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Perceptions around the role of female health workers in performing male circumcision as an HIV/AIDS prevention strategy in South Africa.

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CHAPTER ONE: INTRODUCTION

This chapter presents the background information, the statement of the problem, the rationale, study aims and the report organisation.

1.1 Background

In order to explore men's perceptions of the acceptability of female health care workers in performing circumcision as an HIV/AIDS prevention strategy, it is important to locate circumcision in a historical, political, social and cultural context, as will be done in the sections that follow.

Millennium development goal number 6 is to halt and reverse the spread of HIV (UNAIDS 2010). The UNAIDS global report of 2010 celebrates the gains made in the fight against the disease over the last decade. HIV prevention efforts seem to be working (particularly in some parts of the world), with global HIV incidence having declined by 19% since 1999. In 33 countries the decline has exceeded 25% including 22 countries in sub-Saharan Africa (UNAIDS 2010). The number of people receiving treatment has increased 13 fold, leading to more people living with HIV/AIDS and less HIV/AIDS related deaths (UNAIDS 2010). Yet even with the impressive gains made, the numbers are still in their millions. New infections for both adults and children stand at 2.6 million and HIV related deaths are at 1.8 million. In total, there are 33.3 million people living with HIV and the prevalence is still 0.8% as it was in 1999 (UNAIDS 2010).

Sub-Saharan Africa still has the bulk of the HIV burden, 68% of the global total of people living with HIV/AIDS, although new rates of infections have declined and the largest epidemics (Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe) have stabilised or are starting to decline. New infections stand at 1.8 million and prevalence is at 5%. 72% of HIV/AID related

deaths also occur in sub-Saharan Africa (UNAIDS 2010). The Sub-Saharan Africa epidemic has been and still is predominately heterosexual with some mother to child transmission components (Marck 1997; PlusNew 2008). A survey by the Human Sciences Research Council (HSRC) in 2005 found the HIV prevalence in South Africa to be 10.8% (Shisana et al 2005). With 5.6 million people living with HIV/AIDS, the South African epidemic is said to be the largest in the world (UNAIDS 2010).

Having made significant inroads in achieving MDG 6 globally, the new UNAIDS vision is ZERO discrimination, ZERO new HIV infections and ZERO AIDS related deaths. This is set to be accomplished through universal access to effective HIV prevention, treatment, care and support (UNAIDS 2010). Previously, the nature of the response has been in 'emergency mode' with a lot of focus on treatment. Based on the evidence that prevention is working, the UNAIDS report calls for rapid scaling up of prevention programs. Elsewhere, the United States Presidents Emergency Fund for Aids Relief (PEPFAR) has called for a stronger prevention focus, which is considered to be more sustainable and effective in reversing the HIV/AIDS trend (Bongaarts & Over 2010). The global UNAIDS report continues to say that prevention programs must include combinations of behavioural, biomedical and structural responses. Male circumcision is one of the new tools proposed to expand effective prevention (UNAIDS 2010).

1.1.1 Male Circumcision

Male circumcision is one of the oldest and most controversial surgical procedures. It is the surgical removal of the foreskin from the male sexual organ. Circumcision precedes recorded history. It may have started as an early public health measure for preventing recurrent balanitis caused by the accumulation of sand under the foreskin in ancient societies in the Middle East. It also may have religious beginnings. According to Genesis 17, circumcision is a sign of the covenant between God and Abraham and his descendants. As a result, circumcision is a requirement among Jewish and Muslim religions that have Abraham as a common ancestor, although it is not a requirement for Christianity. Male circumcision therefore has been around for centuries, practised by different communities as a mark of belonging to a certain

community or as a rite of passage. (Bonner 2001; Silverman 2004; Zaheer 2006; Aggleton 2007; El-Hout & Khauli 2007; Bhattacharjee 2008).

In Africa, circumcision appears to have been a general practise for most communities with few exceptions, going by the fact that similarities in the practise of the custom across cultures have been observed. Both male and female circumcision was practised although female circumcision has now been outlawed. In areas where it is practised, traditional male circumcision is regarded as an important rite of passage and is generally done during puberty. The initiates are generally secluded in initiation schools for a defined period of time. During this time, the physical operation and cultural indoctrination are conducted. Elaborate rituals and numerous taboos accompany the ritual including, secret languages, songs and dances, abstainace from certain types of food, liquids and sex. Other events include smearing of the initiates with clay or ashes for the seclusion duration, physical brutality, shaving of hair and elaborate 'coming out' ceremonies. Forceful circumcision for reluctant boys is not uncommon. Death as a result of the ritual has also been reported. Common symbolic themes include the enhancement of masculine virility and fecundity, arboreal fertility, complementary opposition between men and women, preparation for marriage and adult sexuality and hardening of the boys for warfare. In some communities certain practices have fallen away and others have been toned down indicating that the practise has evolved with time. However, the ritual has always an all-men affair where the initiates have little or no contact with women, female relatives included and, of key importance in my study is that both the traditional surgeon and traditional nurses are male. (Marck 1997; Silverman 2004; Mbito & Malia 2008; Mavundla et al 2009; Kepe 2010)

In comparison to traditional circumcision, medical circumcision was mainly practised in the west and was initially done solely for curative purposes. Before the 1870s, primary medical conditions for circumcision were cancerous lesions and phimosis. Championed by Dr Lewis Sayre however, male circumcision, neonatal male circumcision in particular, emerged as a routine medical practise from specific historic anxieties particularly in North America namely, concern with moral physical hygiene and abhorration for youthful masturbation which was thought to cause many physiological and social diseases (Gollaher 1994; Silverman 2004).

Lately, routine medical circumcision has become controversial in the west with both medical practitioners and individuals questioning the necessity of the procedure and calling for it to be abolished (Silverman 2004; Bhattacharjee 2008). Medical circumcision may have come over to Africa with the introduction of modern medicine by the missionaries (Good 1991). Though safer than traditional circumcision, it has still been shunned by some communities such as the Xhosa community in South Africa, which insist on the traditional circumcision rite in order to fulfil the cultural requirements of becoming men (Mavundla et al 2010).

According to the WHO, 30% of men worldwide have been circumcised, mostly in the developing countries for cultural or religious reasons (Bhattacharjee 2008; Peltzer & Kanta 2009). Non-religious male circumcision has undergone changes reflecting cultural mixing and changing perceptions of health and sexual beliefs (Peltzer & Kanta 2009). Even with the loss of tribal ceremonies in modern life, circumcision remains a ritual that is still performed and that is crucial to personal identity and pride (El-Hout & Khauli 2007). The ritual has survived through evolution into new forms such as creative mixes of traditional and medical circumcision or diluted forms of the traditional circumcision ritual (Mbito & Malia 2009) For example, among the Kikuyu community of Kenya, medical circumcision has taken over from traditional circumcision and is now acknowledged as a rite of passage. Although traditional circumcision is no longer practised, some aspects of it like gift giving and celebrations to mark the occasion are still performed (Mbito & Malia 2008; 2009).

1.1.2 Male circumcision and HIV/AIDS

Male circumcision and HIV/AIDS have been linked since the advent of the disease and not always positively. In fact, traditional male circumcision was once largely mentioned in connection to spreading the virus, due to the act of using the same knife for all initiates (Silverman 2004; Zavis 2006). In contemporary society though, male circumcision is now mentioned largely in connection to prevention.

The idea of male circumcision as a preventative measure is not new, having been mentioned since the advent of the disease. However, the protection conferred by male circumcision was in

the past thought to be conditioned by other factors such as culture, religion and geographic location (Baron & Davids 2007; Schoen 2007). However research has succeeded in putting male circumcision firmly on the prevention agenda (Gruskin 2007). Epidemiological and biological studies have provided compelling evidence regarding the protective effects of male circumcision against heterosexual HIV transmission (Bhattacharjee 2008). The fore skin which is removed during circumcision is rich in HIV target cells including macrophanges, langerhan cells and CD4 T-cells, hence providing protective effects against HIV infection (El-Hout & Khauli 2007; Bhattacharjee 2008). Further, the delicate foreskin is susceptible to scratches and tears through which transmission can occur (Silverman 2004). Since the late 1930s, over 30 separate clinical research studies have shown that circumcised men are significantly less likely to acquire HIV through heterosexual intercourse than men with intact foreskin (Schoen 2007). Combined data from three large randomised trials confirmed that male circumcision reduced the risk of heterosexual transmission of HIV by 63% over a 21 week follow up period, a value equivalent to the protection afforded by many vaccines (Williams et al 2006; Cheng 2007; Bonner 2007; El-Hout & Khauli 2007; Schoen 2007).

In light of the compelling evidence of the protective nature of male circumcision, the WHO and UNAIDS in 2007 recommended that male circumcision should be included in the HIV prevention package as an additional prevention intervention (Schoen 2001; WHO 2010). The potential impact of male circumcision on HIV in sub-Saharan Africa is astounding. It is estimated that male circumcision could avert about 2 million new HIV infections and 300 000 deaths over the next ten years. The following decade could see a further 3.7 million new infections and 2.7 million deaths averted (Williams et al 2006). Further, male circumcision has been shown to have other medical benefits including prevention of penile cancer, sexually transmitted diseases and dermatological conditions of the glans penis (El-Hout & Khauli 2007; Bhattacharjee 2008). Women whose partners have been circumcised are also said to have a reduced risk of developing cervical cancer and, unlike a vaccine which may need a booster, male circumcision doesn't 'wear off' (Schoen 2007). An additional benefit is that studies have shown no significant change in sex life (Collins et al 2007; Peterson 2010). So attractive is male circumcision that

Schoen (2007:306) calls it 'a vaccine with many lifetime health benefits.' Put in this way, it is easy to see why the procedure is being advocated for as a part of the HIV prevention strategy, and to many it seems to be the answer to the prevention pray.

Not everyone has joined the chorus, calling for the implementation of male circumcision as a prevention intervention. There have been noted critics of the proposition and voices calling for the exercise of caution in the implementation. Concerns raised include undermining previous prevention programs like condom use as has been seen in Papua New Guinea (Silverman 2004). Questions such as increasing the risk of HIV transmission to women, ethics of neonatal circumcision and informed consent have also been asked. While no one disputes the potential prevention male circumcision may offer, it is felt that implementation could be problematic (Onyando 2008; Green et al 2010). As Gruskin (2007:49) puts it, 'the devil is in the details'. Complications from the procedure can cause deformity or even death (El-Hout & Khauli 2007). The debates around the suitability of male circumcision as HIV prevention strategy will probably continue for some time. The arguments both for and against are not without merit and are beyond the scope of my study. Be that as it may, governments of African countries with high prevalence rates have endorsed adult male circumcision to combat the epidemic (Schoen 2007).

As mentioned earlier, the Sub-Saharan epidemic is largely heterosexual. Penile – Vaginal sex has been and still is the main mode of transmission and the primary demonstrated cause of elevated rates of HIV transmission through sexual contact is genital ulcers diseases (Marck 1997; PlusNews 2008). In Southern Africa particularly, where prevalence of male circumcision is low and HIV rates high, male circumcision could substantially reduce the burden of HIV (Williams et al 2006). 13 Southern and Eastern countries with high prevalence, low levels of male circumcision and a generalised heterosexual epidemic have been identified by WHO as priority countries for male circumcision scale up. With a HIV prevalence of 18.1% and male circumcision of 35%, South Africa is one of them (WHO 2010). Therefore, it is important to identify potential barriers to the uptake of circumcision as an HIV/AIDS prevention strategy.

One of the potential barriers in this regard is the role of female health workers in circumcision; the focus of my research.

1.2 Statement of the problem

One of the recommendations of the WHO/AIDS technical consultations on research implications for policy and programming is that programs on male circumcision should be targeted to maximise the public health population level impact (WHO 2007). Rapid expansion of male circumcision coverage will result in earlier and larger effects on HIV incidence (WHO MOVE 2010). WHO indicates that the initial rate of male circumcision should also be increased to 50-80% and that the service should be given to infants, early childhood and pre-pubertal boys and adult men (Gruskin 2007). Priority it says should be given to younger males ages 12 – 30 who may presently have low incidences which could increase in future (WHO 2007). The greatest impact it is felt would be achieved when circumcision is scaled up together with an intensified focus on reducing sexual risk. Therefore, male circumcision should be offered as part of a comprehensive package, although it should not be done at the expense of other health programs (WHO/UNAIDS 2007). Box I below sets out the minimum package for male circumcision by the WHO.

Box 1. Minimum package for male circumcision services recommended by WHO

- HIV testing and counselling
- Active exclusion of symptomatic sexually transmitted infections (STIs); syndromic treatment where required
- Provision and promotion of male and female condoms
- Counselling on risk reduction and safer sex
- Male circumcision surgical procedures performed as described in the *Manual for male circumcision under local anaesthesia*

Adapted from WHO (MOVE) 2010

The scale up therefore has to be rapid and involved large numbers of men acquiring the service; speed and numbers are the critical factors to the success of the intervention. This in turn means that the health system has to be prepared to deal with the large numbers of males of various ages seeking the service. A vast number of trained and competent health personnel are required to achieve the requisite scale up and pace of delivery (WHO 2010). This is crucial because in the first place, according to Catherine Hankins (the Associate Director of the department of policy, evidence and partnerships at the UNAIDS), 'if the supply of safe practitioners does not meet the demand, men could opt for unsafe service and look to alternative traditional settings' (PlusNews 2008). In such a setting, safety of the procedure is not guaranteed especially with the mushrooming of the so called 'fly by night' initiation schools which 'quacks' have for commercial purposes (PlusNews 2008). A further potential problem that has been identified is the failure to take up the intervention at all.

As will be discussed in the second chapter of this report, in most countries where the scale up has been proposed, the health systems face a myriad of challenges such as severe staff shortages. Africa accounts for 24% of global disease burden but only 3% of the global health workforce. The healthcare system has for a long time been under staffed and under resourced. The public health sector is buckling under the strain of insufficient resources, a serious shortage of health professionals and poor management (Schneider 2006). The crisis is worse at the specialist levels including surgeons and anaesthesiologists (Chu et al 2009). Staffing is therefore one of the considerations for implementing models of optimising the volume and efficiency of male circumcision services MOVE (WHO 2010). Hence, it is proposed that task shifting and task sharing should be utilised.

Ngatia (2010) describes task shifting as the rational redistribution of tasks among health workforce teams. It involves the delegation of certain medical responsibilities to less specialised health care workers (Chu et al 2009). The aim is to re-assign where possible from those providers qualified for such interventions like physicians to other appropriately trained and competent health care providers of a lower cadre for example clinical officers and nurses. This

would free up the more highly trained professionals to attend to more complex clinical tasks, thus helping to address staffing shortages and meet service demands in a more cost effective way (WHO 2010).

While not a new phenomenon, task shifting is only now receiving its due recognition. Acute shortages of specialists like surgeons and anaesthesiologists mean that non physician clinicians perform the bulk of routine surgical services at district hospital level, only referring serious cases to the specialists at the tertiary level (Chu et al 2009). Successful task shifting examples include clinical officers and midwives performing caesarean sections in Malawi and Mozambique (Ngatia 2010). According to a case study of task shifting in Uganda, task shifting mostly occurs informally, either through internal institutional arrangements due to practical leniency in the enforcement of professional practises or out of sheer need (ECSA-HC 2010). In the field of HIV/AIDS, task shifting has gained significant attention and endorsement, where growing evidence is informing policy and practise (Chu et al 2009). Some examples include the use of Community Health Workers, Lay Counsellors and People living with HIV/AIDS to perform various aspects of counselling and treatment (ECSA-HC 2010). South Africa's National Strategic Plan for HIV/AIDS & STIs 2007-2011 also notes the importance of task shifting in addressing the shortage of skilled labour. In terms of male circumcision task shifting refers to the use of non physician providers to complete all steps of male circumcision surgery. Task sharing on the other hand refers to the use of non-physician or lower cadres of health care workers to complete specific steps of male circumcision surgery. It has been demonstrated in Kenya that trained clinical officers can successfully and safely perform male circumcision (WHO 2010).

Bearing this in mind therefore, it is safe to say that male circumcision may be offered by clinical officers and nurses either in part or on the whole in the countries which have been selected for rapid scale up, South Africa included. Further, bearing in mind that South African nursing is predominately a female profession (Mavundla et al 2009), male circumcision may well be offered by female health workers. Therein may lay the problem which my research explores: are female health workers seen as acceptable to men in performing circumcision?

As mentioned earlier, traditionally, male circumcision was and still is an all-men affair. Even in contemporary society, male circumcision still has strong cultural connotations indicating that circumcision is more than 'just a snip' (Aggleton 2007). One of the important tenets of traditional circumcision is that the initiates should not come into contact with women (Mavundla et al 2009). In fact, according to Mavundla et al (2009), so seriously is this taken that it has contributed to the delaying of initiates of botched circumcision accessing medical care for fear of contact with women who in this case would be the health workers. How then would men take the idea of not only initiates having contact with women but having women performing the actual 'cut'? Or in other words how is the notion of female health workers performing circumcision perceived?

1.3 Rationale

Although there is a very strong case for male circumcision as part of HIV prevention strategy, like many other public health interventions the effectiveness would be determined by access and uptake (Kalichman 2010). Although acceptability studies have been conducted in many countries, they have largely focussed on the acceptability of the intervention as a whole rather than in the details of the implementation (Lukobo &Bailey 2007). Gender issues related to the intervention have focused on the effects it would have on the female partners of circumcised men or how acceptable it is to women for their partners or children to be circumcised (Green et al 2010). There has however been little research of gender issues pertaining to health workers especially with regard to the issue of women performing male circumcision, hence the significance of this study.

'Fore skins are facts', writes Silverman (2004), 'cultural facts.' Culture is without a doubt a pivotal point of male circumcision especially in Africa. The UNAIDS/WHO recommendations number 4 on the scale up state that social and cultural contexts should inform male circumcision programming (WHO/UNAIDS 2007);

4) The socio-cultural context should inform MC programming. There is a wide range of socio-cultural issue to consider.....”

Medical circumcision carries with it a host of meaning for the initiate (Aggleton 2007). Even when conducted in a clinical setting, there are still attempts to maintain some of the cultural aspects like seclusion of initiates, counselling and even celebration of the rite with feasting and gift giving (Mbito & Malia 2008; 2009).

In South Africa traditional male circumcision is more common than medical circumcision. The later is also quite low among the black population (Peltzer & Kanta 2009). The South African tribes that perform male circumcision as a rite of passage from boyhood to manhood include, the Xhosa, Sotho, Pedi, Venda and Tsonga (Mavandla et al 2009). In the Eastern Cape where most traditional male circumcisions are carried out, deaths as a result of botched traditional circumcisions are rampant (PlusNews 2008). Attempts to integrate medical male circumcision with initiation into manhood have faced acceptability challenges (Peltzer & Kanta 2009). So have attempts to modernise the ritual for example by introducing the Tara Klamp which is a circumcision instrument. This failure can largely be attributed to lack of support from the traditional leaders (Kepe 2010). In an attempt to legislate traditional circumcision in the Eastern Cape, the Circumcision Bill was passed. Also known as the circumcision act, it sets out certain criteria such as the age of the initiates, the traditional surgeons, parents and guardians and basic hygienic conditions. It has however not been well received (Kepe 2010). A particularly sore point is the involvement of uncircumcised people in the medical aspects which has been called “a slap in the face of amakhosa” (Kepe 2010). According to Chief Patakile Holomisa;

> ***Mabangabhucabhucwa ngoomama nanini na abantu abangena ebudondeni***
>
> *Women should not be fiddling with penises of male who are entering manhood at any time* (Kepe 2010:732).

The implication here is that women have no place in male circumcision. Yet if task shifting in the scale up is to be introduced, women will be instrumental to the success of the implementation of circumcision. Kalichman (2010) contends that neonatal male circumcision would face resistance in African cultures where male circumcision in young men is central to the concepts

of masculinity and maturity. The same argument could be offered in the case of female health workers performing male circumcision. Mavundla et al (2009), when talking about the delay in seeking health care for victims of botched traditional circumcision, proposes that the delay may be attributed to the fact that the national nursing force is largely female and contact with women during initiation is forbidden. This is a further indication of the possible undesirability of women involvement in male circumcision.

Failure to understand and manage social and cultural differences may have significant health consequences (Betancourt et al 2002). There are scores of examples of useful interventions and policies that have failed as a result of socio-cultural ideals; indeed, a good plan remains just that if it doesn't have the right people to make it an eventuality (Schneider 2006; Butler 2005). Failure to take up other prevention interventions like condoms has been attributed to lack of changing societal and cultural norms by Campbell (2003). Tseng et al (2008) offers a long list of medical interventions that have been resisted on cultural grounds regardless of their benefits to the individual. These include, refusing amputation of a diseased body part, refusing to donate body organs because the body needs to be kept intact, refusal to conduct autopsy for the dead which is considered as defilement by the Muslim community, and refusal of blood transfusion by Jehovah Witness faithful to mention but a few. Acknowledging and understanding the cultural and religious beliefs attached to male circumcision will be crucial in the successful scale up of the intervention. Equally important, and strongly linked to culture, are gendered issues, as will be elaborated on further.

Studies on public policy reveal that it is a complex process, involving both public and private sectors (Hill 1997). The issue of power, who has it and how they exercise it impacts which policy is formed and which is actualised. Schneider and Fassin (2002) talk to the issue of the constant battles between the state and other stake holders that has characterised the approach to HIV interventions in South Africa since the beginning (Schneider 2002). Kalichman (2010) goes further to suggest that cultural issues may be the reason why the South African scale up of male circumcision appears to have stalled;

> The slow uptake of male circumcision may be due to a failure to take into account the cultural and behavioural issues surrounding male circumcision...The slow pace risks offsetting the potential long term impact of male circumcision for HIV intervention. (Kalichman 2010:2)

Uncovering these cultural issues is key to resolving them. Callers for the adoption of male circumcision into public health policy have cautioned the need to examine the social and cultural aspects of the exercise and none is more glaring than the inclusion of women in this predominately male domain especially in Africa as a whole and South Africa in particular. The study therefore set out to find out how acceptable it was for men to have female health workers performing circumcision.

1.4 Research Objectives

- To explore men's perceptions of the role of female health workers in male circumcision
- To find out how culture may influence the role of female health workers in male circumcision
- To find out what other factors may influence the role of female health workers in male circumcision
- To find out the current nature of involvement of female health workers in male circumcision
- To find out how acceptable the involvement of female health workers in male circumcision is/can be

1.5 Chapter organisation

Following this introduction, chapter two will focus on literature relevant to the topic and my theoretical framework. This will include discussions on public health in connection to some of

the issues that have been touched on in this chapter, particularly gender and culture. The chapter will also include health behaviour and theories around culture, gender, structure and agency, particularly in the context of prevention and in light of the study aims. Chapter three will deal with the methodology section. I will trace how the research was conducted. Included in this chapter will be study site, participants, ethical issues, sample selection and size, study tools and researcher reflexivity.

In chapter four, using my theoretical framework, I will present the study finding and engage these findings in relevant literature, particularly in the light of literature that will have been discussed in chapter two. Chapter five will draw conclusions from the findings and analysis. The final chapter will be chapter six in which I will conclude this report with a summary of the findings, recommendations and study limitations and suggestions.

CHAPTER TWO: LITERATURE REVIEW

This chapter will explore relevant literature and research into public health (policy, culture, health personnel issues and men's health) and health behaviour in prevention terms. Also discussed will be theories around structure and agency.

2.1 Public health

Perhaps one of the most important functions of any society or nation is to ensure the well being of the citizens. A healthy population is the most important capital in any development agenda worldwide. One of the ways in which nations invest in the health of their citizens is through providing public health services.

In 1920, Edward A Winslow defined public health 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 (Schneider 2006:5).

In other words, it is the activities of a society geared towards achieving health for its members. It can be differentiated from medicine in its focus on the population rather than on individuals and on prevention rather than cure (Schneider 2006). Public health branches include epidemiology, bio-statistics and health services, environmental, social behavioural and occupational health. Thomas Paran (1936) further said of public health;

> 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..... Thomas Paran US Surgeon General (De Cocke 2002:67).

The above statement implies that public health is something that is in direct control of its recipients, the people, who are able to rise to the occasion when need arises. Indeed, De Cocke (2002) refers to the practise of public health as the activities of a society which assures the conditions necessary for its people to be healthy and how this implies that the society is in control of its health. Population health is a reflection of complex and interactive social, political, cultural and economical variables (Maio 2010). It may therefore not always been in the control of the people. Whereas public health is geared more toward the prevention of disease, it is the curative side, which is availability of good care and medication when ill, that most people are after. This means that there is a mismatch between what the people what and what they are offered. This affects the bond of trust between the government which is the provider of public health and its citizens who are the recipients (Streefland 2005). Quoting Garett (2000), Streefland (2005) further asserts that the provision of health care by the state is based on trust by the citizens, the state is entrusted to further protect the public good of health, the citizens agree to follow the rules and give payment (Streefland 2005). Mistrust therefore can affect the effectiveness of public health services because, as Schneider (2006) puts it, public health requires the support of the members of the public who are its beneficiaries. To provide this public good, the state has to invest in health resources including, health care personnel, health finance, health infrastructure, medicine and medical care to mention but a few. The African continent faces immense challenges in all these areas. Yet the continent is still required to provide public health care in line with global standards. In this study, I will highlight in detail some of these challenges in the continent as a whole and South Africa in particular and their effect on the public health intervention under study, namely male circumcision.

Public Health in Africa

With just 13% of the world population, Africa carries 24% of the global burden of disease (Cooke 2009). A history of colonial, post colonial, international and global health agendas have

placed considerable pressure on Africa's health systems (Ngoasong 2008). Decades of economic crises, structural adjustment programs and declining public expenditure have severely restricted the capacity to provide even the most basic of public health services. The continent's huge disease burden and the frail health systems are also embedded in a broader context of poverty, under development, conflict and weak ill managed government institutions (Cooke 2009). The poorest countries are the worst hit. Public health systems of poor countries face a host of problems including procurement systems that work inadequately, public service delivery that is not accountable, supervision that is not effective and massive shortages in all sectors (Streefland 2005).

Population increases and raving epidemics of HIV/AIDS, TB and malaria have worsened an already bad situation by placing enormous strain on the already frail public health systems (Dovlo 2005). The gap between effective prevention and new HIV incidences is of concern since the increase in people living with HIV/AIDS and thus requiring antiretroviral treatment further complicates the situation, necessitating the need to step up prevention of the virus (Bongaarts 2010). New prevention interventions have not done well either. Recent setbacks in vaccine and microbidcide trials as well as cultural and health system obstacles to expanding male circumcision have dealt the prevention brigade a massive blow and there has been a loss of financial resources (Cooke 2009).

The deterioration of public health care in many Sub-Saharan African countries has been interpreted as a 'betrayal of trust' (Streefland 2005) because the government is unable to provide the quality and quantity of public health that is expected by the citizens owing to the problems mentioned earlier in this section. Yet there is pressure to continue with prevention programs like male circumcision in spite of these circumstances. All these problems have affected, and will continue to affect, the implementation of public health policies and interventions. It is in this environment that male circumcision for HIV prevention will be implemented, bringing about questions of how effective the implementation of the policy will be. This is an issue I will focus on with specific reference to culture and HIV/AIDS, rounding off my research in chapter six by offering recommendations in light of my findings.

Public Health in South Africa

South Africa is a large diverse nation with a multi-cultural population and two contrasting societies; one highly developed, educated and relatively well of and the other under developed, illiterate and poor (Beck 1999; Karim et al 2009). The situation has not changed much over the last 17 years that the country has been independent. The social, economic and environmental conditions created by apartheid continue to define the nature and course of disease in general and in turn the health of the population (Karim et al 2009). These conditions have also negatively impacted on the public health system. Physical infrastructure has been damaged by years of neglect and underfunding and deficits in public health personnel are rampant (Karim et al 2009).

One of the biggest public health challenges in the country is the HIV/AIDs epidemic. As mentioned in the previous chapter, the country has one of the largest HIV epidemics (Global report 2010). The key drivers of the epidemic are said to be multiple and concurrent sexual partners, intergenerational sex and low levels of male circumcision in the context of infrequent and inconsistent condom use (PlusNew 2010). Though boasting one of; if not the largest, antiretroviral program globally, there is a wide gap between effective prevention efforts and new HIV infections (Cooke 2009). In fact, according to an international HIV/AIDS scorecard for countries with HIV/AIDS programs, South Africa is said to be doing worse than its neighbouring countries especially when the country's resources and capabilities are factored in (Karim et al 2009). The country's national HIV/AIDS and STI strategic plan for 2007-2011, focuses on five priorities including;

- Prevention,
- Treatment,
- Care and support,
- Legal and human rights and,
- Research monitoring and evaluation.

Quite ambitious also is the objective to reduce HIV incidence by 50% and initiate ART, in 80% of the people who need it. The plan also factors in male circumcision in its prevention strategy (NSP 2007). While impressive on paper, operationalisation of the plan is another story altogether. Until recently, the government response has been marked by denial, scandal, lack of political will and poor implementation of policies and programs (Karim et al 2009). Studies have shown that where there is political will, public awareness, and community outreach and partnership, successful campaigns have been carried out. A good example can be seen in the Malaria campaigns of Eritrea, Zambia and Zimbabwe where significant reductions in malaria infections have been reported (Cooke 2009). With the recent change of guard in South Africa, there is hope that the newly elected government will supply the strong leadership, political will, social mobilisation and financial resources needed to make a success of the national public health system as a whole and reversing the HIV/AIDS trend of the disease in the country (Karim et al 2009). So far however, the implementation of the male circumcision policy has been slow, possibly in part because of the failure to take cultural and behavioural issues into consideration (Kalichman 2010). Uncovering these issues would then feed into policy and implementation, one of the aims of this research.

As mentioned earlier, public health does not occur in a vacuum. There are many factors which may impact on the process of public health. Below follows a discussion on some of these factors which are at the centre of the study.

2.1.1 Public health and culture

The term 'culture' has many varied definitions across various disciplines. From the classics (Durkheim, Parsons and Weber to mention but a few) all attempted to capture the essence of culture through various definitions (Quah 2010). Their definitions on culture can be summarised as 'the lifestyle blue print'. Hulme (2010) defines culture as the total life ways of a human group. It includes thought, styles of communication, ways of interacting, views on roles and relationships, values, practises and customs (Betancourt 2002).

Culture is shaped by multiple influences, including race, ethnicity, and gender and it extends to sexual orientation, physical and mental ability and so on (Betancourt 2002). In other words, it is the reflection of a people's way of life. Pluralism is present when a nation or society contains within it groups that are distinctive in ethnic origin, cultural patterns, religious belief systems and so on (Hulme 2010). This can be said to be the case in most contemporary societies and countries in Africa, including South Africa. Culture is one of the many factors associated with health. It is also the context in which health related behaviour plays out (Quah 2010).

Public health is a social and cultural activity in that both its practitioners and the recipients of the services are in their various interactions and transactions fulfilling socially defined roles in culturally determined ways (Read 2001). More often than not, practitioners and their clients are 'outsiders to each other'. Outsiders tend to see the more obvious customs which do not tally with their own culture as "cultural blocks" to implementation of a health program (Read 2001). Assimilation and pragmatic acculturation (the borrowing of cultural elements and adapting them to meet practical needs), as a result of living in mixed cultures also has influenced health behaviour significantly (Quah 2010). It is in this context that the public health system is constantly challenged to provide health care services to diverse populations that may be culturally homogenous or heterogeneous even within the same community (Porche 2004).

Since culture shapes the preferences and values related to health and illness, cultural competence in planning, assessing, implementing and evaluating public health is critical to delivering effective health care services (Porche 2004; Hulme 2010). Cultural competence has been defined as;

> A congruent set of behaviours, attitudes, skills, policies and procedures that come together in a system, agency or among professionals to enable them to work effectively in cross cultural situations (Mavundla et al 2009:397).

In the ability of systems to provide quality care to all patients of diverse values, beliefs and behaviours (Betancourt et al 2002), the importance of cultural competence in a cosmopolitan setting such as urban centres of most countries in Africa cannot be over-emphasised.

As mentioned before, culture is a very important factor in health. All societies have rituals performed with pomp and ceremony built into their cultures (Read 2001). Such rituals are taken as sacred and a host of taboos is associated with them (Mavundla et al 2009). Fear plays an important role in enforcing these rituals, for example fear of running mad if one divulges the 'secrets of initiation' (Kepe 2010). This fear is culturally determined and ensures the endurance of the rituals. Read (2001:19) also talks about the 'protective' function of the rituals;

> The kind of protection that people seek through the performance of rituals suggests a deeper layer of thought and attitude behind ceremonies, acts and forms of words. Values and people's value systems are elusive and intangible elements in a culture but nevertheless exert a potent and enduring influence on their way of living. They are also the ultimate clue to people's response to health and welfare programs and to the acceptance of new health practices.

According to this passage, this protection that is sought from rituals is not found in modern medicine, hence the need to seek alternatives. In a similar vein, where conventional medicine is deemed to fail, or is not found to be sufficient, other forms of treatment are sought. This brings into play the issue of traditional systems of healing and traditional healers. According to Gilbert et al (2010), in societies where ill health and other forms of misfortune are seen to have causes other than those found in western medicine, the use of traditional healers is common. This could be argued to be the case in most communities in Africa. In fact more than 80% of the South African population consult traditional healers (Gilbert et al 2010:83). Traditional healers generally provide holistic treatment to the patient, covering both the physical (body) and non-physical (mind and soul) (Gilbert et al 2010). Often this treatment covers illnesses that are not recognised by western medicine for example infertility as a result of witchcraft or curses. In this example, whereas infertility is recognised by western medicine, the causes provided are certainly not and this more often than not leads to mixing of treatment plans; getting both western and traditional treatment for the same complaint. Whereas this mixing can be amicable, this is not always the case and the resulting friction may affect uptake and outcomes of treatment plans, particularly, the western medical treatment.

Health workers therefore, need to be aware of the impact of social and cultural factors on health beliefs and behaviour in order to deliver competent care (Betancourt 2002). While it would be ideal for health care workers to obtain cultural information about a patient and apply that knowledge in the course of their treatment and care, this may not be feasible in the 'real life' situation of most Sub-Saharan health care systems which face a myriad of challenges as was discussed in the previous sections. These challenges include, but are not limited to health care personnel.

2.1.2 Public health and health care personnel

At the driving seat of public health are the health care personnel. These include skilled and unskilled health care workers such as doctors, nurses, nutritionists, surgeons, midwives, community health workers and so on, whose duty is to deliver and enforce public health interventions in the society. There are a number of issues that can be looked at in connection with health care personnel. For the purposes of this study, staff shortages and gender issues will be addressed.

Staff Shortages

Health systems require adequate numbers of well trained and well remunerated up-to-date employees, working with adequate facilities and support systems (Tulchinsky & Varavikova 2009). Human resource shortages are a well documented phenomenon in public health systems globally. Up to four million additional health workers are needed worldwide and Africa requires about one million (Ngatia 2010). At least 38 out of 47 countries in Sub-Saharan Africa do not meet the recommendation of the WHO of a minimum of 20 physicians per 100,000 individuals and in 13 countries; the same population is served by five or fewer physicians (Chelala 2007). As was noted in chapter one of this report, the situation is worse at the specialist levels (Chu et al 2009). Increases in both population and disease burden have led to an increased demand for public health services but these have been met with a notably low supply of health workers (Dovlo 2005). Poor remuneration, lack of motivation, lack of political goodwill, high mortality

rates, and poor terms of service, lengthy and expensive academic requirements and brain drain are some of the reasons that have been advanced to explain this phenomenon.

Health personnel working in health centres, clinics and small hospitals find themselves short of health supplies which they are supposed to use in the course of their work and often work in dilapidated buildings, with inadequate and sometimes delayed remuneration (Streefland 2005). This leads to demoralisation and de-motivation, with some health workers resorting to informal economic activities within the system, for example selling drugs or demanding payment from the patients for their services as has been observed in Uganda (Streefland 2005). With about 23,000 health care workers leaving the continent every year, brain drain is a major problem (Chelala 2007). Not only do health care workers leave the continent to work abroad, but there is migration from rural to urban health facilities and from pubic to private sectors in search of the proverbial greener pastures. In addition to this, loss of man hours as a result of illness, fear of exposure to drug resistant infections like TB, stigmatisation as a result of HIV infections and deaths from HIV/AIDS related illness also contribute to the great deficiencies in human resources (Dovlo 2005). All these have impacted negatively on the implementation of public health programs including the male circumcision policy (Cooke 2009; Kalichman 2010).

The health system has tried to come up with an effective response to address the situation. In seeking efficient ways of improving health and health care, health systems have opened many new professional roles in new organisation frameworks (Tulchinsky & Varavikova 2009). In South Africa, HIV programs facing a burden beyond the capacity of currently available health care personnel have created new regiments of health care workers including, lay counsellors, lay HIV/AIDS educators, peer counsellor and so on (Karim et al 2009). Task shifting and task sharing have also been responses to the problem. However, some of these solutions may not always be appropriate and task shifting and task sharing in the context of the male circumcision policy may have negative consequences as was discussed in chapter one of this report.

Gender issues

Wharton (2005:7) gives the definition of gender as "a system of social practices that creates and maintains gender distinctions and organises relations of difference and inequality based on these distinctions". As opposed to sex which is biologically determined at conception, gender is learned and determined by social and cultural values (Anker 1998). It involves cultural beliefs and distribution of resources at the macro level, patterns of behaviours and organisation practises at the interactional level and identity at the individual level (Ridgeways & Correll 2004). Gender is significant because not only does it shape identities and social interaction, but it also organises social institutions. Social institutions are the rules that constitute some area of social life whether formal, for instance hospitals and schools, or informal for instance marriage and family (Wharton 2005). Who does what, where, and how in social institutions therefore is significantly influenced by gender.

Anker (1998) talks about "occupational segregation by sex", where work in female dominated occupations is similar to activities women perform at home. A good example of this would be the nursing profession in the medical sector which is dominated by women. Sex segregation he contends has an important negative effect on how men see women as well as how women see themselves by enforcing and perpetuating gender stereotypes (Anker 1998).

In the modern world, healing operates within a framework of a complex division of labour which is hierarchical in nature, with the doctors controlling this division of labour (Miles 1991). The separation of healing and caring for the sick in modern medicine has made it a male affair at the top echelons; healing being left to men and caring to women in the lower cadres (Miles 1991). While the numbers of female doctors have increased over the years, studies have demonstrated that women continue to be less likely to occupy senior ranks than their male counterparts (Levinson & Lurie 2004). Both the doctor's and the patient's gendered expectations are mutually involved in creating gender differences during the medical encounter (Holge-Hazelton & Maltreud 2009). Yet gender discussions in medicine are not exactly a welcomed topic. This may be because of the perpetuated assumption that medicine is 'gender neutral'.

Notions of normality subtly construct gender in medicine in ways which emphasise the male gender which is considered 'normal' at the expense of the female gender thereby neutralising the concept of gender in medicine (Holge-Hazelton & Maltreud 2009). Western medicine is based on the assumption, though unstated, that doctors are somewhat 'sexless' and 'genderless' beings, hence patients may talk to them, undress in front of them and be examined by them in a somewhat 'asexual' way (Miles 1991). This can further be demonstrated through medical titles like doctor, nurse, physician which are gender neutral. It is therefore common to see in hospital consultation rooms, health centres or clinics, male and female patients alike queuing in the same queue to be seen by the same doctor regardless of their own personal preference or type of illness. I contend that concepts like task-shifting and task-sharing as prescribed in the male circumcision policy, where female health workers may end up providing the service to men may be based on the same perception.

Another assumption is that doctors treat all patients alike regardless of gender, power or class (Miles 1991). This, studies have proved, is untrue. Findings repeatedly show that treatment accorded to patients may vary according to the cultural views held by the servicing health care personnel. For example, female doctors' may be more sympathetic to female problems or patients and the same case could apply to male doctors and male patients (Miles 1991). This is more so in cases where the patient is consulting for a sexual or otherwise potentially embarrassing conditions (Holge-Hazelton & Maltreud 2009). Preference for the same sex physician particularly for men, may affect willingness to seek care, satisfaction or other health outcomes (Levinson & Lurie 2004), and as I argue, male circumcision may very well fall into this category.

2.1.3 Public health and men's health

There is a growing awareness in both academic and clinical fields targeting men's health (White 2004). Despite this increased interest in men's health over the past two decades, definitions of what this entails are still not quite clear (Heyns & Bornman 2008). Two definitions advanced by White (2004: 269) shed some light on this. According to him, men's health issues include;

> Conditions or diseases that are, unique to men, more prevalent in men, more serious among men, for which, risk factors are different for men or for which different interventions are required for men.
>
> A male health issue is one rising from physiological, psychological, social or environmental factors which have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well being either individually or at population level.

Both definitions attempt to isolate men as a group and in so doing enhance and develop understanding of men's specific health problems. While the WHO's advocacy for gender mainstreaming and the importance of the 'gender' factor has greatly benefited women whose issues have been highlighted, the same cannot be said of men (White 2004). Bonhomme (2007) argues that the overall health of any community or nation requires a positive balance between the genders. Society is adversely affected economically by preventable male diseases and death through the loss of time from work, disability and diminished work productivity (Bonhomme 2007). Addressing the health needs of males would likely lead to overall improved health outcomes for communities and nations (Bonhomme 2007).

The last quarter century of focus on women's health has revealed some fascinating examples of fundamental differences between men and women beyond their reproductive tracts. For example, physiological differences between men and women can influence their reaction to drugs. This and numerous examples exist of differences in health outcomes between and among different populations of men and women (Jones 2004). However, in the past men were mostly treated as a homogenous group which led to exclusions of whole male populations in medical discourse. This has also led to hidden populations, where issues of certain categories of men are not taken into consideration because the larger group is compliant. One of the men's health concerns is to rectify this situation.

There seems to be a preoccupation of men's health with diseases of the male body like erectile dysfunction or diseases that have been stereotyped as male (Heyns & Bornman 2008). In fact

according to Heyns & Bornman (2008), there appears to be a common assumption that all health problems in men are a result of 'masculinity' or men behaving badly. Further, a large body of empirical research supports popular beliefs such as men being reluctant to seek help from health professionals. This is in itself an important obstacle to improving men's health for the reason that it reduces the chances of early detection, treatment or even prevention of disease (O'Brien et al 2005). At the heart of this problem may be the culture of 'being male', of glorifying risky behaviours, values around power, entitlement and control (Jones 2004). Men as a group are less likely to utilise preventive care, less likely to have health insurance, and less likely to have seen a physician over the last year compared to women (Bonhomme 2007). Most men, write O'Brien et al (2005), are reluctant to consult with a physician until or unless the symptoms become too severe for fear of challenging the notions of masculinity (O'Brien et al 2005). Men's lower rated involvement in prevention or curative health care appears to be related to the traditional male gender roles such as; achievement orientation, restricted emotional expression, instrumental nature and self reliance (Bonhomme 2007). In other words, masculinity and masculinism is very much a part of men's health and in turn public health issues pertaining to men's health. But what exactly is masculinity?

Masculinity refers to a manly human character that embodies physical prowess, courage and honourable behaviour. Being a human characteristic, it can be attributed to both men and women, although it is mainly attributed to men. Male identity and male behaviour are neither universal nor immutable but rather social constructions generated in a particular context (Montgomery et al 2006). Masculinity is socially constructed and the meanings of masculine identities are prescribed by time, place, race, ethnicity and sex. Masculinism refers to a particular masculine identity that supports patriarchy, which in sum is an ideology that privileges' males and certain masculine values, meanings and culture, over females' feminine values, meanings and culture (Day et al 2003). Patriarchy however is unstable and it changes over time and place in relation to other socio-cultural political and economic shifts, masculinities are performed in this changing context (Meth 2009). Key attributes associated with masculinism include; control, competition, aggression and physical strength to mention but of few (Day et al 2003). Whereas men may not consistently practice masculinity from its

vantage point of masculinism, they nevertheless reap benefits from the hierarchical system of masculinities relative to overall subordination of women. At the same time however, masculinism may oppress men by ensuring that men adopt its trappings or endure challenges to their manliness (Day et al).

Constructions of masculine practise raise particular barriers to the effective and appropriate use of health services and other forms of help seeking (O'Brien et al 2005). Studies show that men do not respond to pain and illness by seeking health care (Bonhomme 2007). For many men, situations that challenge a masculinist identity, for example giving in to pain, losing control, resting when tired etc, may generate fear (Day et al 2003) which in turn would create resistance. O'Brien et al (2005) notes that men may be put off by 'male unfriendly health care centres' where this would mean little or no male personnel in the facility (O'Brien 2005). The notion of females in control (medics) therefore may very well be a challenge to masculine identities in this case. Other barriers to access to health care for men include, low socio-economic status, low education, precarious or no employment, cultural norms and communication difficulties (Whitley 2005). With this in mind, my research is premised on the assumption that cultural norms around the male circumcision policy, coupled with the recommended task shifting which may result in female health workers performing circumcision could present a challenge to masculine identities and in turn affect uptake of the policy.

The importance of men's health cannot be overly emphasised. Not only does men's health challenge them as individuals but the impact may spread to women and children as well, impairing family, health, economics and stability of relationships. To develop a healthier male population, White (2004) suggests three key areas namely:

- To work with men directly,
- To work with practitioners to ensure that they are informed about specific needs of men and
- To formulate ways of targeting men most efficiently and work with policy makers to ensure that health and social policy create the right environment for work with men.

Men's participation in preventive health care, as well as the development of public policy supportive of men's health can be enhanced by improving public awareness of the challenges of men's health at the individual and public levels as well as with health policy makers (Bonhomme 2010). There is also need to explore how the theories relating to men and masculinity can help in unravelling men's health beliefs and behaviours (White 2004). According to Wilkins (2005:13) however, the above is the easy part, the main challenge is to get workable strategies capable of widespread application. In concurring with this, my research aimed at exploring one such aspect.

2.1.4 Public health and policy

Public policy has been defined as the broad framework of ideas & values within which decisions are taken and action pursued by governments in relation to some issue or problem, which in this case would be health (Wilson & Mabhala 2009). Policy making involves the difficult task of selecting the best criteria to apply to achieve a specified goal usually from among other competing interests (Ngoasong 2008). Public health policy has been likened to the development of a treatment plan for a sick patient, involving the use of scientific knowledge to decipher a health problem and to develop a strategic approach to dealing with it, thereby improving general community health (Schneider 2006). Policy analysis is consequently critical to the development of sound policies (Ngoasong 2008).

Public health policy is not designed or analysed in isolation from social and political contexts. It has to be linked to a wide range of social resources and infrastructures, social capital, social interaction and social support (Wilson & Mabhala 2009). Most immediate social goals are more often than not the result of opportunities offered by newly discovered or perceived choices rather than a source (Ngoasong 2009). I argue that the proposal for male circumcision policy falls under the 'newly discovered' category, which means there is still much to be discovered about what works and what does not in the implementation of this process. This study aimed to contribute to this process.

Education and regulation have been the traditional methods of promoting the public health agenda. Education aims to modify or change activities that lead to ill health and regulations to restrict or ban activities or substances that can cause bad behaviour (Schneider 2006). This may require infringement of personal freedoms and application of public recourses. Hence it is important for the recipients of public health interventions to be in agreement with the policies that have been developed. This necessarily means that politics have to be involved in campaigning to popularise or veto policies in line with the public health goals of the community (Schneider 2006). Politics can therefore have a strong impact on the success or failure of policies as has been witnessed in the country's HIV/AIDS strategy in the previous regime.

Political will is therefore vital in the success of public policies. However, political attention has not always been able to focus on health needs sufficiently (Tulchinsky & Varavikova 2009). Lack of political will is one of the leading causes of public health services failure. Take the case of human resources in public health. As was discussed earlier in the chapter, shortages are rampant yet developing, training and sustaining public health human resources has not been a top concern in many governments.

Another potential barrier is health finance. During an African Union meeting in Nigeria 2001, African heads of state issued the Abuja declaration in which they pledged to raise public health spending by 15% of their respective national budgets (Cooke 2009). Almost a decade later very few have made any noteworthy progress towards this. Lack of substantial financial resources is a challenge not only to providing basic public health services to the public but also in incorporating novel concepts such as 'transcultural nursing' and 'cultural competent care' (Mavundla et al 2009) in public health services and interventions. Such concepts are critical in the implementation of policies that have cultural connotations such as the proposed male circumcision policy, particularly in light of the possible involvement of female health workers.

Public health policy specifically reflects an increasingly diverse agenda developed against a context of global forces and changing social and political environments (Wilson & Mabhala 2009). Policy makers in Africa, far from being able to respond locally and autonomously, face enormous global pressures in setting and implementing health policy to facilitate access to

medical and health care (Ngoasong 2009). These policies are often subject to receiving much needed financial aid. Africa is and for a long time to come will remain with an enduring pre-occupation with and target of global public health policies and interventions (Cooke 2009). However, it is important to re-examine proposed global health policies and interventions to ensure their applicability to the continent because culture is very much a part of the individual's daily life and where policy and culture collide, culture more often than not triumphs. The proposed male circumcision policy is one such policy where the collusion of culture and policy may be expected, hence the importance of research such as mine.

2.1.5 The new public health

The new public health is said to be concerned with the total health system and related issues including human resources planning and management, cutting edge technology and research (Tulchinsky & Varavikova 2009). Globally, with infectious diseases largely under control and chronic illness increasingly taking over as leading causes of death, attention has turned to social and behavioural factors in health (Schneider 2006). This necessarily means focusing on individuals and or their behaviours.

The impact of medicine and medical concepts has expanded greatly in the past 50 or so years and behaviours that were once defined as immoral, sinful or criminal have been given new meanings, moving from badness to sickness in what has been termed as the 'mediatisation of society' (Conrad 2007). Conrad (2007) defines mediatisation as the process by which non-medical problems become defined as and treated like medical problems. This includes rites of passage including birth, death and initiation rites like male circumcision which are increasingly done in clinical settings. Szasz (2008) contends that the concept rests on the assumption that some phenomenon belongs to the domain of medicine and others don't. However since virtually all lived life, housing, food, education, work, recreation, procreation and so on has the ability to impact on health, contemporary public health seems to dominate everyday life (Szasz 2008).

The new public health seems to be a moral enterprise that involves instructions on how individuals should conduct their bodies both individually and collectively (Petersen & Lupton 1996). The social is viewed as having the potential to intrude onto the individual while the individual is viewed as having the potential to affect the health of others (Lupton 1995). Risk is a dominant concept, phrased as a property of individuals or an external threat (Petersen & Lupton 1996). Individuals considered 'highly at risk' have been the target of many public health campaigns that aim to change the so called risk behaviour. There is stress on personal responsibility in the language of disease prevention (Armstrong 2008). In the case of this study's focus of interest, the uncircumcised individual is required to present himself for circumcision as part of HIV prevention strategy; regardless of the fact that male circumcision is largely a communal affair since it is a rite of passage. The individual is also expected to be comfortable with the idea of female health workers performing the procedure, regardless of the fact that men are more comfortable with same sex physicians in potentially embarrassing situations (Levinson & Lurie 2004). What seems to be important is the prevention potential of circumcision and the rapid scale up without too much focus on the details of implementation.

According to Petersen & Lupton (1996), the relationship between the state and the individual is tense. This is because the new public health seeks constantly to shift the responsibility of providing public health from the state to the individuals themselves. This is done by using strategies that position citizens as acting of their own free will and in their own interest to protect their health (Petersen & Lupton 1996). For example, using media channels to depict individuals who are healthy because of taking the recommended course of action can be constructed as society trying to get other individuals to 'make the same choice for themselves'. For those individuals who 'fit the bill', that is by having the necessary economic, cultural or symbolic capital, the system works. However those who do not, either have to seek alternative measures where they can find them or undergo assimilation or pragmatic acculturation in order to be accommodated in the system (Quah 2010). There is therefore subtle coercion to get the individual to act in accordance with societal interests even when it is against his own personal preferences or culture. Coupled with the earlier discussion on betrayal and mistrust between the government and the citizens with regard to public health services, it is possible to see

individuals trying to assert themselves by resisting or rejecting health interventions which then fail. This can be said to be the result of many health programs and campaigns. For example, as noted in chapter one of this report, Tseng et al (2008) lists medical interventions that have been resisted on personal preference and cultural grounds regardless of their benefits to individuals. It is therefore pragmatic to closely examine health programs or interventions particularly those that have cultural connotations before they become public health interventions. Hence my study focused on a cultural component of the proposed male circumcision policy.

This section has discussed public health and the context in which the male circumcision policy will be implemented at length; the following section will present the theoretical framework.

2.2 Theoretical Framework

Theory can be defined as 'a scheme or system of ideas and statements which have been held as an explanation or account of a group of facts or phenomenon' (Grbich 2003). Whether at macro, middle range or grand level, all research is based on theoretical assumptions. Social research is at its most useful when theoretical insights and social investigations are such that the collection of evidence is informed by theory and interpreted in light of it (Ritchie & Lewis 2003). Theories around health particularly focus on ideas around prevention, management and cure of diseases.

Disease is socially patterned and population health is a reflection of complex and interactive social, political, historical, cultural and economic factors (Maio 2010). As was discussed earlier, the goal of public health is to control disease and illness, either by preventing or minimising disease impact in the population. Public health practises focus on the prevention of risky lifestyle or personal behaviour that may cause or that causes diseases to occur (Porche 2004). Behavioural factors are said to be the root cause of most of these disease which have also been called 'lifestyle diseases'. It follows that a healthy population is necessarily made up of healthy

individuals. It may be argued that these individuals are healthy as a result of following prescribed public health behaviour for prevention or cure, for example immunisation, hand washing, exercising, eating a balanced diet, proper disposal of waste products, good sanitation, giving up drinking or smoking, taking the full prescribed courses of medication so on. All these practises entail change of behaviour by adopting good health practises in place of 'bad' ones. Adoption of good health behaviour is therefore central to public health.

2.2.1 Health behavior

Hayden (2009) defines health behaviour as the total of all activities undertaken by individuals which influence their physical, mental, emotional, psychological and spiritual beings. In light of the earlier discussion on the mediatisation of society, it could be argued that health behaviour encompasses all human behaviour.

According to Quah (2010), there are three types of health related behaviour; the first is preventive behaviour, which refers to the activity taken up a person who believes he or she is healthy to prevent illness. The second is illness behaviour, which is activity taken up by an ill individual for the purposes of defining the illness and seeking a solution. Finally there is the sick-role behaviour which is an activity taken up by one who is sick for the purposes of getting well. This would also involve seeking professional help. This study's area of interest is the preventive behaviour. As was discussed earlier, the prevention buck stops with the individual who is required to change unhealthy behaviour patterns if they are to avoid ill health (Armstrong 2008). The individuals in public health however do not operate in a vacuum and mostly have their behaviour motivated, oriented and constrained by the social and cultural context in which it occurs (Read 2001). Sociology is founded on the belief that there are social factors which influence behaviour (Elder-Vass 2010). According to Grbrich (2006), there are two major groups of social theories around health; those that focus on social control (structure) and those that focus on the capacity for autonomous action (agency). The ways in which structures are assumed to influence agents are dependent upon what structure and agency are held to be (Archer 2003).

2.2.2 Theories on social control

Theories on social control focus on societal structural organisations that facilitate harmonious co-existence and systems that ensure equilibrium by enforcing patterns of thinking and behaviour (Gbrich 2003). Social structures have been described as the array of costs and benefits or opportunities that are available to the individual (Rubinstein 2001). These structures are held to influence human behaviour by rewarding 'appropriate behaviour' (Elder-Vass 2010). For example, when a child is enrolled in a school, the parent is required to present an immunisation record. So while a person may have reservations about immunisation, this factor may encourage the person to take their child for immunisation.

Structural theories have accommodated the moral nature of social facts, recognising that behaviour is positively motivated through internalised norms (Pappas 1990). However these theories have been criticised for concentrating excessively on processes that produce stability and order, and the maintenance of certain structures with little regard to autonomous action (Gbrich 2003). However a number of medical discourses have come from these theories including Talcott Parsons 'sick role' and Michael Foucault's panoptical circular prison and clinical gaze, which aim to show how medicine and health have been used to regulate social behaviour (Grbich 2003).

2.2.3 Theories on individual capacity for autonomous action

These theories view individuals as possessing the power to make choices pertaining to their lives autonomously; hence the society influences rather than directs individual action (Gbrich 2003). The individual is the agent and agency is described as the degree to which persons are authors of their own conduct or the exercise of human reflexivity of conscious decision making (Elder-Vass 2010). The proponents of these theories include George Mead, Erving Goffman, Max Weber and Jurgen Habermas to mention but a few. They believe that the real power is with the individual who exercises it within particular contexts (Gbrich 2003). Pappas (1990) believes that even the most seemingly powerless individuals are able to mobilise some types of

resources which gives them control over aspects of their lives or the lives of others. In the immunisation example above, the individual would take their child for immunisation because they are persuaded that it is critical in preventing dreaded childhood diseases rather than the need to obtain an immunisation record for the purposes of school enrolment.

These two groups of theories seem pitted against each other. As King (2004:5) puts it;

> Society is seen as consisting of 2 divisible elements; structure and agency. Structure being the cold institutions of the modern world and agency being the creative individual.

The implication that structure and agency represent a binary choice that either behaviour is determined by autonomous individual choice or external structural forces is rejected by many contemporary authors (Elder-Vass 2010). Peter Blav for instance argued for a dialectical social theory in which structure was reproduced and transformed by the individuals in the course of social exchange (King 2004:5). Yet another author is Anthony Giddens. Giddens asserts that this dualism (structure-actor) has to be transcended if society wants to comprehend more adequately the complexity of modern society (Kaspersen 2000). I shall now discuss some of Anthony Giddens' propositions and contributions to contemporary social theory that I believe are in line with this study. These are the theory of structuration, the modern society and the post traditional order.

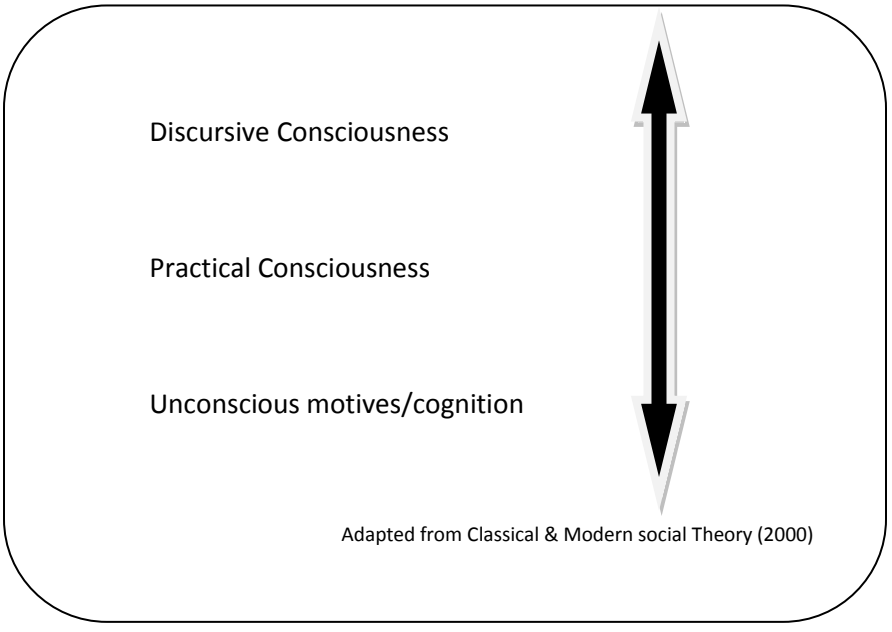
2.2.4 Theory of Structuration

According to Giddens, society consists of social practises that produce and are reproduced across time and space (Kaspersen 2000). Through the process of these social practises, society is constantly created and recreated in a continuous structuration (Kaspersen 2000). Giddens argues that Individuals continuously shape reality through the decisions and actions they take. This is because although social behaviour is guided to some extent by forces such as roles, norms and shared expectations, individuals perceive reality differently according to their backgrounds, interests and motivation. Reality is therefore created through human action (Giddens & Griffiths 2006:130). For Giddens therefore, actor-structure relations must basically

be seen as a duality of structure, which means a coherent relation in which structure is both the medium and outcome of the actors' actions (Kaspersen 2000).

Giddens talks about three levels of consciousness in which social practises occur; the discursive consciousness, practical consciousness and the unconscious motives and cognition. The discursive consciousness refers to that which the agent can verbalise or express in word form about social conditions pertaining to their actions that may not have factual backing for (Kaspersen 2000). Many traditional practises, myths and taboos would fall into this category. The practical consciousness refers to what the agent knows or believes about social conditions, including the conditions of their own actions but is unable to express expansively. According to Giddens, agents are largely knowledgeable about most of their actions and this they express through their practical consciousness (Kaspersen 2000). That fact that the agent 'knows' indicates that systems and structures are not hidden from the agent and he acts in awareness of what they are (Kaspersen 2000). The degree of awareness and how applicable it is in an individual's life is however debatable. Still, this knowledge gives the individual a resource which he can use in making choices in day to day life hence giving him some kind of control over his own life. The unconscious comprises repressed or distorted knowledge and actions spurred by unconscious motives (Kaspersen 2000). Figure 1 below shows these three levels of the agent's motivation or cognition.

Stratification model of the human agent's 3 levels of cognition/motivation



Adapted from Classical & Modern social Theory (2000)

The practical knowledge is to be the most significant for understanding social life since it is where most social relations and interactions take place. The model rehabilitates the large amount of tacit (unspoken) knowledge which is often ignored by social theory and which is very important for the maintenance and reproduction of social life (Kaspersen 2000).

2.2.5 The modern society and the post traditional order

For Giddens, modernity involves the disembedding of relations from local settings and their stretching across time and space (King 2004). This is due to the fact that new methods of communications have replaced face to face relations of pre-modern society (King 2004). In many modern settings, individuals are caught up in a variety of differing encounters and milieu, each of which may call for different forms of appropriate behaviour (Giddens 1991:190). Thus a cosmopolitan person is one who precisely draws strength from being at home in a variety of contexts (Giddens 1991). This is the case for most urban dwellers in this country that have migrated to the urban centres to look for jobs but still maintain ties with their homeland and have to adjust their behaviour according to where they may be residing at any particular time.

Giddens believes that modern institutions differ from all preceding forms of social order in respect of their dynamism, the degree to which they undercut traditional habits and customs and their global impact (Giddens 1991). Both development of science and the secularisation of thought have contributed to the character of the modern outlook (Giddens & Griffiths 2006). In pre-modern societies, the hold of tradition was often more or less unchallenged and the individual had little power to alter or escape from their surrounding social circumstances. In post traditional society however, the individual is no longer committed to one tradition nor restricted to ascribed social relations (King 2004). Giddens (1995b:5) writes that “The more tradition loses its hold, the more individuals are forced to negotiate lifestyle choices among the diversity of options”. Customs and habits are thus no longer accepted merely because of the age-old authority of tradition (Giddens & Griffiths 2006:48).

Since it is no longer obvious what the individual should do or be; individuals have to make decisions in the context within which they find themselves. No longer constrained by tradition,

the individuals have to decide upon what kind of people they will be (King 2004). As Giddens (1991:186) argues “A self identity has to be created and more or less continually reordered against the back drop of shifting experiences of day to day life and fragmenting tendencies of modern institutions” (Giddens 1991:186). The self is seen as a reflexive project for which individuals are responsible (King 2004). Giddens (1999:14) sums it up as;

> Modernity is a post traditional order in which the question “how shall I live?” has to be answered in day to day decisions about how to behave, what to wear - what to eat and many other things – as well as interpreted within the temporal unfolding of self identity

As mentioned earlier, Sociology is founded on the belief that there are social factors which influence behaviour (Elder-Vass 2010). Human behaviour is an integral part of public health interventions since this influences uptake of public health interventions. Whereas culture and traditions influence human behaviour, in the modern society, this is no longer clear cut since tradition no longer has a hold over individuals. My study focuses on cultural beliefs, attitudes and gender and their effect on preventive behaviour in the modern society or post traditional order which in this case is the uptake of male circumcision from female health workers by men. The methodology used in my study will be discussed in the next chapter.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

This chapter outlines how the research was conducted including the research design, procedures, data collection processes, ethical considerations and researcher reflexivity.

3.1 Research Design

Research is the generation of knowledge through systematic processes. Sociological research intends to describe, analyse and understand the practical lived experiences of people's normal day to day life situations (Maio 2010). Health research in particular is concerned with the health of individuals, the care they receive and the services that are delivered to them (Ritchie & Lewis 2003).

The nucleus of empirical research is evidence collected in an objective way. The research design plays an important role in how a study can achieve this effectively. In the process of choosing a suitable research design, I considered two dimensions; its intended use and data collection techniques (Neuman 2000).

The first dimension which I considered was the intended use. The main intention of basic research is to understand the fundamental nature of social reality Neuman (2000). This was in line with my study intentions. The second dimension which is interlinked is the data collection technique used in the research. For this study, I used the qualitative data collection technique.

Qualitative Research

Strauss & Corbin define qualitative research as "any kind of research that produces findings not arrived at by means of statistical procedure or other means of quantification" (Strauss & Corbin 1990). The data collected can be in the form of words or pictures. Its aim is to give an in-depth and interpreted understanding of the social world by learning about people, society,

circumstances, experiences, perspectives and histories (Ritchie & Lewis 2003). Qualitative methods are used to address research questions that require explanation or understanding of social phenomena and their context. It is mainly concerned with the need to explore and understand the social world through the participants and their own perspectives (Ritchie & Lewis 2003). I felt that given the nature of the study, a qualitative method would be the most appropriate method. Hence, the research design used was the qualitative.

3.2 Research procedures

Field work starts by clearing the initial hurdle for gaining entry or being accepted into the selected setting or situation so that one can observe and talk to people about the research question (Wilson 1993 cited in Mavundla et al 2009). I initially wanted to conduct the research in a health care facility, specifically a Primary Health Facility. The participants were intended to be the health care workers and the visiting patients or clients. This would have given the research perspectives from both sides. However, gaining access proved to be very difficult. The procedure proved lengthy and complicated. I encountered a lot of red tape and a good measure of reluctance from the authorities. Communication was not always smooth and a lot of these complications may have been brought about by the extended public servants strike that had probably over-extended already overburdened systems when the public servants resumed their duties. Since time was running out, I had to choose another study site where I could gain access.

It was no longer possible to include the health care workers as participants; hence all the data collected had to come from the male participants. The in-depth interview guide was broadened and modified so as to collect as much data as possible from the remaining participants. Fresh mandate was sought from the ethics committee and interviews were then conducted. I therefore chose the informal areas of Midrand, Ivory Park and Rabie Ridge.

3.2.1 Study area and participants.

As mentioned above, the study was conducted in two of the informal areas of Midrand, namely Ivory Park and Rabie Ridge. Midrand is a young vibrant city located between the two largest urban centres in South Africa, namely Johannesburg and Pretoria. As one of the fastest growing cities in the country, it has attracted a fair share of immigrants both from other rural and urban areas (Sugrue 2000).

Ivory Park is a planned informal settlement that was established in 1991 to provide site and service stands to address the overflow of people from nearby Tembisa and other urban areas. It is however not well developed in terms of social services and amenities. Ridge was formally a 'coloured area' and is fairly well developed with social services and amenities (Sugrue 2000).

Between them, these areas of Midrand are home to more 80% of the total Midrand population. The reason for choosing these areas of study was because as a resident of Midrand, I had easy access to them. Moreover, having both rural and urban immigrants, I was assured of a mixture of cultures and communities which would offer different perspectives to the study. The participants were male individuals residing in the fore-mentioned areas. The men were all above the legal age of consent.

3.2.2 Sampling

Neuman (2000) talks about non probability or non random sampling as being the most common sampling category for qualitative based research. He attributes this to the fact that in non probability sampling, the main emphasis is on the relevance rather than representativeness of the participant to the study (Neuman 2000). The research used this category to identify a suitable type of sampling technique. Due to the sensitive nature of the study, it would not be possible to randomly select participants and hence the snowballing technique was used. The study topic is not only a relatively new topic but also a sensitive one. This method enabled me to gain access to people who would have otherwise been inaccessible to me and who would be in a position to give information that would be relevant to my study (Greenstein 2003).

3.2.3 Ethics

Being research that involved human beings, every effort was made to ensure that their dignity was preserved and their rights protected. Ethical approval was sought and granted from the University of Witwatersrand Research Ethics Committee and an ethics clearance form number H080805 (Appendix 1a) was issued. Ethical clearance was also sought and granted for the changes that had to be made namely the change of study site (Appendix 1b). The participants were also requested for their individual consent before participating which they gave by way of signing an informed consent form (Appendix 2).

3.3 Data collection

Empirical data was collected through in-depth interviews. Additional data was also used and it was obtained through document analysis.

3.3.1 Interviews

Interviews are used to gain insight into how people perceive and understand their situations, experiences and events (Grbich 2003). Individual interviews provide an opportunity for detailed investigations of people's personal perspectives. Which in turn provides for in-depth understanding of the personal context within which the research phenomena are located (Ritchie & Lewis 2003). Due to the nature of the research problem and the fact that it is still relatively new, a suitable method of data collection was needed to draw out the most information and hence in-depth interviews were used (Strauss & Corbin 1990). In-depth interviews were also considered due to the fact that they can enable exploring of private subjects or sensitive issues, such as the one in this research (Ritchie & Lewis 2003). A guide (Appendix 3) was prepared for use in the interview but I also followed other markers as they arose during the interviews.

Procedure

Every effort was made to ensure that study participants remained comfortable, informed and aware of their rights. On contact, the participants were given an information sheet explaining their rights and duties in so far as the study was concerned. I went through the information sheet with them and addressed questions and concerns that were raised. The participants were then invited to participate in the study and give their consent by signing a consent form (Appendix 2). Keeping in mind the importance of gatekeepers in accessing a community, key community members were the first ones invited to participate in the research. I believe that having participated in the process themselves; they were able to refer other people to the interviewer with confidence.

I had a central venue in the community where the interviews were carried out. This served to ensure safety for me. It also helped to create anonymity for the participants since they were assured that I would not have their physical addresses. However this presented a challenge in so far as getting the participants to the venue was concerned. After deliberation with my supervisor, I offered to meet the participants' transport costs to the venue.

3.3.2 Document analysis

In addition to empirical data, document analysis was conducted. Both primary and secondary sources of data were examined and analysed in order to enrich and build on the empirical data that had been collected. The key documents analysed included research reports, general periodicals, newspapers, magazines, journals and other academic writings on male circumcision, public health policy, gender and health, task shifting and task sharing, culture and health and social theories. The documents were obtained from the University of the Witwatersrand library especially the electronic databases, Midrand library and search engines including Yahoo, Brother and Google. The information obtained was instrumental in the designing of study tools and providing background information including a theoretical framework for the study.

3.4 Data analysis and reporting

Data analysis was an on-going activity as more data was collected and more information availed on the research problem. According to Flick (2002), the interpretation serves to develop theory and at the same time is the basis for the decision about which additional data needs to be collected. Data collection and analysis was therefore not in a linear process. The first group of interviews was transcribed verbatim and major trends identified. This information was used to modify and streamline the in-depth guide. This process was repeated once more before the final group interviews was conducted.

Data collection took place over a period of three weeks. At the end of the data collection, the interviews were once more analysed one by one and major themes identified for each interview. The analysis was then done across the interviews, drawing out the major themes which were then applied to the theoretical framework for interpretation and discussion.

3.5 Researcher reflexivity/Bias

Field work involves interaction between participants and researchers and researchers make spirited attempts to present themselves as objectively and neutrally as possible (Ritchie & Lewis 2003). This is because when collecting data through interviews, the richness and accuracy of the data collected may be compromised by the researcher. Issues of dress, sexuality, gender, age, class and race have to be considered (Grbich 2003). The researcher may also impact on the results reported.

In this study, I had to interview male participants on a potentially sensitive topic, in English and at a central venue. Due consideration was given to how I may impact on the study. Central to it all was keeping in constant touch with my supervisor who was able to keep me in check. In addition to this, several approaches and considerations were taken in this regard.

First was gender. Some schools of thought propose that it is ideal for the interviewer and interviewee to be of the same gender. This however is still questioned (Ritchie & Lewis 2003). In this particular context, the use of the snowball sampling technique played a big role as did informed consent. In addition, the participants were given the option of talking to a male

interviewer if they so wished. None of the participants expressed any concern with the gender of the interviewer and they were able to speak freely to the extent of giving personal accounts and intimate details. This could be a testimony to the quality of rapport I created with the participants.

Second was language. Since I do not speak any of the native languages, the interviews had to be conducted in English. While most participants could converse in English, it was not their first language and sometimes they battled to find the right words to express their thoughts. The participants were informed of the provision to speak through a translator but none of them was willing to do this probably due to the sensitive nature of the topic. I encouraged them to not feel bound to speak in English and they often said things in their mother tongue and then translated the same for me in English afterwards.

Third was the issue of circumcision. Coming from a background where circumcision is almost universal, the phenomenon of cultural blocks (Schneider 2006) had to be considered especially when interviewing uncircumcised participants. I strived to keep an open mind and convey neutrality both in verbal and non verbal language to all participants especially the uncircumcised ones.

Fourth was the issue of stipend. While this was offered so as to meet the participants transport costs, I had to consider the potential that it could come across as payment for the interview (Ritchie & Lewis 2003). I tried to counter this by emphasising to the participants that it was not payment for the interview but transport costs. The stipend was also given at the end of the interview and not at the beginning for the same reason.

Having discussed the methodology in this chapter, the following chapters will present the study findings and discussion.

CHAPTER FOUR: FINDINGS AND ANALYSIS

This chapter will present the study findings and part of the discussion.

In total 17 men were referred to me. Of these, 15 agreed to participate and completed the interview. The other two were unable to participate due to time constraints. They however referred me to other participants. Of those who agreed to participate; a total of seven men were circumcised. Four were circumcised at the hospital; three were circumcised at traditional initiation schools and eight were not circumcised. Five were between 20 and 30 years old; six were between 30 and 40 years; two were between 30 and 40 years and two were between 40 and 50 years.

Major Themes

As was discussed in chapter two, health behaviour is influenced by a number of factors including culture, gender and masculinities. Data was collected focusing on these areas which I felt would reflect the research aims. The following discussion is centred on these areas.

1. Culture.
2. Gender - Health care workers in general and female health care workers in particular.
3. Male Circumcision

4.1 Culture

Male circumcision has always had strong cultural connotations in Africa (Silverman 2004; Aggleton 2007). Further, the proponents of the policy have stressed the importance of exploring cultural issues pertaining to the implementation of the policy (WHO/UNAIDS 2007), although inadequate research has been conducted into this arena. For this reason, I felt that exploring cultural issues was important. Of particular interest was to see if culture was a barrier to women performing medical circumcision and to what extent if any.

As mentioned in chapter 2, culture is a people's way of life (Hulme 2010). This is expressed through thought, styles of communication, ways of interacting, views on roles and relationships, values, practises and customs (Betancourt 2002). To the participants, culture seemed to refer specifically to the rites and rituals performed by a community rather than a community's entire way of life. They also associated culture with rules and regulations which had to be followed without question.

All participants stressed the importance of culture; including those participants who said they had 'no culture' or who said they did not practise any form of culture. Failure to follow culture was seen as a way of losing the very essence of the individual. All participants, including those who said they did not follow culture, seemed to be aware of the rituals performed during birth, marriage and death by their respective communities and observed these with varying degrees. This seemed contradictory and pursuing it further revealed that these participants did not consider day to day activities as 'culture' and that culture had to be practised in a family setting, not by an individual alone. One participant explained.

> ***…*** *yeah but me, I won't say like I follow it [culture] like … because I don't have too much of a family. I don't have family that is the problem you see. So most of the things that I do I have been doing it on my own or for myself you see* ***(M: 20s not circumcised).***

Having lost both parents and being an only child, this participant did not consider the things he normally does as part of culture because they were not done in an immediate family context, yet he also mentioned that he took part in his extended family's ceremonies and rites. This would indicate that for him, culture was not day to day life but something more elaborate.

It was also said that failure to follow culture had some consequences including cutting ties with the homelands where cultural practises are strictly adhered to. Having said that participants also felt that there were numerous challenges and influences to practising culture in city life.

4.1.1 Challenges to the practice of culture in the city

According to the participants, cultural practises are adhered to more strongly in the homelands than they are in the city. This view was more likely to be held by participants who had migrated

to the city from the homelands or those who still had ties in the homelands which they maintained through periodic visitation. Migration, especially labour migration is commonplace in the country. According to Montgomery (2006), former Bantustan 'homelands' are characterised by high adult migration with 25% of all household members being non-resident in that area. The main reason for migration is the search for a better life that can be provided for through the employment opportunities that are believed to be available in the city. Modern life being the life that is lived in the city was seen by the participants as the biggest influence on the practise of culture. Desire to embrace modernity, the trappings of modern life, western culture, intermarriages and modern institutions were all mentioned as having an effect on an individual's practise of his original culture.

A particularly enduring view was that there was 'no culture' in the city.

> ***INTERVIEWER:*** *why do people say there is no culture in Johannesburg?*
>
> ***…*** *because I am like …we are mixed up here, we got coloureds… Indians…you know and you can see I'm having a friend like……like a colored friend and a white friend, and m gonna have to tell them, …'guys December I must go down to the mountain' and… and he is gonna tell me he don't approve of that. 'No you can't do that, whatever…… you have been living here with us, you can't do such things, I would just go to the hospital'…. and stuff like that. (The) other colored friend will say, 'no I don't approve of slaughtered meat, I would rather buy meat whatever, I don't approve!' That is why I say that* **(*TF 20s circumcised at the mountain*)**

Two things come out of this participant's observation; the first is the mixed community. This is the basic composition of most cities in South Africa as a result of migration. The second is the aspect of questioning other people's culture which he seemed to think was disrespectful. According to this participant, living in a mixed community takes away the aspect of culture, particularly because the 'others' question one's cultural practises. If there was culture in the city, according to him, people would not question the cultural practises of each other. In the second chapter of this report, culture was defined as a people's way of life. Bearing this in mind, it is not possible that there is no culture in the city but possibly that the participant does not identify with the cultural practises of the city.

Living in mixed communities also lends itself to intermarriages among the different communities. This was also noted as influencing cultural practises by the participants, particularly where the two communities involved did not share similar cultural practises.

> ***…****you see it becomes a problem especially when it comes to marriage. Because you come from different cultures, like in South Africa we are 11 languages, there is this Nguni tribe but we got different cultures. The Zulus, the Xhosas, the Swatis, our language is a dialect. Zulu I think is the original the others are dialects. So when someone speaks in Xhosa, I understand him, in Swati I understand him but there is a difference in the way our culture is…being done you see. So when we are engaged in a marriage, it becomes a very difficult because you want to do your way I want to do my way…..there is friction* **(MM Zulu 30s circumcised at the hospital)**

All participants with a mixed community background claimed to follow their father's culture, which could indicate that in the 'friction' mentioned by this participant, the male partner triumphs. Most African communities practise patriarchy and this would be in line with that practise. Patriarchy was defined earlier in this report as an ideology that privileges males and certain masculine values, meanings and culture, over females' feminine values, meanings and culture (Day et al 2003). This suggests therefore that the male gender is superior to the female gender in this community.

One of the biggest imports to the continent and the country as well is the western culture. This is particularly the case in urban areas. The participants observed that western culture influenced the practise of culture. Particularly mentioned were modern institutions like schools and animal rights organisations. These were seen to restrict or interfere with cultural practises. One participant said;

> ***…****now here [the township] where we are there is no trouble you can slaughter a cow or a goat anything you feel like slaughtering, but like in the town houses, what they normally say, they normally tell you it is the against the law, you will have trouble with the SPCCA and maybe go to jail, so when it is like that,…you supposed to like go to a place like where you can slaughter, take it to a butchery and they cut it up for you then...maybe they can allow that, then plenty people in your yard they are cooking the whole night through…so it depends where you are* (**M, 20s not circumcised**).

According to his statement, there seems to be a different set of rules within the same city, according to physical location. The townships may have more tolerance to cultural practises

than the 'townhouses' which are in more affluent areas. This would imply that (ironically) the more affluent one is in the city; the more difficult it is to keep up with his culture.

Another important issue mentioned was the general knowledge of culture. The participants felt that when one belongs to a family where cultural issues are adhered to, this information is passed on to the younger generations who are then able to keep it up. Yet handing over this information to the younger generations has its own challenges. One participant talked of his experience trying to pass on his culture to his daughter;

> ***…*** *worse our children, I got a daughter who is in grade 4, she is 10 years old. I see she doesn't even like that life. But m trying to let her …get to know about it [culture]. She will tell me of her equal rights. Of her rights, she knows them! She is learning with these coloureds, with these whites. She tells me of her rights. She tells me when I beat [corporal punishment] her when she doesn't understand what m beating me of, it is abuse! Ai, she is telling me lots of things you see…* ***(MM 30s circumcised at the hospital).***

According to this participant, the fact that his daughter is mixing with other cultures ('coloureds' and 'whites') makes her reluctant to take up his culture. This is similar to the participant mentioned earlier TF, who talked about being questioned about his cultural practises by his friends from other communities and this may explain the daughter's reluctance. Important to note here also is that the girl 'knows her rights' and uses this knowledge to challenge corporal punishment from her father. This can be situated in the issue of the knowledgability of the agent as was discussed in chapter two of this report, where the agent uses knowledge in practical consciousness to exercise some kind of control over his/her life.

Discussions around challenges to following culture left me with the impression that some participants experienced confusion in trying to find self identity in the modern life especially for the older generation who still migrate between the rural and urban areas. Giddens talks at length about the effect of the post traditional order which is the modern life on the self identity of the individual. According to Giddens (1991:186), "a self identity has to be created and more or less continually reordered against the back drop of shifting experiences of day to day life and fragmenting tendencies of modern institutions." Whereas tradition gave individuals a guide on

how to live, this guidance is absent in the post traditional order and individuals have to 'feel their way' as they go. As will be discussed in the following sections, this attitude extends to traditional practises such as male circumcision.

4.1.2 Culture and health seeking behavior

According to the information provided by the participants, culture did not seem to forbid any health seeking behaviour, modern medicine included. While two participants from the Zulu community said they go to traditional healers (Sangomas), they did not attribute this to a cultural requirement but rather for convenience. One of them in particular decried the long process of getting treatment from a hospital;

> ***PK:*** *yeah, it depends how do you feel, or what kind of a sick do you have. Because actually we Zulus, we don't depend to the hospital so much. We depend to go to the traditional healers**.....** (Signs) well, to go to the hospital, it is a long process that is why in our culture we prefer to go to the sangoma*
>
> ***INTERVIEWER:*** *I don't understand*
>
> ***PK:*** *you must….queue, go and book your name, ...you must wait for the doctor to come and only to find that that hospital many people they go there….so hospital is long process* (**PK, 30s not circumcised)**

Whereas the term 'culture' was mentioned by this participant, it was more in reference to the ethnic group. The participant also said that the sangoma's services were not free whereas the hospital services were. However the process of getting treatment was not worth the free treatment according to him and hence the preference to go to the sangoma. The participant also implied that there are diseases that would not be covered by the sangoma but would need modern medical intervention. This indicates mixing of traditional and western medicine which was also referred to by other participants. One participant gave an account of the rites around the birth of a baby.

> ***..****well, first when she arrives from the hospital, then she must make sure that…that kid you protect him with medicine sintu mangwara (traditional medicine). But you take treatment before you give birth so that you can have a safe birth. When she arrives, you must make sure that the place is strong..... make it tight. Then you must …for the child here in the head…there is a place making up and down. You must make it tight…make*

sure there is no…yeah but by medicine so that…the child is protected….. yeah…you put it (showing tying around the stomach).... *after 10 days you can go out unless maybe she needs to go to the clinic so that they can give treatment because that person she must take treatment from both sides… [The new mother must take traditional medicine before birth to ensure a safe delivery. The home must be fortified with traditional medicine before she arrives from the hospital and the new born child must also be protected with a charm tied around his abdomen. The new mother has to stay indoors for a period of 10 days and can only come out to go to the clinic for the child to be immunised since the child is required to get both traditional and western medicine].* (**JM, 40s not circumcised**).

From this, one can gather that both traditional and modern medical practises have their own place in the individual and they are not seen to be mutually exclusive. It would seem that the two practises co-exist well in this instance but this is not always the case. As was discussed in the first chapter of this report, the mixing of traditional and medical circumcision in the Eastern Cape Province of this country has not met with success (Kepe 2010). However going by discussions with my participants, there is a possibility of the coexistence of the two, which is positive in terms of the male circumcision policy.

4.1.3 Culture and masculinism

In chapter two of this report, masculinism was defined as a particular masculine identity that supports patriarchy and is the most privileged of masculine identities (Day et al 2003). Culture has ways of conferring masculinism and this is normally done through initiation rites which make boys into men. One of these rites is male circumcision (Silverman 2004). All the participants mentioned male circumcision as a way through which boys become men. This was discussed by all participants even those from non-circumcising communities or who were themselves not circumcised indicating that knowledge of the rite is commonplace. According to the participants, failure to participate in these rites, for example circumcision, would result in ridicule by those who are circumcised. The non circumcised are called 'inkwenkwe' which is a Xhosa term meaning 'uncircumcised boy'. Even when they become adults and they are not supposed to mix with the 'real men'. One of the participants relates his experience with this;

… *like me, me I know, they told me long time. I have never been there (initiation) so I'm not a man. ….. my father's…my father's brothers, and my father's younger brothers you see. There was this*

…..the whole family actually…[As for me, I know because I was told by my family including my father, and his brothers that I am not a man since I have never been initiated](**M, 20s not circumcised**)

To note here is the fact that even though he says that the whole family was involved, he singles out the male relatives and the paternal male relatives for that matter. This could probably be explained by the fact that the rite is an all-male affair. The participant also mentioned that he was not welcomed to visit the homelands because of his uncircumcised state.

Another striking aspect of masculinity that I observed was violence. Whereas the participants were not directly asked about this, it came up during discussions around health seeking. A half of the participants reported having been to the hospital for gunshot wounds or stab wounds and axe wounds. The information was volunteered with much pride, as if the injuries were badges of honour and long accounts were given of ill-health surrounding this. This information was likely to come from the younger participants, those below 30 years although two older participants gave similar reports. Tales of fights and jail time were also reported. Interestingly, none of the circumcised participants reported this. Aggression is one of the key attributes of masculinism as is reported by Day et al (2003). It is possible to conclude that having been locked out of 'manhood' due to lack of circumcision, these individuals sought to become men in other ways including a culture of violence. This is a common observation in the 'lesser' form of masculinities in many studies on masculinities.

Also noted was reluctance to admit to ill health. Most discussions surrounding health seeking behaviour were started by the observation that the participant 'usually didn't get sick';

INTERVIEWER: *let's talk about the hospital, where do you go when you are sick?*

TF: *well…. m not a person of really getting sick but I would go to the hospital yeah.*

(*TF 20s circumcised at the mountain -traditional*)

This participant wanted to make it clear that although he was willing to contribute to the discussion, it shouldn't be taken that he is a sickly person. It would seem that being sick is a weakness that he doesn't want to be associated with. Another one reported that since he was born, he had never been sick enough to go to the hospital:

> ***...****no I'm not going to the hospital. I drink my things, it is my culture. I have never went to the hospital since I was born ...I never that sick that ...now let me go to the hospital no****...****[I don't go to the hospital. I just drink my cultural medicine. Since I was born, I have never been sick enough to go to the hospital]* **(SM 30s not circumcised)**

This participant, while admitting to getting sick, makes it sound as if he is able to manage sickness by himself, hence his not needing to go to the hospital. Although he talks about taking herbal medication that comes from his culture, it comes across as an 'okay' thing to do because it is tied to culture. Once again, reluctance to admit to sickness, which is considered a sign of weakness, is well documented in most men's health studies. As one writer puts it "its cave man stuff but that is to an extent how guys still operate" (O'Brien 2005).

Another issue was the admission of having suffered from Sexually Transmitted Infections (STIs). Once again this information was not sought directly but I noted that it came up frequently especially during the discussions around physical examinations by female health workers. Contracting STIs implies having sexual intercourse without protection, which can be considered daring or risky behaviour. This was also not reported by any of the circumcised participants (traditionally or medically). Daring or risky behaviour is also associated with lesser forms masculinity (Jones 2004) and the findings were consistent with this.

As noted earlier in the report, masculinity is socially constructed and the meanings of masculine identities are prescribed by time, place, race, ethnicity and sex (Day et al 2003). In this study, masculine identities seem to be constructed around robust physical health, risk taking, aggression and male circumcision.

4.1.4 Culture and gender

Gender dynamics in culture are usually clear cut, with everyone knowing what is expected of them. "Culture comes with rules". This was an observation from one of the participants. Going by the information supplied by the participants, most of these rules seem to favour men as opposed to women. Some of the practises mentioned by the participants in this regard included; longer mourning periods for women, more social integration rules for women like

what to wear, where to seat, how to seat, the right of man to physically discipline an 'errant', wife to mention but a few. Women seem to be there to do the man's pleasing;

> ***"*** *..... Coz they have got respect, and they do whatever they want they must do. Cooking, taking care of children, many things…. All the things that make a man happy"* ***(PK 30s not circumcised)***

According to this participant, whereas women can do whatever they please, it has to be centred on pleasing the man or 'making the man happy'. Hence women's importance is defined in terms of the activities they engage in that result in making the man happy. This would imply that women are then subordinate to men.

This phenomenon is more common in the homelands where there is greater adherence to cultural prescriptions. In the urban areas, the rules seem to be somewhat relaxed. One participant explained;

> ***…****yeah it is different because you know it would be very difficult for her to go to work with those long skirts, when she goes to the gym or wherever she doesn't put on those tights, it is totally out, she is sitting at home, she has to put on…usually what happens at home (homelands), women don't usually sit on stools, she is …you know those stools, we have got something like…..like a mat, a woven mat so I cannot say she cannot seat on the sofa. But when she goes home, she has to go sit maybe …..with my grannies with my mother. It is like when we are at home, we don't sit together, we only meet when we go to sleep or retire for the day. But here in town when I' m with my friends, I have got visitors, she will sit with us….. yeah but what is important she must know what to do when she is with who and when.* **(MM 30S Zulu circumcised at the hospital**)

Here therefore, so long as the woman can adapt her behaviour to the circumstances, she is in the clear. This links back to the discussion in chapter two of this report around cosmopolitan individuals in the modern society, who have to adapt their behaviour to fit whatever context they find themselves in. Such prescriptions however did not seem to apply to men, which again suggest men are viewed as superior to women.

The participants did not provide any reason as to why this is the case (culture making men superior to women) just that it was how things have always been done. According to one of the participants it is important to follow the rules and regulations since they are culturally prescribed and have always been there;

> ***TF:*** *I don't know why, these things are there, since I have been growing up and …..ages and ages, they have been happening since before I was born…. yeah so when we come, we just have to go along with the rules and the regulations* ***(TF 20s circumcised traditionally)***

Further inquiry into this revealed the assumption that culture would not tell you to do something wrong and this justifies carrying on with the cultural prescriptions whether they are indeed right or not;

> *.... But if your culture says okay, make children and spread them all over, then you can't change [that]. But I don't think culture will say spread kids and just leave them****.... (LK 30s circumcised at the hospital)***

Generally therefore, it would seem that women were portrayed as inferior to men. However, there was a certain calibre of women who seem to hold equal or even greater importance than men and these are the sangomas. These sangomas can be either male or female. Interestingly the name 'sangoma' seems to be the same whether it's a woman or a man, just like the term doctor is the same for both sexes. So it could also be seen as a sexless genderless institution just like western medicine is supposed to be. Here women are judged by how powerful they are rather than by their gender.

> *...people they are talking. They say 'hey man hey that mama is dangerous (powerful), you do like that that that' then you say 'oooh! I want to go there and check'.....yeah, it depends on how good is them [People talk. They say that sangoma is powerful; she will tell you how to do things. And you say you want to go and try her out. So it depends on how good they are]* ***(PK 30s Zulu not circumcised).***

The reputation of the sangoma therefore is what is considered and not the gender. It would seem therefore that a female sangoma who is 'dangerous' could be preferred over a male sangoma who isn't. The concept of women as competent healers therefore is not foreign to the community.

The discussions around culture bring out certain themes. In the challenges of practicing culture in the city, the constant creation and recreation of the self in line with modern society was brought out. This indicates the chaotic state of the post traditional order. So was the need to be 'cosmopolitan' although this seemed to apply more to women than to men. Both traditional and modern medicines seem to be practiced concurrently since the view is that both have their

own role to play in the individual's well being. Masculine identities seem to be constructed around traditional initiation rites including male circumcision, a culture of violence and display of physical strength. The female gender seems to be constructed as secondary to the male gender except in the case of the sangoma. In the next section, the issue of gender will be discussed in line with these themes.

4.2 Gender

As mentioned earlier in the chapter, health behaviour can be influenced by a number of factors and gender is one of them. I was particularly interested in finding out whether gender (female health workers) would be perceived as a barrier to the male circumcision policy as per the research question. The gender under discussion here is the gender of the health care workers in general and female health care workers in particular. Whereas the term health care workers is normally used to denote lower cadre health professionals such as nurses (Freidson 2008), the term in this discussion covers both doctors and nurses. The discussion below outlines my findings with regard to gender.

Out of all the participants, only one claimed not to have any experience with hospital treatment. Three out of the remaining 14 participants specifically stated that they had never been treated by a male health worker. As noted in chapter one of this report, in South Africa, there are more female nurses than male nurses (Mavundla et al 2009) which could explain this especially since most medical encounters in public health institutions are with nurses.

4.2.1 Female health workers and health seeking behavior

The discussion around receiving health care from a female health worker was divided into two. General consultation where there was talking or advice without a physical examination that required undressing and the consultation which included a physical examination requiring undressing.

All participants reported not having any problem with the consultation that did not require physical examination. This would include general triage consultations like taking temperatures, taking a history of the illness, taking weight and height measurements and general medical advice. This was in line with my expectations since these are basic nursing duties.

When it came to the physical examination, 11 out of the 15 participants said they had no problem with a physical examination conducted by a female health worker. This was the case even for those who had undergone traditional circumcision. According to these participants, the important thing was to get treatment and not the gender;

> ***AMT:*** *in the hospital….hospital is hospital. You can't refuse. If the doctor is a woman, it is a woman, just treat me. I want to get better…* ***(AMT 30s circumcised traditionally)*****.**

The other view was that in the public hospital, one is not given a chance to choose but is attended to by the health worker who is available;

> ***PK:*** *... it doesn't matter because if you go to the hospital and you are on the line, they say next, you go in.* ***(PK 30s not circumcised)***

Yet another view was that there are more female health workers than male health workers so there was really not much of a choice;

> ***MG:****…but…I can choose the woman[health worker] because the men[health workers] are so scarce, the women in the hospital is …nurses are all women* ***(MG 40s circumcised at the hospital)***

While it is not correct that all nurses are women, female nurses are certainly the majority (Mavundla et al 2010). It is also true that the issue of choice of health worker doesn't apply in public health institutions due to the shortages as was discussed in chapter two of this report. These participants seemed to present a resigned attitude which may suggest that the structure (in this case the health system) is in control. However, the next paragraph will show that the individual/actor can still make choices even in this context albeit at a cost to himself.

Four out of the 15 participants said they would not accept a physical examination from a female health worker unless it was in an emergency situation. Interestingly, three out of these four were uncircumcised and below the age of 30. In fact, only one participant in this group (below 30, uncircumcised) was okay with the notion of a physical examination from a female health

worker. The main reason given for this was the fear of getting an erection during the procedure which would be considered embarrassing. These participants felt that they would be uncomfortable with this and were likely to ask for a male health worker or seek out another hospital if need be;

L: *I will say HELL NO…you go fetch a guy, hell no*

INTERVIEWER: *if there are no guy doctors?*

L: *leave everything…I would rather go somewhere else.*

(L 20s not circumcised)

This particular individual seemed to use his knowledge of the existence of male health workers even if it is in other hospitals to exercise control over his body. This therefore means that the individual has choices. However the applicability of the choices is another matter since they may require incurring additional cost.

All in all structural issues notwithstanding, there was a lot of acceptance of female health workers. It may be that this large acceptance was partly due to the community being used to the notion of women as healers. Since the health care worker one was bound to be served by in a public health facility was most likely to be female (and this has probably been the case since birth), the men were more likely to accept the concept of women as healers. Further, the presence and use of female sangomas by the community also rendered them more accepting of the concept of women as healers. The next section will compare the female health workers and male health workers according to the participants' contributions.

4.2.2 Female health workers Vs male health workers

There was a general feeling by the participants that the men and women are the same in terms of qualifications and education, with only one person who thought that men are better educated than women. There was also the feeling that both could competently perform the tasks that accompanied the job. However given a choice between the two; four participants didn't mind being treated by either, three participants preferred female health workers and eight participants preferred a male health worker.

For the participants who preferred female health workers; the main reason given was that women were gentler than men and more forth coming with information;

> *… no it [gender] doesn't affect the care you get, but I think with woman you rather get better care and understanding of what you sick of and how you can reduce your sickness and stuff like that, from like a man's point of view, he wouldn't do stuff like that, he would just like… assign you to take tablets and come next week to fetch the other pills you know, woman she would rather tell you, when to take the pills and if you feel you got a headache you can come again and stuff like that…you know yeah* ***(TF 20s circumcised traditionally)***

For those who did not mind being treated by either, the main reason was that, when one is in pain, the most important thing is pain alleviation and not the gender of the health care provider. These participants were also of the view that a doctor is a doctor, and that they are all trained and qualified for the job which was the important thing;

> ***…****Me for my side, I take any. Even if a little child comes as long, as she has got the degrees and says this is my profession, I will take it* ***(LK 30s circumcised at the hospital)***

For those who preferred male health workers, the main reason was simply because he was a man just like they were men. Men's preference for health care workers of the same gender has been noted in many studies (Levinson & Lurie 2004) as was discussed in chapter two of this report and the findings were consistent with this.

In general, male health workers were portrayed in a positive light even by those who preferred to be treated by female health workers. Female health workers were viewed as harsh, capable of mocking the patient, moody, judgmental, uncaring and likely to take out their personal problems on the patient. This view was also put forth by those who did not mind being treated by them. Male health workers on the other hand were thought to be less likely to bring their personal problems to work, which was interpreted as being more professional. According to one participant;

> ***….*** *the women is more [likely to bring personal problems to work]. Definite sure it is more ladies, ….always especially you know, the thing is this, you work with people every fucking day, you can't treat people the same. Sometimes you got your problem from your house, your husband want to kill you or what…kick you or whatever, when you get to the hospital you are not in that mood…you haven't got the time for any patient.* **(MG 50s circumcised at the hospital)**

Whereas this participant acknowledged job pressure, that is dealing will large numbers of people, may be the reason why female health workers are harsh, he gives more emphasis to the personal problems as a reason for their dismissive attitude. According to Holge-Hazelton & Maltreud (2009), patients tend to be more assertive and when dealing with female health workers and find it easier to confront them than they would with male health workers. Therefore female health workers may feel like they have to be firmer with the patients and this could be what is interpreted as harshness. This however may impact negatively on health seeking behaviour. One participant reported leaving a clinic without getting treatment after seeing how a fellow man was treated by a female worker**;**

> ***….*** *yeah…you see like when I was stabbed here on my cheek, I had to go to Tembisa hospital that side. When I got there I only found female doctors and they were quite rough on the people. I end up not even stitching and I was bleeding, so when I saw what they had done to this other friend of mine, so he went through that, they actually hit him with an axe so he was open here (showing the back of his head)…., they never even like try to …assemble him, they just call him in and start stitching and swearing him, like you are drunk!…why are you drunk?…don't come here making noise, you go go go…so he had to walk like with that head of his like that. So me I never …..I said I won't go there, I am fine like this so I end up treating myself. But if it was a man doctor, you know…he would have done something better I think* (**M 20s not circumcised)**

This participant opted for self medication on the account of someone else's experience which may or may not have been accurate.

The preference for male health workers was rather high. No tangible reason was given for this preference other than the fact that they were fellow men. This displays the discursive consciousness discussed in chapter two of this report. Though preference was for male health workers, many participants said they would still go for treatment from a female health worker which suggests pragmatism, a characteristic of the post traditional order. However the negative view of female health workers was prevalent and it appeared to serve the purpose of making the male health workers look better. This has undertones of underlying perceptions of gender inequality. This likely emanates from cultural issues and the way the female gender is constructed to be inferior to the male gender. The next section takes this further in the discussion of female health workers and masculinities.

4.2.3 Female Health Workers and masculinity identities

Earlier in this chapter I discussed the concept of masculinities in relation to culture. According to the information from the participants, both male health workers and female health worker seem to reinforce masculinity types or identities. This was by telling the patients to 'act like a man' especially when facing pain. One participant was of the view that coming from female health workers this could actually challenge an individual to act accordingly;

> ***....*** *Honestly speaking I' m telling you the truth, women are harsh. They are like, come on men! What's wrong with you, be a man! ....But the thing is being harsh like that, they give you courage. Yeah, they make you strong; you become strong and say, let me go for it.... there is no way I can retreat. You need to do this. And you gonna really do it because you get someone is pushing you... you know and you are also going to be like, no man, ... this woman called me a chicken!,..do it. you see****.(BH 40s not circumcised)***

According to this participant, the individual is called upon to prove his manhood by not showing fear of pain. He thinks that this is positive in that it makes the individual face up to his pain, if only to prove to the female health worker that he is a man.

Masculinities were also at play when it came to accepting or rejecting health care from female health workers. Acceptance of general consultation could be because there is no threat to masculinity as everything is done through talking and probably with the health worker asking questions and the patient giving answers. For physical examinations, those who said they had no problem with it found ways of rationalising their choice. For example, according to one participant, the female health workers see lots of male patients so 'you are not the only one'. It would seem to this particular individual that the fact that she has seen many other men makes it okay as opposed to if you were the only man she has treated.

For those who have a problem with female health workers, there were two main reasons given. One was the fear that the individual would get an erection during the examination and the second was the fear of being ridiculed by the female health worker. On the first issue, ordinarily it would seem that getting an erection would be something a man would be proud of. One of the participants gave an indication of this;

.....unless they come to the age of 13, 'hey you know I had a dream, I dreamt of this', then that means you are a man now, and then the other friends will tell him you are a man....'last night, eh I was erected, you know… things like that…you know **(LK 30s circumcised at the hospital)**

The context was sharing information about manhood among boys. This boy being referred to here seems to be proud of getting an erection, which is taken to indicate that he is now a man. Why then should there be fear of getting one during a physical examination? After all, as Lorentzen (2007) writes, the male organ is the only part of the male body that is not controlled by will but by a complicated interaction between blood, nerves and muscles. As a result, men can experience erections in the most inconvenient of situations that may have nothing to do with sexual desire. Yet many men believe that an erection equals sexual desire and should be dealt with sexually (Lorentzen 2007) and this could be why these are a source of pride. However increased prudence in society has made the issue of penis erection almost unmentionable without invoking giggles and winks. It is supposed to be a secret, private affair and having a visible erection in public would be considered a taboo. It would seem that men are expected to have or display control over this part of their bodies and this control is further proof of masculinity.

Back to the physical examination in the medical encounter between a man and a female health worker, a conclusion may be drawn that there is fear of losing control in front of a potentially inferior/weaker sex who is already in a superior position (medic); and more so if you are in the 'lesser men' category (uncircumcised). The internal dialogues discussed by the participants give insight into this tension;

SM: *I will go where I want to go to, if it is a woman, I will go there, if it is a man, I will go there, what are you going to do there [hospital]?… you must not think something…you must not think, now because I'm with a woman now I am thinking…no, that is not right. You must tell your feelings now I am going to do this… [You] mustn't think about certain things.*

INTERVIEWER: *things like …?*

SM: *yah because if you will talk about that, will think, ah now it is a woman and about touch ...and what what .... my thing now is gonna …you know…tell yourself no! I' m here for do this not to come to enjoy life. No not come to enjoy life...* ***(SM 30s not circumcised)***

"...*maybe if she can touch me you know I can get ....(showing up one finger)...feelings and all that* ***...*** *I don't know about women but with men yeah it does happen. When I discuss this with a woman it is gonna.... 'react' you know….it is always there* ***(GE 20s not circumcised)***

Following from these discussions, it would seem that whenever a man is 'touched' by a woman sexual or amorous thoughts are automatic and one needs to give himself a pep talk 'you must not think', ' you must tell your feelings' to keep in check. Hence, one is supposed to be in control of the situation which as discussed above may be very tricky. Getting an erection then could be interpreted as losing control of your body and thus the situation. When this is considered within the context of the discussion earlier on where female health workers told male patients to 'be a man', which can be interpreted as to be in control, then it can be a potential problem area for the men.

There is also fear of ridicule. This was directed toward the penis itself, two participants mentioned fear of ridicule of their penis as an important reason why they would have preference for either male or female health workers. This ridicule though was seen to potentially come from both male and female health workers;

> ***...*** *yeah…what can I say, it does matter because of you know I ....for a woman to come and just …hold your private parts and cut your private part…that is like …maybe what is she thinking, you don't know what is she thinking in her mind you know..... ah this guy, he has got a small penis…what what what you see. Things like that* ***(GE 20s not circumcised)***

> ***…*** *I think it is better when it is a woman than it is a guy then a guy is gonna tell you a lot of things hey why didn't you get circumcised and stuff like that and he is gonna tease you on how…big or small your…your thing is so I think it is better if it is a woman (****TF 20S circumcised traditionally)***

It would seem insecurities about the size of the penis transverse gender lines since both male and female health workers were accused of this. It may also be a further indication of reinforcing masculine stereotypes by health workers as was discussed earlier.

From the discussions around female health workers, one gets a sense that they are tolerated rather than fully accepted by male patients and the masculine stereotypes feed back into this. Whereas modernity has brought about equality issues such that men and women can both do the same jobs, the cultural notions of the superiority of men still seem to reign. This is indicated by the preference for male health workers and the negative attitude the participants had of female health workers. Further, the notion also of a genderless sexless medic is also dispelled here by the overwhelming preference for male health workers over female health workers. This preference further gives an insight to the relationship between structure and agency in which

the agent tries to exercise control but still has to operate within the limits of the structure. That participants are not able to get what they want (to be served by the male health workers) and they have to settle for what is available, can also be seen in the light of the discussion in chapter two on the trust issues between the government (the providers of public health) and the citizens (the recipients). What then would happen when a cultural equation is thrown in the mix is what will be discussed in the next section with regard to male circumcision.

4.3 Male circumcision

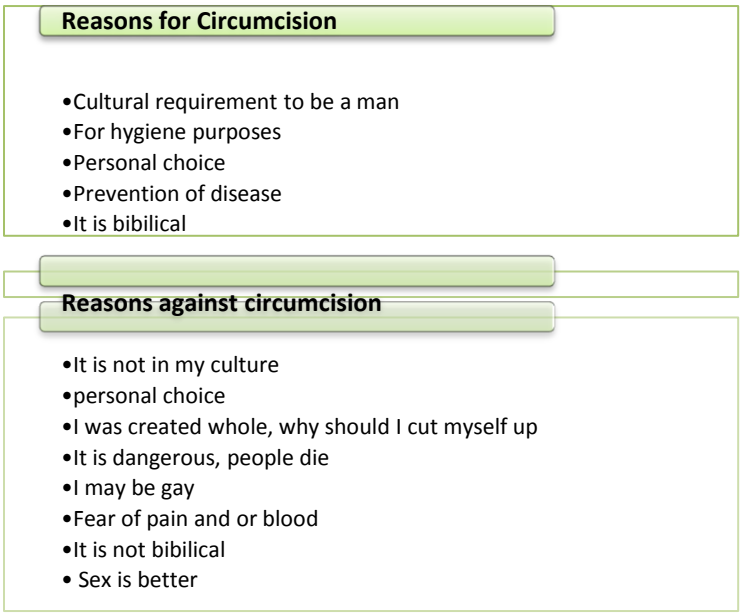
Male circumcision was discussed at length in the first chapter. The study was on male circumcision as a HIV prevention strategy. In this, the focus was on female health workers offering this service in the hospital and how acceptable it was hence data was gathered around this issue. As declared in chapter 3, I come from a circumcising culture so may have had pre-conceived ideas of what I might be find. Notably, I thought there would be resistance to the idea since circumcision was culturally an all male affairs, even when done in the hospital. This however was not the case. Whereas the participants were given information on the particulars of male circumcision for HIV prevention under study; this didn't seem to reflect much in their discussions. The discussion follows below.

4.3.1 Reasons for and against circumcision.

In order to even consider acceptance of circumcision by a female health worker, there has to be acceptance of circumcision itself in the first place and specifically medical circumcision. Various reasons were given both for and against the procedure.

The most common reason for circumcision was that it was prescribed by culture in some communities. Another popular reason for circumcision was for hygiene purposes and prevention of diseases. Also mentioned was the influence by other people, notably parents. One participant reported a request from his girlfriend as the reason. Yet another was personal preference. The bible was also used as a basis for circumcision.

The reasons against circumcision were just as varied and almost parallel to the ones above. Culture was also prominently quoted as a reason against the procedure. Fear of pain was also mentioned as a reason against circumcision as was the fact that circumcision interfered with one's sex life. Also common was the feeling that this was a part of the individual's body so it should not be tampered with. Box 2 below sets out some of the reasons given both for and against male circumcision by the participants.



Box 2 Reasons for and against circumcision

4.3.2 Medical Vs traditional circumcision

Traditional based circumcision was discussed at length by all participants, including those who had not undergone it. The participants reported most of what was discussed in chapter one of this report about traditional circumcision. In the past, this was a prerequisite for becoming a man in some communities and it was an all men affair (Marck 1997; Silverman 2004). This is still the case in the contemporary society (Kepe 2010) and the participants said as much. The procedure was shrouded in secrecy, seasonal and was also done by professional circumcisers. Of the three participants who had undergone this circumcision, only one was willing to give

details on what it was about and even this information was guarded. This is because of the secrecy attributed to the going-ons during circumcision;

> *…. It is painful there in the mountain. No injection…it is painful, painful but…after 7 days, it is nice nice nice. We can, sing, we can talk, every night we can make a lot of fire, sing around the fire and talk about the things of …yeah the secret things for a man. Because they didn't like for you to tell the boys..eish…men is what what what or tell my girlfriend what is happening there…it is a big problem yeah a big problem. But nowadays…they bring it on TV you see what is happening..eish…no secret anymore.* ***(AMT, 30s traditionally circumcised at the mountain)***

This participant mentions talks around 'secret thing for a man', which he doesn't elaborate on and that can't be mentioned to boys or girls/women which puts them (boys, girls and women) at par is so far as this is concerned; that is beneath the circumcised men. Although he never talked of the consequences of telling these secrets, these have been reported elsewhere, like the possibility of a person running mad (Kepe 2010). Still, the secret age of this rite of passage seems to have come to an end, with the media constantly reporting on this rite especially during circumcision season which is typically June and December. The participant sounded very disappointed with this state of affairs, probably because it reduces the significance of the rite.

The reports in the media are almost always negative, reports being largely on deaths and botched circumcisions (PlusNews 2008). This more than anything else was focussed on by the participants, both those circumcised and those uncircumcised. Two of the participants who were uncircumcised and who came from circumcising communities sighted this as the main reason why they did not get circumcised.

All participants also mentioned the lack of involvement of women in this practise. One participant gave a reason for this;

> *... they don't want woman because now the thing [penis] must stand up and now it is hurting other people you see. When automatically when a woman comes there now, you get now, your feelings become hot you see. Then you end up hurting yourself you see so they don't allow women there"*. **(M 20s not circumcised)**

This participant was from a circumcising community although he was not circumcised and that could have been the reason he was free with the information. According to him, the reason is

to protect the initiates from hurting themselves. His explanation seems to make sense because when one has an erection, the cavernous spaces in the erectile tissue expand as blood is pumped through them at high pressure and the penis becomes hard and erect (Lorentzen 2007). Considering that there is a wound in that area as a result of the circumcision cut, this would be a rather painful experience and might even lead to excessive bleeding. The reason then for excluding female health workers, going by his explanation is a practical one. Another participant mentioned that one of the teachings given to these initiates was how to have sex. Coupled with the first explanation it gives even more reason why women are not allowed at the traditional circumcision. While I would consider the first explanation may still be a valid reason for refusing to allow women to perform circumcision in the hospital, the second is not. This however does give food for thought in so far as allowing woman into this domain is concerned.

The participants felt that currently in many instances, the procedure was conducted by quacks who were out to make money and that this had led to fallen standards. Some participants also questioned the some of the practices carried out during this period including; not drinking water, eating food without salt, avoidance of protein, sleeping in the cold and generally the tough conditions associated with this procedure. This has resulted in deaths and deformities as was mentioned earlier. Nevertheless, these form the core of the rite of passage and cannot be excluded from it. Also questioned were the teachings given to the young boys, which were considered inappropriate especially in the modern society;

> *...yeah… for that what is happening at the mountains. Besides I don't even know what they are teaching there besides fleshly circumcision. The mindset that they are giving...that they are feeding those boys….other things that maybe are wrong …that maybe wrong because we are being civilized"…. (**MM circumcised at the hospital)***

One participant who had undergone traditional circumcision gives an account of some of these teachings;

> ***"**…sometimes the advice is not so right because, they tell you if the woman has done something or not come home early to cook, you must raise your hand for her [hit her] and stuff like that to show that you are a man and consider who wears the pants….so you must raise the hand to show that you are a man and so she can listen to you. That is the only advice that I ever heard when I was up there" **(TF 20s circumcised traditionally)***

This account which basically shows that the initiates are taught that wife beating is justifiable seems to support the one above about teachings that may not be appropriate.

Hospital based or medical circumcision on the other hand was highly favoured by all the participants including the three participants who had undergone traditional circumcision. It was generally thought that the procedure was safer, cleaner, offered better pain management and a shorter recovery period and, most importantly, no death has ever been reported as a result of hospital based circumcision. One participant however did report a botched hospital circumcision and on this basis was against hospital circumcision. Medical circumcision is also done all year round and can be done at any age. However, going to the hospital for circumcision was not recognised culturally and thus those who have undergone hospital based circumcision are still regarded as 'uncircumcised' especially in the Eastern Cape as has been found elsewhere (Kepe 2010). This included those who had started out at the mountain but had to go to the hospital due to complications. One participant explained;

> *…if you come back to the location [from the hospital]…aah you are not a man…you are told like that. Because if you go there to the mountain, it is bad. You enjoy life...if you go to the hospital [that is]…in our culture…no…m not a man. It is better I go there and die than to go to the hospital… if it is a celebration, you cannot come to us. Because you didn't go to… whole mountain [experience], you go [went] to the hospital so you are not a man (laughs)* ***(AMT 30s, circumcised traditionally)***

The declaration by the participant that death in the mountain would be better than a hospital based circumcision gives an indication of how serious the rite is to the community. The view here is that the hospital experience is 'soft' because the individual gets good treatment, pain blocks and every need is catered to, while the mountain experience is very tough. It would seem therefore that rather than the 'cut' itself, the tough experiences (as noted previously) are what makes one a man. Another view that has been advanced is that in the hospital, it is difficult to keep women from the initiates, which is forbidden (Mavundla et al 2010). The combination of the 'soft' initiation and the contact with women would then render the rite null and void and this could explain why hospital circumcisions are frowned upon to the extent that one is willing to risk his life in the mountain than go to the hospital for circumcision.

4.3.3 Circumcision and age

On the question of the most suitable age for circumcision, the participants felt that the younger the boy, the better. Reasons given for this included the fact that since one couldn't know when the boy would start having sexual intercourse, it was better to get him circumcised earlier, just to be on the safe side. One participant also felt that neonatal circumcision would be cheaper and hence preferred it. Also noted was the contribution from one participant who felt that for non-circumcising communities, it may be better to start with the young boys since the adults were most likely to resist. This is consistent with findings in non-circumcising communities in Zambia who felt the same (Lukobo & Bailey). Gollaher (1994) also refers to the preference of British men to take their boys for circumcision rather than take it up themselves, during the height of campaigns for routine circumcision in Europe. Neonatal circumcision therefore seems to have gotten the nod from the participants. As will be discussed later, neonatal circumcision is not culturally recognised in the community and this acceptance from the participants suggests pragmatic acculturation.

4.3.4 Circumcision and HIV

Knowledge of the protective function of male circumcision against HIV was wide spread among the participants, with nine participants saying they had heard of the link before the interview. Of these, six were uncircumcised and among these six, only one had a positive opinion on it. The rest had reservations with some going as far as to say that they thought the information was untrue;

> ***..****you know what. We once had that kind of talk but my answer was like this. It doesn't mean if you are circumcised you won't get infected. To me it doesn't make sense. It doesn't make sense. I mean circumcised or not circumcise, HIV doesn't come through circumcision and there is no way you can prevent it if you have unprotected sex. There is no way you can say that. I mean if you have unprotected sex even if you are circumcised wont you get it? Can you see that it doesn't make sense? It doesn't make sense!... to me…I….to me it is a lie. It doesn't make sense* ***(BH 40s not circumcised)***

The participant rightly notes that HIV is transmitted through unprotected sex, which is probably a testimony to the entrenchment of the ABC of HIV prevention. However for this individual,

circumcision for prevention doesn't make sense because circumcision doesn't cause HIV in the first place. Yet another felt that whether or not one is circumcised, so long as there was blood contact, HIV transmission was possible hence circumcision for prevention would not work;

> *….I don't think so. Because what can reduce HIV and AIDS is…there is still blood contact even if they circumcise there is still blood contact. It doesn't mean now because they are circumcised, men don't produce sperms or women don't produce …..plasma….there is still a blood contact, that is what I' m saying, whatever, there is always gonna be blood contact and while there is blood contact it is always possible that if someone has a second illness it will be transmitted to the other…so I don't think we should take it as something to do with …reducing STI and HIV and AIDS but probably you could say it is on the route to hygiene…that is all* ***(PM 40s circumcised at the hospital)***

Another view was that 50% was not good enough protection. Building up to this knowledge of the ABC of HIV prevention to the partial protection of circumcision may present a delicate situation since as noted in the first chapter, some people have taken this as an either or situation being either the ABC or circumcision as was the case in Papua New Guinea where condom use suffered as a result of male circumcision (Silverman 2004).

I found it interesting that those who knew of the link were the most likely to have a negative view of it. This was the same for young and old, circumcised and uncircumcised although more so with the uncircumcised, who may have felt they had to defend their status. It may be that the problem is the way the message is getting across to the community in the first place. This could be something to anticipate because such information may get entrenched in the community and present a problem during implementation of the policy.

4.3.5 Female health workers and male circumcision

Four participants said they were not comfortable with females performing circumcision. One of these participants was circumcised at the hospital and he recounted having to research in advance whether the procedure was done by a male or female health worker because he was not comfortable with the idea of a female health worker performing the procedure on him;

> ***….****it becomes very difficult. That is what I thought of, by then I was 20, I was working part-time, I was school full time but working part-time. I thought to myself no…actually I had a discussion*

> *with my girlfriend, then she said lets go because of this thing that I was talking about. So I thought…hmmmh…what if a woman comes…who is a nurse there and attends to me for this operation. I felt really so bad that I investigated… [who] are the people [health workers] who are doing this thing[circumcision]? Then fortunately it was a man…* ***(MM 30s circumcised at the hospital)***

Of the three uncircumcised participants, one reported having actually turned back after he encountered a female health worker when he went for the procedure;

> ***...****the one who interviewed me that day it was a nurse [female]. It was a nurse yes.... yes. ..They also circumcise (laughs) maybe I can say that had something to do with it [leaving before being circumcised] yes because of that day I was very conscious you know. Because my appointment was for 3 o'clock I had to be there by 3 o'clock. I went there by one o'clock and they told me I have to wait...it was a lady and she told me I had to wait and I just went home* (**GE 20s not circumcised**)

This participant admits to being very conscious after seeing it was a lady although the fact that he came for the appointment very early may indicate he was nervous about the procedure in the first place and this could have been pushed further when he saw it was a female health worker who would be performing the procedure. It is particularly concerning that this particular age group, that is below 30s, have a problem with the procedure being carried out by female health workers since according to the WHO recommendations, they are a priority group for scale up (WHO 2007).

11 participants said they had no problem with male circumcision being offered by female health workers. It would seem therefore that this got the nod from the participants. A closer look at the data revealed otherwise. Of the people who endorsed the concept, most were either already circumcised or expressed strong views about having no intention to ever get circumcised. The ones who had reservations were those who were considering or were open to the idea of undergoing male circumcision at some point. For the former participants therefore, it is possible that since they would never need the service, they had no problems endorsing it since they would not be directly affected. On the same note, however, the same individuals had no problems with physical examinations from female health workers so there could be some honesty in their observation. In fact, I discovered that those who were likely to accept physical

examination from female health workers were also the ones who would accept male circumcision from them.

From this, it is possible to conclude that acceptance of physical examination from female health workers was a good indicator that the individual would also accept male circumcision from them. This would in turn suggest that overcoming the objections to one may lead to overcoming the objection in the other. Figure 2 below shows a side by side comparison of this phenomenon.

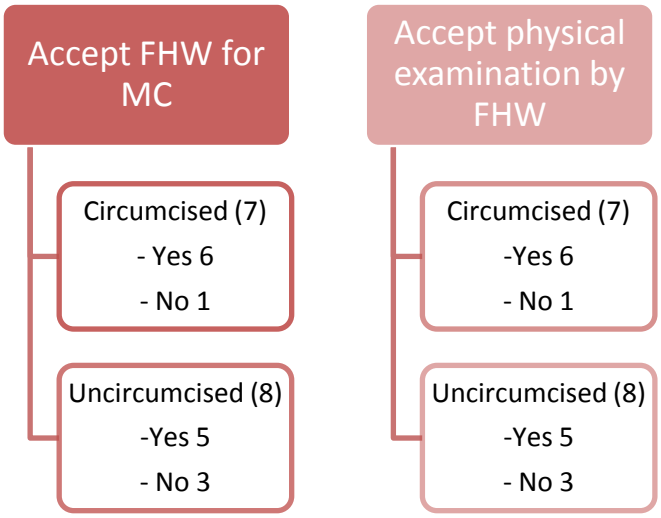


Figure 2, side by side comparison of acceptability of male circumcision and physical examination by female health workers

The reasons given for the two were also the same, with those saying no having the same concerns as when asked about undressing for physical examinations, namely fear of ridicule and fear of having an erection and the discussion was more or less the same. The participants saying yes felt that the hospital operated on different terms and one had to do what they were told. In addition to this, female health workers treated people for other disease which required handling of the private parts and this was not far removed from that. In fact most participants felt that women would be better at performing this procedure because they had a gentler and softer touch. One participant went as far as stating that a male health care provider may maliciously 'cut too much' out of jealously.

Two participants knew of people who had been circumcised by a female health worker. One gave an account of this and his reaction to the news;

> *"...Desmond, in fact he is my cousin, he told me, a woman circumcised me and I was like HUH! You allowed a woman to do that? (laughing) and he said to me, it doesn't matter man as long as what I wanted was done perfectly. So the gender doesn't matter..... you know what, by that time, I didn't think he would tell me that you know. But you know it was like it is a shock but when you come to realise, there is no big deal".* ***(BH 40s not circumcised)***

Although this participant says there is no big deal, his reaction to the news indicates otherwise. This reaction has the potential to discourage others from following in these footsteps especially considering that although it may not have mattered to the cousin (Desmond), it is easy to see that he has had to defend his action every time the topic comes up.

The most interesting aspect was that although culture was a strong factor in accepting or rejecting male circumcision itself and the participants said as much, culture was not mentioned as a reason for to rejecting male circumcision from female health workers even from those who were circumcised traditionally. Traditional circumcision seemed to be a package deal with a "take all of it as it is or leave it" stance. This has been found to be the case in areas where there is resistance to the integration of medical and traditional circumcision (Kepe 2010; Mavundla et al 2010) as was discussed in chapter one of this report. This may present a problem in those areas when it comes to the implementation of the policy. However since medical and traditional have been known to be used simultaneously as was shown by the discussions on the rites of birth where a child gets treated by both sides, there is hope that the same can be achieved for male circumcision.

Also interesting was the suggestion that the age of the individual being cut and the age of female health worker should be considered. One participant said;

> *…since we saying that maybe circumcision…the boys will go at the age of 12 someone [female health worker]around 30 she is fine to do it. But you see for a 30 year old man, for a 32 year old men to be operated on by a 33 year old woman or a 30 woman…is something else (laughs)(****MM 40s circumcised at the hospital)***

This participant's observation implies some undermining of women, i.e. a 30 year old woman is only fit to operate on a 12 year old boy. It is almost similar to the notion that women and boys

are at par and not fit to be in the company of 'men', as was discussed earlier. What was not said and can be assumed is that with an older woman say 50 years, it may be okay to give the service to the 32 year old. Once again, this suggests that women are somehow inferior to men.

In light of the discussions around male circumcision, most of the policy recommendations as stated in the first chapter seem to be okay with the participants. This included medical circumcision and neo natal circumcision. Bearing in mind that this is a society where circumcision is largely a rite of passage which involves boys in puberty, this acceptance is significant and suggests pragmatic acculturation may be in the near future of these communities. Another explanation can be situated in the discussions around the post traditional order, which were presented in chapter two of this report, whereby individuals are no longer tied to traditional practises and hence are able to make decisions independent of traditional conditions. These discussions however were conducted with participants who are in an urban setting and the result could be different in a rural setting.

The issue of female health workers performing male circumcision however is likely to be thorny. It is clear that the gender divisions prescribed by culture as still adhered to whether consciously or subconsciously and hence a 'male territory' is unlikely to welcome women even if the law says so. Whereas culture was not necessarily mentioned as a reason against men performing male circumcision, it may still be a factor albeit indirectly especially with regard to gender roles and socialisation. This could present problems in the implementation of the policy eventually and needs to be addressed.

Having discussed these three factors, that is culture, gender and male circumcision, the next chapter draw present the conclusions reached in light of the data and structuration and post traditional order as was discussed in chapter two of this report.

CHAPTER FIVE: DRAWING CONCLUSIONS

5.1 Conclusions from the study findings

Using the discussions and finding in the previous chapter, the following conclusions were drawn.

1. Culture

Whereas culture is regarded as important, it is somewhat relaxed in the city which gives the individual some autonomy in choice and decision making. However this is not without consequences like being locked out of the homelands for refusing traditional circumcision which the participants mentioned. Although culture was given as a reason against hospital circumcision, it is not give as a reason against female health workers performing male circumcision. The impression given is that having crossed over to the hospital circumcision side, the details like who does it are not important. I felt that this was quite significant since this is a country where there is more traditional circumcision than medical circumcision. Hence convincing individuals to choose medical circumcision seems to be all that is needed. None of the participants specifically listed desire to be circumcised as emanating from cultural requirements. This was quite surprising given that traditional circumcision is more prevalent in this country. Even among those who were traditionally circumcised, only one would advocate for the traditional circumcision, the others rather preferred hospital based circumcision.

I offer two possible explanations for these cultural observations. One is that the society is in the process of undergoing pragmatic acculturation. Whereby the rite is being adapted to fit in with the contemporary society as has been reported by other writers elsewhere (Mbito & Malia 2008;2009: Peltzer & Kanta 2009). The second is situated in the discussions around post traditional societies. According to Giddens (1995b:5) “The more tradition loses its hold, the more individuals are forced to negotiate lifestyle choices among the diversity of options”. This

could explain the acceptability of the new concepts such as neonatal circumcision and female health workers performing circumcision. Culture therefore could be perceived as a barrier to female health workers performing male circumcision.

2. Gender

Traditionally there were distinct gender roles for example exclusion of women in circumcision rite. Although modernity has tried to bridge this gap by giving women the same jobs as men, Women are still considered beneath men and they are more tolerated than accepted. Even in the cities, which claim to be modernised or have 'no culture' the underlying cultural gender divisions or tensions are still evident. Women still judged by their gender in the workplace and have to prove themselves before acceptance grudgingly given. Gender issues therefore can be perceived as a barrier to female health workers performing male circumcision especially in reference to masculinities.

Mentioned earlier in this report was the notion that medicine is genderless and sexless and anyone can be treated by anyone without a problem. This as mentioned in the second chapter seems to be underlying assumption in the task shifting and task sharing call in the provision of male circumcision as part of HIV prevention intervention. Ideally then female health workers should not be perceived as a barrier to accessing services, especially since the notion of women as healers is well entrenched in the community. The reality of course is different because is being played out in a largely patriarchal society where men are supreme, This can be seen in how men talk about female health workers even those who don't mind being treated by them and confronting nurses when waiting for treatment, not to mention the huge preference for treatment from male health workers. Hence there is potential for female health workers to be perceived as barriers to the service.

Giddens' (1991) three levels of consciousness in which social practises occur; the discursive consciousness, practical consciousness and the unconscious motives and cognition can be used to explain this. Knowledge by the agents (participants) is displayed in the practical conscious. The participants know that female health workers are just as well educated or trained as their

male colleagues and this is shown by their willingness to accept services from them. However the same participants also prefer male health workers in large numbers although this does not seem to be substantiated by facts like for example, male health workers being more qualified than their female counter parts. In fact there is no tangible reason given for this other than the fact that they are both male. This seems to be happening at the discursive conscious level. The preference for male health workers could be attributed to underlying cultural constructions of gender which put women secondary to men. Figure 3 below gives a diagrammatic representation of this.

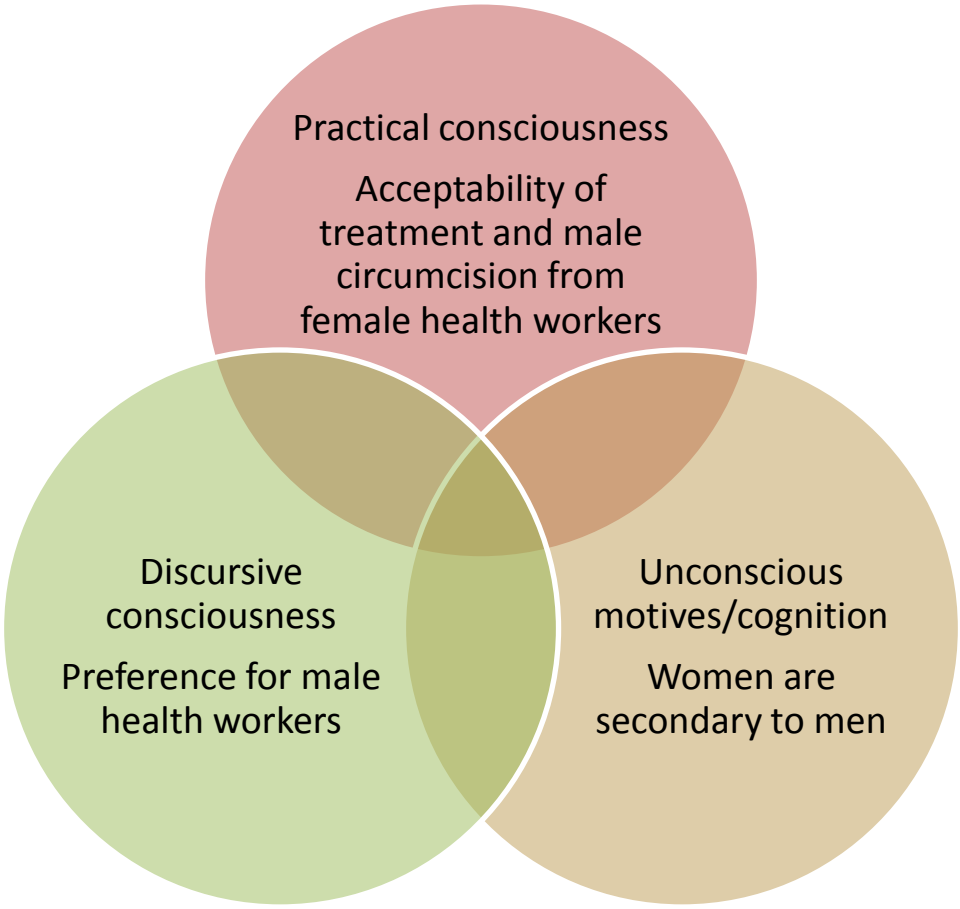


Figure 3. The 3 levels of cognition/motivation in relation to gender and the male circumcision policy

3. Masculinities

Acceptability of female health workers performing male circumcision was found to be rather low in the target population, that is, sexually active uncircumcised young men. This could be attributed to the playing out masculinities and identities. I found out that masculine identities in this community were defined in a number of ways, traditional male circumcision, a culture of violence and aggression and risky behaviour. Apart from male circumcision which is conferred by the community, the rest are mostly attributed to lower forms of masculinity and seemed to be ways in which the individuals locked out of the traditionally acquired masculinity sought to acquire for themselves. In masculinities, the issue of being in control is regarded as important especially control of emotions. The participants who were against the idea talked of the possibility of getting an erection during the procedure if it were to be performed by female health workers and this was the chief reason for rejecting the service for this group. Getting an erection could be interpreted as losing control of the situation. Masculinity issues could therefore be viewed as a potential barrier.

4. Knowledge

Knowledge of the protective function of male circumcision in HIV transmission should ideally be a potential benefit to getting the intervention done but in this case it was just the opposite, knowledge didn't seem to translate into acceptance of the intervention. If anything it seemed to put up the guards of the uncircumcised participants who came out fighting to defend their positions on male circumcision. In chapter two of this report, the knowledgability of the agent was discussed and the fact that this knowledge gives the individual a resource which he can use in making choices in day to day life hence giving him some kind of control over his own life. This seemed to be the case for these participants. Knowledge therefore in this case can be viewed as a potential barrier.

5.2 "It is what I want" Vs "I have no choice"

All participants insisted that decision were largely guided by personal choice, “it is what 1 want”, “I will do what I want”, “it depends on how I feel”, “I will go where I want”. This would indicate the capacity for autonomous decision or agency. However the same participants would also turn around and use lack of choice as a reason for making the decisions that they did. “I have no choice but to do it”, “I can’t choose because they are the ones who say come”. “I can’t choose because men are scarce, women are more”. “The hospital is the hospital; you have to follow the rules.” This would suggest tension between the structure and the agent’s actions.

In the second chapter of this report, I discussed the new public health in which is a moral institution, telling individuals how to act. According to Petersen & Lupton (1996), the relationship between the state and the individual is tense, because the new public health seeks constantly to shift the responsibility of providing public health from the state to the individuals themselves. This is done by using strategies that position citizens as acting of their own free will and in their own interest to protect their health (Petersen & Lupton 1996). There is however subtle coercion to get the individual to act in societal interest even when it is against his own personal preferences or culture. This tension can be seen in this seemingly contradictory disposition of the participants. The structure therefore, seems to influence the individual’s actions while at the same time is influenced by them. The two therefore are not mutually exclusive.

5.3 The role of female health workers in performing male circumcision

From the study, I found out that women were not involved in traditional male circumcision and this is still the case in communities that practise male circumcision as a rite of passage. This main reason for this, as was told by one of the participants, was to protect the initiates from hurting themselves. From this perspective, the reason is a practical one, which should be taken into account in this policy.

In the medical field, it would seem women have been involved in male circumcision before. The participants recounted instances where female health workers have performed male circumcision in the hospital with mixed reactions. One participant knew of someone who had

been circumcised by a female health worker and had no complains. However some of the instances recounted suggested great discomfort with the idea of female health workers performing circumcision. One participant reported having to research in advance as whether the procedure was performed by female or male health workers because he was not comfortable with the notion of female health workers performing the procedure. Yet another reported having walked away when he found out that he would be attended to by a female health worker.

Among the participants, there seemed to be high acceptance of the notion of female health workers performing male circumcision. A closer look however indicates that there are some subtle objections to the same suggesting that this could be a situation that requires delicate handling.

CHAPTER SIX: CONCLUSION

This study's aim was to find out perceptions around the role of female health workers performing male circumcision as part of HIV prevention strategy. The aim was to locate the study in the socio—cultural context in which the policy is to be implemented. In the first chapter, I discussed male circumcision. I presented both the traditional male circumcision and the medical male circumcision and observed the differences between the two. I highlighted one of the main differences between the two; the fact that women are not involved in the traditional male circumcision. I argued that in the male circumcision policy, there is a possibility of involving women in performing male circumcision. I also stated the potential problems that the involvement of female health workers in male circumcision can bring about, especially in a country like South Africa where traditional male circumcision is mainly performed a rite of passage. I argued that integrating medical components to traditional male circumcision has not worked in the past and one of the problem areas has been the difficulty of keeping the initiates away from women which is a key element of traditional circumcision. While a policy may look good on paper, the elements of the policy determine how successful the implementation and uptake will be. I therefore proposed the need to find out the perceptions of involving women in performing medical circumcision as part of HIV prevention strategy.

In the second chapter, I presented and discussed literature relevant to the study topic. I explored the role of public health in ensuring a healthy nation and discussed some of the factors which could potentially affect the provision of public health services. I singled out culture, health care personnel, men's health and policy for discussion in relation to public health. I discussed how culture and public health interact and argued that when the two clash, culture almost always triumphs. I also discussed health personnel, focusing on gender and staff shortages, which I argued were the main reasons behind the proposed task shifting and task sharing in the male circumcision policy. I also highlighted issues surrounding men's health and the reluctance of men to access public health interventions which are partly located in cultural constructions of hegemonic masculinity. This reluctance has been known to exacerbate in the

absence of same sex physicians especially for potentially embarrassing problems or situations and I argued that male circumcision could be one such instance. I also presented the theory of structuration and the post traditional order. In the theory of structuration, structure and agency are seen to have a symbiotic relationship such that neither can exist independent of the other. In the post traditional order, culture is seen as not having a firm hold on the individual who then can make decisions that are not entirely influenced by culture or tradition. I used these as theories to understand decision making in the modern society. In the third chapter I presented the methodology I had used to conduct the study. I argued that the most appropriate methodology was qualitative. Whereas the sample size was small, this was an exploratory study and further research could look at a wider population. I also presented the challenges I had undergone in the course of the study and potential bias and how these may have impacted on the study. I then presented the findings and analysis in chapters four and five, which I will now summarize in the remainder of this section.

The participants did not perceive culture to be a direct barrier to female health workers performing male circumcision. None of the participants stated that it would be culturally wrong for female health workers to perform male circumcision in a clinical setting. However, cultural constructions of the female gender as secondary to the male gender may present barriers to female health workers performing male circumcision. This was concluded from the attitude the participants had toward female health workers in general and the overwhelming preference for male health workers. There were no concrete reasons for preference for male health workers other than the fact that they were fellow men. Using the structuration model, I argued that the preference for male health workers could be situated in the discursive conscious and the unconscious motive could be the inferiority of women to men as is culturally constructed in this community. In the practical conscious, the men accept treatment from the female health workers for pragmatic reasons. Culture therefore could be barrier to female health workers performing male circumcision.

Traditional circumcision was found to be a package deal brooking no interference or changes to it. Medical circumcision was found to be acceptable even if it were to be performed by female

health workers. In fact it would seem that accepting medical male circumcision was synonymous with accepting the possibility of female health workers performing male circumcision. However medical circumcision was found not to count as a rite of passage and those who undertook it were still considered 'uncircumcised', precisely because the initiate would not avoid contact with women. That medical male circumcision would be found acceptable even in this context suggests that the practice is the process of evolving but this may take time. Therefore in a community where male circumcision is still traditionally performed as a rite of passage like in the Xhosa community, medical circumcision may not be welcomed and with it the possibility of female health workers performing male circumcision. In a community where there is no male circumcision or where male circumcision is not performed as a rite of passage, medical circumcision may be more tolerated as would female health workers performing male circumcision.

The study also found out that female health workers have been involved in medical male circumcision in the past. Some participants knew of people who had been circumcised by female health workers and had no problem with it. Some participants also reported having no problem with the notion of being circumcised by a woman. Yet others, notably in the policy's target group, mentioned reluctance to undergo male circumcision if it were to be conducted by a female health worker. The main reason given against was fear of getting an erection during the procedure if it were to be performed by a female health worker.

I argued that this and other reasons against were largely dictated by masculinism and masculine identity issues. As discussed in this report, I found masculine identities in this culture to be constructed around traditional male circumcision, physical health, aggression, and violence and control issues. Traditional male circumcision seemed to confer a superior kind of masculinity. I argued that those locked out of this kind of masculinity as a result of not having undergone traditional circumcision seemed to seek for it in other avenues like violence and aggression and the need to maintain control. I further argued that getting an erection during physical examination or circumcision performed by a female health worker could be viewed as losing control which would render them less masculine. This fear of losing control I proposed was the

main reason for the men's rejection. Masculine identity issues therefore were found to be a barrier to female health workers performing male circumcision.

Personal choice was a common response to many questions. So was the issue of not having a choice. I attributed this contradiction to the interaction between the structure and agency. The agent may desire to exercise autonomous decision but he still has to contend with what the structure is able to offer. The agent's decisions are influenced by structure and cannot be made independent of the structure. Similarly the structure does not dictate all of the agent's decisions. I therefore concluded that structure and agency are not mutually exclusive.

Overall, there was a high acceptability rate for medical circumcision, neonatal circumcision and for female health workers performing male circumcision. This is despite the fact that male circumcision in this country is largely performed as a rite of passage in which none of these would be acceptable. I also found it interesting that the participants who had entered manhood as a result of traditional male circumcision did not want their children to undergo the same process because they thought it was tough and at times fatal. They preferred medical circumcision despite the fact that it was not culturally recognised as a rite of passage simply because it was safer. Some participants also questioned some of the traditional circumcision practices. One participant who had undergone traditional male circumcision disagreed with the teachings they were given to justify wife beating.

This I attributed to the post traditional order in modern society such as the one in which the study was taking place. In the post traditional order, rites and customs are not accepted merely on the grounds of culture or tradition, which would explain the questioning of the practises, particularly those that are deemed harmful. Further in the post traditional order, tradition no longer has a firm hold on the individual and the individual can then make decisions according to the variety of options available to him or her without necessarily adhering to cultural prescriptions. The mixed cultural composition of many modern societies lends itself to issues such as assimilation and acculturation, where new cultural practises are adopted and others toned down or abandoned all together and this is reflected in the choices that are ultimately made by the individuals. This may explain why those who were traditionally circumcised

preferred medical circumcision for their children even though it (medical circumcision) is not culturally recognised as a rite of passage. Other African communities such as the Kikuyu community in Kenya as was mentioned in chapter one of this report have undergone similar evolutions whereby medical male circumcision has now taken over from traditional male circumcision as a rite of passage. Such evolutions however take time and are not without issues. In the modern setting therefore, the male circumcision policy may be acceptable to a large degree although a number of issues may still need to be addressed. In a more rural setting like the homelands where culture is adhered to more stringently, it may not be as acceptable.

6.2 Limitations and recommendations

One of the main limitations to the study was the scope. The number of participants was very small and hence drawing conclusions from it would be limited in terms of population level application. Also due to the number of participants being small, not all ethnic groups of the country were included in the study. Each ethnic group has its own cultural values. So while I did not find any cultural resistance to female health workers performing male circumcision in the ethnic groups that were represented; this may not be the case in other ethnic groups.

Another limitation to the study was potential bias, which was discussed at length in chapter three under researcher reflexivity. In that chapter, I set out potential bias areas and how these were dealt with in order to ensure maximum objectivity during data collection and findings and interpretation. Time was also a fact since the initial study area was not accessed and a lot of time was lost looking for another study area. This left a very short time to conduct the research and write the report. Time constraints resulted in adjustments to the number of study participants and methods of data collection.

Another concern was missing out on the health care workers perspective. Since I was not able to access a health facility for my study as I outlined in chapter three of this report, I was unable to collect data from health workers. Since they also live within culture, it would have been interesting to find out whether female health workers have any inhibitions cultural or

otherwise to performing male circumcision. I recommend further research on a larger scale incorporating the issues concerns I have outlined here.

6.3 Findings (and recommendations) in relation to the policy

In chapter one of this report, I outlined the elements of the male circumcision policy, which are deemed crucial for the success of the policy;

- Male Circumcision has to be done in a clinical setting.
- Male circumcision has to targeting a large number of men who are not circumcised especially in the sexually active age groups
- Male circumcision also has to be offered to infants and young boys
- Due to the numbers of men expected to demand for it, it may be necessary for women to perform male circumcision through task shifting and task sharing
- Male circumcision has to be acceptable to its target population

I will now discuss them in relation to the findings of the study.

Clinical Setting

All participants were in favour of hospital based male circumcision. The general consensus was that while traditional circumcision is a cultural requirement in some communities, it is too dangerous and carried a high death rate. This was mentioned even by the participants who had themselves undergone traditional circumcision who said they would rather send their children to the hospital for male circumcision. As was mentioned earlier, there are other concerns that may undermine this acceptability which need to be addressed. Nevertheless this finding is positive for the policy which requires a clinical setting for it to be carried out successfully.

Targets uncircumcised men in sexually active age groups.

The uncircumcised men in the study seemed to be divided into two. Those who were not circumcised for cultural reasons and those not circumcised for personal reasons. Both groups were very defensive about their status. The cultural group were not willing to change their

mind because they said was important for them to follow their culture. They would however be willing to advocate for it to other people. The personal choice group also felt strongly about defending their decision but were more likely to consider changing their minds and undergoing circumcision under certain circumstances. Most of these men were under the age of 30 and sexually active. They were also willing to advocate for it.

In terms of the policy, this could provide a challenge especially for the group using culture as a reason against circumcision. I would recommend engaging with custodians of culture and traditional leaders in addressing this issue. With regard to the personal choice group, suitable health promotion materials, positive campaigns and counselling should be utilised in addressing their concerns.

Male Circumcision to be offered to infants and young boys

All participants thought that male circumcision for infants and young boys was best. This was because it was thought to be less painful and recovery was faster the younger the individual is. Some participants also felt it was best because nowadays individuals were engaging in sex at very young ages so doing it at infancy would cover such boys as well. For the policy, this was a positive finding as it is in line with what the policy proposes. As was discussed previously, this contradicts the requirements of traditional circumcision and whereas these participants seemed okay with it, it may not find much favour in areas where traditional circumcision is strongly adhered to and policy makers ought to factor this in.

Female health workers performing male circumcision

As mentioned in the previous chapter, there was a high acceptability rate for the notion of female health workers performing male circumcision by the participants in general. However, in the target group, which is uncircumcised sexually active young men, acceptability was rather low. This group was also most likely to refuse a physical examination by a female health worker. The main reason given for this was the fear of getting an erection during the process which would be embarrassing. Fear of mockery and gossip from the female health worker were also reported. Since this is a target group for the policy, it could pose a challenge. Further, one

participant reported simply walking out when he discovered it was a woman performing the procedure, without letting on that this was the problem. This could be an added complication. Further investigation into this group is warranted and suitable health promotion material should be formulated to address this challenge.

Acceptability of the procedure by the target group.

Most acceptability studies in male circumcision have reported high levels of acceptability of male circumcision. I was however surprised by the number of men who even though they knew about the link between male circumcision and HIV, were against the use of this procedure as a HIV prevention strategy. Most people didn't believe that this would work simply because HIV transmission was as a result of exchange of bodily fluids which occur whether or not one is circumcised if they have unprotected sex. This was expressed by both circumcised and uncircumcised men. In terms of the policy, it would be necessary to step up advocacy and especially on how the prevention from male circumcision comes about. Care though has to be exercised so as not to erode the gains of the ABC of prevention, which most participants quoted as the only sure way of preventing the disease.

6.4 Concluding summary.

The globe has come a long way from the first reported case of HIV and substantial gains have been made in the fight against HIV/AIDS and the new prevention methods such as male circumcision may contribute positively to these gains. Previously in this country, circumcision was for cultural, religious or personal reasons and was largely voluntary. Its partial prevention against HIV has changed this and it has now assumed an urgent note, especially with the need for rapid scale up. This study was not about the suitability of male circumcision for HIV prevention or acceptability of male circumcision in general, but rather the acceptability of a particular aspect of the policy that being the notion of female circumcisers. Having said that, I would like to add my voice to those calling for caution in the implementation of the male circumcision policy. It is imperative that the policy should be implemented in the context of greater gender equality, empowerment of both men and women and with attention to

changing hegemonic masculinity issues in the society. This is because as this report has shown, the devil is indeed in the details and therefore addressing these issues as were raised in the study is paramount to the success of the policy and the fight against HIV/AIDS as a whole.

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