot be classed as such.

5.8.1.2. Multi-stage models.

There are four key features to stage theories (Weinstein, Sandman & Blalock, 2008), namely: (1) stages are defined by the fulfilment of a particular construct or category; (2) stages are constructed in a particular order and the individual must move through all of the stages in order to meet the end point of behaviour maintenance. People may regress to repeat previously encountered stages (relapse) or find that they are incapable of moving beyond their current stage; (3) each stage is characterised by a set of obstacles that must be overcome in order to progress to the next stage; and (4) obstacles encountered at each stage must differ

from each of the other stages. Multi-stage models are particularly useful in the theorising of behaviour with regard to overcoming alcohol and drug abuse, changing unhealthy eating habits, as well as developing and maintaining a healthy exercise programme. The primary stage theories include: (1) The Stages of Change Theory (Prochaska, DiClemente & Norcross, 1992); (2) Precaution Adoption Process Model (Weinstein, 1988); and (3) Health Action Process Model (Schwarzer, 1992).

While these models and approaches each have their merits, the fact that they terminate either in the individual relapsing, or ideally, maintaining the particular positive health behaviour, means that their relevance to theorising VMAMC is limited, and thus was not considered further during data analysis. However, it should be noted that these models would be theoretically valuable in considering VMAMC, not as a stand-alone behaviour, but rather as part of a comprehensive HIV prevention strategy. In such cases, they would assist researchers in theorising the link between VMAMC and ongoing safer-sex practices (such as consistent and correct use of condoms). However, the behavioural enactment models discussed below were considered as having more relevance to the GT of VMAMC meaning-making as they consider the bridge between intention and the actuation of the health-related behaviour.

5.8.1.3. Behavioural enactment models.

Motivational models assume that the intention to behave in a particular manner will typically result in the activation of that behaviour. Several studies, however; have found that this is not the case (Godin, Bélanger-Gravel, Eccles & Grimshaw, 2008; Rhodes & Dickau, 2012; Schwarzer, 2008; Sheeran, 2002). Behavioural enactment models theorise ways in which to bridge this gap between intention and behaviour.

Orbell and Sheeran (1998) present health psychologists with a theory that can account for some ways through which individuals convert intentions into action as they relate to the adopting of particular health-related behaviours. The phase of goal intention (of the motivational models of health behaviour) is one when the individual will initiate the planning of his/her behaviour adoption. These plans are referred to as implementation intentions when the individual adds details (such as place and time of behaviour adoption) to his/her plans.

The inclusion of these details has been shown to increase the probability of actually carrying out the adoption of the desired behaviour (Godin et al., 2008; Rhodes & Dickau, 2012). The theoretical reason for this increased probability is due to the visualisation of the behaviour at a particular time and location, making it more tangible and achievable. A cognitive trace is formed between the desired behaviour, performer, and context. The behavioural enactment model, however;; does not consider the issue of cultural relevance to the adoption of health behaviour, which is of pivotal importance to the South African context.

Nonetheless, the partial relevance of this model to the factors involved in individual meaning-making of VMAMC may be particularly useful when considering the population of males in South Africa who practice traditional cultural MC, during a particular time and at a specific location such as during initiation rites. In considering the contextual conditions that underpin this GT, participants who were able to align the aspects of *medical modernity* that are inherent to VMAMC with the personal and collective relevance of traditional MC, regarded VMAMC as a favoured method of HIV prevention. Thus there might be, at least theoretically, an increased probability that HIV preventative VMAMC will be selected by such participants, based on their intention (and detailed plan of when and where) to use a novel HIV prevention intervention such as VMAMC.

In considering the GT developed in this study, it seems as though the meanings of VMAMC cannot be neatly accommodated within in existing health theory. This may be because these models were developed with traditional public health in mind. Traditional public health has a population focus and is unable to detect and address the nuances that direct individual health behaviours. This study highlights how the success of public health interventions requires us to consider individual factors (such as meaning-making) of the intervention beneficiaries and stakeholders, which can result in particular decisioning and action, resulting in either the uptake of, or resistance to, the intervention. The New Public Health (NPH), while having the same population-based focus as traditional public health, is able to consider wider socio-environmental determinants of health but it is my proposed inclusion of Public Health Psychology (PHP) (Hepworth, 2004) that may result in a better understanding of the location of the individual within a public health framework. These theoretical frameworks were considered and are presented in the sections that follow.

5.9. The New Public Health

Although the factors discussed in the GT developed thus far allude to the concerns that resulted in the NPH movement. The NPH can be defined as a philosophy that encompasses the contemporary relevance of the entire health system (including the social conditions that relate to human capital planning and management, as well as revolutionary technologies, science, research and development), which is implemented with the aim of improving the health of individuals and the populace (Tulchinsky & Varavikova, 2010).

This approach to public health attempts to eradicate current, changing, and recurring threats to population health, while considering modern issues that are related to just access to healthcare (Honoré, Wright, Berwick, Clancy, Lee, Nowinski & Koh, 2011). The NPH acknowledges the complexity of health and illnesses as they occur within a socio-political, cultural, and economic context, which are often characterised by tremendous inequalities.

Many public health experts have indicated that the core of successful health interventions is the individual's efforts to adopt healthier lifestyles and embrace medical services and technology (Honoré et al., 2011). As such, HIV prevention efforts in South Africa have consistently relied on the mobilisation of individual responsibility to adopt and maintain safer-sex practices to avoid the consequences of becoming infected with HIV. However, such interventions have had limited success as research has shown that risky sexual practices are increasing among South Africans (UNAIDS, 2013) and that its citizens (in general) are not practicing safer-sex behaviours (Mugwanya et al., 2013; Reddi, Powers & Thyssen, 2012).

For example, Maluleke (2010) found that 90% of young adults do not know their own HIV status, 76% are not aware of the HIV status(es) of their sexual partner(s), 48% practice unprotected sex, 19% have multiple sexual partners, 17% engage in transactional sex, 26% have had coerced sexual intercourse, and 17% have had forced sexual intercourse. This is why an intervention that targets the body rather than behaviour has been considered necessary by public health policy makers and practitioners in South Africa and many other African countries.

Relying on individuals to change their high-risk sexual practices to reduce their risk of HIV infection may have a limited impact on the epidemiology of HIV in South Africa. This may be because encouraging changes in sexual behaviour that can be sustained over time is a complex public health activity (given that non-compliance to safer-sex practices is low), and requires time, effort, and funding in order to make successful gains in the containment of HIV.

Furthermore, the sheer scale of HIV in South Africa can mean that public health interventions that target individual behaviour modification seem to have a modest impact on the pandemic as a whole. However, population-based approaches to HIV prevention can generate a sense of despondency through individuals feeling that their personal behaviours are of no consequence to the pandemic (Green, Richard & Potvin, 1996). Thus health psychologists should be ever more vocal about public health interventions needing to consider the broader social context in which illness occurs when developing individual behaviour modification interventions regarding HIV prevention.

Traditional public health has had a number of successes in the past with respect to the prevention and control of disease, as well as increasing the overall quality of health and population longevity (Brown, Grootjans, Ritchie, Townsend & Verrinder, 2014; Gilmore et al., 2011). It has impacted the HIV epidemic as evidenced by decreases in fewer new HIV infections when aggregated globally. These decreases are not happening as quickly or impressively in particular in LMICs. This may be due to the limited application of the NPH approach in these developing nations, as the harmful effects of poverty are not always considered to the extent that they should be in the implementation of traditional public health interventions.

The NPH advocates insist that health be considered within a developmental framework to ensure that it is a protected feature of public policy (Bell, Salmon & McNaughton, 2011). Thus the goals of the NPH should continue to shift with the developments in science and medicine, making it relevant to all societies and countries, but this is not without its challenges (Kumar, Chen, Choudhury, Ganju, Mahajan, Sinha & Sen, 2011). Traditional public health has relied on a multi-disciplinary approach to effective disease prevention and control. The inclusion of a PHP to the NPH is therefore critical to furthering our understandings of meaning-making as it directs health decisioning and behaviour.

5.10. The Inclusion of PHP to the NPH

There has been increasing pressure to involve health psychologists in re-evaluating existing traditional public health infrastructures and policies (Hepworth, 2004). The NPH continues to consider more environmental, social, culture, political, economic, and community variables in its understandings of health behaviour. The movement insists that experts beyond the disciplines of biomedicine and epidemiology need to be consulted in order to contextualise health decisioning and action by accounting for the psychosocial and cultural environments in which health and illness occur (Saïas & Delawarde, 2013).

With such contributions to the understanding of individual health behaviours, the NPH has been evolving traditional public health approaches to include "a conceptual and practical framework of PHP theory, methods and practices" (Hepworth, 2004, p. 45). Some say that without PHP, public health policy makers cannot understand and account for the seemingly universal (but also agentic) psychological drives that underpin the unalterable aspect of what makes us human, and thus promote human well-being (Seager, 2012).

For the existing health models to be useful in contributing to our understanding of the way individuals attach meanings to HIV prophylactic VMAMC, they would have to take cognisance and integrate some of the fundamental tenets of Hepworth's (2004) framework. Clearly, the existing health psychology literature must adapt to reflect the complexities involved in making meaning of permanent body modification as a health related behaviour in the context of existing frames of social and economic reference beyond 'the medical'. Such adaptations may be better equipped to theorise not only as to the factors involved in meaning-making of VMAMC for HIV prevention, but also to other practices that have related biomedical and psychosocial consequences.

The Knowledge, Attitudes and Practices (KAP) model utilised in health psychology attempts to address psychosocial factors that impact health and illness by suggesting that 'knowledge' influences attitudes, beliefs, perceptions of risk and vulnerability, and that particular health-related intentions correlate with behaviour in a simple or linear mode (de-Graft Aikins, Boynton & Atanga, 2010), however; empirical studies consistently show that these can never be causal nor linear (Fitzgerald-Husek, Martiniuk, Hinchcliff, Aochamus & Lee, 2011; Mbengashe, 1996).

Three theoretical assumptions of existing health theory have been challenged in the KAP model. First is the Predictive Assumption, where a large proportion of existing health theory implies that knowledge regarding disease prevention will result in the uptake of preventative behaviours. Health psychology-based research proves that this is not the case as, for example, having accurate knowledge regarding HIV prevention and modes of transmission does not automatically result in safer-sex practices (Howard-Payne & Kiguwa, 2008). Secondly, the KAP model shows that the existing health theory assumption that a person is able to practice independent decision-making is not always accurate (Andersson & Cockcroft, 2012; Cameron, Cockcroft, Waichigo, Marokoane, Laetsang & Andersson, 2014) since, as also supported by the findings of this current study, people are not always autonomous in their thinking, decisioning and behaviour when it comes to their health. Finally, existing health theories and models assume that matters such as culture, which might impact on health-related behaviours, can simply be amalgamated into existing national public health strategies (de-Graft Aikins et al., 2010). Findings from this study add to the existing body of knowledge that proves that this is not always the case.

As such, South Africa needs to embrace the NPH and further include the empirical investigation and theoretical support of PHP to move beyond its current limitations in addressing the psychosocial factors that impact meanings, decisioning, and the uptake of public health interventions in South Africa. Albee and Fryer (2003) contested the top-down process of traditional public health to rather advocate for PHP that will consider psychosocial factors that impact on health decisioning and action endpoints.

I argue that to consider VMAMC a public health intervention (without acknowledging the very important individual-level meanings and decisioning required for implementing it), would undermine the intricacies involved in this intervention. Thus the relative neglect of the importance of meaning-making in traditional public health thinking is cause for concern. This study illustrates that individual meaning-making may be one leverage site that has been largely neglected in the potential roll-out of this public health intervention. PHP, through the generation of novel health theories such as the GT resulting from this study, may be broad enough to address the psychosocial factors involved in the meaning-making of VMAMC (as a public health initiative) required for interrogating the intervention's utility and possibilities for upscaling it. At the same time, it may be nuanced enough to detect important distinctions in the individual meanings attached to this intervention.

5.11. Addressing Meanings in the Upscaling of VMAMC

The five key areas of concern for the National HIV and STI strategic plan include: (1) prevention; (2) treatment; (3) care and support; (4) legal and human rights; and (5) monitoring and evaluation. Of these, prevention efforts were allocated the greatest proportion of resources to meet the objective of halving the number of new HIV infections over the duration of the plan (Department of Health, 2007). Such prevention plans included the implementation of VMAMC in various 'high-risk' communities.

This ambitious strategic plan was difficult to operationalise due to several challenges, particularly the fact that, as a LMIC, South Africa is dependent on funding for HIV prevention and treatment efforts that can vary in relation to donor fatigue (Grépin, 2012), as well as the global economic landscape (Harries & Zachariah, 2010), and restriction on funding by donor countries (Allan, 2010). As a result, the implementation and subsequent uptake of VMAMC-orientated HIV prevention interventions has been relatively slow in South Africa.

This slow uptake of VMAMC may be due to the failure of such interventions to appropriately consider the critical psychosocial factors involved in the individual attaching meaning to VMAMC as the core method of HIV prevention for the general male population of South Africa, which is comprised of both traditionally circumcising and non-circumcising groups (Peltzer, Nqeketo, Petros & Kanta, 2008). If the state aims to develop and implement an effective and efficient public health policy regarding current and future VMAMC and HIV prevention, such factors must be considered and addressed. This is discussed in the following section.

5.11.1. Citizen rights and responsibilities in times of HIV.

The role of the state was noted as a property within the GT of factors involved in VMAMC meaning-making. This draws attention to government leadership in providing its people with a high standard of health. Since almost all organs of the state can be seen to influence public health, I would propose that those involved in HIV prophylactic VMAMC policy-making work collaboratively with administrators in other governmental departments. While there are a number of possibilities for collaborations between these departments in the upscaling of VMAMC, I will provide a few suggestions that would service the tenets of the GT of this study.

In areas where VMAMC HIV prevention is being upscaled, the arts and culture department could liaise with the department of education as well as the department of science and technology to develop 'entertainment' content that can be presented at schools to inform youngsters about the mechanisms of VMAMC as part of a comprehensive HIV prevention intervention. The departments of social development, human settlements, public works, and rural development should be consulted to ensure that existing and developing public health infrastructures have the capacity to effectively roll-out VMAMC at clinics and hospitals. The department of higher education and training could work collaboratively with the department of traditional affairs to ensure that traditional healers are included in VMAMC upscaling strategies and so that those training to be future healthcare workers can be included in discussions about the relevance of traditional medicine in South African public health.

5.11.2. Men's health.

In response to the HIV pandemic in Sub-Saharan Africa, the WHO (2011) proposed an intensification of VMAMC (increased to 50-80%), with particular focus on adolescent and young adult males (aged 12-30). Should South Africa embrace this proposed upscaling of VMAMC, this study suggests that emphasis be focussed on younger men since these individuals may have lower incidences of HIV infection at the time, but this is likely to increase substantially as they mature sexually. For these participants, hegemonic masculinity is challenged by females (as mothers or intimate sexual partners) inserting themselves into decisioning about men's health. This is important to consider for public health messaging about VMAMC. As such DoH may need to consider who they rely on for VMAMC education and promotion campaigns since a large number of men in South Africa may reject VMAMC if women are included in this messaging. Similarly, the DoH may need to consider who they rely on for VMAMC education and promotion campaigns. While this is not without its own philosophical, ethical, and political concerns, it would seem as though public health messaging should target men directly. Of course, this will create tensions within a South African legal framework that emphasises gender equality. However, without critical engagement with such tensions VMAMC will continue to be regarded as a biological intervention only. Targeting men directly should also be considered carefully as such a strategy could make men the object of HIV risk and blame. Thus PHP must play an important role in facilitating the exploration and amendment of existing theoretical perspectives to better understand, design, implement, and evaluate the future upscaling of HIV prophylactic VMAMC that is relevant to the South African public.

5.11.3. Politics of implementation.

Existing public health structures cannot effectively upscale VMAMC interventions in South Africa without substantial delays. However, such delays have political, economic, and scientific consequences. There has been a significant time lapse between the first hypothesised link between MC and the prevention of HIV infection (Alcena, 1986) and its approval for use as a public health intervention. The psychological consequences of these delays should also be investigated if the state wishes to pursue the upscaling of VMAMC. This sort of information would be helpful in understanding the psychosocial significance of future delays in the implementation of interventions loaded with socio-historical and traditional layers of meaning.

The NPH seeks to develop and implement a programmatic and inclusive approach to public health services with manifold corresponding interventions to reduce the spread of HIV (Tulchinsky & Varavikova, 2010). As such, I would recommend that the state-advocated upscaling of VMAMC be offered only as part of a comprehensive HIV prevention strategy, and not be implemented to the detriment of existing HIV prevention programmes (including abstinence, condomising, and being faithful to one sexual partner). In the South African context, this requires consideration of traditional health issues as they relate to an understandings of illness and the prevention or treatment thereof. As such, those that work within the public health system should be aware of the psychosocial factors that impact the meanings attached to seemingly apolitical public health interventions. This requires some understanding of health and illness meaning-making, decisioning and behaviour outcomes.

5.12. Conclusion

This chapter discussed the implications of the findings from my data analysis. As is required of the GT approach, this discussion was substantiated by a post-hoc analysis of the literature and the novelty of the GT highlighted in instances where none could be found. Specifically, this novelty lies in the theory's support of a new public health strategy that seeks to initiate and grow a nested PHP as part of the inevitable adaptations of public health approaches to health threats in LMICs. In keeping with this argument, the chapter demonstrated that without an appreciation of the psychosocial dimensions of seemingly biological interventions such as MC, the feasibility of VMAMC roll-out in South Africa will remain a fraught, protracted and potentially paralysing debate.

Chapter 6: Conclusions

6.1. Introduction

This chapter summarises the main findings of the study in relation to its overall aims. The methodological approach used in this study is then evaluated to provide a high-level overview of its strengths, utility and limitations. The chapter concludes with a discussion of the implications of the project and several recommendations for future studies that take seriously the significant role that meaning-making should play in the design, implementation and evaluation of MC programmes specifically, and public health interventions more generally.

6.2. A Synopsis

The first and second chapters of this thesis identified and contextualised the HIV pandemic in South Africa and provided an overview of the developments in public health responses that now include VMAMC. It then located the aims and objectives of this study (including its guiding research questions) in relation to the need to augment our understanding of such interventions by developing a substantive GT that accounts for individual meaning-making of VMAMC as a precursor to health decisioning. *Chapter 3* outlined the theoretical and philosophical basis for the Straussian GT approach utilised in this study. Furthermore, the research process, which including sampling, data gathering, and analysis procedures, was also described. *Chapter 4* described the findings of the data analysis by demonstrating that *plurality and fusion* in the contextual conditions that frame *performances of masculinity* as the basic social problem in the context of HIV prevention in South Africa. In response, the basic social process was identified as the *negotiation of the tensions between tradition and medicine* driven by the causal condition - *crisis in medicalised modernity*. The resultant GT was located within existing health theory as a means to demonstrate its contribution to knowledge in *Chapter 5*.

This GT contributes to existing health knowledge by highlighting the significantly important psychosocial dimensions of health behaviours encapsulated as the meanings made of HIV prevention through VMAMC amongst urban men in Johannesburg, South Africa. The GT takes places in the existing literature by showing that appreciating the importance of and accommodating these meanings will be imperative in deciding on the role and form of any future VMAMC programmes as HIV prevention interventions in South Africa.

6.3. Assessing the Rigour of the Study

No matter the type of GT developed, the value of the theory rests with its quality which can be assessed against two criteria, namely: (1) the value of the content used to produce the theory needs to be conclusive; and (2) the research procedure needs to be of unassailable quality (addressed in *Chapter 3*). Strauss and Corbin (1998) highlighted that rigorous grounded theories must by definition demonstrate flexibility, as they are the analytic products derived from invariably complex human behaviours, thoughts and actions. Thus the focus of the quality assessment can never be on the validity of the theory in any 'realist' sense, but rather on its theoretical sufficiency. So while validity, in its more traditional sense, is consequently not a concern in GT research, four primary conditions must be met before a theory can be regarded as adequate in addressing the phenomenon being investigated. The section that follows considers Strauss and Corbin's (1990) four primary criteria of a sound GT analysis - fit, understanding, generality, and control - as means to determine the relevance of the emerging theory to the phenomenon of individual VMAMC meaning-making in the context of HIV prevention in South Africa.

6.3.1. Strauss and Corbin's criteria for the GT.

There are four points of assessment. The first criterion is fit – where common reality, in all its complexity, can be reflected by the theory (making it of particular value to the application of everyday occurrences). Secondly, understanding – where the theory can be fully comprehended by those who work within the area and context of the phenomenon being studied. Thirdly, generality – with the implication that the theory is not so rigidly located within a particular context that its relevance fades beyond the scope of its immediate application. Lastly, control – that theory indicates how its concepts are interrelated (under a reasonably broad range of conditions) so as to allow its user the capacity to utilise it in a meaningful manner under differing conditions (Harry et al., 2005).

These criteria for quality were achieved in various sections of *Chapter 4* and *Chapter 5*. For example 'fit' was achieved as the theoretical account of the factors involved in individual meaning-making of VMAMC reflects the inherently complex reality of health and illness in the context of HIV prevention. 'Understanding' is reflected in the theory as it represents the views of VMAMC beneficiaries (adult males from the general population) as well as future implementers (student-doctors) of this intervention. This is also evidenced in the extensive use of verbatim quotes (which were 'cleaned' from the interview transcripts to remove any non-essential data) and that represent a wide range of perspectives provided by the participants as well as the descriptive and conceptually grounded theoretical accounts of the factors that they described. The fit and understanding criteria are further addressed as I present my findings with the target audiences of this GT in mind. These audiences include scholars of critical health psychology as well as public health policy makers and implementers.

'Generality' is evident in the theory as the theoretical accounts of meaning-making attempts to extend the transferability of this study's findings beyond the context in which it was located. That is to say that the meaning-making factors identified in this study may be relevant (to various degrees) to other countries that are implementing and upscaling HIV prophylactic VMAMC as part of a comprehensive public intervention. 'Control' is present in the theory since it highlights how meanings of VMAMC may be pertinent to understanding public responses to other biomedical procedures that require the individual to consider health (or disease prevention) in relation to permanent modification of the physical body by way of surgical intervention.

6.3.2. Evaluating the quality of the GT.

Five elements were identified as being required in order to meet the aims of this study in generating a theory that can be considered as comprehensive and of good quality. Firstly, I had to present the application of a simple allegory in the GT (Harry et al., 2005; Miller & Fredericks, 1999; Strauss & Corbin, 1990). While it was challenging to formulate one single unifying theory that could account for the factors involved in a phenomenon as complex as individual meaning-making of VMAMC in South Africa as a mode of HIV prevention, I did so by relying upon several theoretical frameworks to unpack the differing aspects of the phenomenon under investigation, where each of their qualities and restrictions could be evaluated as making a contribution to knowledge.

This evaluation was presented in *Chapter 5* in which I situated the GT in relation to motivational-, multi-stage-, or behavioural enactment-based theoretical frameworks and demonstrated its novelty and application particularly in the area of disease prevention (or the promotion of health) through permanent surgical interventions that target the body rather than behaviour modification.

Secondly, the analytic outline had to identify key dimensions to unpack the various factors involved in individual meaning-making regarding VMAMC for HIV risk reduction. These dimensions were presented under each property that collectively contributes to the contextual conditions that underpin the GT. Thirdly, the GT had to represent a theoretical account of the most important conceptual considerations inherent in determining the feasibility of a national roll-out of a HIV prevention strategy that includes VMAMC as the method of HIV prevention. This was achieved in *Chapter 5* when I highlighted the various elements that public health messaging may wish to address should South Africa implement the upscaling of HIV prophylactic VMAMC. Fourth, the GT had to provide some details regarding the time, place, and manner in which the intervention should unfold to best match the theoretical account of VMAMC meaning-making, and lastly, the GT had to offer a description of the roles that the various actors of the intervention will adopt. These two conditions were met in *Chapter 5* as I made recommendations for the ways in which the VMAMC meanings could be considered in the upscaling of this HIV prevention intervention in South Africa. The implications of this study are summarised further below.

6.4. Implications of the Study

Prior to the initiation of this study there was little to no literature on the role of meaning in understanding individuals' potential 'buy-in' to the much debated roll-out of VMAMC as part of the South African government's comprehensive HIV prevention strategy. Acceptability studies in South Africa had been restricted to economic feasibility projects, anthropologically led foci on the role of culture and the bioethical implications of an MAMC public health programme. South African health psychology had not contributed to any disciplinary or multi-disciplinary understanding of the psychological implications of VMAMC as a public health intervention in South Africa. Thus the study's resultant theory holds significant implications for deepening our understandings of the challenges to and possibilities for rolling out VMAMC in the country.

The practical implications to this study, which are detailed in *Chapter 5*, speak to tangible recommendations for potential revisions to the current roll-out of VMAMC for HIV prevention that are largely related to ideological framing of such a programme within the languages of the new public health movement. For example, the perception of the state as being an effective (or ineffective) implementer of VMAMC was critical to the meanings made of this intervention. Faith in the state is not a common variable for study in mainstream public health feasibility studies.

Future upscaling of VMAMC may require the state to consider how various governmental departments (beyond the DoH) could play an active, effectual, and collaborative role in educating the public about the implementation procedures of VMAMC, as well as in providing quality HIV prevention interventions in under-resourced, marginalised and/or disadvantaged communities. Furthermore, the role of women in VMAMC needs to be seriously considered given the concerns that were addressed in this study. If the success of upscaling VMAMC depends on the exclusion of mothers or other female caregivers/ guardians - particularly those who head single-parent households, intimate female partners, and female healthcare workers - this will require further debate given South Africa's clear legal and institutional commitment to gender equality.

Chapter 5 also addressed the theoretical value of this study since there is now a theory that accounts for the way that factors that influence meaning-making of a novel biomedical intervention to the male body for prevention of HIV are tensioned against the meanings made of its traditional practice. This study demonstrated that while still potentially valuable, existing health psychology theory seems to lack the conceptual capacity to account for how extra-health factors will impact on the individual meaning-making process attached to VMAMC. The study also shows that existing health-behaviour theory cannot adequately be used to understand VMAMC as the practice challenges traditional definitions of health-related behaviour. This is because many of the theories consider health-related behaviours to result from ongoing decisions by a rational agent in order to pursue 'health' as a goal. However, this study reveals that decisions regarding health behaviour may be underpinned by meanings that are not based in rationality. This is further complicated when such behaviours are not ongoing but rather once-off and result in permanent body modification(s) that have broader psychosocial implications for the individual.

The findings highlight meaning-making as a valuable theoretical tool that partly accounts for the tension that exists between the position of the individual and the objectives of public health policies that have body modification as their objective. An ever-expanding body of research is starting to focus on the importance of meaning-making as it relates to health and illness, as well as the individual's response to perceptions of risk of illness such as HIV infection. This study is therefore one of the first attempts to apply this new way of thinking to VMAMC in South Africa.

6.5. Limitations of Study

I defined my understanding of meaning-making in *Chapter 1*, however; it should be noted that while this is a growing area of scientific investigation in the social sciences, there is still a dearth of strong, cognitively informed models of how meaning is implicated in health decisioning. This limitation largely extends to the existence of vague definitions and a persistent focus on the relationships of meaning-making to various health phenomena as opposed to studies of the fundamental mechanisms of just how meaning-making may mediate or moderate health action.

Addressing this limitation will require the development of new models and theories about the place of individual meaning in existing health behaviour frameworks, with an emphasis on the limits of their generalisability to particular forms of behaviours directed to health. This study represents one step in that direction. However, future studies that advance on this goal may need to develop new methodologies for studying the psychology of health.

Some of the limitations of this study were discussed in previous chapters, including the restricted role that I was able to play in the collection of the data during the interview process and interactions with the participants. This was primarily due to the nature of the study and the cultural and gendered implications for myself and the participants, thus there is an absence of direct observational data that could be used to supplement the substantive theory. However, I described in *Chapter 3* how this may also have been a methodological advantage to this study since I could not form an observationally-based bias of the participants that could have influenced the way in which I interpreted the interview data.

Additionally, in the case with the data gathered from the interviews conducted with the sample consisting of the student-doctors, much of the data was based on recalled conversations and experiences with adult male patients in clinical settings. Thus, while this exposure to different patients makes the student-doctor narratives distinctive and significant, patients that had volunteered for MAMC for HIV prevention would have formed another important group of stakeholders for the study. However, obtaining such a sample would have carried with it a host of ethical challenges that would have been a limiting factor in the recruitment of participants. Furthermore, a focus on such sampling would have excluded the participation of males in South Africa who have not considered the uptake of VMAMC (for any number of reasons), as the meaning-making of VMAMC that underpins this form of health decisioning.

It may also be worth considering the limitation of the demographic make up of the sample participating in this study since there may have been an over-representation of isiZulu man. Typically, isiZulu men do not practice traditional MC and this may have coloured the type of interview data gathered regarding VMAMC meanings. Thus, future studies of this nature may seek to include the participation of men who represent a broader scope of experiences regarding various forms of traditional circumcision practices (religious and/or cultural).

While a generalisation of this study's findings to other countries that find that are also labouring beneath the weight of the AIDS pandemic would is possible, the uniqueness of the South African climate of health and disease may present difficulties in a simple transposition of the study in other contexts. It may, however; be worthwhile to conduct such research in similarly pluralistic societies and compare such findings with those generated from other empirical investigations conducted in South Africa.

Since GT is period, location and circumstance constrained, this study has local relevance within the South African context at a time when the HIV pandemic is in need of a somewhat radical solution that has the potential to side-step the common challenges that arise in rolling out existing HIV psycho-education strategies. These include consistent condom usage, the inequalities in social power needed in order to negotiate such usage, the promotion of delayed sexual debut, and interventions that target issues related to increase sexual risk-taking (such as substance abuse) that require individuals to make ongoing behavioural change decisions regarding their sexual practices in order to reduce their risk of HIV infection.

While this study focuses on contributing to the psychology of VMAMC, it also implies the need for renewed thinking about the role of risk-management, perceptions of HIV and cultural and gendered perspectives on sex and sexuality as well as health and disease across the health sciences. This study, therefore, compelled me to be critical of scrutinising the research phenomenon from the standpoint of existing theoretical prescriptions, and to rather fashion novel theoretical understandings of the psychosocial precursors health-related action.

I had attempted to offset some of the challenges of being the central analytic instrument of the study by attempting to conduct as many follow up interviews as possible, or at least receive some confirmation from the participants that my interpretation of their interview responses was accurate, and also to ask clarifying questions about statements made during the initial interviews. However, participants were not always available (or even able to be contacted) for follow-up interviews, and thus responses that were unclear had to be in relation to the general narrative of the interview.

Finally, given the unanticipated lack of awareness and understanding of VMAMC and HIV prevention, some of the interview questions may have been misunderstood by some of the participants. The interview questions were generated based on the assumption that participants would have had some understanding of HIV prevention through VMAMC, since the upscaling of this public health intervention has been on the NDoH's agenda since 2007 (UNAIDS, 2013), however; the data gathered showed this not to be the case in particular instances. As a result information sharing formed part of the interaction between interviewer and participant. Given that this interaction was not the unit of analysis for the study, it is unclear whether or how this sharing may have shaped some of the responses.

6.6. Future Research

In order to address the limitations implied by this current study, I would recommend that a number of mixed method ethnographic studies be conducted in as many diverse South African communities as possible. This may increase the transferability of the theory and broaden the explanatory scope of the substantive GT generated by this study. I would suggest that women be included in future studies since they have been shown to play particular roles in the meaning-making of HIV-preventative VMAMC. However, since ethical approval of research proposals depends on the voluntary nature of participation in empirical investigations, this recommendation may be difficult to fulfil considering that no female wished to participate in this study.

Nonetheless, a mixed method ethnographic approach would also allow for researchers to directly observe VMAMC in clinical settings and communities and thus further understand this interaction more meaningfully. Additionally, researchers would be able to collect various KAP data that would enable further testing of the relationships between knowledge and attitudinal attributes and VMAMC uptake.

This on site clinical work would also minimise the proxy effect of this study by interviewing and studying men who have or have not selected to undergo VMAMC within their own perceived socio-historical and cultural contexts thus enhancing the results of other feasibility projects that have not considered these dimensions of influence in VMAMC uptake.

The study's GT analysis also shows that HIV self-risk assessments may be a method of implicit strategic meaning-making with the causal condition of modernisation. This implicit strategy was inferred from the interview data of participants who essentially rejected the potential personal benefits of VMAMC, since they indicated that they were not at risk of HIV infection. Given the aims of GT, I was not able to obtain data (given the objectives of this study) that could empirically confirm whether or not these risk assessments were accurate or not, since the interview questions were not directed to collecting information on sexual practices or other behaviours that impact one's risk of HIV infection. This may be worthy of future investigations.

While it was not a primary aim of this current study, the constant comparative method of the Straussian GT inductive analysis exposed (at least partial) insight into the actual *process* of individual meaning-making of VMAMC for HIV prevention. This process appears to involve four stages that include: (1) an initial reaction to first learning about VMAMC as a mode of preventing HIV infection; (2) the confrontational experience that initiates the meaning-making process as the individual is compelled to consider his subjective perceptions of this HIV prevention intervention; (3) reflection upon meanings made as additional information regarding the implementation of VMAMC by DoH as a method of HIV prevention in South Africa; and (4) active responses to the meaning-making of this intervention.

Future examinations could potentially make use of formal cognitive models of meaning-making (Park, 2013) to validate these observations. This may provide an additional theoretical tool with which to understand the process of HIV-preventative VMAMC meaning making and its place in public health psychology.

The core recommendation of this study is that the public health programmes take seriously the way that providers, beneficiaries, targets, and policy-makers make meaning of the proposed interventions. These meanings should be targeted for research by a PHP in line with the tenets of the NPH movement.

In doing so, such programmes should consider the psychosocial complexities inherent in the development and implementation of public health interventions that, for example; seemingly target only the body as a feasible site for HIV prevention. In this study, such attention to meaning showed how tensions between traditional and medical circumcision are underpinned by various *performances of masculinity*. Considering these tensions, a PHP should appreciate the significance of the gendered body in considering the uptake of VMAMC as a form of HIV prevention.

6.7. Conclusion

HIV and its prevention have preoccupied the health sector in South Africa and beyond for over three decades. While much has been accomplished in arresting the spread of the disease via bodily-directed interventions, the recalcitrance of the virus attests to the fact that such interventions must understand their target as more than the sum of its biological parts. VMAMC is a body-directed intervention. However, this study, in the final analysis, is able to demonstrate that this body-oriented intervention is inextricably bound to the social and psychological frameworks that attach meanings to bodies. The study is able to account for and explain the way that such meanings are implicated in the diverse responses from the participants, as well as their perspectives and experiences of traditional, religious, cultural and medical MC in relation to other HIV prevention strategies in South Africa. In so doing, it offers one more step in understanding the complex picture of HIV prevention as it intersects with the meanings inherent in managing human sexual and gendered health.

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APPENDIX A: PARTICIPANT INFORMATION SHEET

Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559

Hello,

My name is Lynlee Howard-Payne; I am a Ph.D. candidate from WITS University. I am conducting a study to investigate what people think about using voluntary medical adult male circumcision as a method for reducing the risk of HIV infection. I would like to invite you to be interviewed for my study. Please note that you have the option of being interviewed by me or by the fieldworker who has given you this information sheet. If you would like to participate in this study, please confirm with the fieldworker who you would want to be interviewed by so that this can be arranged.

The interview should not take more than one hour to complete but you may be called upon to participate in some follow up interviews. You will be required to sign a consent form at the interview to show that you have read and understand the aim and process of this study. I would like for you to be aware that participation is completely voluntary and there will be no consequences if the decision is made not to participate. You may choose not to answer any questions that you do not feel comfortable answering. There are no foreseen consequences or benefits to participating in this study, however; you can contact me to discuss any concerns that you might have regarding this study.

Please note that the interviews will be audio taped so that it can be transcribed for data analysis. Your name and/or contact details it will not be attached to the transcripts in any way nor will your name be mentioned in the thesis, any presentations or resulting publications. Once the interview has been transcribed, the audio recording will be saved on my personal computer, which is password protected. Please exchange contact details with the fieldworker to set up an interview that will take place at a safe and private location at a time that is suitable to both you and the person you would like to be interviewed by. Once I have completed this study and had the thesis examined, I will contact you to see if you are interested in my findings and if so, I will arrange the delivery of a one page summary of my findings.

Thank you so much for your time.

Ms. Lynlee Howard-Payne

Email: lynlee.howard@wits.ac.za tel.: 011 717 4522

APPENDIX B: PARTICIPANT CONSENT FORM

I (the participant) have been given the participant information sheet for the study being conducted by Ms Lynlee Howard-Payne. I have read this information sheet and understand its contents.

I understand that:

- My participation in this research is entirely *voluntary*; as I am free to choose to participate or not to participate.
- I may decide to stop participating at any time during the interview, since there is *no penalty* for withdrawing or refusing to participate.
- I may choose not to answer specific questions and there is *no penalty* for refusing to address these questions.
- All identifying information will be treated with the utmost *confidentiality*.
- No names will be recorded on the interview transcription.
- If I agree to participate that I need to *sign* this form as proof of my acceptance.

I understand the conditions and accept to participate in this study voluntarily.

Participant signature: _____

Date: _____

APPENDIX C: PARTICIPANT CONSENT FORM FOR AUDIO RECORDING

I (the participant) have been given the participant information sheet for the study being conducted by Ms Lynlee Howard-Payne. I have read this information sheet and understand that the interview will be audio recorded.

Please accept my signature as my consent to being audio recorded in this interview

Participant signature: _____

Date: _____

APPENDIX D: INITIAL SEMI STRUCTURED INTERVIEW SCHEDULE

Information to be given to participants:

You may have heard that research has been done that shows that men who are circumcised have a lower risk of being infected with HIV than men who are not circumcised. It is because of this research that HIV prevention programmes in South Africa may want to include male circumcision of new born boys to try to reduce the spread of HIV in this country. I would like to talk to you about how you feel about this possible prevention strategy and find out how you think that it may affect you. While we talk, please help yourself to the tea/coffee and biscuits.

Interview Questions:

- What is your personal opinion of male circumcision in general?
- What do you think of the idea of using VMAMC as a way of preventing HIV infection? Why do you say that (or on what or would you base your decision)?
- How do you think South Africans in general would feel about this? Why?
- Does male circumcision have any particular relevance to you outside of HIV prevention?
- How you think that different cultural/religious groups will react to this possible HIV prevention intervention? Why?
- Which is more important - maintaining traditional practices or preventing HIV infection? Why?
- Would you go for a VMAMC to reduce your risk of HIV infection? Why?
- Would you want your adult son to have VMAMC to reduce his risk of HIV infection in the future? Why?

Before we end our interview, I just want to remind you that circumcised men still need to practice safer-sex, like using condoms, to prevention HIV infection. Also, I would like you to take some of the pamphlets (on HIV prevention and VMAMC) that I have brought with me so you can read them at home. They have the contact details of various facilities that can answer any questions or concerns that you might have about HIV or VMAMC.

APPENDIX E: FOLLOW UP SEMI STRUCTURED INTERVIEW SCHEDULE

- Do you think that the government has a right to pass policies that require that you change your body to prevent disease? Why?
- Do you think that parents have the right to decide if their son will undergo HIV-preventative MAMC? Why?
- Does anyone other than the boy/man involved have the right to decide whether he will undergo MAMC or not? Why?
- Do you think that men who are circumcised are more or less masculine than uncircumcised men? Why? Are there any differences between traditional male circumcision and VMAMC in this regard?
- What is it about circumcising (or not circumcising) that makes it so important to masculinity?
- What is it about the foreskin that makes it so important to men? Either in keeping it or removing it?
- Do you think that men (in general) would avoid VMAMC even if they knew that it would reduce their risk of HIV infection because of the pain or discomfort experiences during recovery?
- Is avoiding pain/discomfort more important than preventing HIV infection? Why?
- What do you think that women prefer a circumcised or uncircumcised penis? Why do you say that?
- Are men concerned that VMAMC could reduce their level of pleasure experienced during sexual intercourse? What are your views on this matter? What about having to avoid having sex for at least six weeks after having this surgery?
- Is maintaining sexual pleasure more important than preventing HIV infection? Why?
- What if your partner asked you to go for a circumcision so as to reduce your risk of HIV infection?

APPENDIX F: SEMI STRUCTURED INTERVIEW SCHEDULE FOR STUDENT-DOCTOR SAMPLE GROUP

Information to be given to participants:

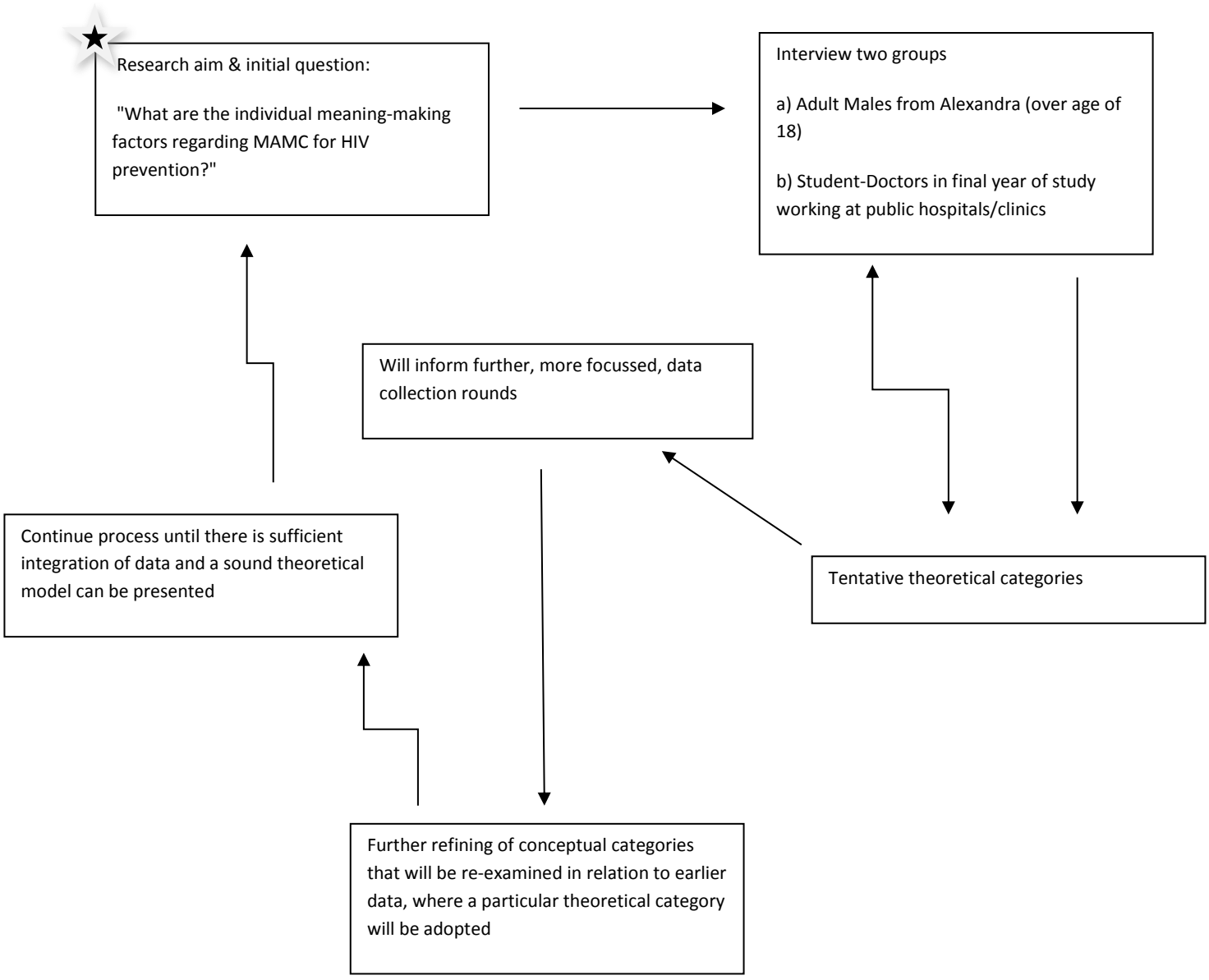
You may have heard that research has been done that shows that men who are circumcised have a lower risk of being infected with HIV than men who are not circumcised. It is because of this research that HIV prevention programmes in South Africa may want to include male circumcision of new born boys to try to reduce the spread of HIV in this country. I would like to talk to you about how you feel about this possible prevention strategy and find out how you think that it may affect you. While we talk, please help yourself to the tea/coffee and biscuits.

- What is your personal opinion of male circumcision in general?
- Can you tell me about any clinical cases that you have encountered where a patient has shared their views about male circumcision?
- Based on what you know about the clinical trials on male circumcision and HIV prevention, would you support or oppose DoH following a national roll-out of medical adult male circumcision as part of an HIV prevention strategy?
- How do you think the general South African population would respond to DoH promoting this method of HIV prevention?
- Does male circumcision have any particular meaning for you?
- Do you think that a cultural circumcision is more important than MAMC for HIV prevention?
- Have you heard about botched circumcisions in the media?
- Have you had to deal with any cases from that?
- Would you go for a MAMC to reduce your risk of HIV infection if your partner asked you to do it?
- If you had a son, would you have him circumcised to reduce his risk of HIV infection in the future?
- Would he have to go through the cultural way, or medical way?
- Do you think that the government has the right to make MAMC mandatory, which is essentially a permanent change to their body, to reduce the spread of HIV in this country?
- At what point though does the government override the rights of the individual for the good of the collective?
- Do you think that parents have a right to decide that their son will be circumcised or not?

- Who else has the right to make the decision on the boy's behalf?
- Are there any developments with regard to MAMC and HIV prevention taking place at the institution that you are training at?
- Male circumcision often has notions of masculinity attached to it, do you think that men who are circumcised are more of a man or less of a man than uncircumcised men?
- Do you think that men would avoid MAMC because they are concerned about the pain of having a circumcision, even if they know about the health benefits like HIV prevention?
- Do you think that women prefer: a circumcised or uncircumcised penis?
- Are men concerned that MAMC could reduce their level of pleasure experienced during sexual intercourse?
- Have any patients expressed concerns of losing their libido?
- What do you think about giving a financial incentive to men to encourage them to undergo MAMC to reduce their risk of HIV infection?
- Should DoH be incentivising such decisions?
- What do you see as being the problems/obstacles with a MAMC-based HIV prevention a strategy based on your experience in your clinical training?
- Might there be a concern that men will feel “immune” to infection if they are circumcised and so increase their risk-taking behaviour?
- As a future doctor, what do you see your role as in the use of MAMC as a method of HIV prevention?
- Every surgery does come with a level of risk. Circumcision is, essentially, a surgery. So what are the risks involved in circumcision? Whether it be in a medical or traditional field?
- Is there anything else you would like to add?

Before we end our interview, I just want to remind you that circumcised men still need to practice safer-sex, like using condoms, to prevention HIV infection. Also, I would like you to take some of the pamphlets (on HIV prevention) that I have brought with me so you can read them at home.

APPENDIX G: DIAGRAMATICAL OUTLINE OF DATA ANALYSIS



APPENDIX H: DATA PREPARATION & TRANSCRIPTION PROTOCOL

Formatting of Transcript:

General Instructions

The transcriber should transcribe all individual interviews using Microsoft Word on the following formatting:

1. Times New Roman, 12 size, 1.5 line spacing

2. Default margins

3. All text shall begin at the left-hand margin (no indents)

4. Entire document shall be left justified

Labelling Transcripts

Individual interview transcript should include the following labelling information at the top of the document:

Example:

Participant Number: Marital Status: Age:

Cultural group (Home Language): Highest level of education:

Saving of Audio-Recordings & Transcripts

The transcriber should indicate the participant number allocated as the label for mp4 file that will be saved on the provided flash drive in folder labelled 'AUDIO' and the same will be done for the relevant transcript, which will be saved on the same drive in a folder labelled 'TRANSCRIPT'.

Documenting Comments

Comments or questions by the interviewer should be presented in plain text and any comments or responses from participants should be presented in italics.

Example:

You may have heard that research has been done that shows that men who are circumcised have a lower risk of being infected with HIV than men who are not circumcised.

I have not heard anything about this.

Content:

Audiotapes should be transcribed verbatim (recorded word for word, exactly as said), including any nonverbal or background sounds (laughter, sighs, etc.) and typed in plain (non-italicised) text that is square bracketed [...].

Interviews should be presented as raw transcripts thus, transcripts will reflects everything as it occurred including profanity, slang, grammatical errors, or misuse of words or concepts.

Non-English words should be translated an typed in square brackets.

Filler words (uhm, ummm, ja, huh, ah, etc.) must also be transcribed.

Indistinct Information

The transcriber must identify parts of the interview that are indistinct or inaudible on the audio-recording by typing [inaudible] in the relevant portions of the interview.

Silences and Pauses

Should there be any pauses during the interview, whether interviewer nor participant are speaking, the transcriber must note this in square brackets and indicate duration of pause as being either brief or long.

Trailing of Thought

In the participants do not finish their sentence or a sentence trails off, the transcriber must use three ellipses to indicate this on the transcript.

Sensitive Information

If a participants says their name or refers to another private person, the transcriber should replace this information with a pseudonym indicate this with a superscripted asterisk i.e. *

Quality Control

The transcriber must proofread all transcripts against the audio-recordings and make any necessary corrections accordingly.

APPENDIX I: READING INFORMATION PROVIDED TO PARTICIPANTS

Voluntary Medical Male Circumcision for HIV Prevention (VMMC)

For more basic fact sheets in this series on emerging HIV prevention strategies visit www.avac.org/intro.

This fact sheet provides basic information on voluntary medical male circumcision (VMMC), an HIV prevention strategy that has shown efficacy reducing risk of HIV infection in HIV-negative men. The intervention is currently being rolled out for HIV prevention in 13 sub-Saharan African countries with high HIV prevalence and low levels of adult male circumcision For in-depth coverage of male circumcision for HIV prevention, please visit the Clearinghouse on Male Circumcision for HIV Prevention (*www.malecircumcision.org*), a collaborative effort among AVAC, FHI 360, the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO).

What is medical male circumcision?
Medical male circumcision is the removal of all or part of the foreskin of the penis by a trained health professional. The term voluntary medical male circumcision differentiates circumcision that is performed by a trained health professional from traditional circumcision, which is performed as part of a religious ritual or cultural rite of passage.

Why is VMMC a key part of combination prevention?
VMMC reduces men's risk of acquiring HIV from their female partners by up to 76 percent. It is not a user-dependent strategy—once a man is circumcised, it cannot be reversed. Epidemiologists studying the AIDS epidemic calculate that scaling up VMMC could have a major impact on rates of new HIV infections. For example, if 80 percent of males aged 15-49 in Zimbabwe undergo VMMC between now and 2015, 42 percent of new infections in both men and women will be averted by 2025. In many other countries, roughly 20 percent of new infections would be averted. Prevention is cost-saving: scaling up VMMC will result save approximately US$20 billion in costs associated with treatment and care.

What are the data supporting VMMC for HIV prevention?
Male circumcision for HIV prevention was evaluated in three large-scale randomized controlled clinical trials that enrolled in total about 10,000 men in Kenya, Uganda, and South Africa. Each of these trials used surgical techniques that had proven safe and effective over years of use in other contexts. Participants in these trials have now been followed for several years. A follow-up study in Uganda showed effect of circumcision climbed over time to a 73 percent decrease in HIV risk at five years. In Kenya, protection persisted at 60 percent at 4.5 years. A program in South Africa found that VMMC had reduced the rate of new HIV infections among men by up to 76 percent outside of the controlled trial setting. Moreover, these follow-up studies did not identify increases in sexual risk behavior among men after VMMC. "Behavioral disinhibition"—in which men assume that they are completely protected and increase risk behaviors—has been one concern related to VMMC.

What types of research are still going on?
Even though VMMC is a proven strategy, there is still ongoing research. Programs need to be efficient, cost-effective and community-supported to reach the targeted number of circumcisions needed to have the greatest impact on the global epidemic. There is operational research ongoing to understand how to improve efficiencies of surgical VMMC. There is also progress in development of devices that would allow for non-surgical VMMC. Two devices currently being explored, PrePex and Shang Ring, have been developed to perform adult male circumcision without surgery. Both are single-use, disposable devices based on the principle that cutting off the blood supply to the foreskin causes the tissue to die or "necrotize." These new technologies could make VMMC simpler and faster to perform for health providers, versus the current surgical techniques used for the procedure. The devices also have the potential to allow for faster training and may influence countries to implement task-shifting (in which a specific procedure or service is shifted from a more highly-trained health worker to a health worker with a more limited skill set—such as from doctors to nurses, nurses to clinical

officers, or clinical officers to trained lay people). The new devices could reduce the total cost per procedure—and they might be more appealing or acceptable to some men and/or their partners.

Why does male circumcision work as an HIV prevention method?
There is no definite answer to why medical male circumcision reduces men's risk of HIV infection during vaginal sex, but there are several possible explanations. The foreskin of the penis has many cells of a type that are vulnerable to HIV infection. Removing the foreskin removes these "target cells" and makes the penile skin more durable, which might also reduce risk. Medical male circumcision also reduces the rate of genital ulcer disease. Genital ulcers can increase the risk of HIV infection.

What is the status of VMMC implementation countries?
Five years have elapsed since the launch of the WHO and UNAIDS VMMC guidance. Since then the pace of VMMC scale-up has been slow and the effort varied among the 13-targeted sub-Saharan countries.

What are the key considerations for "implementation advocacy"?

- **National strategy**. Countries are in varying stages of rolling out operational, communications and community engagement strategies to meet national circumcision targets for the next five years as well as a longer-term strategy that focuses on the provision of early infant and adolescent services.
- **Political and community leadership**. There is a need throughout the targeted countries for local, national and international champions to foster circumcision demand creation and political will.
- **Financial support to scale-up VMMC**. This is currently available from Global Fund, BMGF, PEPFAR, World Bank and UNITAID. Over time greater reliance on national and local resources will be needed, and planning for this should be initiated or strengthened.
- **Women**. They play a pivotal role in VMMC's scale-up. Though circumcision reduces heterosexual men's risk of acquiring HIV from female partners, there may eventually be benefits to women if male circumcision coverage increases to where it reduces the number of HIV-positive men.
- **Gay men and MSM**. It remains unclear whether medical male circumcision could have an impact on HIV transmission among gay men and other men who have sex with men. A meta-analysis of available data found insufficient evidence of circumcision's protective effect in MSM. However, recent findings show that circumcision might help reduce transmission in MSM who report a preference for the insertive sexual role.

VMMC is currently one of the most powerful biomedical HIV prevention tools at hand and success in ending countries' epidemics depends on how well it is implemented. Therefore, AVAC is currently supporting civil society and high-level political advocacy for ambitious scale-up of VMMC in slow-implementing countries.

Priorities for 2012
AVAC's *Playbook 2012* sets out top strategic goals and priorities in HIV prevention for ourselves—and for the world. Here's what we have to say about microbicides. For more, visit *www.avac.org/playbook*.

Global Goals	AVAC Priorities
▪ Roll out VMMC with strategic, long-term plans in countries that meet WHO-recommended criteria, with goal of 80 percent circumcision.	▪ Catalyze civil society advocacy for ambitious scale-up of VMMC in slow-implementing countries. ▪ Implement "Accelerated VMMC Scale-Up Advocacy" strategy.

For more resources on HIV prevention research and for information on AVAC programs, visit www.avac.org.

APPENDIX J: ETHICS CLEARANCE CERTIFICATE

APPENDIX K: PARTICIPANT FEEDBACK SHEET

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Hello,

My name is Lynlee Howard-Payne; I was a student from WITS University. You were interviewed for a study that I did on voluntary medical adult male circumcision (VMAMC) for HIV prevention. I would like to give you a short summary of some of the issues that came up from that study.

Firstly, it seems as though most men are concerned about what VMAMC means for them personally and how VMAMC would impact on them and their ability to keep on practicing their traditions around religious or cultural circumcision or non-circumcision. It would seem as though people would like government to give them very clear answers about this before they will consider having a VMAMC for HIV prevention.

Secondly, people seem to want more information from government about how VMAMC will actually be put into action in their communities. People want to be sure that there will be access to good HIV education that will teach people to still use condoms even if they are circumcised. My study found this to be a big concern that men had in deciding on whether or not they would support VMAMC being rolled out in their communities.

Lastly, the men who were interviewed for my study were worried that VMAMC would not be done for free at government hospitals or clinics. The Minister of Health has confirmed that VMAMC would be provided at no cost to South African men wanting to have a VMAMC. But another concern that men seemed to have was that, even though VMAMC would be done for free, the government would not have enough money to pay doctors and nurses (or supply medication) to provide good quality healthcare to men who decided to have a VMAMC. It seems as though government needs to do something to make people believe that they can provide good medical care to all people.

I have put together some documents that outline these and other important concerns that people have about VMAMC in South Africa and will send them to be published so that government and other HIV prevention organisations can be aware of your concerns and try to come up with some solutions to the issues with VMAMC for HIV prevention.

Thank you again for participating in my study, your honest responses about this important topic were essential to helping me understand what you thought about VMAMC and HIV in South Africa.

Regards

Lynlee Howard-Payne

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