Early Childhood Male Medical Circumcision

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Declaration

I, Eurica Palmer, declare that the thesis with interrelated, publishable manuscripts/published articles that I herewith submit for the doctoral degree, Doctor of Philosophy with specialisation in Development Studies, at the University of the Free State, is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.

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Abstract

Medical male circumcision studies concerning decision-making often focus on acceptability and feasibility among parents, with limited application of theoretical frameworks. The involvement of Black women in medical male circumcision policies and programmes has received limited attention. The research investigated infant and child male circumcision (ICMC) decision-making in South Africa and analysed the different perspectives and debates. Furthermore, the study focused on ICMC as an HIV prevention strategy. The constructs of three theoretical frameworks, including the Social Constructivism Theory, Ecological Systems Theory, and Social Norms Theory, were applied across three independent articles. In-depth interviews were conducted to collect data from parents, Black women, and a young male participant who has undergone traditional male circumcision to determine their experiences of ICMC decision-making in the Diepsloot and Diepkloof areas in Gauteng, South Africa. The data analysis was conducted using a thematic and framework analysis. The findings showed that policy positions do not reflect the social contexts, including social sanctions, the social network, and the social construction of masculinity prevalent in ICMC decision-making. The results showed that the involvement of Black women in medical male circumcision policies and programmes should be central as men dominate ICMC decisions and women are on the periphery of the decision-making process.

Keywords: infant and child male circumcision; medical male circumcision, traditional male circumcision, gender, women, Social Constructivism Theory, Ecological Systems Theory, Social Norms Theory

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Dedication

This thesis is dedicated to the memory of my late father.

I am sad that Daddy did not get to see my completed thesis.
Your support was endless and unwavering in whatever I did.
I miss you every day and I will forever remember you.

Walter Palmer

April 1940 – January 2022

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Acronyms and Abbreviations

AIDS	Acquired immune deficiency syndrome
CHAPS	Centre for HIV-AIDS Prevention Studies
EIMC	Early infant male circumcision
HIV	Human immunodeficiency virus
IBM	Integrated behavioural model
ICMC	Infant and child male circumcision
MMC	Medical male circumcision
NGO	Nongovernmental institutions
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PRISMA-Scr	Preferred Reporting Items for Scoping Reviews
SA	South Africa
SA DoH	South Africa. National Department of Health
SCT	Social Cognitive Theory
SNT	Social Norms Theory
SoC	Stages of Change
STIs	Sexually transmitted infections
TMC	Traditional male circumcision
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

Chapter 1
Setting the Scene

1.1 Background

1.1.1 Infant and child male circumcision

The study investigated early childhood male medical circumcision (birth to eight years), focusing on infant and child male circumcision (ICMC). Furthermore, early childhood male medical circumcision is used as an all-encompassing term, inclusive of ICMC and early infant male circumcision (EIMC). This is consistent with the age range of circumcision practices performed worldwide by circumcision practitioners: newborns (less than one month), infants (1 to 11 months) and children (age 1 to 12 years) (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2010a).

ICMC is a controversial procedure in the popular and medical literature, representing a complex choice for parents. The decision to circumcise a male infant or child is influenced by numerous factors, including having their child's appearance match their father's, reducing the risk for infections, and improving genital health and hygiene (Amuri et al., 2016; Keetile & Bowelo, 2016; Mavhu et al., 2017; Morgan et al., 2021).

Male circumcision offers a variety of health benefits. It protects against certain medical conditions, including sexually transmitted infections (STIs) (Bisono et al., 2012), genital cancer (Morris et al., 2012), and the human immunodeficiency virus (HIV) (Sardi & Livingston, 2015). Parents make ICMC decisions, and they must understand the health benefits of the procedure and they are required to provide consent for the circumcision procedure. Parental decision-making needs to be understood and assessed to maximise the effectiveness as well as the cost-effectiveness of ICMC (Njeuhmeli et al., 2016).

ICMC rates in South Africa have increased. Among children between the ages of 0 to 4, the prevalence of male circumcision rose from 2.0% in 2012 (Shisana et al., 2014) to 3.9% in 2017 (Simbayi et al., 2019). While the circumcision prevalence among 5- to 14-year-olds was only 9.1% in 2012, this increased to 11.4% among 5- to 11-year-olds and 37.4% among 12- to 14-year-olds by 2017 (Shisana et al., 2014; Simbayi et al., 2019).

Currently, the South African Department of Health (SA DoH, 2016) has its own *South African national guidelines for medical male circumcision*. However, the South African government's position on ICMC is unclear. Therefore, health care professionals are left to their discretion

when communicating guidance regarding ICMC. Against the background of the national and international debates about the health benefits and complexity of the decision-making process, it is an opportune time to investigate ICMC in South Africa.

The next section reflects on the situational analysis of the acquired immunodeficiency syndrome (AIDS) caused by HIV. HIV prevention is one of the many reasons why parents decide to pursue ICMC. Some consider male circumcision as an acceptable intervention that can protect against HIV infection because it reduces the risk of sexual transmission from females to males by approximately 60% (Auvert et al., 2005).

1.1.2 HIV/AIDS situational analysis

Over the last four decades, countries incurred adverse health and economic impacts associated with HIV/AIDS. Since the first HIV infection in 1981, 79.3 million people have become infected and there have been over 36 million HIV/AIDS-related deaths (Joint United Nations Programme on HIV/AIDS UNAIDS, 2021). Yet, there has also been significant progress in the response towards HIV. UNAIDS (2021b) estimated that in 2020, 37.7 million people were living with HIV, of which 27.5 million were receiving antiretroviral therapy. In 2016, the UN General Assembly set a target of reducing new HIV infections to 500 000 by 2020. Despite these targets and interventions, the number of new HIV infections has tripled in 2020 with 1.5 million new infections (UNAIDS, 2021a). To end AIDS will require an HIV prevention focus.

The level of resources for addressing HIV/AIDS has been unprecedented. The Global Fund began operating in 2002, distributing funds to developing countries for their HIV, tuberculosis and malaria responses (Bridge et al., 2016). The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003 to fund HIV/AIDS programmes in developing countries (Bendavid, 2016). Between 2000 and 2015, the international community spent $562.6 billion on HIV/AIDS in 188 countries. This amount includes domestic government resources and international development assistance (Dieleman et al., 2018). Despite the significant level of funding, the resources allocated to developing countries have not matched the need. Only 37% of all HIV/AIDS resources are earmarked for low-income and lower-middle-income countries, even though these countries account for 75% of all HIV-related disability-adjusted life years (Dieleman et al., 2018). Given the prioritisation of resources to address COVID-19 in 2020 and 2021, it is unlikely that additional resources will be available in the short term (Global HIV Prevention Coalition & UNAIDS, 2021). As a result, countries are currently focusing on domestic resource mobilisation and allocating funds to the most cost-effective HIV interventions (Haakenstad et al., 2019; McGillen et al., 2016; Stover & Teng, 2018). In addition

to the magnitude of resources, the allocation of HIV/AIDS resources has also changed over time (Dieleman et al., 2018). At the start of the millennium, only a few developing countries had access to HIV treatment, which meant that most countries were allocated resources predominantly for HIV prevention (Forsythe et al., 2019; Marseille et al., 2002). However, by 2015, HIV care and treatment accounted for 56% of all HIV resources, with prevention accounting for only 19% (Dieleman et al., 2018).

Despite significant progress, Eastern and Southern Africa remain the most heavily HIV-affected regions globally. Between 2000 and 2020, the number of new HIV infections in Eastern and Southern Africa declined by 43% and the AIDS-related deaths decreased by 50% (UNAIDS, 2021b). In Eastern and Southern Africa, 89% of people living with HIV know their HIV status and 77% of people living with HIV receive treatment. The number of people living with HIV in the region reached 20.7 million in 2019, or 54% of the world's HIV infections. Despite the high treatment coverage, 300 000 people in the region died of AIDS in 2019 (UNAIDS, 2020).

South Africa accounts for the largest number of people living with HIV globally, with an estimated 5.3 million infected individuals in 2020 (Kaiser Family Foundation, 2021). The 2019 prevalence of HIV for people between 15 and 49 was 19% (UNAIDS, 2019a). Approximately 92% of South Africans living with HIV know their status, and 75% of those who know their status are receiving ART, of which 92% are virally suppressed (UNAIDS, 2019a). Despite South Africa's progress in scaling up HIV treatment, 72 000 people died of AIDS in 2019 and the number of new HIV infections remained at 200 000 per year (UNAIDS, 2019a). Notwithstanding HIV prevention messages, intergenerational sex, multiple concurrent partners, low condom use, low rates of male circumcision and gender inequality continue to drive the HIV epidemic in South Africa (Maharajh & Haffejee, 2021; Weiss et al., 2009).

HIV/AIDS resources have focused on care and treatment, as the price of antiretroviral drugs has declined. However, there is recognition that these programmes have not achieved the prevention targets and that without better prevention interventions, the goal of eliminating HIV by 2030 remains elusive. Given the limited resources available for HIV/AIDS, prevention resources will need to target those interventions that are the most cost-effective, including medical male circumcision (MMC) (Njeuhmeli et al., 2016).

1.1.3 HIV prevention strategies

A range of HIV prevention services has demonstrated success in reducing HIV infections. Current HIV prevention services include distributing male and female condoms, pre-exposure prophylaxis, treatment of sexually transmitted infections, needle and syringe exchange

programmes, opioid substitution therapy, prevention of mother to child transmission, behaviour change communication, post-exposure prophylaxis, treatment as prevention, and MMC. HIV prevention services are generally categorised as either behavioural, structural or biomedical (UNAIDS, 2010a). Behavioural interventions include condom use, reducing the number of sexual partners, and delaying sexual debut. Structural interventions include addressing stigma, legal, political, and cultural factors. Biomedical interventions rely on medical or surgical procedures to prevent HIV infection, including pre-exposure prophylaxis and MMC. Governments may focus their HIV prevention response on the general population or key populations with a higher incidence of HIV. These key populations may include men who have sex with men, female sex workers and serodiscordant couples (Hargreaves et al., 2016; Pretorius et al., 2020). Other vulnerable populations include adolescent girls and young women (UNAIDS, 2019b). Unlike most other HIV prevention services, MMC targets heterosexual adolescent boys and men, reducing their risk of becoming infected by women (Cork et al., 2020).

1.1.4 History of circumcision as an HIV prevention strategy

Cameron et al. (1989) confirmed a relationship between a low prevalence of male circumcision and susceptibility to HIV infection among heterosexual men. Patterson et al. (2002) argued that circumcision could reduce the chance of HIV infection two- to eight-fold. Subsequent studies emphasised that MMC could be an effective HIV prevention intervention (Weiss et al., 2008). A meta-analysis evaluated 34 studies and found a relationship between MMC and HIV incidence among heterosexual men (Siegfried et al., 2009). The authors recommended the inclusion of MMC in current HIV prevention programmes. Three randomised control trials were conducted between 2005 and 2007 to determine if circumcision programmes reduced the probability of adolescent boys and men becoming HIV infected. The trials occurred in Orange Farm in South Africa, Kisumu in Kenya, and Rakai in Uganda (three areas with a high HIV prevalence and a low circumcision) (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). The studies found an average 60% reduction in HIV transmission (from women to men) among men who were medically circumcised. Subsequent studies in South Africa identified HIV prevention benefits in entire communities where circumcision was prominent (Auvert et al., 2013). MMC forms part of the HIV prevention strategy in 15 African countries[1] with a high HIV prevalence and a low prevalence of male circumcision (WHO & UNAIDS, 2010). Mathematical modelling conducted in 2011, projected that if an 80% male circumcision prevalence could be achieved in these 13 countries by 2015, it could avert 3.36 million new HIV infections

[1] Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland (now eSwatini), Tanzania, Uganda, Zambia, and Zimbabwe.

(Njeuhmeli et al., 2011). Estimates set the cost of this strategy at $2 billion, compared to the benefits of $16.5 billion (Njeuhmeli et al., 2011). As a result, international funders promoted MMC in these countries.

1.1.5 Scaling up of medical male circumcision

Figure 1.1 provides an overview of the increase in newly circumcised men since 2008 (UNAIDS & WHO, 2021). There was a rapid rise in uptake between 2008 and 2014, followed by a decrease between 2015 and 2016. Since 2017, the number of new circumcisions has remained flat. Tanzania accounted for only 4% of all circumcisions in Eastern and Southern Africa in 2010 but 19% by 2019. In 2010, South Africa accounted for the largest share of MMCs performed (31% of all circumcisions). However, by 2019, South Africa accounted for only 11% of all circumcisions (UNAIDS & WHO, 2021). One of the obstacles faced by South Africa has been an inability to generate sufficient demand for MMC services, causing policymakers to reduce targets over time. The lack of demand highlights programme sustainability, planning and innovative strategies. It has also raised the possibility of expanding the MMC platform to include ICMC.

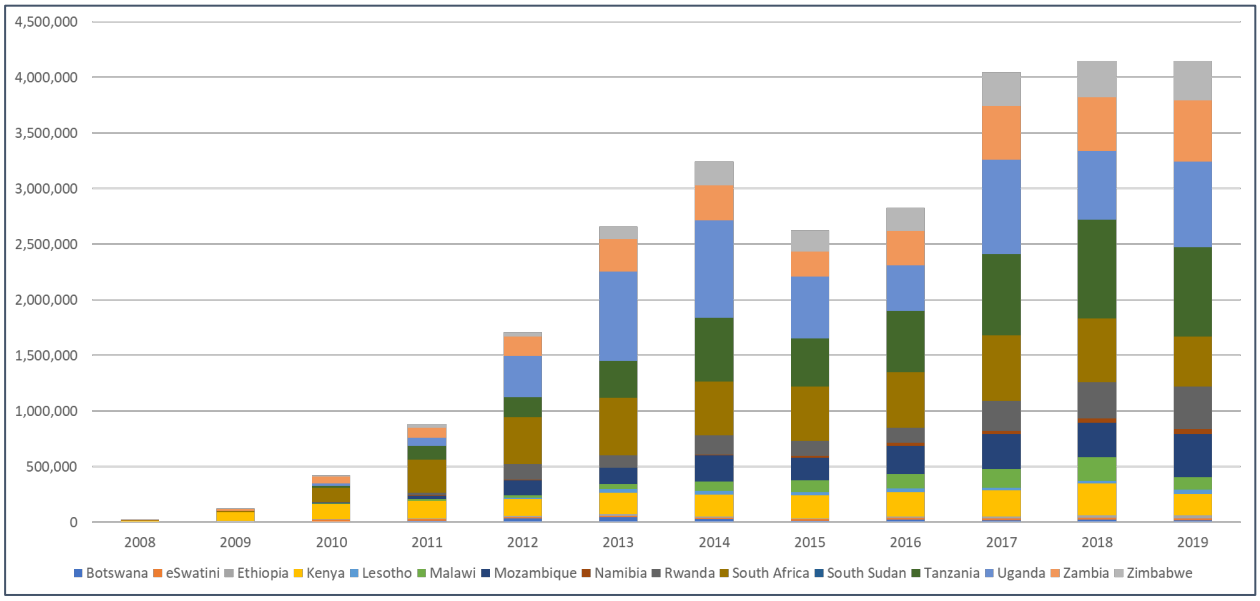

Figure 1.1 ***Increase in the number of newly circumcised men in 15 countries (2008–2019)*** (Global AIDS monitoring, 2019)

In 2016, the UNAIDS set a cumulative target of performing 25 million circumcisions between 2016 and 2020. By 2019, over 15 million circumcisions took place (UNAIDS & WHO, 2021). However, in 2020, countries failed to reach their circumcision targets due to COVID-19 (Global HIV Prevention Coalition & UNAIDS, 2021). For example, in South Africa, male circumcisions declined by two-thirds between 2019 and 2020 (PEPFAR *Panorama Spotlight,* 2021).

Table 1.1 illustrates how South Africa performed against the set targets. South Africa did not achieve any of its annual MMC targets, with 2020 being particularly problematic given the spread of COVID-19. The large decrease in circumcisions performed in 2020 raised the issue of whether South Africa's circumcision programme can still be successful over the long term and if the associated benefits of male circumcision in terms of HIV infections averted and if the targets can be achieved.

Table 1.1 Number of circumcisions targeted and achieved between 2017 and 2021 in South Africa

	2017	2018	2019	2020	2021
Target	700 000	650 000	600 000	550 000	500 000
Achieved	591 941	572 442	451 636	159 739	Not applicable

Source: Targets from South Africa's 2017–2022 National Strategic Plan (SA National AIDS Council, 2017). Achievements based on the voluntary medical male circumcision (VMMC) progress report of the UNAIDS and WHO (2021) and the PEPFAR Panorama Spotlight.

1.1.6 Medical male circumcision and infant and child male circumcision as HIV prevention strategies

As HIV financial resources moved from prevention to care and treatment, the focus shifted to the need to spend HIV prevention resources more cost-effectively (Kates et al., 2019). MMC is one of the most cost-effective HIV prevention strategies (Haacker et al., 2016; SA DoH, 2016 & South African National AIDS Council, 2017). With the limited scaling up of MMC, the debate about the inclusion of ICMC as an HIV prevention strategy has gained momentum (Kebaabetswe et al., 2003; Tobian et al., 2010). ICMC is safer and simpler than adolescent and adult circumcision (Weiss et al., 2008). Studies found high ICMC hypothetical acceptability, but actual acceptability in numerous countries, including Botswana, Malawi, South Africa and Zimbabwe (Chilimampunga et al., 2017; Mavhu et al., 2012; Plank et al., 2010; Spyrelis et al., 2013). ICMC is affordable and is a long-term strategy in countries unable to achieve their MMC targets (Njeuhmeli et al., 2016). As a result, eSwatini, Zimbabwe and Kenya have prioritised ICMC (Fitzgerald et al., 2016; Mavhu et al., 2017; Young et al., 2012).

eSwatini was the first sub-Saharan African country to introduce ICMC into an existing MMC programme. eSwatini performed more than 5 000 procedures between 2010 and 2014 (Fitzgerald et al., 2016). Lessons learnt from the programme included the importance of stakeholder involvement within and outside the HIV prevention programmes, health facility support, informed demand, and regional and national support to promote institutionalisation and country ownership. Tanzania also included ICMC as a long-term HIV prevention strategy in a project called *Strengthening high impact interventions for an AIDS-free generation*

(AIDSFree) project); however, myths and misconceptions from inadequate information prevented the widescale adoption of ICMC (Amuri et al., 2016).

While targeting infants and children for circumcision may not immediately avert significant HIV infections, the expectation is that ICMC can have a sustainable, long-term HIV/AIDS response. Since the procedure takes place before the males initiate sexual activity, early infant male circumcision (EIMC) offers a lifetime of protection (Lawal & Olapade-Olaopa, 2017; Njeuhmeli et al., 2016). Therefore, EIMC may be a more effective long-term HIV prevention strategy (Mavhu et al., 2014). UNAIDS (2010b) noted that EIMC has an advantage over MMC because it produces fewer complications at a lower cost and more rapid healing. Furthermore, neonatal circumcision uses devices such as Mogen, Gomco and Plastibell. These devices do not require stitches, recovery is faster and there are fewer complications (WHO & UNAIDS, 2007). ICMC avoids barriers to MMC, such as (sexual abstinence during the healing period, stigma and discrimination, and fear of learning one's HIV status. Since ICMC occurs before sexual activity starts, there are no concerns about pain from erections or resumption of sexual activity before the wound heals (Kikaya et al., 2016).

1.1.7 Infant and child male circumcision: International, regional, and national perspectives

1.1.7.1 International overview

ICMC policies vary between countries. In Australia, for example, most circumcisions were performed routinely on infants since the 1950s. However, in 2012 the Australian Academy of Paediatrics changed its view on infant circumcision, concluding that there is insufficient evidence to recommend routine newborn circumcision (Na et al., 2015). The Royal Australasian College of Physicians (2010) argued that the benefits of newborn circumcision do not justify the procedure. They further stated that parents should decide on the risks and benefits.

There have also been recent shifts in male circumcision policies in the United States (Morris et al., 2017). According to the 1999 policy statement of the American Task Force on Circumcision (1999), there was no evidence that the benefits of neonatal circumcision exceeded the risks. However, 13 years later, the Task Force on Circumcision et al. (2012) concluded that neonatal circumcision benefits exceeded the risks. In 2018, the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (2018) indicated numerous benefits for both MMC and neonatal circumcision. These benefits included reduced risks of urinary tract infections, STIs and HIV. Despite the noted benefits, neonatal circumcision declined in the US, from 83% in the 1960s to 77% in 2010 (Morris et al., 2017). This decline resulted from the

rise of the Hispanic population in the US, which is less likely to practice circumcision. In addition, the Hispanic population faces challenges of health insurance access, which also represents a barrier to neonatal circumcision (Castro et al., 2010).

Other countries have taken various positions regarding neonatal circumcision. The British Medical Association (2019) has not taken a position on the acceptability of neonatal circumcision, while the Royal Dutch Medical Association (2010) indicated that neonatal circumcision violates the child's rights.

The WHO and UNAIDS (2007) first recommended MMC and ICMC as an HIV prevention strategy in 2007 and advised that neonatal circumcision is a simple procedure with few adverse effects. The WHO operational guidance (2008) concluded that a short-term strategy should focus on adolescents and adults, while a longer-term strategy focuses on infants and young boys. Furthermore, they recognised the debate around ICMC, noting that "there may be differences of opinion and practice regarding the age at which circumcision is performed (neonate, young child, adolescent or adult)" (WHO & UNAIDS, 2008, p. 16). In 2011, the WHO and UNAIDS established a policy framework for scaling up male circumcision in Eastern and Southern Africa. This framework emphasised the important role of women in the MMC decision-making process.

Until 2020, PEPFAR supported the circumcision of adolescent boys in Africa as young as ten years old (Davis et al., 2021). More than two-thirds of MMC procedures were performed between 10 and 19 years (Kripke et al., 2017). However, in 2020, PEPFAR increased the lower age limit for MMC to 15 years because of the increased risk of adverse events among younger boys. Of all 36 glans injuries reported between 2015 and 2018, all were among patients under 15 years old, raising concern about the circumcision procedure among children (Lucas et al., 2020).

In 2020, the WHO set new guidelines for circumcision among adolescent boys and men (WHO, 2020). The guidelines introduced several new considerations for MMC with boys between the ages of 10 to 14. These considerations related to the age of consent, greater risks associated with adverse events and the immaturity of the genitalia at such a young age. Furthermore, the WHO guideline states that parental preferences are important when considering the age for MMC for boys.

1.1.7.2 Regional: Eastern and Southern Africa

Mavhu et al. (2012) highlighted concerns about ICMC acceptability in Zimbabwe. The country addressed this by commissioning research to assess the acceptability of ICMC to inform policy

development, service delivery models and strategies. Their study findings highlighted that despite low levels of ICMC knowledge, the community was willing to have their sons circumcised. The importance of the father in the decision-making process was also highlighted (Mavhu et al., 2012). Tanzania is also widely recognised as a benchmark for ICMC scaling up (AIDSFree Project, 2016). A pilot study in the Iringa community in Tanzania stated that the main factors influencing parents not to circumcise their infants were myths and misconceptions arising from inadequate information (Amuri et al., 2016).

Many MMC priority countries have also included ICMC in their HIV prevention programme. In 2010, the government of eSwatini was the first sub-Saharan African country to expand their ICMC programme (Fitzgerald et al., 2016). A study analysing the knowledge and attitudes of women attending rural hospitals in eSwatini highlighted the role of the extended family in the decision to circumcise a son (Jarrett et al., 2014). Furthermore, the main lessons learnt from the programme include the need for stakeholder involvement within and outside the HIV prevention programmes, health facility support, informed demand, regional and national support to promote institutionalisation and ownership. eSwatini addressed their human resource constraints by implementing task shifting that allows nurses to perform minor procedures previously conducted only by doctors, including male circumcision (Fitzgerald et al., 2016).

In 2016, an EIMC feasibility and acceptability study in Malawi noted low levels of knowledge and experience among study participants (Chilimampunga et al., 2017). Lesotho implemented a phased approach to introducing an ICMC programme by integrating ICMC into existing maternal, neonatal and child health programmes. A review of facilitating factors and challenges of the programme identified cultural acceptance, gaining consent from family members and concerns about pain and complications as significant factors in the decision-making process for parents (Kikaya et al., 2016).

1.1.7.3 National: South Africa

South Africa launched its MMC programme in 2010 (Korenromp et al., 2021). In South Africa, the scaling up of MMC does not include infants. However, acceptability studies and pilot studies have attempted to understand the potential opportunity for circumcising infants and children. An acceptability study in KwaZulu-Natal found high acceptability of neonatal circumcision (82.9%) among pregnant women attending selected antenatal care facilities (Phili & Karim, 2015). However, the authors found that sociocultural factors, including the preference for traditional male circumcision (TMC), influenced the decision-making process. Another acceptability study conducted from 2011 to 2012 in the Gauteng province interviewing mothers

and fathers of infant boys, found that 92% of mothers and 87% of fathers found circumcision to be an acceptable practice, with the majority preferring that their sons undergo the procedure within the first week after their birth (Spyrelis et al., 2013). The United Nations International Children's Fund, in partnership with the Centre for HIV-AIDS Prevention Studies (CHAPS), implemented an ICMC pilot study for HIV prevention in Orange Farm and Soweto in South Africa between 2015 and 2017 (CHAPS, 2017). The pilot programme found that in 83% of cases, the mother had sole responsibility for determining whether to circumcise their sons.

South Africa's 2017–2022 National Strategic Plan emphasised that 2.4 million adolescent and adult males received MMC through the government MMC programme between 2011 and 2016 (South African National AIDS Council, 2017). The plan prioritised MMC but did not mention ICMC. According to a survey conducted in 2017, 61.6% of males 15 years and older have been circumcised (Simbayi et al., 2019). Between 2008 and 2020, 4.46 million circumcisions took place (UNAIDS & WHO, 2021). Modelled data projects that the scaling up of MMC resulted in between 71 000 and 83 000 HIV infections averted, compared to a scenario without any scaling up of MMC (Korenromp et al., 2021).

Table 1.2 Circumcision prevalence among children in South Africa

Age	2012	2017
0–4	2.0%	3.9%
5–14	9.1%	
5–11		11.4%
12–14		37.4%

Source: Shisana et al. (2014); Simbayi et al. (2019).

Despite South Africa's decision not to implement a national ICMC programme, the circumcision prevalence among children has increased (Table 1.2) as parents have pursued the procedure (Spyrelis et al., 2013). Among children under the age of five, the prevalence of circumcision has increased from 2.0% in 2012 to 3.9% in 2017 (Shisana et al., 2014). Circumcision prevalence among boys between the ages of five and fourteen was 9.1% in 2012. The 2017 study disaggregated this population into five to eleven and twelve to fourteen years. The circumcision prevalence reached 11.4% in the five- to eleven-year-old group and 37.4% among boys between twelve and fourteen years old (Shisana et al., 2014; Simbayi et al., 2019). This indicates a significant increase in circumcision prevalence, particularly among the twelve- to fourteen-year-olds.

1.1.8 Infant and child male circumcision and decision-making

The decrease in the number of adult circumcisions performed in 2020 raised the concern that the successes in reducing new HIV infections could be stalled or even reversed. South African policymakers questioned whether an increase in ICMC could mitigate the impact of a decline in adult circumcisions. For South Africa to increase the number of ICMC in the country, it will be necessary to increase the number of providers and increase demand by parents. Increasing demand requires that policymakers understand the decision-making process, including the factors that influence parents to seek circumcision services for their sons and the barriers that limit access to these services.

Studies in various countries have found high levels of hypothetical acceptability of ICMC among parents. Studies in Botswana, Kenya, Zambia and Zimbabwe found acceptability between 90% and 99% (Davey et al., 2016). A study in Botswana found that ICMC was more acceptable when one or both parents were HIV-infected, the father was circumcised and the father had himself pursued MMC (Keetile & Bowelo, 2016). In KwaZulu-Natal (South Africa), 82.9% of pregnant women interviewed favoured circumcising their sons (Phili & Karim, 2015).

Male circumcision decision-making is complex because multiple factors influence the decision to circumcise or not to circumcise. Consequently, a large body of research has emerged on these topics; yet the male circumcision literature is contested. Furthermore, various country programmes followed different approaches to develop and implement policies and programmes and to support men or parents to pursue male circumcision.

A range of factors influence whether to adopt ICMC circumcision or not. The irreversible nature of circumcision means that the decision made by the parents will affect their sons for the rest of their lives. Therefore, it is necessary to understand the factors that influence the parental decision-making process, including the role of the father, social networks, religion, policies, and culture (Figure 1.2).

Figure 1.2 Factors that influence infant and child male circumcision decision-making (Own construction)

1.1.8.1 Fathers and decision-making

One common theme from all the ICMC studies indicates that fathers play a critical role in ICMC decision-making processes. For example, in one Tanzanian pilot project, fathers held substantial decision-making power, despite being the least exposed to male circumcision messages (Amuri et al., 2016). Studies in Kenya and Zimbabwe found that fathers often had a negative perception of ICMC, especially if the fathers had been traditionally circumcised (Mavhu et al., 2012; Young et al., 2012). Multiple studies have noted that the circumcision status of the father is a major factor that influences whether or not their sons should be circumcised (Rediger & Muller, 2013; Spense et al., 2017). Moreover, fathers who experienced pain during MMC were less likely to accept EIMC (Mavhu et al., 2017).

1.1.8.2 Social network and decision-making

Parents identified the lack of knowledge and information as a barrier to the uptake of ICMC (Lee et al., 2003; Pan et al., 2012; Wouabe, 2013; Xu & Goldman, 2008). At the same time, parents noted that extended family members influenced their decision-making process. Several studies have found that extended family members (particularly the uncles and

grandparents of the child) play an important role in decision-making (Jarrett et al., 2014; Phili & Karim, 2015; Spyrelis et al., 2013). A South African study highlighted that women who could not decide whether or not to circumcise their sons often felt that they needed feedback from the extended family (Phili & Karim, 2015).

1.1.8.3 Religion and decision-making

Religion also plays an important role in influencing the parental decision-making process. WHO & UNAIDS (2007) estimated that two-thirds of the 30% of males circumcised globally are Muslim. One study in Cape Town, South Africa, found that while Muslims represent only 8% of the general population, they represent 22% of the circumcised population (Marais et al., 2021). Converts to Islam represented a large proportion of this sample. A study on circumcision in India found that religion was one of the most significant factors in determining whether or not a child becomes circumcised (Sahay et al., 2014). Furthermore, infant male circumcision is widely practised for religious reasons in the Jewish faith. As a requirement for inclusion in the Jewish faith, infant male circumcision represents the covenant between God and Abraham as described in the Old Testament (Kacker & Tobian, 2013).

1.1.8.4 Culture and decision-making

Circumcision decision-making does not occur in isolation from culture and traditions; therefore, circumcision programmes need to address the factors that influence the cultural acceptability of circumcision (Kalichman, 2010). Cultural beliefs are often major barriers to the uptake of ICMC programmes, especially when they either discourage circumcision as being *foreign* or encourage circumcision to only be performed as part of a traditional ritual (Mavhu et al., 2016). For example, in Kenya, the Luo tribe is traditionally non-circumcising, presenting a major barrier to MMC and ICMC for HIV prevention purposes (Sgaier et al., 2015). A programme was developed to address the barriers by working with traditional leaders to create a supportive environment where cultural beliefs could coexist with the medical procedure. This demonstrates that addressing cultural beliefs through the relevant traditional and community structures (including traditional and religious leaders) can promote the procedure. A study in eSwatini found that culture and tradition could represent either a barrier to ICMC or an opportunity (Jarrett et al., 2014).

TMC, a cultural rite of passage to manhood, is a practice that connects to perceptions of masculinity and gender (Kalichman, 2010). In South Africa, TMC is practised by several cultural groups, including the Venda (90.2%), Pedi (71.2%), and Xhosa (64.3%) (Connolly et al., 2008). The ritual takes place in secret and initiates are not allowed to speak about the ritual with outsiders. Those who do not comply bear consequences and sanctions from the

community (Douglas & Maluleke, 2018). TMC often competes with ICMC, as parents view ICMC as a modern alternative to TMC (Mavhu et al., 2012). Interviews with 1 778 pregnant women in KwaZulu-Natal, South Africa, for example, found that among the women who refused circumcision for their child, 15.9% identified cultural reasons (including a preference for TMC) as the main reason to refuse ICMC (Phili & Karim, 2015).

1.1.8.5 Pain and decision-making

Studies in Lesotho and South Africa found that fear of inflicting pain on the child was the main reason parents did not adopt ICMC (Kikaya et al., 2016; Phili & Karim, 2015; Spyrelis et al., 2013). In Lesotho, for example, expectant parents were interviewed as part of the study by Kikaya et al. (2016). The main concerns regarding ICMC included a focus on pain for the neonate, the age when the procedure should be performed and the risk of potential adverse effects on the newborn. In KwaZulu-Natal, South Africa, mothers who rejected ICMC were concerned about the pain associated with the procedures (Phili & Karim, 2015). Another acceptability study in the Gauteng province, South Africa, found that one potential barrier to circumcision was the concern about the infant suffering discomfort. The authors argued that accurate information for parents could address the concerns (Spyrelis et al., 2013).

1.1.8.6 Health and hygiene of the child and decision-making

A study of African American parents found that 96% of the parents interviewed felt that circumcision was healthy and 41% indicated that health was the main reason for circumcising their sons (Ahaghotu et al., 2009). The mother was 12 times more likely to be the decision-maker relative to the father. Hygiene was identified as a major factor in deciding to circumcise. A Canadian study found that hygiene was identified by 62% of the respondents, followed by the prevention of infections or cancer (45%) (Rediger & Muller, 2013). An Australian study confirmed that in circumcising sons, 78% of parents indicated that hygiene was the main reason, followed by other medical reasons (36%). In acceptability studies in Africa, the HIV prevention benefits of ICMC was particularly important. In Malawi and Zambia, there were high levels of hypothetical acceptability, with HIV prevention being the most important factor influencing parental decision-making (Chilimampunga et al., 2017; Waters et al., 2013).

1.1.8.7 Financial resources and decision-making

Financial considerations pose a barrier to male circumcision uptake (Djimeu, 2013). These financial considerations include opportunity costs (lost income due to taking time off from work during or after the procedure) (Herman-Roloff et al., 2011), traveling costs for the procedure and subsequent follow-up visits, and the actual cost of the procedure itself (when the

procedure is not available for free) (Chinkhumba et al., 2014). Studies in Kenya found that men who received food vouchers were more likely to adopt MMC (Thirumurthy et al., 2014). Concerns about cost particularly apply to ICMC, as MMC procedures are often provided for free, while ICMC usually requires payment, for example, in South Africa.

1.1.8.8 Ethical considerations in decision-making

The child's and the parent's rights and questions about the child's best interests are important ethical considerations in determining how to address ICMC. Those opposed to ICMC emphasise the child's right to bodily integrity. They argue that the child's bodily integrity is violated by ICMC, as the procedure attacks their bodies without their consent (Domashevskiy & Domashevskiy, 2016; Fadel, 2003; Hodges et al., 2002). According to Svoboda and Van Howe (2013), ICMC violates a child's rights because it permanently changes a part of the body and should not be promoted. The lifelong consequences for a child who cannot give consent have also raised particular concerns about autonomy (Di Pietro et al., 2017). Hammond and Carmack (2017) viewed parental consent to circumcise their sons as inadequate since parents do not know the future wishes of their sons. Bolton (2013) supported this by arguing that parents should not be permitted to decide based on the fear that their sons will become HIV infected in the future. Therefore, circumcision should occur when the child reaches the age where he can give consent.

The ethical arguments made by both opponents and proponents of ICMC depend on bodily integrity, the autonomy of the child, the responsibility of the parents and an evaluation of the benefits of ICMC to the child and society as a whole. There remains significant debate around these issues, both when applied to newborns and children too young to provide their consent. These debates are likely to be influenced by the growing literature on the potential risks and benefits of ICMC. However, even if there are clear health benefits to the child and society, the debates will continue.

1.1.8.9 International and national policies

The circumcision of adolescent boys and adult men has been common in South Africa since the country initiated its MMC programme for HIV/AIDS prevention (Kripke et al., 2016). However, current limits established by PEPFAR have made circumcising children less common, as funding no longer allows the circumcision of boys under the age of 15 (US Department of State, 2021). While neonatal circumcision is becoming more common in South Africa, the public health system does not support a national programme to promote ICMC. As a result, parents have to seek out services from private providers. This limits opportunities for

parents seeking neonatal circumcision, as most parents have limited resources to have the procedure performed in the private sector.

The WHO (2020) recommendations did not specifically mention neonatal circumcision, but they addressed circumcisions performed among boys under 15. While not recommending the prohibition of circumcisions on boys under the age of 15, the WHO (2015) referenced guidance on human rights as a major factor to consider when circumcising children. The United Nations Educational, Scientific and Cultural Organization (2005) argued that performing circumcisions based on public health benefits is not ethically defensible. They, therefore, recommended that countries consider delaying circumcision until the age of 15.

In South Africa, the General Regulations Regarding Children (SA, 2010) and the 2005 Children's Act, Act 38 of 2005, regulate the circumcision of boys under 16. This legislative framework provides an outline for the protection of children and the procedure for the circumcision of children (Smith et al., 2011). The Children's Act specifically states that circumcision of male children under the age of 16 is prohibited, except when

- the circumcision takes place for religious purposes following the practice of the religion concerned and, in the manner prescribed; or
- the circumcision is performed for medical reasons on the recommendation of a medical practitioner.

Furthermore, the 2005 Children's Act emphasises the child's best interests as the main criteria affecting decisions about medical decision-making. However, the South African laws remain unclear regarding the interpretation and application of the Children's Act's guidance (Strode et al., 2016). For example, the term *religious purpose* is not explained, and some have interpreted *medical reasons* to include the health benefits from performing a circumcision.

The South African Medical Association does not support ICMC; they regard it as unethical and illegal (Friedman et al., 2016). Furthermore, according to Smith et al. (2011), the United South African Neonatal Association views ICMC as a human rights burden on the child. They indicated that existing scientific evidence is insufficient to recommend ICMC to prevent HIV in later life.

The MMC guidelines (SA DoH, 2016) emphasises that all circumcision clients (and parents in the case of a minor) must give informed consent before MMC is performed. While noting that the basic principles of human rights are important, they do not specifically identify an age in which circumcisions should not take place. They only noted that those under 16 must obtain the parent's or legal guardian's written consent (SA DoH, 2016).

Overall, the policy issues outlined in international and South African policy documents create uncertainty regarding how ICMC may expand. It is not clear, for example, if parental consent is an adequate proxy for the child's consent.

1.2 Problem statement

The intended benefits of public health interventions such as ICMC and MMC, commonly used as HIV prevention programmes, should ideally balance out any related, adverse, and unintentional consequences. The intended benefit of ICMC and MMC in Eastern and Southern Africa is the reduction of HIV infections. Consequently, a large body of research has emerged on these interventions. However, the male circumcision literature remains contested and complex, particularly regarding whether to circumcise or not.

Worldwide, male circumcision decision-making is complex as multiple factors influence the circumcision decision-making process. Country programmes in East and Southern Africa have outlined different approaches to developing and implementing policies and programmes to convince men and parents to pursue male circumcision to reduce the risk of HIV infection (Jarrett et al., 2014; Sgaier et al., 2017; Waters et al., 2012). In addition, MMC programmes are transitioning from scaling up and expansion of plans to maintain the programmes. Njeuhmeli et al. (2016) argued that it is important to consider ICMC as a strategy to sustain high levels of circumcision in the population and integrate ICMC into maternal, neonatal and child health programmes.

It is unclear what the South African government's position on ICMC is as it does not offer ICMC as part of its HIV prevention package of services (SA DoH, 2016). The lack of a clear ICMC policy presents specific consequences for communities. Parents who want to have their children circumcised have little choice but to access services from the private health care system at their own cost or through medical aid. This raises issues of affordability that could be a barrier to accessing male circumcision services. Clear policy guidance can help address the barriers, facilitate the uptake of ICMC and assist parents in making informed decisions (Lilleston et al., 2017). The input and involvement from stakeholders at the policy and health facility levels are essential to the success of ICMC programmes (CHAPS, 2017).

Social, gender, cultural and economic factors influence ICMC decision-making (Fitzgerald et al., 2016; Jarrett et al., 2014; Kenu et al., 2016). TMC practices are an important part of the belief system of many South African communities. Cultural practices such as TMC are closely associated with the transition from boyhood to manhood and play a significant role in the socialisation of men and boys, influencing their circumcision decisions (Palmer et al., 2020). Furthermore, fathers play a central role in the decision to circumcise their sons

(Chilimampunga et al., 2017; Mavhu et al., 2014). Several studies have associated masculine norms and ICMC decision-making where men's reasons for ICMC acceptance or non-acceptance seemed to emerge because of their perceptions of them dominating the decision-making process and the expectation that women are playing a passive role (Mavhu et al., 2012; Spyrelis et al., 2013; Waters et al., 2013). It is important to explore the role that men and women play in decision-making and understand parents and families' perceptions and experiences regarding ICMC.

Black women's voices in MMC programmes have received limited attention. Despite the extensive literature on MMC decision-making, little scholarly publications specifically addressed Black women's views about ICMC and the consequences for decision-making (Nxumalo & Mchunu, 2019). This trend resulted from MMC programmes prioritising men and defining women to provide support for men and boys in their male circumcision decision-making (Kaufman et al., 2018; Mati et al., 2016).

Current ICMC literature focuses on feasibility and acceptability, ethics, and human rights, documenting programme lessons, achieving MMC targets and creating demand for ICMC. While these aspects are important, the perceptions and experiences of men, parents and Black women are missing. This study is the first in South Africa to investigate the phenomena of ICMC from the perspective and experiences of young men, parents, families, and Black women. The study contributes to an increased understanding of the perceptions and experiences of role players and informs MMC programmes and policies, thus improving access, quality, safety, efficiency, and effectiveness of MMC programmes as outlined in the *South African national guidelines for medical male circumcision* (SA DoH, 2016). The experience and perceptions of Black women, parents, and men have not received adequate attention. To fill the research gap, parents, families, women, and men need an opportunity to tell their stories and make their voices heard, rather than having the views, understandings and considerations held by MMC implementing partners, funders, civil society, and policymakers.

1.3 Aim and objectives

The study investigated ICMC decision-making in South Africa and engaged with the different perspectives and debates around the issues. The following research objectives applied:

1. To assess the value of the exercise of choice in traditional male circumcision, which may influence cultural perceptions of gender and masculinity.

2. To investigate the factors that influence parental decision-making for infant and child male circumcision.
3. To investigate Black women's perceptions of infant and child male circumcision decision-making.
4. To provide a scoping review of the ICMC and MMC decision-making literature that identifies and maps the available literature and identifies the gaps in knowledge to inform policy, practice, and future research.
5. To analyse the background, principles, ambiguities, and implications for MMC and ICMC decision-making of the South African national guidelines for medical male circumcision.

1.4 Theoretical grounding

The research study is underpinned by the Social Constructivism Theory, Ecological Systems Theory, and Social Norms Theory across three independent articles.

1.4.1 Social Constructivism Theory

Article 1 (Chapter 4) employed Social Constructivism as a theoretical framework for understanding a young Black man's (Simon's) experiences of TMC within the context of the Pedi culture in South Africa. Social Constructivism was developed by psychologist Lev Vygotsky (1978). Social Constructivism seeks to expand an understanding of how people co-create and assign meaning to their social world (Creswell, 2013b). The emphasis is on human experience, knowledge construction, and how people interpret their actions and experiences (Harris, 2008). A sociological theory of knowledge examines how individuals construct and apply knowledge in socially mediated contexts. The theory clarifies the multiple and interconnected social and cultural dimensions to TMC as a rite of passage to manhood. Social Constructivism can help understand social systems, how they function and impact traditionally circumcised men. The Social Constructivism Theory supports Simon in expressing this knowledge and experience and interaction with TMC. The theory is instrumental in highlighting how it shaped his male circumcision decision-making based on the cultural meaning of male circumcision, his socially constructed experience of the practice, and the social construction of male circumcision knowledge.

Social Constructivism theories have been applied in public health research to understand social construction and social representation of HIV among men living with HIV related to their experiences, lifestyles, and conceptions of the disease (Aguirre, 2017). A common criticism of the Social Constructivism Theory lies in its focus on previously acquired knowledge, while

neglecting important contextual factors, which include the environmental and technological factors (Ackermann, 2001).

1.4.2 Ecological Systems Theory

Urie Bronfenbrenner's Ecological Systems Theory views child and adolescent development within a complex nexus of reciprocal interactions between individuals who influence their environment (Bronfenbrenner 1977, 1979). According to Bronfenbrenner (1979), individuals' environments have five ecological systems: microsystem, mesosystem, exosystem, macro-system, and chronosystem. These systems are characterised by influence, interconnected-ness, and relationships.

The microsystem, the immediate relationships in the individual's network, is the most powerful and influential of the five systems. According to studies conducted in Zimbabwe and Kenya, parents indicated that their children's grandparents and uncles influenced the circumcision decision-making of infants and children (Mavhu, 2014; Young et al., 2016). The mesosystem consists of systems and organisations in which the individual is directly involved and forms and builds the individual's social environment. Early childhood development organisations offer programmes that are a foundation for early childhood development and parental support in South African communities (Shertiel, 2018). The exosystem is a larger social environment that does not directly affect the individual but is affected by the changes. This can include economic and political systems, policies, and laws. eSwatini identified the importance of political leadership in policy directives that guided the implementation of ICMC programmes (Jarrett et al., 2014). The macrosystem focuses on beliefs and values reflected in the individual's cultural context. Sociocultural beliefs and practices related to privacy, medical mistrust, and lack of male involvement influenced the utilisation of institutional birth delivery services in communities in Ethiopia (Ababor et al., 2019). The chronosystem includes transitions and changes in one's lifespan, consisting of landmark events, physical changes, and major life changes or events. Peñalba (2021) used the Ecological Systems Theory to understand the ecological transitions related to the COVID-19 pandemic for vulnerable populations in the Philippines. In Article 2 (Chapter 5), three ecological system constructs (micro-, meso- and exosystem) were applied to explore how it provides meaning to parents' ICMC decision-making experiences.

1.4.3 Social Norms Theory

Perkins and Berkowitz (1986) developed this theory to study students' alcohol consumption. According to Cislaghi and Heise (2018), social norms are the unwritten, informal rules that

define acceptable, appropriate, and obligatory behaviour in a group or society and set expectations about how others will act and help foster coordination in social situations.

The social norms approach has been used to study health and health-related behaviours. One study among college and university students investigated the role of social norms interventions in reducing excessive alcohol consumption, alcohol misuse, and alcohol-related negative consequences (Foxcroft et al., 2015). Furthermore, McChesney (2015) applied Social Norms Theory (SNT) to change female genital cutting practices in Senegal through participatory, community-led interventions. Every day, ICMC beliefs are socially constructed and culturally enacted in communities. Therefore, SNT was used to help understand Black women's perceptions and social constructions of ICMC that influence their rejection of the practice. By employing the SNT as a theoretical framework, women's perspectives were used to inform the development of a perceptions framework for ICMC decision-making for a population that is generally exclusively Black South African. A common critique of SNT lies in its failure to appreciate the deep complexity of human behaviour because norms are tied to social identities and social interaction that evolve as the social context changes (Thomas et al., 2019).

1.5 Methodology

The following section provides a condensed description of the general methodology employed in this thesis. This section explains the setting, research design, sample and sampling methods, data collection, data analysis and ethics approval. The three respective articles (Chapters 4, 5 and 6) provide detailed information about the methodology because they are independent papers.

1.5.1 Setting

The setting where research occurs is the cultural, physical, and social location in which researchers conduct a study (Cook, 2008). A dominant feature of qualitative research is the context in which a phenomenon is located, constructed, and experienced. Therefore, contextualisation is an important standard by which qualitative research studies are judged (Shenton, 2004). In the townships[2] of South Africa's Gauteng province, 10% of males aged 14–24 years and 22% of males aged 19–29 years were circumcised, with traditional surgeons performing the procedure in 58–65% of the circumcisions (Lagarde et al., 2003; Rain-Taljaard et al., 2004). The overall geographical contexts for all three articles were Diepsloot and

[2] "Townships are defined as areas that were designated under apartheid legislation for exclusive occupation by people classified as blacks, coloreds, and Indians. Townships have a unique and distinct history, which has had a direct impact on the socioeconomic status of these areas and how people perceive and operate within them" (Donaldson, 2014, p. 624).

Diepkloof in the Gauteng province of South Africa. Figures 1.3 and 1.4 provide a map of the study areas, Diepsloot and Diepkloof.

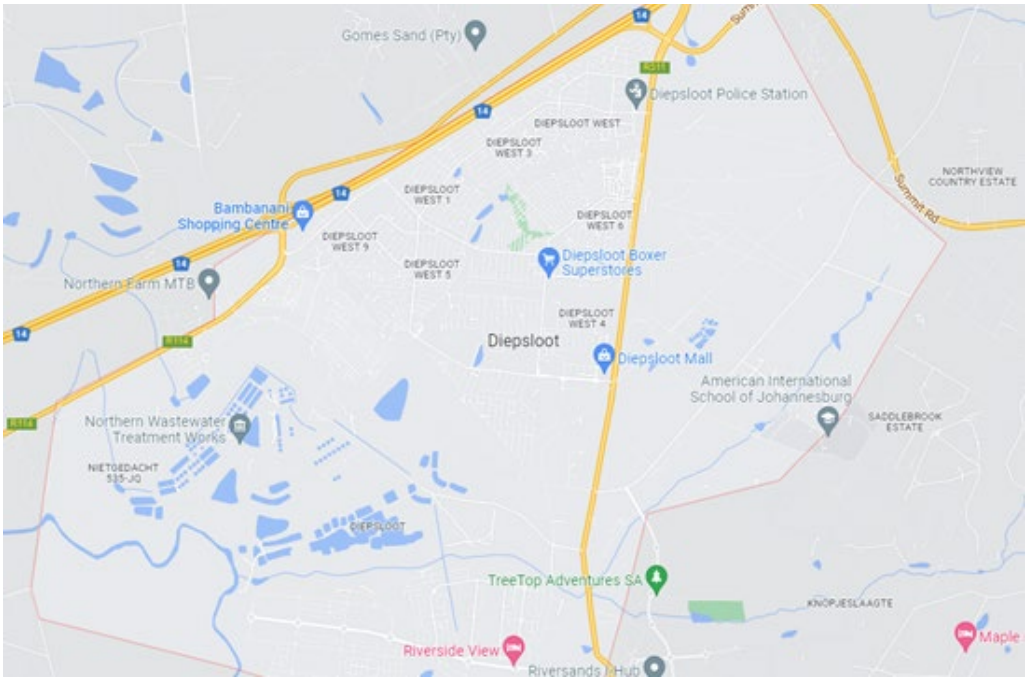

Figure 1.3 Map of Diepsloot (Retrieved from Google Maps)

According to Heller et al. (2021), Diepsloot was established in 1995 by the then Rand provincial administration as a provisional (informal) accommodation for people removed from informal areas in Alexandra, Honeydew and Sevenfontein. Diepsloot is primarily a black African community that is culturally mixed. Most residents are of the Pedi, Tsonga, Shangaan, and Venda ethnic groups, while the residents were also from the Zulu, Tswana, and Xhosa cultures.

Figure 1.4 Map of Diepkloof (Retrieved from Google Maps)

According to Hoosen and Mafukidze (2009), the apartheid government established Diepkloof in 1959 as a relocation settlement to house families who were forcefully removed from Alexandra. Diepkloof's history of youth politics links to South Africa's struggle for freedom. The apartheid government played an instrumental role in ensuring that domestic zones for Black families were of low value with poor services, specifically paralleled to those for White people (Gasennelwe, 2011).

1.5.2 Research design

All three studies employed a qualitative approach because it gives a voice to individuals' lived experiences and give deeper insight into the unique experiences of individuals (Hammarberg et al., 2016). A qualitative research approach recognises the human experience in ordinary locations to understand phenomena related to individuals' meanings (Erickson, 2011). Furthermore, qualitative research allows researchers to learn about participants' innermost experiences and interpret how meanings are formed in and through cultural practices (Corbin & Strauss, 2008). Complementary to a qualitative research approach, Table 1.3 indicates the design for each of the three articles.

Table 1.3 Research design for each article

Article 1 (Chapter 4)	Single case study
Article 2 (Chapter 5)	Exploratory case study
Article 3 (Chapter 6)	Descriptive qualitative study

1.5.3 Description of the sample

Article 1. This single case study tells the story of one participant, Simon, a single 25-year-old Black Pedi man, who lives and studies in Johannesburg, South Africa. His experience originates from the Limpopo province and the TMC cultural practices of the Pedi. The Pedi, a Northern Sotho subgroup, speaks different vernaculars of the Sotho language, one of the eleven approved South African languages. Simon provided descriptions of his opinions, feelings, and emotions related to his changing viewpoint from undergoing TMC to promoting MMC.

Article 2. This exploratory case study analysed factors influencing parental decision-making related to ICMC acceptance and non-acceptance. Parents, grandparents, and uncles of the boys and government officials and members of civil society were the participants for this paper. Parents were recruited through snowball sampling. Purposive sampling was used to identify the grandparents, uncles, government officials, and members of civil society organisations. The government officials were selected based on their public sector MMC programmes. A

total of 48 participants between 18 and 64 years of age participated in in-depth interviews. This included 31 parents, four uncles, five grandparents, four members of civil society and four government officials.

Article 3. This descriptive qualitative study analysed the concerns of Black women to inform ICMC policy and programmes. Black women were selected through purposive and snowball sampling. Twenty-five Black women aged between 21 and 52 years participated in semi-structured interviews.

1.5.4 Data collection

Information leaflets and consent forms were used to gain informed consent from the participants (see the different informed consent documents in Appendices B to E). An interview schedule guided the in-depth interviews (See Appendix F). According to Rodriguez et al. (2003), interview schedules are useful because they are a flexible way to obtain participants' lived experiences. The interview questions were derived from the literature, theoretical constructs, and the objectives of this study. Importantly, open-ended questions allowed participants to provide comprehensive data about their experiences. All interviews were undertaken in English and took approximately 40–60 minutes at participants' homes, while some interviews were conducted telephonically. It was only in the case of Simon (*Article 1*) that multiple interviews lasted for one to two hours and took place over a period of three months. Interviews were audio-recorded with participants' consent, and follow-up telephonic interviews were conducted to address questions that required clarification. Data saturation was achieved when no new information emerged during the interviews.

1.5.5 Data analysis

According to Maree (2007), qualitative data analysis comprises working with data, consolidating them, classifying them into controllable components, combining them, searching for patterns, learning what is significant and coming to reliable inferences about the data. In Articles 1 and 2, data were analysed through thematic analysis, while a framework analysis was applied in Article 3.

In *Article 1*, thematic analysis was applied to analyse the data to offer a comprehensive, rational description of Simon's lived experiences (Riessman, 2008). A two-step coding procedure was implemented. At first, all the transcripts were read to develop a preliminary coding structure. The co-authors examined the initial coding system. The data were coded to capture the meanings of statements, codes were then scrutinised to ascertain relationships and patterns. The themes were then identified to search for similarities and differences,

connecting Simon's personal experiences to the broader social setting and linking the interpretations to the literature.

In *Article 2*, thematic analysis was applied to analyse the data. The lead researcher read the transcribed raw data after each interview. Coding took place in two stages. An initial coding structure was developed after having considered the interview transcriptions. Each interview was coded, and the coding framework comprised the identified codes from the initial reading of the transcripts. Codes were grouped into categories and emerging themes were identified using thematic analysis.

In *Article 3*, the framework analysis helped to analyse the ICMC concerns of Black women. Framework analysis was applied to structure and organise research data to enhance the researcher's identification of noticeable themes (Gale et al., 2013). Framework analysis is a five-step process which includes data familiarisation, coding framework development, coding, charting, and mapping and interpretation. NVivo 12 (QSR International, Melbourne, Australia) was used to ensure transparency and a clear audit trail and to manage the data.

1.5.6 Ethics approval and consent to participate

The Ethics Committee of the Faculty of Health Sciences, University of the Free State, provided ethical clearance (UFS HSD2018) (Appendix A). The study followed all standard ethics procedures of informed consent, voluntary participation, and confidentiality. The National and Gauteng Departments of Health (South Africa) authorised the study (Appendix G).

1.6 Conceptual definitions

In this study, *medical male circumcision (MMC)* is defined by the South African Department of Health (SA DoH, 2016) as the complete removal of the foreskin to prevent HIV. The procedure is targeted toward males between the ages of 15 and 49.

This study uses early childhood male medical circumcision as an all-encompassing term, inclusive of *infant and child male circumcision (ICMC)* and *early infant male circumcision (EIMC)*. This is consistent with the age range of circumcision practices performed worldwide by circumcision practitioners: newborns (less than one month), infants (1 to 11 months) and children (age 1 to 12 years) (UNAIDS, 2010a).

In this study, *traditional male circumcision (TMC)* will mean a practice that takes place at puberty as a rite of passage from boyhood to manhood and plays an important role in the socialisation of boys and men (Ntozini & Abdullahi 2018).

Early infant male circumcision (EIMC) refers to removing the foreskin among infants or children in a facility setting (Amuri et al., 2016), with the long-term objective of reducing the risk of HIV infection.

1.7 Outline of the study

This section provides a brief overview of the flow and logical development of the study. Consistent with the University of the Free State's regulations, the thesis consists of three articles. (At the time of submitting the thesis, two articles were published, and one was submitted for publication.) These articles investigated ICMC decision-making in the context of HIV prevention. This thesis employed a qualitative research approach across the three articles (single, exploratory case study, and descriptive research design). Each article (here presented as a chapter) is a stand-alone study, yet all the articles were linked to the objectives of the overall study. While two of the three papers have already been published, the third article was submitted for publication, retaining the style and requirements of the journal. The thesis is structured with seven chapters, narrowly connected with the study's objectives.

Chapter 2. A scoping review to map the theoretical literature of ICMC and MMC decision-making. Scopus and PubMed and the PRISMA-Scr guidelines were used to review the literature and identify knowledge gaps to inform policy and policy guidelines. The scoping review results demonstrate the narrow application of theoretical frameworks to understand the factors influencing MMC decision-making.

Chapter 3. Document analysis of the South African MMC guidelines. These guidelines served as a technical guiding framework for implementing the MMC programme in South Africa by health care workers and programme managers. This chapter analyses the *South African national guidelines for medical male circumcision's* background, principles, contradictions, and implications for MMC and ICMC decision-making.

Chapter 4. The first article: *Changing cultural practices: A case study of male circumcision in South Africa.* Using a single-case study design, the article investigates the value of the exercise of choice in traditional male circumcision, which may influence cultural perceptions of gender and masculinity. The article has appeared in the *American Journal of Men's Health 14*(4).

Chapter 5. The second article: *Parental decision-making in infant and child male circumcision: A case study in two townships in Gauteng, South Africa*. This article reflects on the complex, multi-layered factors that influence the acceptance and non-acceptance of ICMC among parents. Decisions of acceptance highlight the father's role in the decision-making process

and the supportive role of the social network. Circumcision policies and financial considerations negatively influence decisions on the non-acceptance of ICMC. Understanding ICMC decision-making from an ecological perspective enabled the development of context-specific strategies to guide the demand generation and education for parents and families. The article has been published in the *African Journal of AIDS Research*, *21*(1).

Chapter 6. The third article presents *Analysing Black women's perceptions towards infant and child male circumcision in two South African townships.* This article explores Black women's perceptions of ICMC decision-making. The article directly highlights the negative perceptions about ICMC by understanding women's ICMC beliefs, unique experiences, and complex decision-making processes influenced by prescriptive gendered and social norms. Furthermore, it underscores the need for inclusivity and equitable representation of Black female voices in the MMC discourse to inform policy directions.

Chapter 7. Conclusion. This last chapter identifies the main findings, delineates the study contribution, makes recommendations, and sets an agenda for future ICMC research.

1.8 Limitations

The study had several limitations. The study was conducted in a metropolitan city, using a purposive sample of Black male and female participants living in two townships (Diepsloot and Diepkloof). Another possible limitation was that the interviews were conducted in English, a language which was not a first language for the participants.

Furthermore, the three respective articles (Chapters 4, 5 and 6) will provide detailed information and specifics about the limitations related to each study because they are independent papers.

Chapter 2
Scoping Review of Infant and Child Male Circumcision and Medical Male Circumcision Literature

2.1 Introduction

Male circumcision decision-making is complex. Multiple factors influence the decision to circumcise or not to circumcise. ICMC and medical MMC are commonly used as HIV prevention programmes. Furthermore, various country programmes followed different approaches for developing and implementing policies and programmes to promote male circumcision.

Three randomised control trials on MMC provided evidence that MMC is 60% effective in reducing the transmission of HIV from women to men (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). Consequently, the WHO and UNAIDS (2007a) recommended MMC as an additional strategy to reduce new infections in Africa. Research shows that MMC is one of the most cost-effective HIV prevention interventions (Haacker et al., 2016; Sarkar et al., 2019). However, it requires a medical procedure to which a man or his parents (in the case of ICMC) must give consent. UNAIDS (2017) estimated that the number of new HIV infections could be reduced to 500 000 by 2020, based on the inclusion of MMC. New HIV infections remained relatively flat, with an estimated 1.5 million new HIV infections in 2020 (UNAIDS, 2021). This current number remains three times higher than the target set in 2016. One of the contributing factors for the above reality is that the targets set for MMC were not met. For example, despite governments in Eastern and Southern Africa aiming to circumcise 25 million men in 2016, they only reached 18 million MMCs (UNAIDS, 2021).

Considering the inability to achieve the targets with MMC, ICMC can maintain MMC programmes. ICMC is a longer-term strategy, and the benefits materialise only when the infant becomes sexually active. ICMC has advantages that include being more affordable, faster wound healing, no period of abstinence and the provision of a lifetime of protection (Njeuhmeli et al., 2016). However, ICMC remained highly controversial (Delaet, 2012; Merkel & Putzke, 2013). In 2020, the WHO raised ethical concerns about circumcision for boys younger than 15. This relates to human rights and safety (Svoboda, 2013).

Various African countries have ICMC policies, including eSwatini, Zimbabwe and Kenya (Fitzgerald et al., 2016; Mavhu et al., 2017; Young et al., 2012). One challenge these countries

experience is creating an adequate demand for the ICMC services. Demand creation requires an understanding of how parents decide whether to circumcise or not to circumcise their sons. Numerous studies have been conducted to understand how ICMC decision-making occurs (Chilimampunga et al., 2017; Mavhu et al., 2017; Phili & Karim, 2015). Despite these studies, there are limited theoretical constructs available to understand how parents decide about circumcising their sons and whether men seek circumcision services themselves. This chapter provides a scoping review of the ICMC and MMC decision-making literature. For this study, the scoping review identifies and maps the available literature, profiles the evidence and identifies the gaps in knowledge to inform policy, practice and future research (Munn et al., 2018). In executing this scoping review, a central scoping review question is: What theoretical frameworks have been used to understand ICMC and MMC decision-making?

2.2 Methods and search strategy

This chapter provides a scoping review of the ICMC and MMC decision-making literature. A scoping review was appropriate because it provided a comprehensive search, description, and summary of the ICMC and MMC literature.

The researcher used two online electronic databases: Scopus and PubMed. The review adopted the following guidelines from the Preferred Reporting Items for Scoping Reviews (PRISMA-Scr): PRISMA flow diagrams, search, and screening decisions to identify the studies included in the scoping review (Tricco et al., 2018). There was a deliberate attempt to provide clarity and transparency in selecting articles to ensure a rigorous, comprehensive, evidence-focused scoping review. The review includes literature between 2000 and 2021 because it provided a comprehensive overview of recent literature and debates relevant to ICMC and MMC.

There were various limitations of the scoping review. The literature review included only two databases: Scopus and PubMed. A review of a more extensive set of databases may have identified additional studies. Furthermore, some studies may have used theoretical frameworks to address decision-making but did not specifically identify those theories. The scoping review may be subject to language bias because it only included articles published in English. Despite these limitations, the researcher was confident that the scoping literature review of applying behaviour and behaviour change theories in ICMC and MMC decision-making will be helpful to MMC policies and programmes. The research provides a limited disciplinary (HIV-prevention) perspective of the theories by not identifying emerging or less popular theories. Three reviewers were involved, and discrepancies were resolved through discussion, until consensus was reached.

2.3 Literature review on infant and child male circumcision

2.3.1 Inclusion and exclusion criteria

The following inclusion criteria applies: English language articles on infant circumcision, neonatal circumcision, and child circumcision. The exclusion criteria included articles not written in English because of the unavailability of financial resources to accurately translate the articles, and articles that focused exclusively on adult circumcision. Articles that focused on female genital mutilation or female circumcision; articles that focused on medical aspects or complications associated with the circumcision procedure, including articles about phimosis and pain management; articles that focused on the use of circumcision devices or techniques, as well as letters to the editor, editorials, and commentaries, were excluded.

2.3.2 Summary of infant and child male circumcision articles with identified theories

Full-text articles were retrieved and reviewed by applying the inclusion criteria (see Figure 2.1). There were 3 950 articles from SCOPUS and 2 945 articles from PubMed, thus a total of 6 895 articles. A total of 2 451 were duplicate articles on the two databases. Using the exclusion criteria, 4 358 articles were removed, leaving 86 articles. These 86 articles were then reviewed by reading the full text of each article to identify a theoretical framework. Only three of the 86 articles identified a theoretical framework related to ICMC decision-making. These theoretical frameworks were the *Theory of Planned Behaviour (TPB)*, the *Theory of Reasoned Action (TRA)* and the *Integrated Behavioural Model (IBM)*.

The descriptive PRISMA flow diagram of the relevant ICMC literature review in Figure 2.1 outlines the flow of information through the different phases of an ICMC scoping review. It sets out the number of records identified, included, excluded, and the reasons for the exclusions.

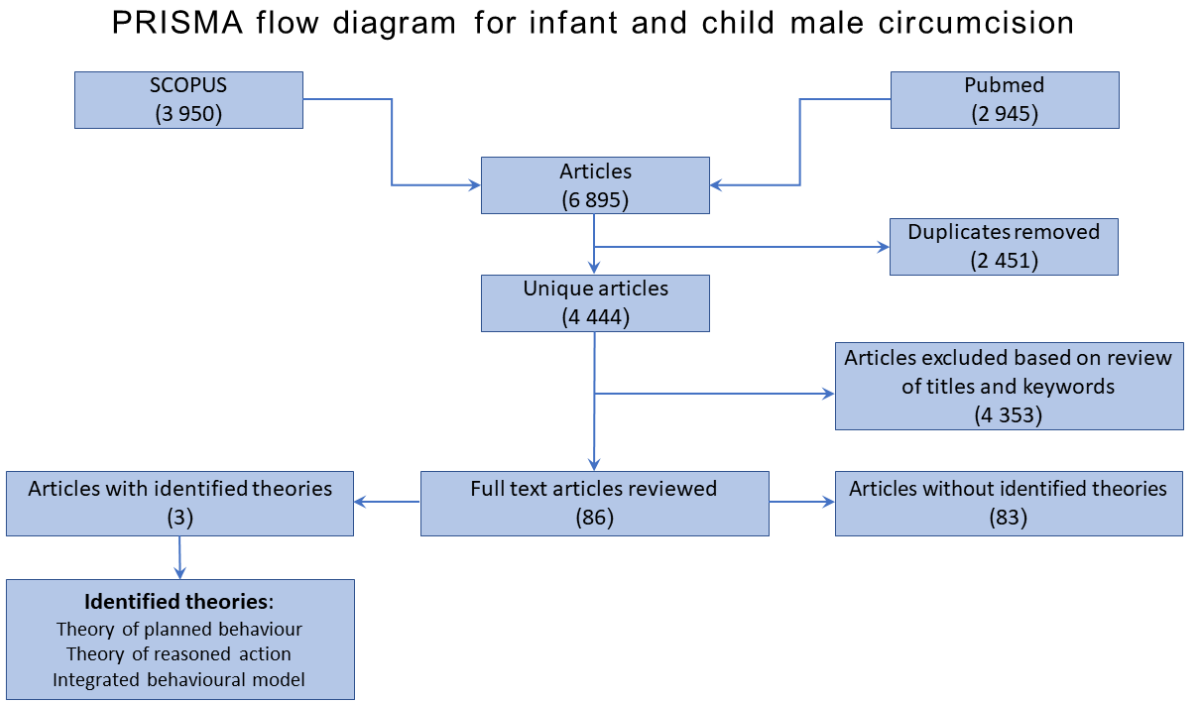

Figure 2.1 PRISMA diagram for infant and child male circumcision (Own construction)

The three ICMC articles that described a theoretical framework are organised chronologically in Table 2.1.

Table 2.1 Chronicle summary of infant and child male circumcision articles

Authors, Title, Journal	Year published	Purpose	Theory	Main decision-making themes
Jarrett, P. et al., Early infant male circumcision for human immunodeficiency virus prevention: Knowledge and attitudes of women attending a rural hospital in Swaziland, Southern Africa. *Journal of Social Aspects of HIV/AIDS.*	2014	To explore the knowledge of and attitudes to early infant male circumcision of women attending a rural hospital in Swaziland, Southern Africa	Theory of planned behaviour	1. Men play a significant role in decision-making. 2. Brings voices of women into the debate. 3. Culture and religion influence acceptance and rejection in decision-making. 4. Information, education and communication materials play an essential role in decision-making.
Keetile, M. & Bowelo, M., Factors associated with acceptability of child circumcision in Botswana – A cross-sectional survey. *BMC Public Health.*	2016	The main aim of this study was to assess factors associated with acceptability of safe male child circumcision in Botswana.	Theory of Reasoned Action	1. Age of the child is important in the decision-making process. 2. HIV positive parents demonstrated more willingness to accept child circumcision. 3. Circumcised men were more willing to accept child circumcision.

Authors, Title, Journal	Year published	Purpose	Theory	Main decision-making themes
Montaño, D. E. et al. Evidence-based identification of key beliefs explaining infant male circumcision motivation among expectant parents in Zimbabwe: Targets for Behavior change messaging. *Journal of AIDS and Behavior.*	2018	To identify the beliefs that best explain Zimbabwean parents' motivation to have their infant sons circumcised	Integrated Behavioural Model	1. Understanding the beliefs of parents for infant and child male circumcision (ICMC) decision-making is important to inform information, education, and communication materials. 2. Perceptions around availability and efficiency in service availability at health facilities influence motivation to accept or reject ICMC. 3. Integration of ICMC into maternal–child health services platforms is a consideration for parents making the circumcision decision.

2.3.3 Summary of infant and child male circumcision articles without identified theories

The articles without theoretical frameworks were analysed based on four indicators: geographical location, methodology, target population and decision-making themes.

2.3.3.1 Geographical location

Among the 83 studies identified in the literature review, 31 studies focused on Africa, 14 on North America, 8 in Europe, 6 in Asia, 2 in Australia/New Zealand, 2 in the Middle East, 2 in the Caribbean, and 18 were unspecified (Figure 2.2). The countries with the largest number of ICMC studies were the United States (13), Turkey (6), Zimbabwe (6), Kenya (5), South Africa (4) and Zambia (4).

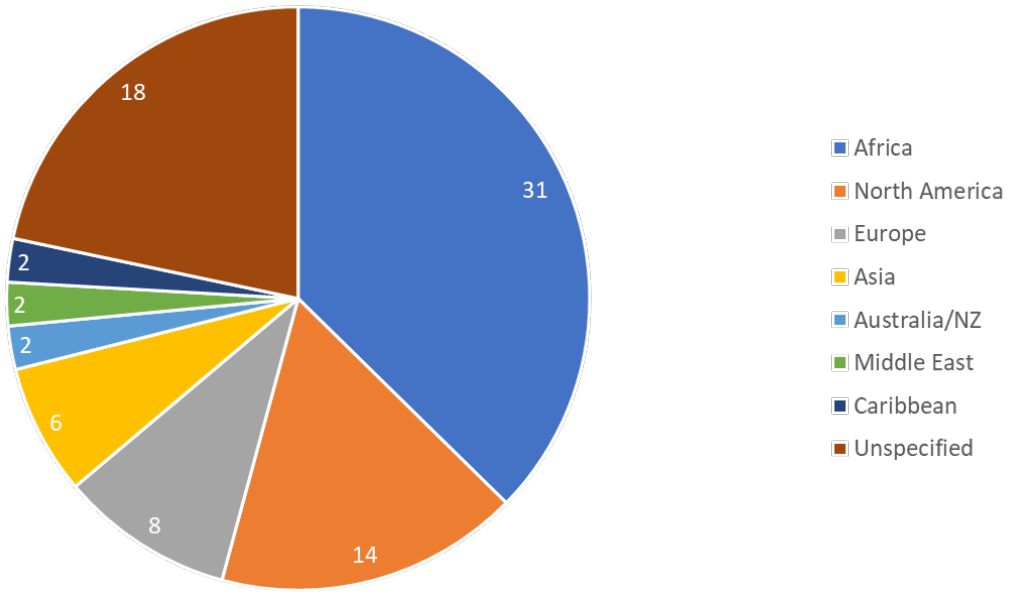

Figure 2.2: Geographical location of infant and child male circumcision studies (Own construction)

Among the 83 studies, the largest proportion were qualitative studies (45), followed by quantitative studies (13), mixed-method studies (10) and unspecified (15) (Figure 2.3).

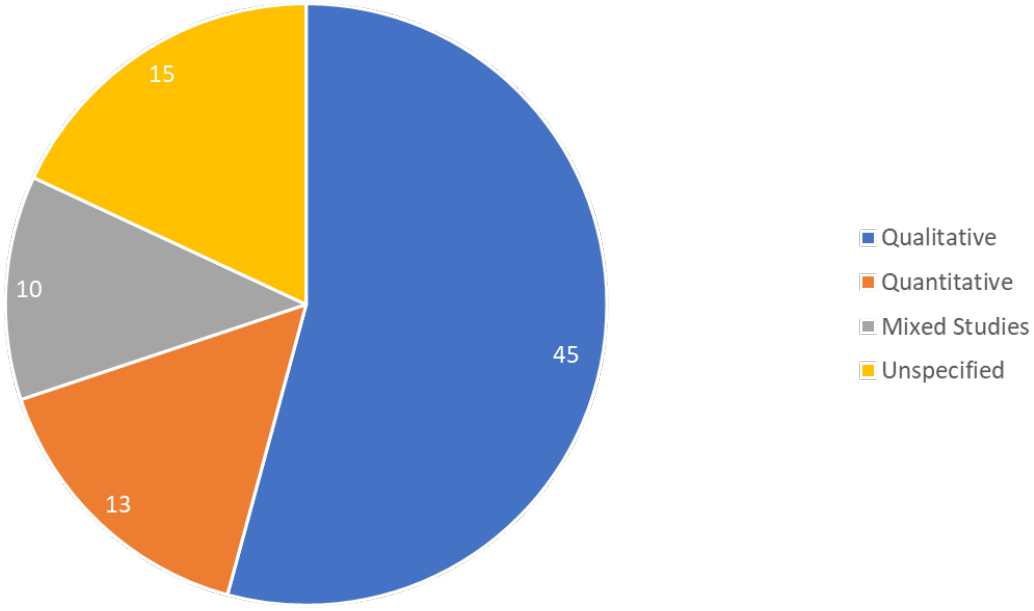

Figure 2.3: Qualitative versus quantitative infant and child male circumcision studies (Own construction)

2.3.3.2 Target population

Some studies targeted multiple populations (e.g., health care providers and parents) concerning the target population. The most common target populations were parents (36 studies), policymakers (22 studies), women (11 studies), health care providers (8 studies), men (6 studies) and “other” (12 studies). The other themes included religious leaders, grandparents, traditional leaders, and unspecified target populations (Figure 2.4).

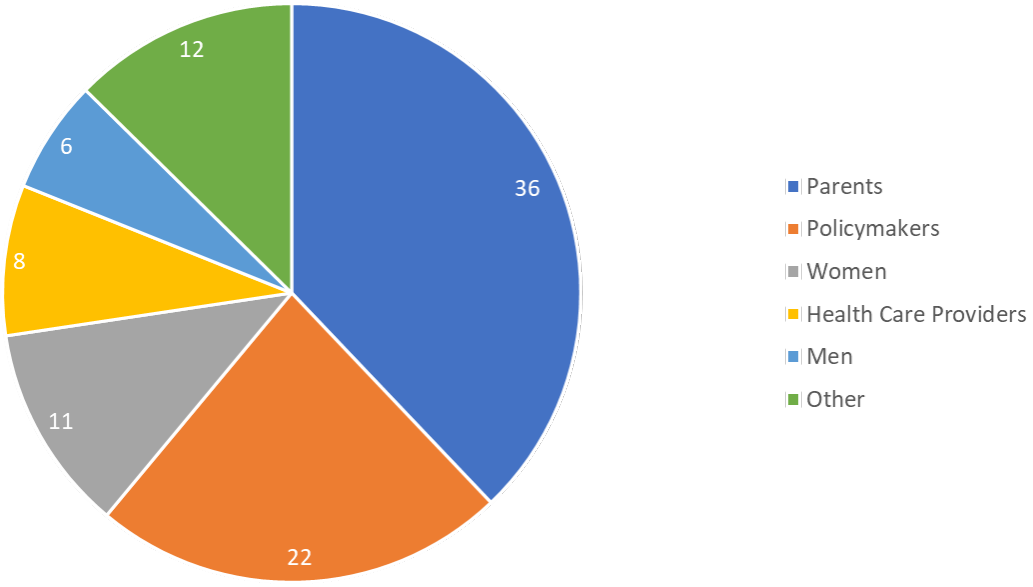

Figure 2.4: Target populations of infant and child male circumcision studies (Own construction)

2.3.3.3 Themes

The most common themes were acceptability (42), decision-making (36), knowledge, attitudes, and practices (33), human rights (18), ethics (18), policy (16) and “other” (23) (Figure 2.5). The “other” themes included circumcision complications, education, women, perceptions and misperceptions, masculinity, sexual, performance and desirability, devices, and demand generation.

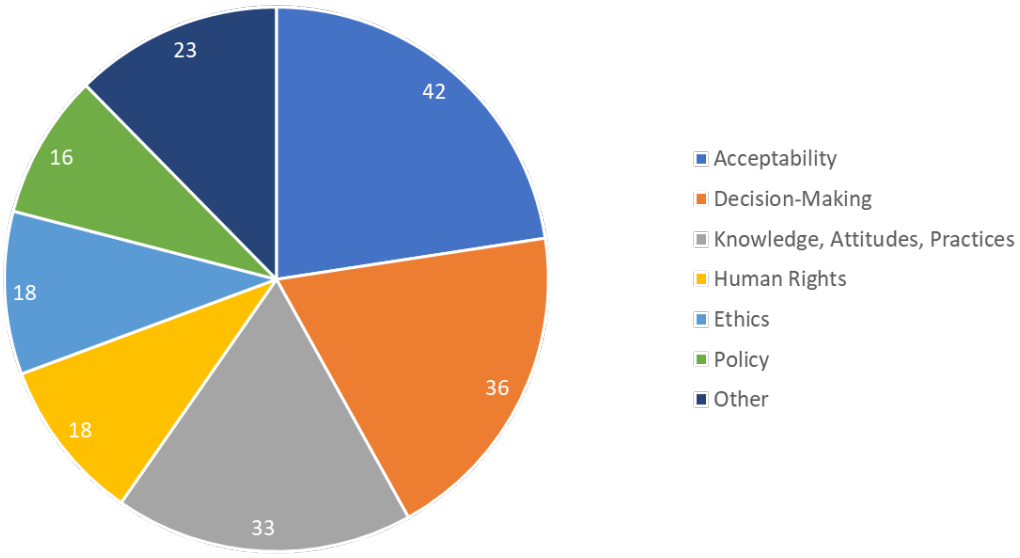

Figure 2.5: Common themes in infant and child male circumcision literature (Own construction)

2.3.4 Discussion of identified theories on infant and child male circumcision

The study also sought to establish which theories were applied to ICMC studies. The findings revealed that theories were only used in a limited number of ICMC studies. Three theories were found: the Theory of Planned Behaviour (TPB), the Theory of Reasoned Action (TRA), and the Integrated Behavioural Model (IBM).

2.3.4.1 Theory of Planned Behaviour

Icek Ajzen developed the TPB in 1985. TPB originates from the TRA (Glanz et al., 2015). TPB emphasises personal motivational factors as determinants of specific behaviour (Montaño & Kasprzyk, 2008). It assumes intentionally ordered activities when linked to decision-making because behaviour is deliberative and planned (Ajzen, 1985). According to Montaño and Kasprzyk (2008), three considerations drive behaviour in the TPB, namely:

- **Behavioural beliefs**. Beliefs about the possible consequences of the intended behaviour.
- **Normative beliefs**. Beliefs about the perceived behaviour expectations of other people.
- **Control beliefs**. Individual beliefs about the presence of factors that may act as barriers or facilitators to the performance of the behaviour.

TPB is well recognised and guided by health-related research across various disciplines. Manyaapelo et al. (2017) used TPB to understand the psychosocial factors influencing

condom use among young men in KwaZulu-Natal, South Africa. The study findings suggested that interventions should consider targeting attitudes and beliefs at the social and individual levels. Jarrett et al. (2014) applied TPB to study attitudes and knowledge of pregnant women attending a rural hospital in eSwatini regarding infant male circumcision. The main decision-making findings in this study were the following: men play a significant role in decision-making; culture and religion influence acceptance or rejection; information, education, and communication resources play important roles in decision-making. TPB can be used to understand how sociocultural beliefs and practices influence ICMC decision-making. Furthermore, TPB constructs help analyse ICMC knowledge and attitudes of parents to inform the design of interventions focusing on the acceptability and adoption of ICMC.

TPB, however, does have limitations. First, TPB does not consider emotions related to anxiety, mood, or past events as part of behavioural intention and motivation of human behaviour (Conner et al., 2013). Second, TPB assumes that behaviour is a static, one-dimensional decision-making process and does not change over time, producing difficulties in understanding future behaviour (McEachan et al., 2011). Finally, Sheeran et al. (2013) highlighted that TPB selectively focuses on logical thinking and excludes the unconscious influences on individual decision-making and behaviour.

2.3.4.2 Theory of Reasoned Action

Fishbein and Ajzen (1975) developed the TRA to explain the behavioural intentions of individuals. TRA suggests that an individual's health behaviour, such as alcohol use, smoking, breastfeeding, and physical exercise, is motivated to change based on attitudes, norms, and control over their behaviour (Jack Jr, 2010). According to Montaño and Kasprzyk (2008), constructs of TRA includes the following:

- **Attitude**. This includes an individual's beliefs that the behaviour will lead to certain outcomes and the individual's value on those outcomes.
- **Subjective norms**. This relates to personal perceptions of social norms and the motivation to conform with the perceived standard.
- **Perceived behavioural control**. This includes beliefs about barriers or facilitators and the perceptions of ease or difficulty to affect behaviour change in the context of the obstacles.
- **Intention**. This is concerned with the likelihood that an individual will carry out behavioural control.

- **Behaviour**. Single, observable action performed by an individual or a category of actions with a specification of target, action, context, and time.

According to TRA, individual behaviour results from a link between attitudes, beliefs, and intentions in behaviour. TRA expounds decision-making practices that underpin human behaviour, assuming that people base their decisions on existing knowledge and willingly take action to perform a behaviour (Ajzen, & Fishbein, 1980; Fishbein & Ajzen, 1975). Keetile and Bowelo (2016) employed TRA to understand the factors that influence parents' decisions to adopt child male circumcision in Botswana. In this study, the following factors were central to parental decision-making: religion, the HIV status of parents and the circumcised status of the fathers.

When employed in the male circumcision context, TRA highlights the individual behavioural factors that influence the acceptance and rejection decisions of ICMC. TRA provides a framework for explaining the factors that influence the beliefs that motivate decision-making to accept or reject ICMC. Therefore, applying TRA constructs can employ resources to target male circumcision messages that influence attitudes, beliefs, subjective norm, and perceived control, resulting in changed behaviour and intention. For example, programmes promoting ICMC acceptability can target attitudes and beliefs of parents, which influence decisions of rejection.

There are several limitations to the use of TRA as a theoretical framework. TRA undervalues the impact of past behaviour. Therefore, the theory has received criticism for not clarifying behaviour change and underestimating the result of habits and past behaviour (Yousafzai et al., 2010). Additionally, the theory excludes demographic, personality and cultural variables that impact health behaviour, intentions, and attitudes and does not explain unreasonable fears and thoughts (Sharma & Kanekar, 2007).

2.3.4.3 Integrated Behavioural Model

The IBM originates from two former theories within social science (Alemayehu et al., 2021): TPB and the TRA (the two theories discussed above). Like TPB and TRA, the model considers intention as the most important determinant of human behaviour.

This theory has five features: instrumental attitude, injunctive norm, descriptive norm, self-efficacy, and perceived control, which indicates if a behaviour can be carried out (Montaño & Kasprzyk, 2015). Fishbein (2000) argued that if individuals plan to act and have the necessary skills and abilities to behave in a certain way, it is likely to enact the behaviour.

Various public health researchers have applied IBM. For example, Alemayehu et al.'s (2021) study utilised this theory to explain individuals' intention to screen and seek early treatment for sexually transmitted infections (STIs). The study found that IBM-based HIV prevention interventions should focus on "at-risk populations" (e.g., sex workers) and the content of information, education and communication materials should impact their self-efficacy to access STI treatment and earlier screening (Alemayehu et al., 2021). Montaño et al. (2018) applied IBM constructs to identify the beliefs that motivate parents to accept infant male circumcision. Notably, parents believed that infant male circumcision provided protection against HIV later in life and the procedure was safe if performed when the child was older.

IBM integrates constructs from other behavioural theories: TPB, TRA, health belief model, and the Social Cognitive Theory. Combining these approaches could add value for studies investigating ICMC belief-based constructs in decision-making. IBM can provide a structure for considering how control, efficacy and normative opinions define the individual model constructs and affect behavioural intention and decision-making in ICMC (Montaño & Kasprzyk, 2015).

Rhodes and De Bruijn et al (2013) criticised IBM because it highlights personal health behaviours and not the connections between behavioural intention and actual behavioural engagement. In addition, Webb and Sheeran (2006) noted that IBM was inadequate when applied to interventions for concomitant behaviour change. IBM integrates findings and constructs from various models and theories. Therefore, a critical analytical approach is required to determine the value addition of the constructs and the interaction between the theories (De Vries et al., 2004).

2.4 Literature review on medical male circumcision

The following subsections outline the scoping review for MMC.

2.4.1 Inclusion and exclusion criteria

The following inclusion criteria applied, MMC or medical male circumcision, VMMC or voluntary medical male circumcision, adult circumcision, and adolescent circumcision. The exclusion criteria included: duplicate articles; articles not published in English; letters to the editors, commentaries, or responses to letters; articles that focused on infant and child circumcision; articles that focused on the medical reasons for circumcision (e.g., phimosis) or medical complications associated with MMC (e.g., bleeding, sepsis); articles that focused on female circumcision or female genital mutilation; articles that assessed circumcision devices (e.g., Shang Ring, PrePex); articles that focused on circumcision techniques (e.g., dorsal slit

method; and articles that focused on traditional male circumcision. These 170 articles were then reviewed by reading the full text of each article to identify a theoretical framework.

2.4.2 Summary of medical male circumcision articles with identified theories

The SCOPUS database produced 4 522 articles and PubMed 1 547 articles for a total of 6 069 articles. A total of 1 461 duplicate articles were removed. A review of the titles and abstracts of these articles excluded another 4 438 articles that were not written in English, were focused on medical aspects of MMC or were letters to the editor, commentaries or focused on female circumcision or female genital mutilation. This left 170 articles remaining. These articles were then reviewed in full text. The full-text review revealed that 167 articles lacked a theoretical framework for assessing decision-making. Only three of the articles included an identified theory.

The descriptive PRISMA flow diagram in Figure 2.6 outlines the flow of information through the different phases of the scoping review. It sets out the number of records identified, included, and excluded and the reasons for exclusions.

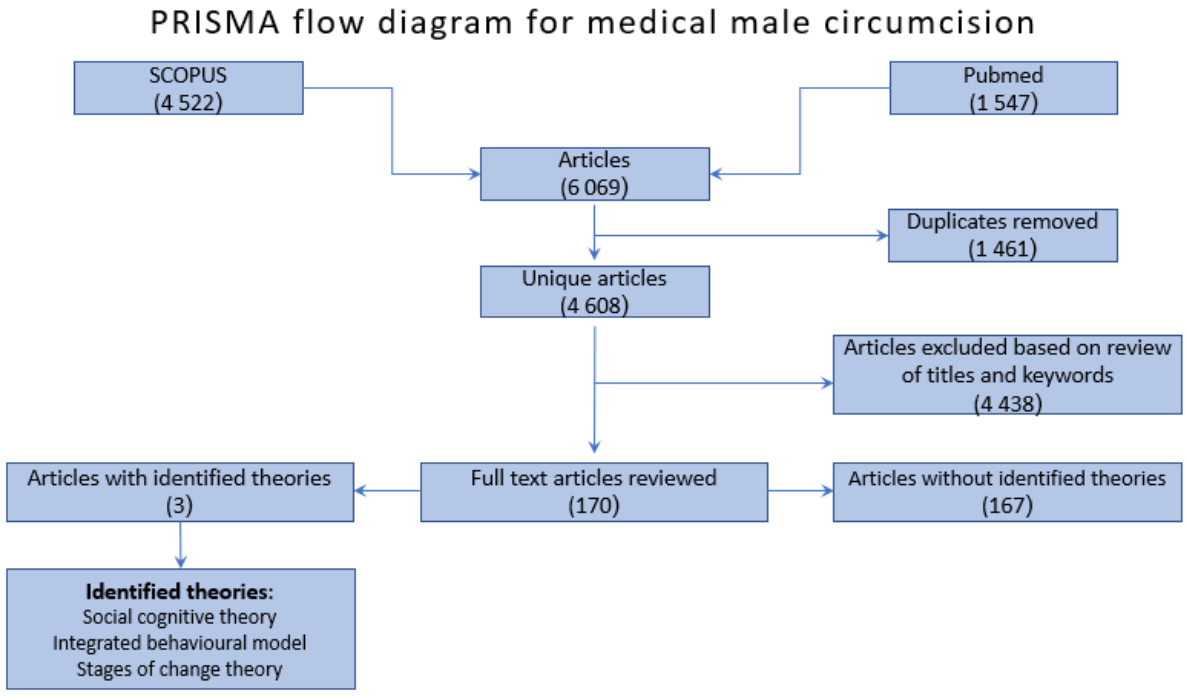

Figure 2.6: PRISMA flow diagram for medical male circumcision (Own construction)

2.4.3 Summary of medical male circumcision articles with identified theories

Three of the 170 articles cited theories. These articles are organised chronologically to determine the scope of the MMC research across time.

Table 2.2 Chronicle summary of male medical circumcision articles

Authors, Tile, Journal	Year published	Purpose	Theory	Main decision-making themes
George, G. et al. Barriers and facilitators to the uptake of voluntary medical male circumcision (VMMC) among adolescent boys in KwaZulu-Natal, South Africa. *Africa Journal of AIDS Research.*	2014	To identify barriers and facilitators to the uptake of VMMC amongst adolescent boys in KwaZulu-Natal.	Social Cognitive Theory	1. At a personal level, the main concern for participants was the decision to undergo HIV counselling and testing before circumcision because of fears of stigma and confidentiality. 2. Social and cultural contexts influence the decision to undergo medical male circumcision. 3. Adolescent boys' decisions to undergo VMMC are influenced by social network (family (brothers) and friends).
Montaño, D. E. et al. Evidence-based identification of key beliefs explaining adult male circumcision motivation in Zimbabwe: Targets for behaviour change messaging. *Journal of AIDS Behavior.*	2014	To investigate the factors affecting male circumcision motivation among men in Zimbabwe.	Integrated Behavioural Model	1. Men with medical male circumcision (MMC) intentions may still require additional communication to prompt them to decide to act. 2. Friends or brothers as sources of influence may facilitate decision-making in men who are motivated to undergo medical male circumcision. 3. Individual beliefs about healing and possible disfigurement influence circumcision decision-making.
Price, J. E. et al. Behavior change pathways to voluntary medical male circumcision: Narrative interviews with circumcision clients in Zambia. *PLoS ONE.*	2014	To understand men's voluntary medical male circumcision-seeking behaviours and experiences to improve communication and interventions to accelerate the uptake in Zambia.	Stages of change	1. The fear of a long healing period delayed acting on the decision for another 21 months. 2. Social pressure influenced participants to decide to get circumcised. 3. Personalising reasons, rationalisations, and (justifications) the advantages of MMC in the decision to get circumcised.

2.4.4 Summary of medical male circumcision articles without theory

The 167 articles without theoretical frameworks were statistically analysed based on four indicators: geographical location, methodology, target population and decision-making themes.

2.4.4.1 Geographical location

A total of 167 MMC studies were analysed. Of this number, 133 were in Africa, 18 in Asia, ten in other regions (North America, Europe, Caribbean) and 6 were unspecified (Figure 2.7). The country with the most studies identified was South Africa with 36 studies. This indicates that most MMC research were generally focused on Africa and South Africa.

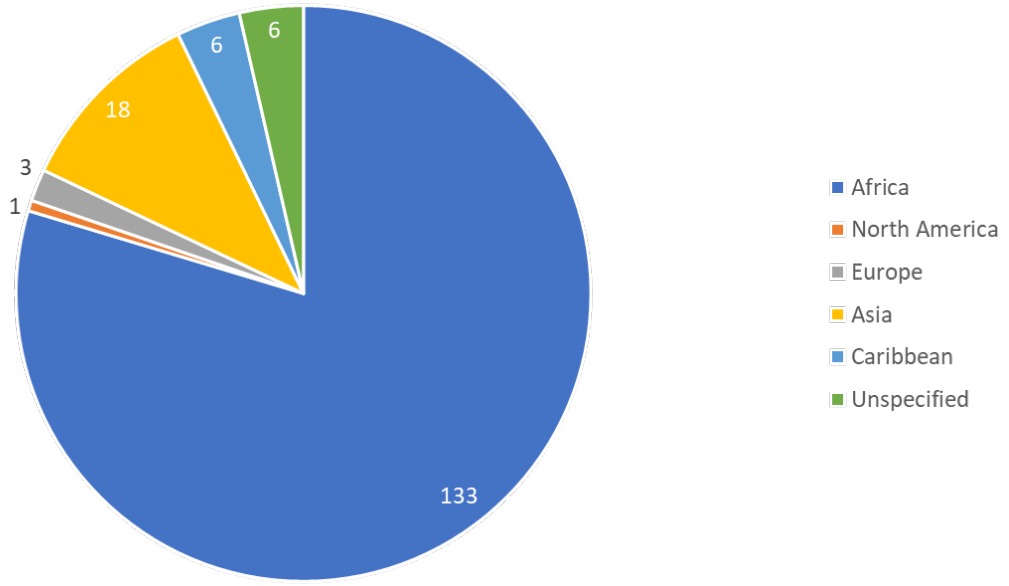

Figure 2.7: Location of medical male circumcision studies(Own construction)

Of all the studies, 62 were qualitative, 56 were quantitative, 29 were mixed methods and 20 were unspecified (Figure 2.8). This reveals that qualitative analyses remain the dominant form of research regarding MMC.

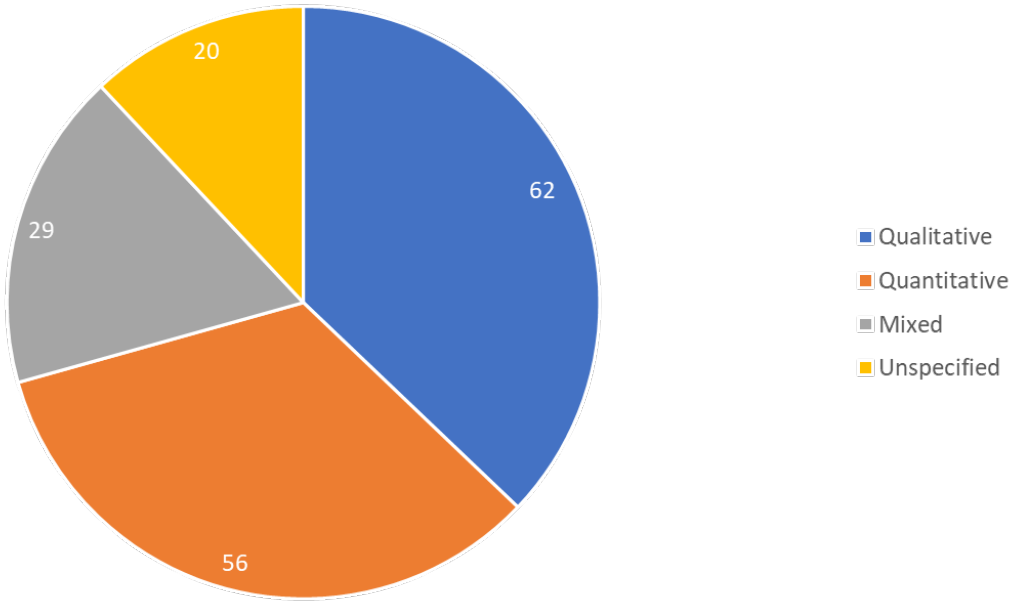

Figure 2.8: Qualitative versus quantitative medical male circumcision studies (Own construction)

2.4.4.2 Target population

The most common target population were men (71), followed by adolescents (36), men and women (35), health care providers (11), women (8) and unspecified (48) (Figure 2.9).[3] This indicates that most research studies focused on men, with very little focus on women in the MMC literature.

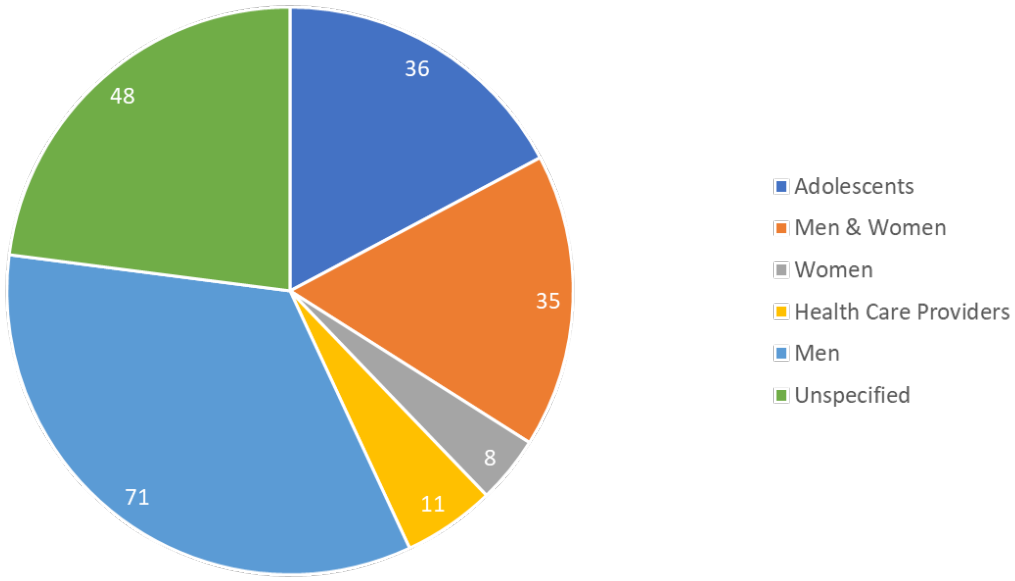

Figure 2.9: Target population of medical male circumcision studies (Own construction)

[3] The studies did not necessarily focus on only one target population.

2.4.4.3 Themes

The most common themes in the MMC literature were knowledge, attitudes and practices (84), education (53), and acceptability (45), followed by decision-making (24), demand generation (18) and "other" (15).[4] The "other" themes included ethics, sexual performance and desirability, masculinity, policy and patient satisfaction (Figure 2.10).

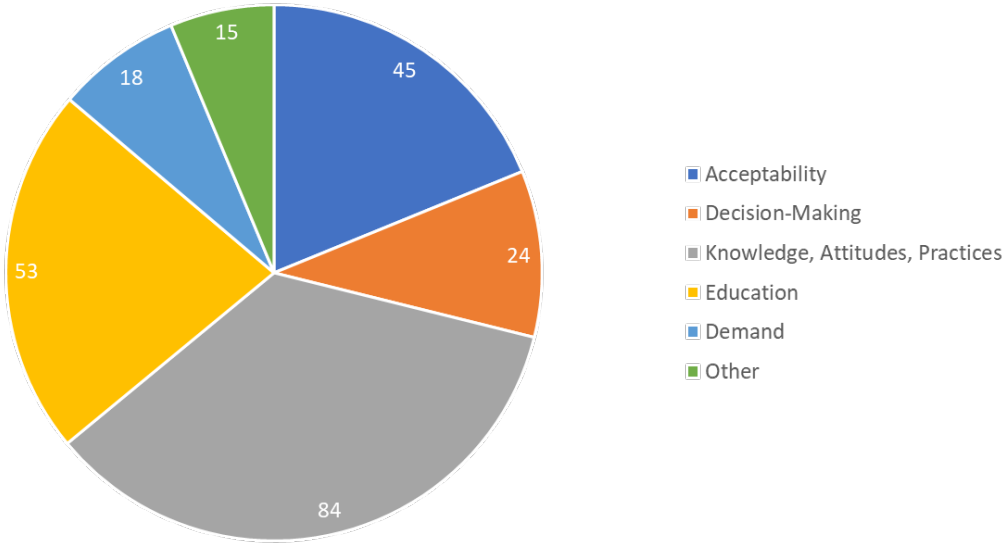

Figure 2.10: Medical male circumcision themes (Own construction)

2.4.5 Discussion of identified medical male circumcision theories

The study sought to establish which theories were applied in MMC studies. The findings demonstrated limited use of theories in MMC studies. Three theories were found namely the Social Cognitive Theory (SCT), the Stages of Change (SoC) theory and the IBM model.

2.4.5.1 Social Cognitive Theory

The SCT, developed by Alfred Bandura, evolved from the Social Learning Theory in the 1960s. The theory emphasises the mutual influence between personal, environmental and behavioural factors in human behaviour (Bandura, 1986). It assumes that individuals and environments interact and influence each other, defining this interaction as reciprocal determinism. A significant element of SCT is observational learning and modelling, which argues that individuals learn through observing and imitating others within the social

[4] Note that the number of themes does not add up to the total number of studies, since some studies had multiple themes.

environment and this, in turn, informs their behaviour (Bandura, 2004). According to Costlow Bornstein (2018), the SCT features five theoretical constructs related to individual behaviour:

- **Modelling**. In the social environment, modelling is defined as individual learning through observation and imitating others.
- **Outcome expectations**. This relates to the feedback that individuals expect to receive from others based on their past behaviour and observed behaviours of others; therefore, shaping decisions about which behaviours to continue and which to discontinue.
- **Self-efficacy**. This involves the individual's control over their behaviour and the ability to perform the behaviour that motivates future behaviour.
- **Goal setting**. Goal setting is the primary element of SCT because goal setting is shaped by self-efficacy and outcome expectations. Through goal setting, individuals set standards for their behavioural outcomes and develop plans for self-regulation.
- **Self-regulation**. This describes individual behaviour change to reach the desired behavioural outcomes. Furthermore, individual agency is demonstrated through self-regulation because it forms the foundation for deliberate action.

SCT has been applied in various disciplines, including human resources, education, psychology, and communication (Erlich & Russ-Eft, 2011; O'Kelley, 2019; Swearer et al., 2014; Zhu et al., 2019). SCT has been utilised within public health to examine anxiety in the context of the coronavirus pandemic and the links between risk awareness and information seeking to improve understanding of the individual, social and behavioural factors that influence vaccination decisions (Graf et al., 2021). Furthermore, in a study related to MMC, George et al. (2014) applied SCT to investigate interpersonal and individual elements that influence MMC acceptance. They found that personal cognitive aspects and social factors facilitated the acceptance of MMC. This included the reduced risk of contracting HIV and enhancing sexual performance and desirability. The study further emphasised the need to focus on the involvement of women in MMC decision-making based on their influence and the role they play in MMC scaling-up activities.

When related to MMC, SCT can assist with defining the impact of personal experiences, others' actions, and environmental elements on individual health behaviour. Therefore, SCT provides the opportunity to use the complex set of relationships between personal, social, and behavioural factors linked to adopting MMC. The constructs in SCT can be used as a framework to map out the predictors of the individual's intention to pursue MMC and develop strategies to support the individual seeking MMC. Additionally, SCT can also explore the social

influences to explain decision-making. Targeting beliefs around these social influences can help develop information, education, and communication materials for communication campaigns for targeted behaviour change.

SCT, however, has limitations. Flamand (2017) argued that SCT focuses on knowledge practices, but ignores the hormonal and biological influences that can affect individual behaviour without or with previous expectations and experience. Furthermore, Alahmad (2020) regarded SCT as unclear and abstract because human behaviour is complex, and the environment is dynamic in which individuals make decisions and execute behaviours.

2.4.5.2 Stages of Change Theory

Prochaska and DiClemente developed the Stages of Change (SoC) theory in the late 1970s through studies examining individuals who quit smoking (Prochaska et al., 1992). SoC is a model of deliberate adjustment that emphasises the individual's decision-making. It works on the supposition that individuals do not change behaviours rapidly and conclusively. Instead, behaviour modification, particularly habitual behaviour, transpires uninterruptedly through recurring practices, for example, in the use of contraceptives or physical activity and dietary habits (Holmen et al., 2016; Lowrey et al., 2019).

The five fundamental stages of SoC (Han et al., 2015) are the following:

- **Precontemplation**. Individuals have no intention to act in the probable future. Individuals have limited or no awareness that their behaviour is challenging or may yield undesirable outcomes.
- **Contemplation**. Individuals intend to start healthy behaviour in the probable future. Individuals become aware that their behaviour may be challenging, and a more considerate and concrete deliberation of the negatives and positives of altering the behaviour occurs.
- **Preparation**. Individuals are prepared to act within the ensuing 30 days. They take minor initiatives toward behaviour modification, believing that action towards changing behaviour may contribute to a healthier life.
- **Action**. Individuals have altered their behaviour and anticipate continuing with a transformation in behaviour.
- **Maintenance**. Individuals ensure that they do not experience a relapse and remain adamant not to return to undesirable behaviours and are further adamant about avoiding a reversion.

This theory has been mostly applied across a broad range of public health concerns, including diabetes management, gender-based violence, mental health, addiction, and weight control, to demonstrate the stages of change in behaviour (Raihan & Cogburn, 2021). Specifically, Kyegombe et al. (2014) applied the SoC in low-income settings of Uganda to reduce gender-based violence through the development of programmes that address gender roles and expectations. Furthermore, Price et al. (2014) applied the SoC constructs to understand men's MMC seeking experiences and behaviour to develop interventions to accelerate the uptake of the service. Their study results highlighted that the main factors influencing the decision to undergo MMC are related to the fear of an extended healing period, social pressure, and personal reasons.

The SoC theory can be applied to male circumcision programmes to understand the stages of change for MMC decision-making. Therefore, the focus of MMC programme interventions on intent, readiness, risk behaviour and perceived risk and its links with decision-making can facilitate MMC uptake. MMC programmes are not meeting the national MMC targets due to the demand on generation challenges. The use of the SoC theory can therefore help MMC programme planners to understand readiness and intention linked to the important individual, social and environmental factors that influence MMC decision-making processes. Theory-driven MMC programmes can use the SoC constructs to develop stage-specific messages for MMC demand generation campaigns and support behaviour change.

However, there are some limits to the SoC theory. For example, there is no strong logic for the desired timeframe for each phase, and the model accepts that people make rational and reasonable strategies in their decision-making practices, when this is not always true (Brug et al., 2005; Raihan & Cogburn, 2021).

2.4.5.3 Integrated Behavioural Model

The IBM is discussed in detail in the ICMC section (2.3.4.3), including the background, application, and theoretical value of applying IBM in an MMC context.

2.5 Theoretical literature review gap

The ICMC and MMC literature is multidisciplinary, complex, and contested. The study identified and described several theories applied in ICMC and MMC research and offered the decision-making themes for each article. In addition, the ICMC and MMC articles with and without theoretical foundations were analysed for their geographical context, methodology, target groups and themes. The results offered a methodological synthesis that contributes to existing knowledge on ICMC and MMC and highlighted the limited availability of theoretically

informed research designs and implementation interventions. This scoping review related to ICMC and MMC research pointed to limitations in applying theoretical frameworks.

The theoretical literature review demonstrated how ICMC research does not consider theory in assessing decision-making. The analysis highlighted the gap in the theoretical literature due to the minimal, limited application of theoretical considerations for understanding ICMC and MMC decision-making. This thesis may contribute to the glaring gap about the lack of a theoretical approach in MMC decision-making research. This thesis uniquely conceptualised and applied three theories to the ICMC decision-making literature and HIV prevention from a South African perspective. More specifically, the researcher used the following three theories in each of the papers in this thesis: Social Constructivism, Ecological Systems Theory, and Social Norms Theory. These theories provided the structure for the study, guided the analysis, and provided overall support for the study because the theory is the foundation of knowledge construction (Grant & Osanloo, 2014). Approaches to the MMC demand generation could include using behavioural segmentation approaches to categorise and target potential MMC clients. This involves constructing segments based on factors influencing decision-making, which are linked to shared attitudes, perceptions, emotions, values, behaviours, and beliefs related to MMC (Mavhu et al., 2021). Articles in the study make a definitive contribution to theory and practice by providing accounts of phenomena not previously reported in the ICMC literature. This could open future possibilities for researchers to develop theories about ICMC decision-making.

2.6 Conclusion

This scoping review shed light on the spectrum of theories applied in the ICMC and MMC decision-making literature. It highlighted the limited application of theoretical frameworks in the ICMC and MMC research literature. This scoping review contributed to the body of ICMC and MMC theoretical literature. The analytical findings may guide policymakers and programme planners in developing ICMC and MMC programmes with a strong commitment to including theories as an indispensable component for MMC programmes. The findings showed a small group of behavioural theories used in this area of ICMC and MMC with reflections on the history, theoretical constructs, limitations, and theoretical value from their use.

The articles that follow in Chapters 3, 4 and 5, each has a specific theoretical framing. The final conclusion shall reflect on the value of the theoretical constructs used in the thesis.

Chapter 3
Document Analysis:
South African National Guidelines for Medical Male Circumcision

3.1 Introduction

The government of South Africa adopted MMC as an HIV/AIDS prevention strategy in 2009. The implementation of the MMC programme started in 2010. MMC became part of South Africa's response to HIV/AIDS following randomised control trials that found male circumcision results in a 60% reduction in HIV transmission from women to men (Siegfried et al., 2009; WHO & UNAIDS, 2007).

Despite accepting MMC as an HIV prevention strategy in 2010, South Africa only developed guidelines for MMC services in 2016. The *South African national guidelines for medical male circumcision* (SA DoH, 2016) provide the rationale for the MMC programme and offers information on the circumcision procedure, the care and management of the procedure, informed consent, human rights, confidentiality, and the use of circumcision devices. In addition, the guidelines target service providers in the public, civil society, and private sectors who provide MMC and ICMC services.

The *Manual for male circumcision under local anaesthesia* (WHO, UNAIDS & Jhpiego, 2009) guided the development of the South African national guidelines. The WHO and UNAIDS (2007a) strongly encouraged the voluntary circumcision of men, young boys, and infants. They concluded that "countries with hyperendemic and generalised HIV epidemics and low prevalence of male circumcision should consider scaling up access to male circumcision services in a safe, culturally acceptable and sustainable manner" (WHO & UNAIDS, 2007:9). In 2008, the WHO and UNAIDS first published the global MMC guidelines and provided operational direction to countries (UNAIDS, 2008; WHO, 2008). Furthermore, the WHO and UNAIDS (2008) guidelines recognised the right of the parents to provide consent and make informed decisions for their minor sons. Additionally, these guidelines emphasised the circumcision of infants and children before becoming sexually active. The WHO and UNAIDS (2011, 2016) established the MMC frameworks for Eastern and Southern Africa, respectively. In both frameworks, ICMC services were

recommended, parallel with adult and adolescent male circumcision programmes, as part of a long-term strategy to sustain MMC programmes.

Figure 3.1 shows the influences that directed the development of the guidelines.

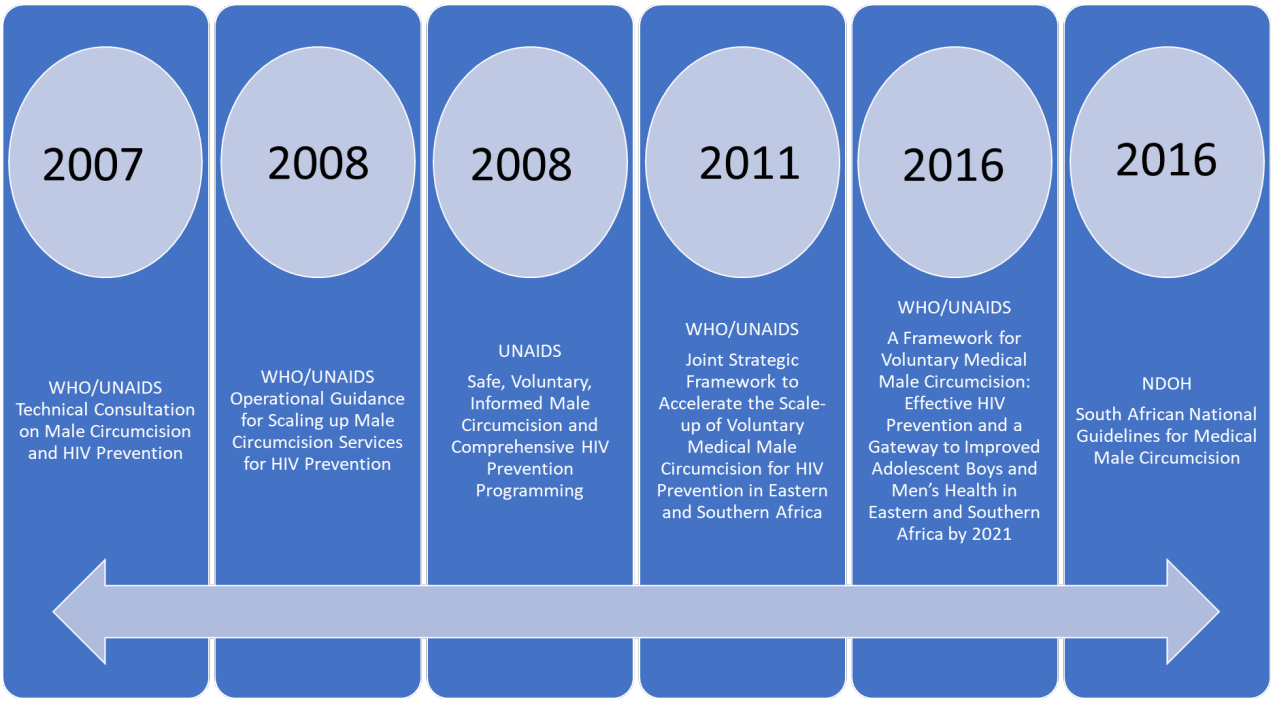

Figure 3.1 Influences that directed the development of the guidelines (Own construction)

3.2 Structure and content of the South African national guidelines for medical male circumcision

The *South African national guidelines for medical male circumcision* was published by the SA DoH in 2016, to direct the country's MMC programme. The guidelines have ten chapters, as outlined in Table 3.1.

Table 3.1 South African national guidelines for medical male circumcision

Chapter 1	Background to medical male circumcision in South Africa
Chapter 2	Target population, benefits, and risks
Chapter 3	Linking male circumcision to other male sexual and reproductive health services
Chapter 4	Education, counselling, and informed consent
Chapter 5	Facilities and supplies, screening of patients and preparation for surgery
Chapter 6	Surgical procedures for adults and adolescents
Chapter 7	Circumcision of infants and children

Chapter 8	Post-operative care and management of complications
Chapter 9	Prevention of infection
Chapter 10	Managing a circumcision service

Furthermore, the guidelines specifically identified the following age groups for MMC and ICMC services:

- Males 18 years and older (men).
- Males between 16 and 18 years old (adolescents).
- Males younger than 16 (young adolescents and boys).

Among these three age groups, the guidelines prioritise adult men because of the immediate HIV prevention benefits and their ability to consent. Next on the priority list are adolescents who offer long-term HIV prevention benefits (Kripke et al., 2017). The SA DoH (2016) recommends that young adolescents and boys should be able to receive services but cautions when considering circumcision for children aged 10–14 years because of the increased risk of injury. For boys younger than 16 years, the guidelines recognise the parent or guardian's role in providing consent. It states that "[b]boys younger than 16 years require a written informed consent of parents or legal guardian to undergo circumcision. The parent must also be present on the day of the circumcision" (SA DoH, 2016:51). Furthermore, the guidelines recognise TMC as a cultural rite of passage that marks a transition from boyhood to manhood (SA DoH, 2016).

3.3 Methodology

The guidelines serve as a technical guiding framework for health care workers and programme managers for implementing the MMC programme in South Africa. The document analysis helps in understanding policy content, how information and ideas are presented formally, and how issues are framed (Dalglish et al., 2020). This chapter analyses the background, principles, ambiguities, and implications for MMC and ICMC decision-making of the *South African national guidelines for medical male circumcision* (SA DoH, 2016).

3.4 Principles of the South African national guidelines for medical male circumcision

Context-specific guiding principles support the overall policy objectives of the guidelines by expressing the values and intentions for the MMC programme. The following guiding principles

underpin the guidelines: quality and safety, informed consent, human rights principles, privacy and confidentiality.

3.4.1 Quality and safety

The quality and safety guidance includes a hygienic environment, trained professionals, adequate post-operative care, and the use of sterile equipment linked to a referral system for complications (UNAIDS, 2008). Various qualitative studies found that the safety of the procedure plays a significant role in the decision-making process for patients because of the risks associated with the procedure (Kebaabetswe et al., 2003; Lagarde et al., 2003; Scott et al., 2005). Furthermore, the guidelines are committed to providing MMC and ICMC services of a high standard and adopt a continuous quality improvement strategy for the provision of circumcision services. To guide the standards of quality of the MMC services, the guidelines consider quality dimensions such as accessibility, acceptability, continuity of services, interpersonal relations, efficiency, and effectiveness, as well as choice and safety to direct the delivery of quality and equitable MMC and ICMC services.

3.4.2 Informed consent

The guidelines emphasise voluntary and informed consent and the application of basic human rights. Adolescents, adult men, and parents should not be forced or coerced into accepting MMC or ICMC procedures. This means that the guidelines uphold the right to bodily integrity, dignity, and personal autonomy as fundamental human rights. The guidelines emphasise that all circumcision clients (and parents, in the case of a minor) must give informed consent. Consent covers the right to information about risks and benefits, and the right to choose whether or not to be circumcised (SA DoH, 2016).

3.4.3 Confidentiality

The focus of the guidelines is the provision of confidential MMC and ICMC services. The principle of confidentiality is important because of the sensitive nature of HIV services, including HIV testing before circumcision for adult males. This means that discussions between the male circumcision provider and the individual are confidential, and that no disclosure will occur without consent. The guidelines particularly emphasise the unique needs of adolescents, noting that health workers need to ensure that the confidentiality of adolescent boys is respected (SA DoH, 2016). In a male circumcision study among men from KwaZulu-Natal, South Africa, Humphries et al. (2015)

highlighted that men typically regard confidentiality as a strong requirement in their decision to undergo MMC.

3.4.4 Human rights principles

In line with the WHO (2020), the guidelines protect and respect the human rights of men. These human rights encompass the right to bodily integrity, the right to future autonomy, and the right to make their own circumcision decisions (Hammond & Carmack, 2017). The WHO (2020) emphasised the need for MMC programmes guided by a human rights approach and consider the relevant laws, policies, and regulations in developing policies.

3.4.5 Accessible services

The guidelines emphasise that male circumcision services will be accessible to increase demand and uptake. This includes ensuring that HIV prevention, reproductive health and male circumcision services reach the youth. Makoni et al. (2020) analysed why adolescents did not access adolescent sexual and reproductive health services. They proposed the strengthening of referrals between MMC clinics and adolescent sexual and reproductive health services. Accessibility to MMC services can be improved through mobile services, campaigns and the use of geographic information systems (Atkins et al., 2020).

3.5 Ambiguities of the South African National Guidelines for Medical Male Circumcision

This section highlights the ambiguities in the guidelines, namely consent, religious and cultural and cultural exemptions, and the interests of the child.

3.5.1 Consent

The guidelines require written, informed consent for males over 18. The guidelines state that “[a]ll clients over the age of 18 years must complete a written informed consent form before undergoing male circumcision” (SA DoH, 2016:166). However, consent procedures are unclear for adolescents (under 18 years). Additionally, the guidelines state that “[i]f the client is a minor and he appears unsure of undergoing the procedure, advise him to think about it for a few days, even if his parents insists [sic] that he has the procedure now” (SA DoH, 2016:50). For example, it is unclear how a 10-year-old boy could express his uncertainty given that the decision to perform the procedure has already been made by the parent. The guidelines place responsibility on the

parents for providing consent, stating that "[t]he parent or legal guardian should make the decision in the best interests of the child and the boy must receive proper counselling" (SA DoH, 2016:51). The application of parental consent and the interpretation of guidelines remain unclear and a policy concern. The guidelines indicate that boys younger than 16 require written, informed consent from parents or legal guardians to undergo circumcision (SA DoH, 2016). However, the document also indicates that for boys under 16, circumcision may only occur for religious or medical reasons.

For ICMC, consent is even more complex. The guidelines recognise that parents can provide that consent. Moreover, the guidelines do not offer the option of delaying the circumcision so that the child can give full, informed consent when he is old enough. The implication could be viewed as an infringement on the child's decision-making autonomy and his right to bodily integrity. This contradicts the guiding principle of respecting the human rights of boys. Svoboda (2013) contended that parental consent for ICMC is without foundation because it denies the child the right to give full, informed consent for the procedure.

3.5.2 Religious and cultural exemptions

The extent to which religious or cultural exemptions permit circumcision presents a challenge. The Children's Act 38 of 2005 allows circumcision for boys older than 16 with the child's consent and adequate counselling. It states that boys under the age of 16 can only receive circumcision services if they have a religious exemption or if the circumcision is performed for medical purposes. However, it does not contain an exemption for cultural purposes. Furthermore, the Children's Act does not define what medical reasons are or what constitutes religious purposes, for example, the extent to which cultural practices are, or are not, included under religious practices is not clear (Strode et al., 2016).

The guidelines allow circumcision for boys aged 16–17 for social or cultural reasons, provided the provision of written consent of the boy and the parent or guardian. Therefore, the guidelines include cultural exemptions for boys over 16 years. This guideline contradicts the Children's Act of 2005, which does not provide for cultural exemptions. Furthermore, TMC on boys under 16 years occurs in various cultures in South Africa, including Venda, Tsonga, Pedi, Xhosa, and Sesotho. According to Douglas et al. (2018), in several indigenous communities in South Africa, TMC for boys between 12 and 18 years provides a rite of passage from boyhood to manhood. A study by Nomngcoyiya and Kang'ethe in 2019 analysed the shortcomings of the Eastern Cape Health Standards in the Traditional Circumcision Act of 2001 and highlighted that TMC often takes

place without parental consent and medical screening. This is in contrast to the guidelines, which require consent from the parents for boys over 16. The reality is that TMC could be performed on boys under 16 without the parents' consent.

3.5.3 Interests of the child

In the case of ICMC, the guidelines state that the procedure must be in the child's best interests. Yet, definitions of what those interests constitute are not explicit in the guidelines. The guidelines say that "[t]he parent or legal guardian should make the decision in the best interests of the child and the boy must receive proper counselling" (SA DoH, 2016:51). Moreover, what constitutes "proper counselling" and the "best interest of the child" is not clarified or defined in the guidelines, therefore leaving it open for interpretation.

Undefined terms are open to constrained and unreasonable translations, which could affect decision-making regarding circumcision. Providing definitions may assist in establishing the meanings of main terms in the guidelines. Children's interests comprise their economic, physical, intellectual, emotional, moral, religious, cultural, social and spiritual welfare (Nevondwe et al., 2016).

3.6 Implications for infant and child male circumcision and medical male circumcision decision-making

3.6.1 Parental or guardianship consent

Pertinent questions about who signifies the "parent" or "guardian" have implications for decision-making related to the circumcision of infants and children. In most instances, health care staff handling the paperwork may not be fully aware of the authenticity of the documentation required to provide consent. It may be challenging for health care workers to determine whether the accompanying adult is the parent or guardian. Furthermore, should they ask for supporting documents, probe further, or accept consent documents at face value? This could imply that consent could be open to interpretation by the health care professional. Conversely, any request for documents to verify parental or guardian status may fuel mistrust and result in barriers to accessing male circumcision services. Therefore, health care staff must have the capacity to manage consent, understand scenarios for consent, and tactfully probe parents when requesting the relevant documents and information they require.

3.6.2 Religious and cultural exemption

The guidelines are vague regarding the religious and cultural exemption for performing circumcisions. The guidelines do not define religious and cultural exceptions. However, it remains a sensitive concept. Given that the current definition is absent, this could lead to inconsistent interpretations and decisions by programme planners. Therefore, underscoring the need for clear definitions may avoid different interpretations of the language used in the guideline document. A clear definition will allow for ICMC decision-making and consistent application by health professionals and clients. Male circumcision applies various cultural and religious considerations in the decision-making process, and therefore, the decision to pursue it is open to interpretation (Svoboda, 2013). Additionally, community members may also perceive the guidelines to be side-lining their cultural and religious practices and beliefs based on the inconsistent interpretations and the absence of clear definitions.

3.6.3 Recognition of sociocultural factors

The social context can impact how clients seek and access circumcision services. Sociocultural factors, which include traditional customs, social beliefs towards post-operative care and abstinence during the healing period, influence the circumcision decision-making process. Powerful cultural and religious beliefs play a significant role in ICMC decision-making (Jarrett et al., 2014). The guidelines acknowledge that religious, traditional and health reasons could allow for male circumcision. However, the guidelines do not capture broader sociocultural influences, which play a significant role in male circumcision decision-making. Khumalo-Sakutukwa et al. (2011) underscored the importance of understanding and addressing sociocultural barriers that influence MMC decision-making. In a Malawian study, Chilimampunga et al. (2017) found that cultural and traditional concerns are major barriers to the uptake of circumcision services. Spyrelis et al. (2013) contended that communities in their study conducted in South Africa did not approve or accept ICMC due to TMC practices and perceptions about pain and adverse events.

3.6.4 The age of circumcision and consent

Programme planners need to consider that the age of circumcision varies depending on the country and the sociocultural and religious background of the community. This will have a pronounced effect on decision-making. Therefore, MMC and ICMC demand-creation messages need to be specifically tailored for different ages, amplifying the need for circumcision age clarification and consent as it will impact a client's decision-making process. A Zimbabwean study

by Hatzold et al. (2014) concluded that age and context influence MMC myths and misconceptions about male circumcision; therefore, demand generation messages should be informed by the context and age-specific understandings.

3.7 Summary

This chapter presented the *South African national guidelines on medical male circumcision*. The guidelines could benefit from incorporating a set of common definitions to assist with interpretation and understanding to avoid debates and controversy among programme planners, parents, and boys. The guidelines were made available in 2016 and recommendations regarding MMC are evolving as new research and information become available. Consequently, the DoH should ensure effective policy management by reviewing and updating the guidelines. This will ensure that the guidance provided represents the most recent and updated, accurate information to avoid inconsistent practices, risks, and litigation in the management of the MMC programme. Furthermore, incorporating insights from health care providers into the strategic decisions related to MMC and ICMC programming in South Africa, is important because attitudes and perceptions influence the interpretations. In high HIV prevalence settings such as South Africa, ICMC and MMC programmes should incorporate decision-making considerations as multiple factors at individual, social network, community, and broader society level may influence the male circumcision decision-making process. Male circumcision programmes have both an opportunity and an obligation to assist adolescents, adult men, and parents in making informed male circumcision choices with due consideration of the principles of safety and quality, informed consent, confidentiality, human rights and privacy and confidentiality.

Chapter 4
Changing Cultural Practices:
A Case Study of Male Circumcision in South Africa

Article 1

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Changing Cultural Practices: A Case Study of Male Circumcision in South Africa

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Abstract

This paper presents a case study of Simon, a 25-year-old Black South African male. According to his Pedi customs, Simon underwent traditional male circumcision (TMC) as a 12-year-old adolescent. He tells of his fears relative to this experience and how, over time, he transitioned from a belief in TMC to a strong preference for medical male circumcision (MMC). Using a single-case study design, the aim of the research was to explore the value of the exercise of choice in TMC, which may influence cultural perceptions of gender and masculinity. The study unpacks the way in which the meaning and experience of TMC is shaped by the social and cultural contexts of South Africa. This qualitative exploration complements conventional medical accounts of circumcision, which are often focused on the medical procedure while ignoring cultural and social factors. Issues of gender, particularly the construction of hegemonic masculinity and how it positions men, women and young boys in relation to each other and their communities, are discussed. Simon's case study provides new insights and perspectives on personally and culturally sensitive issues which are not easily accessed nor commonly understood. Data collected via in-depth interviews were transcribed and analyzed thematically. Analysis applied information from the literature and key concepts from the theoretical standpoint of Social Constructivism. Case study analysis allowed space for unexpected, emergent themes to arise from the data. Four main themes were identified, notably language, silence, patriarchy, and masculinity.

Keywords: traditional male circumcision, medical male circumcision, gender, masculinity

4.1 Introduction

The South African Department of Health introduced medical male circumcision (MMC) as part of the national HIV prevention strategy (SA DoH, 2016). While the rollout of MMC for HIV prevention has been scaled up in South Africa, traditional male circumcision (TMC) remains widely practiced. Statistics South Africa (2019) estimated that the HIV prevalence between the ages of 15 and 49 years is approximately 13.5%. MMC reduces men's risk of HIV acquisition by approximately 60% and it has the potential to reduce the national HIV-prevalence rate (Auvert et al., 2005). In view of this, the South African Government has actively engaged in the scale-up of MMC to prevent new HIV infections.

In South Africa, men can opt for one of two types of circumcision: TMC performed in initiation schools by traditional circumcision practitioners, or MMC at private or public health facilities. At present, only MMC is integrated into the South African National Strategic Plan for HIV, TB and STIs 2017–2022, forming part of the HIV prevention package of services offered at the public health facility level. MMC and TMC involve the removal (and sometimes the partial removal in TMC) of the foreskin. Circumcision is practiced in many cultures around the world for ritual, religious, and medical purposes (including HIV prevention). Other purposes for TMC include the preparation of boys for warfare and for improving masculine virility (Siweya et al., 2018).

In South Africa, 57% of males between the ages of 15 and 49 years are circumcised, with wide variation in numbers across the nine provinces. Of all males in South Africa, 30% were circumcised by a health worker or medical professional, while 27% were circumcised by a traditional practitioner (Statistics South Africa, 2019). Among the Black African population group, Peltzer et al. (2014, p. 127) reported "the prevalence of male circumcision to be 48.2%, of which 32.1% were traditionally circumcised and 13.4% were medically circumcised". Setswe et al. (2015) identified a similar proportion of Black African men undergoing circumcision.

Geographical variations and differences such as culture, language and religion play a significant role in the practice (Moses et al., 1998). A study conducted by the Human Sciences Research Council revealed that circumcision is common among ethnic groups such the Venda (90.2%), Pedi (71.2%) and Xhosa (64.3%) (Connolly et al., 2008).

TMC is an integral part of the belief system of various ethnic and cultural groups in South Africa—such as the Pedi, which forms part of the Northern Sotho culture—and is performed in a non-clinical setting by a traditional circumcision practitioner with no formal medical training

(Bottoman et al., 2009). Among the Pedi ethnic group, TMC is considered the pride of the nation, meaning that the Pedi's grew up with this cultural practice and it must remain part of their lives (Setswe et al., 2015). TMC is seen as a rite of passage to manhood and plays an important role in the socialization of boys and men. Initiation involves an informal learning process during which older men transfer the knowledge and skills that they deem necessary for being an adult male in their society. These teachings can include information about the cultural group and its rituals, relationships, adult roles, and responsibilities, and respecting your parents. In Black South African communities that practice TMC, information about the custom is jealously guarded and is not for public consumption. Therefore, the details of what is taught have not been well documented (Sideris, 2005).

There have been concerns in South Africa about the safety of Black initiates undergoing TMC, many of whom have suffered injury and even death (World Health Organization [WHO], 2008). This has led to increased scrutiny by government, civil society, and the media, which have called for regulations on the practice and the development of strategies to deal with the problems. Nevertheless, these circumcision-related complications and deaths have not stopped communities from continuing with the practice (Vincent, 2008).

In South Africa, attempts to integrate MMC with traditional manhood initiation rituals still lack acceptability; 70% of Black men fear being stigmatized if they are circumcised medically and not traditionally (Peltzer, 2009).

TMC has longstanding historical significance and men seem content to rely on personal accounts from their communities, "families, and peers regarding the value of maintaining such traditional practices" (Howard-Payne, 2016, p. 52). Despite the support enjoyed by TMC, the practice is being revisited by former initiates owing to costs and safety concerns (Setswe et al., 2015). Traditional teachings accompanying TMC are being questioned in terms of gender and masculinity and the ways in which these (re)construct normative notions of, and options for, the expression of manhood (Nkosi, 2005).

In the Limpopo province of South Africa, the Northern Sotho people were raised with the practice of TMC and tie this to a cultural rite of passage to manhood. Accordingly, one of the key social requirements to attaining manhood in a village in Limpopo is to undergo TMC. The decision to do so is "influenced by social structures which promote TMC as the best acceptable practice" and, thus, young men opt for it (Douglas & Hongoro, 2018, p. 64). Limited research on TMC in Limpopo is a challenge (Sedibe, 2019; Siweya et al., 2018). The present study addresses this gap using the case study of Simon, a young Black man aged 25 who underwent TMC as a 12-year-old adolescent in a rural village in Limpopo. In recounting his experience,

he describes his emotions, feelings, and perceptions as these relate to his shifting perspective from favoring TMC to advocating for MMC.

In so doing, Simon considers the broader social and cultural systems of shared beliefs and representations in which his experience is embedded. The aim of the study was to explore the value of the exercise of choice in TMC which may influence cultural perceptions of gender and masculinity.

Who is Simon?

Simon is a 25-year-old Black, Pedi, unmarried male. Simon is currently enrolled at a local college and lives in Johannesburg, South Africa. His TMC experience is rooted in the Limpopo province and in the cultural practices of the Pedi, the ethnic group to which he belongs. The Pedi are a Northern Sotho sub-group that speaks various dialects of the Sotho language, one of the eleven official languages of South Africa.

4.2 Theoretical Positioning

4.2.1 Social Constructivism

Generally, the case study focuses on the content and structure of a participant's story (Riessman, 2008), as well as the participant's growth and transformation (Clandinin & Connelly, 2000). The present case study is underpinned by Social Constructivism, which provides conceptual anchors for understanding Simon's everyday experiences and memories of circumcision within the Pedi culture. Social Constructivism posits that social reality is constructed through human interaction. The emphasis is on human experience and knowledge construction and how people create meaning of their actions and experiences (Brinkmann, 2012). Memory is an important aspect of meaning making, as it is continually sustained and modified by interactive conversational activity (Berger & Luckmann, 1966). Processes in Social Constructivism can be seen to be working in TMC, which has deep roots in the social norms and structures of many traditional Black South African societies and ethnicities. Aggleton (2007) posits that male circumcision, whether performed in a medical or a traditional context, is a practice that holds a multitude of social meanings. Moreover, Northern Sotho social systems and the way they operate have an impact on men who are traditionally circumcised and manifest in the way they perceive and make meaning of their everyday life experiences. In the context of gender and masculinity, these social structures shape a man's worldview, beliefs, values and expectations, and his sense of what is considered as normal and as right or wrong.

In this study, there is a link between Simon's personal experience of TMC and how he challenges dominant norms in his Pedi community, particularly their reluctance to accept MMC as a valid and valuable choice. The growing negative public focus on TMC and its underlying hegemonic masculinity and power—as opposed to his own world view of what it means to be a man—all motivate Simon to speak his mind and truth to his parents, brother, and young boys and men he encounters.

These social exchanges offer new ways of thinking about TMC and MMC and allow Simon to engage in the collective generation of new meaning among people. He creates new knowledge by sharing his experiences and encouraging young boys and men to share their fears with him, creating a platform to engage and giving them a voice. Through this endeavor, he is creating a social space for dialogue and interaction, empowering, and liberating their minds in terms of socially constructed issues of patriarchy, masculinity, power over women, and urging them to exercise choice in the matter of circumcision.

4.3 Method

4.3.1 Research approach and case selection

This study employed case study research as a qualitative approach. A single case study is an exploration of a bounded system where the inquirer has a clearly identifiable case and seeks to provide an in-depth understanding of it (Creswell, 2007; Gustafsson, 2017). Pertinent to this study, the case potentially provides an indication of the broader population which it represents in an imperfect manner (Gerring & Cojocaru, 2016). In exploring Simon's experience, the qualitative case study approach provided a platform to gain a deeper understanding of the complexities and problems regarding TMC within a specific cultural context.

The single-case study design is appropriate for this study as it provides an opportunity for the researcher to access the personal experiences of the participant—the storyteller—in his natural setting and thus to understand his behavior, actions, and feelings in context (Clandinin & Connelly, 2000). Shakir (2002) mentions that the value of single case research is methodologically viable in the study of extreme or unique cases. Simon's unique personal experience as well his challenge to culturally endorsed perceptions of TMC fits this requirement, and furthermore, is of interest and value to broadening existing literature on the topic.

The subject in this holistic, single-case design Yin (1981, 2009), was purposefully selected through a local public health facility offering MMC services. Purposive sampling allows the researcher to locate participants who can speak authoritatively on the research topic by virtue

of their knowledge and experience. Purposive sampling is suitable for this study because circumcised men are a hard-to-reach population group, and they are often not prepared to share their circumcision experiences (Neuman, 2012). The selection of Simon took place in two phases. The primary researcher (the first author) delivered a presentation about the purpose of the study to the staff of a public health facility, who were then encouraged to share the details of the study with eligible participants and refer them to the primary researcher. Simon approached the primary researcher directly and expressed an interest to participate.

Although pragmatic considerations such as participant expertise and access were relevant for selecting the case, these were not the overarching reasons. The case itself was interesting for what it represented and conveyed (Merriam, 1998). As indicated by Searwright and Gerring, (2008), it is important to select case studies that are influential. Simon was perceived to be both an influential and an atypical case of a young man who had been through TMC, but who subsequently reconsidered its value.

4.3.2 Data collection

This study employed in-depth interviews as a data collection tool. To complement the in-depth interviews, data collection included a demographic questions and researcher field notes. The researcher recorded field notes in a separate notebook as observational insights for the study. Field notes facilitated the capture of different dimensions of the conversations with the participant to facilitate a better understanding of the information provided, and to extend the picture from the fieldwork (Babbie & Mouton, 1995).

A series of three in-depth interviews lasting one to two hours each were conducted with Simon over a three-month period. Rodriguez et al. (2003) point out, in-depth interviews enjoy great flexibility in obtaining information and are used with the aim of obtaining the maximum detail about participants' lifeworld experiences. An interview schedule (Annexure 1) was used to lead the interviews; this was developed using information from the literature, theoretical constructs, and the key research questions of this study. Open-ended questions gave the participant the opportunity to provide detailed information about his experience. Data saturation was achieved by the third interview, when no new information arose. The interviews were audio-recorded and conducted in English as Simon is fluent in the language.

4.3.3 Data processing and analysis

The lead researcher transcribed the audio-recorded interviews verbatim. Transcriptions were then exported to Nvivo©, a qualitative data management software package. The lead author used thematic analysis to analyze the data to provide a detailed, reasonable explanation of

Simon's lived experience (Riessman, 2008). A two-step coding process was followed. The lead researcher read through all transcripts to develop an initial coding framework. The coding framework was examined by, and discussed with, the co-authors. The data were coded in order to capture the meanings of statements, and the codes were then examined to identify patterns and relationships.

Analytical processes included the interpretation of the identified themes, exploring differences and similarities between the themes, linking Simon's individual experiences to the wider social context, and connecting the interpretations to the literature. The case study analysis thus consisted of an integration of the factors of the case (Gerring & Cojocaru (2016). The analysis revealed four main themes namely language, silence, patriarchy, and masculinity.

4.3.4 Quality of the data

The researcher promoted quality (Flick, 2018) through conducting multiple follow up interviews with Simon to verify existing data over a three-month period. During interviews, the principal researcher requested the participant to provide concrete examples with the objective of increasing the accuracy of the data and the interpretations. As a quality feature, she then reflected her understanding of his experience back to Simon to ensure that his views were correctly represented and respected (Fick, 2018). To further enhance credibility, the researcher's interpretation and description of the case study were presented to Simon and he was asked to verify whether they were accurate and a true reflection of his experiences. To improve coherence, the researcher established a decision trail that details the decisions and interpretations she made throughout the study (Speziale & Carpenter 2003). The use of data management software (in this case Nvivo©) also renders analyses visible to co-researchers and the ethics committee.

4.3.5 Ethics

The research obtained ethical clearance (UFS HSD2018/1443) on January 9th, 2019, from the University of The Free State's Health Sciences Research Ethics Committee. Ethics protocols were mindfully designed, informing the participant about the researcher and the nature of the research before he agreed to participate. His participation was entirely voluntary, and he had the right to withdraw from the study at any time. During the informed consent process, Simon indicated that he was content talking to a female researcher about circumcision. Additionally, the researcher ensured that she was as well informed as possible about the relevant cultural beliefs and practices of the Pedi community so that she could recognize and appreciate these throughout.

4.4 Findings

Simon was raised to believe that the central tenets of masculinity within his culture are embedded in its traditional circumcision practices. Cultural beliefs dictate that when the time is right, young men should go to initiation school. Cultural practice also prescribes that anyone who is in violation of the rules governing circumcision, is to be taken away from the village. The ritual of TMC is one of the most exclusive, secretive, and sacred rites among the Pedi people and allows little outside interference (Skosana, 2011). “These rites play a social role, mediating intergroup relations, renewing unity and integrating the socio-cultural system of the community” (Douglas & Hongoro, 2018, p. 603).

The results of this study are presented in terms of four main themes that emerged from the data analysis, namely: (1) language as a form of power in TMC, (2) silence and social secrets surrounding TMC, (3) confronting the traditional patriarchal system by refusing to be silent and (4) and the significance of masculinity in the context of TMC.

4.4.1 Language as a form of power in TMC

Simon shares his interaction with his peers via a “new language” used to communicate after the TMC procedure:

> I heard it [the language] at school before I was circumcised. I asked questions about it. “Can you teach me the language?” And they will tell you “You go to the mountain and learn it for yourself, you are a young boy.” I was left out of talking to them and I felt bad, it’s not a nice feeling.

These quotes clearly demonstrate how speech is loaded with power and authority:

> Only the boys that underwent traditional circumcision were in charge of discussions with other boys; they were the ones who spoke to girls and boys. And they tell boys who are not traditionally circumcised to go away and [they] laugh at us. This thing took over my mind and made me feel helpless.
>
> This language is known only by traditionally circumcised men and when they speak it, it is proof that they have been circumcised. A person who did not come from the mountain will not hear and understand what is said by those who have come from the mountain.
>
> Yes, there is a different language we speak to each other; [they] teach us at the mountain, and they speak that language at the mountain. When we are back from the mountain, they use the language to tell if you are from the mountain or not.

> It's hard when you can't speak that language because you feel left out, isolated and ignored and no one is your friend. The only thing you can do is to do traditional male circumcision to fit into the group and for them to stop calling you names like "small boy".
>
> I asked questions about it and they will tell you to go to the mountain and learn for yourself. I felt like really now that I am not a man enough because there are things that people know that I don't know, so I wanted to go to the mountain because I was teased at school because I didn't know.

The new language is used very directly as an instrument of power:

> The language is not used anywhere else, it's used between those we know is from the mountain, and no one can teach you that language unless you have done traditional male circumcision. It separates the boys from the men, they say. If you don't know it, you can't do anything, you are powerless.
>
> I do try and influence my friends and family and will have a word and tell them that I have gone to the mountain and ask them what's the difference between the going the traditional circumcision route and going to the clinic. They will have their point of view, but I still put it out there to make them aware.

4.4.2 Silence and social secrets surrounding TMC

Silence emerged as a key theme in the study and was embedded in the descriptions of Simon's TMC experience.

> They didn't want to tell me anything, nobody explained, they are so secretive, very secretive. When I asked around, no one wants to talk to me.
>
> I was so scared, afraid to die. I was disappointed, angry. They should have told us what is going to happen so that I was better prepared to face it. It was hectic and I didn't know if I will make it out alive.
>
> I don't see a reason to be secretive because it's something that's done in mountains, in the hospitals and advertised on TV, radio and billboards. It's well known that you get circumcised, we should be talking about it.
>
> It's my turn, I don't know if I can describe it. [There] are men on both sides, you feel someone grabbing you, strong man. Yoh! They grab you and close your eyes and after that you are going to sit down, after sitting down, they cut. Yoh! You can't scream, you are becoming a man. But you don't know what's happening, you will see afterwards.

Simon presents a grim picture of his experience of TMC. This has motivated him to influence his parents and prevent his 12-year-old younger brother from going through the same experience.

My dad, he wanted to take the boy [brother] to the mountain and I spoke up. I discouraged him and it was big argument. I asked him [father] why he should force him to go to the mountain because there is no difference and it's safer to go to the hospital. He was very upset, but he came around.

I couldn't allow what happened to me to happen to my brother all over again. It's too much. We should look out for each other and talk about this thing before it goes too far. We see boys lose their lives and not come back from the mountain and we still keep quiet. We have to do better. That includes us men and boys, our parents, and the chiefs in our communities as well.

My brother had no choice or say in this matter; he wasn't consulted to check what he wanted to do; it was expected that we follow what the culture taught us. And my parents were going to go through with it.

Another reason I challenged it is also about safety. We have a lot of TV shows, news and don't talk to me and my mother because of this thing that happened with my brother not going to the mountain. To them we have disrespected their family, and our culture more in particular.

4.4.3 The significance of masculinity in the context of TMC

This case study reveals that preserving Pedi cultural tradition is, more often than not, deemed to be important. In Simon's case, there are no answers or guidance from the men in his life about his TMC experiences and his emotional fears. He then oversteps a major boundary – he confides in his mother about his experience. This is reflected in the following excerpts:

I told her [mother] everything and the men there said you shouldn't say anything. I told her everything because it's not worth it, I didn't want my brother to go through the same thing I did. And she supported that he doesn't go to the mountain.

I was scared, afraid and I didn't know what to do, I have a good relationship with my mother, she always supports me. They don't allow us to talk to our mothers, before and after the ritual, it is not a female thing and in fact females are not part of the process at all.

I felt bad for my mother, as they are not allowed a say in this ritual. She was totally excluded. and I felt bad for her, and I decided that women must have a space and a voice in this.

My mother knew that I am the one with the powerful view and voice and influence on my brother. She used me to talk to my brother to not go the traditional way and choose to go to the clinic. My voice is more powerful than my father, because we [my brother and I] are very close and he listens to me. My mother makes the decision in the household as my dad is not home, so his role is not that powerful.

Our mothers don't know much of what happens on the mountain, nobody talks about it. When boys get sick or anything happens with their health, they are the last to know about it, even if the boy isn't coping emotionally, she will not know about it. And when women want to do

anything with the hospital, they have to go through the men, and they will not achieve anything because the men are in control.

4.4.4 The significance of masculinity in the context of TMC

TMC positions men within a certain masculine arena—it constructs men as the dominant and controlling gender with power over women and control of resources.

> What they teach is as men we should be more powerful than women and not be controlled by women. And when we speak, what we say goes, our word is final. If you are controlled by a woman you are not man enough.
>
> As men who have gone to the mountain, we are in charge, and our women have to listen to us. We take the lead and that's how it is, and that's what we should expect from women after the ritual. That's what is out there.
>
> Men who are not traditionally circumcised can't handle their women and families you know; the women handle the men. That's how they were teaching us: these men who are not traditionally circumcised are not man enough.

From what Simon says, there is pressure from culture, family and friends to demonstrate one's manhood.

> In the rural areas where they perform the rituals [other than circumcision], they identify men who are not traditionally circumcised, and they are not allowed to participate in the rituals. They say you are not man enough. But in the urban areas nobody supports the traditional rituals, so we are all just the same here, no one's culture is above another in the city. So, I can be who I am as a man without culture, pressure from family and friends, and without shame. I have a choice.
>
> Because I don't believe in TMC anymore—they treat us differently and they criticize us [saying] we see ourselves as better people because we don't want to do rituals for our ancestry. At the end of the day, I am sticking to my decision no matter what people say and I don't really care that much. So, the people who say this is my family and relatives; and saying things because we are family and should believe in this.
>
> Not only men should have a say in a relationship, I don't think it's something wise to be taught as men to be in charge and control things.
>
> Being "a man" refers to someone who can make good choices, treat women with respect and is responsible. It's not about being in control and making the decisions and showing women who's in charge.
>
> I still put it out there and I will ask them if singing traditional songs and speaking the language make you to be a man, because I don't believe so, and I mention that I don't believe in traditional circumcision and tell them why.

Circumcision is a highly guarded ritual with males assuming dominant roles.

> Not only men should have a say in a relationship, I don't think it's something wise to be taught as men to be in charge and control things. When I got to dating stage, I realized that this is not working—for a man to be in control. It's not going to work; we are abusing women by doing so. Each one must have a say. That's what changed for me, and I try and influence my peers as to how they think and approach this thing.
>
> We are taught that we are the ones that make the decisions about sex, when and how it happens. And the women must be ready and not complain or have issues because you are now a man who has been through traditional circumcision.
>
> This is even true when it comes to condoms. We decide and we control the use of condoms, sometimes you use it and sometimes not. And it's your decision as a man, the woman can ask questions, but we have the final say in it.

4.5 Discussion

4.5.1 Language as a form of power in TMC

Simon tells of his interactions with boys and men who have undergone TMC and how they exercised power in ways that were dominating and coercive—particularly in the way they controlled conversations using a "new language", thereby acting as gatekeepers of culture and status. Language may be regarded as a form of social action that provides the basis on which human beings make sense of the world (Burr, 1995). It provides the means through which we interpret memories as well as new experiences. Additionally, it provides its users with the classifications and characteristics to order people and events (DeLemater & Hyde, 1998). Common perceptions abound that individuals use language to negotiate and construct their power as well as a way to maintain it. As the sociologists Bourdieu (1977) and Schütz and Luckmann (1989) point out, language is not only an instrument of communication or even knowledge, but also an instrument of power. Language thus becomes "necessary for the maintenance of power, and the power and effects of language in turn rely on the power" expressed in the attitudes and actions of individuals and institutions (Mayr, 2008, p.40).

During traditional circumcision rituals the initiate is taught a "new language" which, on completion of the rite, the initiate may use to defend his manhood (Mavundla et al., 2010). Men who have undergone TMC use this exclusive language to get information about other men's circumcision status in the community (Mavundla et al., 2010). As Simon's case shows, the values underpinned by TMC can trigger "identity, cultural and language confusion and difficulties" Sedibe (2019, p.2), which can be observed when initiates who have been traditionally circumcised look down on those who have not. Furthermore, this notion of feeling

superior to others often leads to confrontation and marginalization, both of which can result in negative psychological effects such as guilt and the internal conflicts that arise from it (Sedibe, 2019). Over a period of three interviews, Simon spoke about how he felt about being of a lower status prior to being traditionally circumcised.

He tells of his interactions with boys who had undergone TMC, and how they exercised power in ways that were dominating and coercive, particularly in the way they controlled conversations using “new language”, thereby acting as gatekeepers of culture and status. As Nieto (2002) points out, those who share language and cultural identities that differ from the dominant group norms, are often perceived as functioning with a deficiency stemming from the very identities they claim. The traditionally circumcised boys who understand and speak the “new language”, on the other hand, exercise linguistic agency and power.

The use of language in Simon’s story tells us about belonging and identity. Pitsoe and Letseka (2013) argue that identity is never complete because it is continuously being (re)defined and (re)inscribed and new configurations of identity are made accessible in language. Similarly, Kramarae et al. (1985) argue that systems of dominance etch themselves on both people and their contexts, largely through language. Therefore, a sense of identity is underpinned by several elements where systems of power are (re)constructed and either reinforced or opposed, in and through the use of language (Pitsoe & Letseka, 2013). The language that the Pedi initiates use to communicate with each other offers a powerful tool for understanding the cultural dynamics of TMC and the social construction of the identity of initiates, the wider network of men, and the community at large.

4.5.2 Silence and social secrets surrounding TMC

Simon’s story shows how the ritual of TMC is one of the most guarded, secretive, and sacred rites among the Pedi people and allows little, if any, outside interference. These rites play a social role, mediating intergroup relations, renewing unity, and integrating the socio-cultural system of the community (Skosana, 2011; Douglas & Hongoro, 2018). In the Limpopo province, TMC is a practice that is generally not disclosed to any uninitiated person, including women and strangers, and the consequences of disclosing what happens “on the mountain” are far reaching (Bottoman et al., 2009; Sedibe, 2019).

Thus, the silence and secrecy surrounding the TMC initiate is “encoded in traditional culture” and details are safely guarded (Ratele, 2016, p.48). In the case of Simon, however, he had no hesitation in sharing his own ideas and experiences with regard to this cultural practice, mainly due to the fact that he made a transition from believing in it unquestioningly to pulling

away from it after seeing and experiencing some of its shortcomings. Nonetheless, during the research process Simon did not go as far as to describe processes in detail

Ben-Ze'ev, Ginio and Winter (2010) regard silence as a "socially constructed space in which, and about which, subjects and words normally used in everyday life are not spoken" (p.4). Many Black South African men undergo circumcision as young boys without engaging in any discussion about the matter with parents, peers, or family members. This may be a personal and social choice to protect the silence around the TMC practice. But it may also be a response to the warnings of negative consequences should they share information—warnings that appear to be very effective in deterring the young men from talking openly about their experiences. The code of silence is broken when Simon expresses feelings of pain, isolation, uncertainty, shock, confusion and disappointment towards fathers, uncles and brothers who chose to remain silent instead of helping him to understand what he was going through. In addition, the veil of silence and secrecy surrounding the practice contributes to the fear of death he experienced as a young boy undergoing TMC. In the context of TMC, the primary aspects present in the social construction of silence are power, patriarchy, and the framing of masculinity and what it means to be a man. The elders control the behavior of initiates through their pledge of silence and the judgment that follows should they speak out (Wetherell & Edley, 1999). This exercise of power by men, over men and their silence, is a defining factor in their recognition as being "real men" in their communities and (as they interpret it) in the wider society. Through TMC, silence as a form and expression of masculinity is recognized as the norm, and this silence side-lines and represses other ways of being a man.

Not being afraid of the judgment that will follow, Simon breaks the silence, challenges cultural barriers, and engages his father by motivating for his brother to undergo MMC and not TMC. The act of speaking out about his TMC experience is a form of resistance, challenging TMC practices and ultimately breaking the culturally endorsed silence. In so doing, he confronts the power of a well-defined and established practices and processes, not only in terms of actual circumcision, but in terms of normative patriarchal hierarchy. As a result of defying norms, he experiences challenges when engaging his father on the issue of his brother's circumcision. Elders in the community are the gatekeepers in men's transition from boyhood to manhood. They wield power by controlling access to land, capital, wealth, and opportunities (Barker & Ricardo, 2005). Young men are then positioned to be at the service of the older men, and this creates strife and contributes to tensions. The power of the elders' functions is to construct the identity of men either as being part of the community (traditionally circumcised) or as outsiders. This judgement has extreme social and individual consequences, so men comply in order to fit in and not be labelled as an "outcast". It is a clear-cut process in the social

construction of reality, and it works like a well-oiled machine in which men are socialized to comply with every socio-cultural aspect of the TMC ritual.

4.5.3 Confronting the traditional patriarchal system by refusing to be silent

In South African Black cultures women are prevented from participating in TMC practices (Nkosi, 2005). This exclusion may be viewed as a tool for perpetuating patriarchy in a society where the men are the heads of the family and hold the power, while women are largely excluded and isolated from exercising power. Thus, TMC as a social construction is gendered (Nkosi, 2005), with the teachings that take place in the circumcision schools being designed to communicate and entrench certain gender biases. As hooks (2005) points out, patriarchy is a dominating political-social system in which men are considered superior and are endowed with the right to rule over the 'weak' to maintain that dominance.

This patriarchy is illustrated in two studies conducted in Zimbabwe and Tanzania, which show that fathers are the primary decision makers for their male children who are not traditionally circumcised (Hatzold et al., 2014; Osaki et al., 2015). But traditions and cultures are not forever fixed, as can be seen in the growing interest and focus on changing gender relations in society. Black South African mothers, for instance are beginning to play a key role in the circumcision decision-making process and becoming involved in the preparation and post-operative processes (Chilimampunga et al., 2017; Mavhu et al., 2017; Peltzer et al., 2010). Simon's mother became an agent of change in the circumcision practice in her family by influencing the decision-making process in relation to her youngest son's circumcision (Simon's brother) and thereby challenging patriarchy, even though this is not traditionally accepted or allowed. The role of Black South African women in circumcision decision-making has been amplified and publicized in several research studies (ibid.). But there is still limited literature on how women influence men's decisions in this regard, or that explains how women perceive their roles and negotiate and transform their personal identity in a traditionally male space (Osaki et al., 2015). This is an important area for further research.

When Simon shares his TMC experience with his mother, it opposes the tradition of silence, particularly in respect of speaking to a woman about matters regarded as an exclusively male domain. In doing so, he confronts the traditional patriarchal system and refuses to be an agent of its reproduction. Patriarchy has a strong effect on everyone and operates at all levels of society. In not believing that he should be silent and complicit, Simon did not submit to patriarchal rules. Instead, he challenged the ideas and actions that protect traditional male behaviors in a patriarchal culture that relies on submission, and which is potentially harmful on both the physical and the psycho-social level. Simon effectively reframes patriarchy as an

issue for all gender identities. As hooks (2010, p.170) contends, “patriarchy is not gender specific, therefore all genders and communities should join together to contest it”. Moreover, men as fathers in unison with the broader community of men, must embrace the fact that women are at the center of their children’s survival and development and that in terms of a child’s health, mothers are central in making decisions as well as accessing health services for their children. For these reasons, and at a policy level, circumcision for HIV prevention should consider women and gender issues for policy and programming purposes.

4.5.4 The significance of masculinity in the context of TMC

In Simon’s Pedi culture, TMC is practiced as a rite of passage from boyhood to manhood. As part of the circumcision practice, boys are orientated to their multiple identities as sons, brothers, husbands, lovers, and prospective fathers (Vincent, 2008). Both formal and informal ways of orientation create an awareness in a man of what society expects of him, and society informs him when he is falling short of being a man (Ratele, 2008). As Simon’s experience confirms, manhood in the context of the TMC practice points to notions of masculinity defined by dominance, status, power, and privilege within the patriarchal system (Nkosi, 2005).

MC is inextricably attached to social power and is connected to firmly established beliefs and a system of ideas and ideals about the commonly sanctioned social order in a community (Aggleton, 2007). A man’s masculinity depends on both his public and private behaviors and interactions, as well as the way in which his social environment judges them. “These patterns of behavior become embedded in culture, institutions and policies, and thus create social structures that are a powerful force in people’s lives” (Fleming et al., 2016, p. 2).

Simon speaks about being in the city, away from restrictive cultural ideas about what it is to be a man, and how this frees him and other men to find alternative ways of living their masculinity. Acknowledging the plurality of masculinities, and certain common practices that contribute to the construction of masculinity in the context of South Africa, is important (Lynch et al., 2009). As noted earlier, TMC is practiced by 31.9% of Black African men including the Venda (90.2%), Pedi (71.2%) and Xhosa (64.3%) (Connolly et al., 2008). Meanings of masculinity and conceptions of manhood become established in male circumcision practices in South Africa where hegemonic masculinity is “performed” and entrenched through TMC. This is demonstrated in the norm that young men are expected to undergo and succeed in dealing stoically with physical pain in the process of symbolically marking the transition of their bodies and minds from boyhood to manhood (Kepe, 2010). Simon endured physical pain and emotional scarring which he did not want to be re-visited upon his brother. It touched his sense of being a (hu)man in such a significant way that he could not be silent about it.

The construct of hegemonic masculinity has been taken up by leading gender theorists (for instance, Connell, 1987; hooks, 2010), who apply it as an analytical instrument to identify attitudes and practices that perpetuate gender inequities—that signal men's domination over women and other (often minority groups of) men. Hegemonic masculinity has long been a dominant form of masculinity precisely because it is "distinguished from other masculinities, especially subordinated masculinities, and as the currently most honored way of being a man, it require[s] all other men to position themselves in relation to it" (Connell & Messerschmidt, 2005, p. 832). "Not being man enough" is a masculinity script that Simon identifies with in this case study. He does not want to perpetuate this practice because it legitimizes men adopting a dominant position in society and subsequently marginalizes non-conformers, including women. He wants to open spaces for other voices—voices that challenge the key characteristics of hegemonic masculine identity, including defense, dominance, and aggression and choosing violence to solve conflict (Haegerich & Hall, 2011). Men who do not "perform their masculinity in these and other culturally accepted ways, including the injunctions to stoicism and silence, face isolation or even punishment" (Beynon, 2002, p. 11). The dilemma that faces a Pedi male is that if you have not undergone TMC, and if you do not buy in to sanctioned male behaviors, you are not considered a man; you are seen as a boy, a notion that Simon could not align himself with.

Simon's case study ultimately highlights that in any culture there is not just one way of being a man that is acceptable, or that is the "only" or "best" way of being a man. This is supported by Ratele's (2016) argument that "instead of thinking of men as coming in one model, it is better for men themselves and society to recognize the possibilities in having a variety of models of masculinity" (p. 8).

4.6 Recommendations

The privileges and benefits men enjoy from patriarchal structures that give them the upper hand is a key cultural element of many societies, and as the case study of Simon demonstrates, this applies in Black African societies such as the Pedi. The voices of men are often present and represented to the exclusion of women, which is inequitable, therefore a more inclusive approach is required. Several studies (Venter, 2011; Osaki, 2015) identified the limited participation of women in TMC as a barrier, suggesting that programs designed to include women are required. These would provide *both* parents with accurate information about the procedure, address their concerns and emotional fears, and create a platform for dialogue (ibid.). Simon's story highlights the fact that women have an important role to play in influencing circumcision choices both personally—through discussion and advice to men and

young boys who are not traditionally circumcised, and politically—through representation at relevant circumcision platforms.

There are deep seated norms, beliefs and practices dictating that males should play a lead role in the TMC decision making process. There is an urgent need to challenge this exclusivity and explore the role of women (especially mothers) in TMC practices at the levels of decision making, consultation and communication, as well as making women equal stakeholders in the practice. This will require quite radically new ways of thinking and acting at a wider community level. In addition, it is critical to engage traditional and religious leadership structures in communities to educate, support and raise awareness of choices, and to promote knowledge, and acceptance of different practices. Future research is needed to better understand previously under-studied groups of men who are speaking out about their circumcision status, their experiences of TMC, as well as the issues of choice and access to alternatives within their respective cultural groups.

Extended research is required with men, particularly those raised in cultures where TMC is practiced, to better understand the barriers that may prevent them from learning about alternatives, and exercising choice, including accessing related resources and services. In essence, there is a need to develop a series of approaches where communities can create spaces for Black males to commence a process of re-thinking, recreating, and re-telling what it means to be a Black male in South Africa—circumcised or not.

4.7 Conclusion

This study demonstrates that TMC as a rite of passage to manhood carries complex significance, with multiple and interconnected social and cultural dimensions. Simon's story demonstrates that normative beliefs about masculinity can be challenged, that addressing fundamental traditions within culture can still be done without dishonoring culture. Simon's courage to speak out reveals that fear should not be a debilitating emotion, but that it may be used to empower and support others who experience it. In Simon's Pedi culture, as well many other Black African cultures, the manhood status achieved after the TMC ritual accords men power and authority in the community. As a result, men and boys who have not been traditionally circumcised experience peer pressure to undergo TMC, pressures that include violence, limited access to resources even to rituals, as well as exclusion, rejection, and stigma. One of the most striking issues Simon relates is his desire to share his complete experience, so that others can learn from it and make informed choices with their families, including their mothers. The implication of this stretches far beyond the boundaries of familial relationships—it extends to the need for increased education, dialogue and awareness of

TMC, as well as a reframing of gender-based cultural practices to include a sensitivity to all genders. Furthermore, TMC rituals could be performed by a clinician of the same culture to address concerns related to traditional cultural practices. Simon learnt from his collective interactions how to empower men to be confident in their own cultural identity, to become knowledgeable about the options of choice available to them, and how to revalue themselves as “real men” within their culture and beyond. He considers these processes of social engagement and social cultural learning as paramount to reshaping conceptions of manhood and male circumcision practices.

4.8 Limitations

Krusenvik (2016) argued that the methodological criticism levelled against case studies is based on the fact that the single case study cannot provide insights into causality and cannot be generalized to the wider population. The authors wish to re-iterate that the aim of this article is not to generalize, but to open out new understandings of the under-reported phenomenon of TMC as illustrated in the single, yet powerful, voice and subjective experience of one man. Further research is required to mitigate this limitation and to bring more individual and collective stories to publication; these multiple voices could provide more insight and shed more light on the topic.

This case study is focused on the TMC experience of one male and therefore female voices are not heard, at least, not directly, although they are not entirely absent because Simon’s story recounts the responses of his mother. This may be mitigated in future research where the female voice is directly sought and included.

The principal researcher is a South African female, and a female interviewer discussing a gendered and culturally sensitive topic with a male participant is potentially problematic. The researcher situates herself and her work in third-wave feminism (cf. Connell, 2005; hooks, 2005) according to which men and women work together towards emancipation from inequitable gender norms that impact on men as well as women. In this context it is congruent for a female researcher to work with masculinity and vice versa. Nonetheless, that the principal researcher is a woman no doubt had some influence on the degree of information that Simon was prepared to share.

Declaration of conflicting interests

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Chapter 5
Parental Decision-Making in Infant and Child Male Circumcision: A Case Study of Two Townships in Gauteng, South Africa

Article 2

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Parental decision-making in infant and child male circumcision: A case study in two townships in Gauteng, South Africa

Eurica Palmer, Lochner Marais & Michelle Engelbrecht

Abstract

Parental decision-making in infant and child male circumcision is influenced by complex, interrelated factors on many levels. Several studies have highlighted reasons for the acceptance and non-acceptance of child male circumcision. This study investigated the factors that influence parental decision-making in this matter and proposes a parental decision-making framework. The study was conducted in the townships of Diepsloot and Diepkloof in Gauteng, South Africa, using 48 in-depth interviews with parents, grandparents, and uncles of the boys, as well as government officials and members of civil society as part of an explorative case study. Purposive and snowball sampling were used to select the participants. Thematic analysis was used to analyse the data by applying the conceptual framework of Bronfenbrenner's Ecological Systems Theory. Three main themes emerged from the data: microsystem factors related to health and hygiene, the father's circumcision status, cultural expectations, pain, the child's autonomy, and the extended family; mesosystem factors related to early childhood development centres; and exosystem factors related to circumcision policies and financial considerations.

Keywords: early childhood development; Ecological Systems Theory; medical male circumcision, traditional male circumcision

5.1 Introduction

Males can be circumcised at any age for religious, medical, cultural, or social reasons. There are two main public health arguments for male circumcision: it is a cost-effective intervention and can provide significant protection against HIV infection for life (Njeuhmeli et al., 2016; Sint et al., 2016). Medical reasons for infant and child, rather than adult male circumcision, are faster wound healing, reduced complications, and fewer adverse events (Fitzgerald et al., 2016; Chilimampunga et al., 2017).[1]

Several African countries with a high HIV prevalence, such as Eswatini (formerly Swaziland) and Kenya, have included infant and child male circumcision in their medical male circumcision (MMC) programmes (Mapureti et al., 2015; Kenya Ministry of Health, 2018). Although South Africa has no formal child male circumcision programme, circumcision has increased for male infants and children. For example, for children aged 0 to 4 years, the rate increased from 2.0% in 2012 (Shisana et al., 2014) to 3.9% in 2017 (Simbayi et al., 2019). In 2012 the rate for children aged 5 to 14 years was 9.1%, but by 2017 it had increased to 11.4% for children aged 5 to 11 and to 37.4% for children aged 12 to 14 (Shisana et al., 2014; Simbayi et al., 2019).

In 2020, the World Health Organization (WHO) issued new age-specific recommendations for voluntary medical male circumcision (VMMC) for HIV prevention. The WHO (2020) recommends that countries that decide to offer VMMC services to boys under the age of 15, should consider factors such as safety, ethics and human rights.

The circumcision of infants and children raises significant ethical concerns because it is performed without their consent (Di Pietro et al., 2017). Critics argue that the child's right to bodily integrity is compromised when parents give consent to circumcision for the child and that the child should decide for himself later on in life (Sardi, 2011; Hammond & Carmack, 2017). In a letter to the editor of the South African Journal of Bioethics and Law, the United South African Neonatal Association stated that children cannot provide informed consent and parents have no right to provide proxy consent (Smith et al., 2011). Deciding on infant and child circumcision remains a complex choice for parents. Factors influencing parental decision-making include the father's circumcision status (Mavhu et al., 2017), health and hygiene considerations (Justman et al., 2013) and religion and culture (Kenu et al., 2016). A South African study investigating the decision-

[1] In this study, the age of circumcision for infants is defined as between birth and twelve months and for children between one and twelve years (UNAIDS, 2010).

making for infant circumcision, found that pregnant women were reluctant to provide consent to the procedure, because they wanted to consult partners and extended family members (Phili & Karim, 2015). Sardi (2011) and Rediger and Muller (2013) cited individual internal determinants of behaviour, such as attitudes, knowledge, skills, and beliefs, as the strongest decision-making factors in infant and child male circumcision.

Parents' infant and child male circumcision decision-making remains a largely neglected area of research in sub-Saharan Africa. This paper begins to fill part of the gap by investigating the decision-making rationale of a small sample of South African parents.

5.2 Theoretical framework

The Ecological Systems Theory (EST), developed by American psychologist, Urie Bronfenbrenner, conceptualises the development of children and adolescents as taking place within a complex, reciprocal system of interactions between individuals that shapes their environment (Bronfenbrenner 1977) The theory evolved over three phases. The first (1973–1979) was an ecological approach to human development, the second (1980 to mid-1990s) added biology and the chronosystem to the ecological framework, and the third (mid-1990s to 2006) became a process-person-context-time model (Rosa & Tudge, 2013).

Bronfenbrenner (1977) identified five ecological systems that make up a person's environment: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. He highlighted influence, interrelatedness and relationships as central features.

The *microsystem*, the immediate relationships in the individual's network, is the most powerful and influential of the five systems. Individual decisions depend on direct contact and interaction with family, friends and peers who support and share experiences and information. Studies in Zimbabwe and Kenya found that parents perceived the child's grandparents and uncles to have influence on their ICMC infant and child male circumcision decisions (Mavhu, 2014; Young et al., 2016).

The *mesosystem* consists of institutions and organisations, such as churches, schools, civil society organisations and workplaces, in which the individual directly participates in and that shape and structure the individual's social setting. A South African study found that Early Childhood Development (ECD) organisations produce long-term benefits in the community, because they build trust, solidarity and agency (Murray & Rudolph, 2019).

The *exosystem* is the wider social setting that does not involve the individual directly, but the individual is affected by changes in it. This could include economic and political systems, policies and laws. A review of barriers and facilitators influencing the acceptance of MMC in Uganda, identified the role of clear policy guidelines in the decision-making process (Lilleston et al., 2017).

The macrosystem consists of beliefs and values reflected in society's socio-economic, religious and cultural organisation. Cultural beliefs about reproductive health were found to influence access to reproductive health services for couples living with HIV in Malawi, where men's involvement in reproductive health services is considered taboo (Gombachika et al., 2012).

The chronosystem consists of changes over time, including historical events, significant life changes, and biological changes. A study that explored the transition to adulthood of young people living with a complex medical condition, applied EST constructs for policy improvement (Joly, 2014).

Public health researchers have applied Bronfenbrenner's theory. For example, McDonald-Hill (2018) applied EST to analyse the influences in sexual health decision-making among disadvantaged youth. Furthermore, researchers used the EST as a conceptual tool to understand and demonstrate the levels of influence in adherence to antiretroviral therapy (Coetzee et al., 2015).

Using the three constructs of the EST in the study analysis, gives meaning to the experiences of parents. We situate culture at the microsystem level, as other studies have done (e.g., Ren & Hu, 2014; Vélez-Agosto et al., 2017), because it is a product of human interaction and not detached from the individual (Markus & Kitayama, 2010).

5.3 Methods

5.3.1 Setting

The sites for data collection were in the townships of Diepkloof and Diepsloot in the Gauteng Province.[2] These townships were purposively selected, as both are included in the government's MMC programme for adolescents and adults.

[2] Under the Group Areas Act of 1951, the apartheid government developed townships on the fringes of South African cities to control black urbanisation. For many, these were a 'gateway' to the cities. The townships suffer from poverty, unemployment, overpopulation, and underdevelopment (Ellapen, 2007). Gauteng is South Africa's smallest province but the most highly urbanised and densely populated.

Diepsloot, situated north of Johannesburg, has a population of 138,329 living in 62,882 households (Statistics South Africa, 2012). The population is 54.5% male, but over a quarter of its households (28.6%) are female-headed. Diepsloot has high levels of unemployment and poverty, with half of the population earning less than R20,000 (US$1,300) a year and more than a third of the households lacking electricity (Statistics South Africa, 2012). Diepkloof, with a population of 104,098, is located within the township of Soweto (Statistics South Africa, 2012). The Gauteng province has an HIV prevalence rate of 17.6% for people aged 15 to 49, slightly lower than the national average of 20.6% (Simbayi et al., 2019).

5.3.2 Research design

This study employed a qualitative, exploratory case study approach. This design allows for an in-depth analysis when not much is known about a complex social phenomenon (Yin, 1989).

5.3.3 Description of the sample

A total of 48 participants between 18 and 64 years participated in in-depth interviews (Table 1). Parents, grandparents of the children, uncles of the children, government officials and members of civil society organisations were purposively selected to participate.[3] The participating parents included some who had accepted infant and child male circumcision and some who had not. This study defines infants as between birth and 12 months and children as between one and 12 years (UNAIDS, 2010). The sample included ten single mothers (it should be noted that single motherhood does not necessarily mean the father is not involved in the children's lives). A total of 48 participants between 18 and 64 years participated in interviews (Table 5.1).

Table 5.1 Description of participants

Population	Gender		Marital status			Age range		
	Male	Female	Single	Married	Other	18–29	30–49	50–64
Parents	13	18	12	16	3	13	16	2
Uncles	4	0	2	1	1	0	1	3
Grandparents	3	2	2	3	0	0	2	3
Civil society	2	2	2	2	0	0	3	1
Government	2	2	0	3	1	0	3	1

[3] In this study, "uncle" refers to the uncle of the male infant or child.

Pamphlets with information about the study were distributed to identify potential participants. Interested parents contacted the first author, and she set up interview appointments. Snowball sampling was used to select subsequent parents. Purposive sampling was used to select the grandparents, uncles, government officials, and members of civil society organisations. The government officials were selected based on their involvement in public sector, medical male circumcision programmes. The members of civil society organisations who participated, were involved in healthcare service delivery in the area. Data saturation was considered to have been achieved when no new information emerged during the interviews.

5.3.4 Data collection

A semi-structured interview schedule guided each interview. The interview schedules were guided by the study's research question, the EST and scholarly literature. All interviews were conducted in English and were audio-recorded with the permission of the participants. An information leaflet and consent form were used to gain informed consent. The interviews were conducted in-person at the homes of the participants and in a few cases, telephonically. Each interview took 40 to 60 minutes. Follow-up telephone interviews were conducted to address issues for clarification. Data collection took place between January 2019 and June 2019.

5.3.5 Data analysis

A thematic analysis was used to analyse the data. The lead researcher read through the transcribed raw data after each interview. Coding took place in two stages. This involved developing an initial coding framework, based on the interview transcriptions and weekly analytical meetings with co-authors. The interviews were then independently coded by the lead author and then reviewed by the co-authors. Differences were resolved through discussions with co-authors until an agreement was reached. We used NVivo 12 (QSR International, Melbourne, Australia), and fully coded the data using a modified coding framework. Codes were grouped into categories and emerging themes were identified.

5.3.6 Reflexivity

The lead researcher demonstrated reflexivity by making a personal undertaking to remain open during the data collection process by continuously considering and questioning her assumptions, beliefs, and practices. During the fieldwork, the lead researcher was aware that male circumcision was a sensitive topic. The researcher therefore contacted the participants to establish whether

they were comfortable with being interviewed. None of the participants said they were anxious or apprehensive.

Figure 5.1 shows the EST systems integrated with the data collection process.

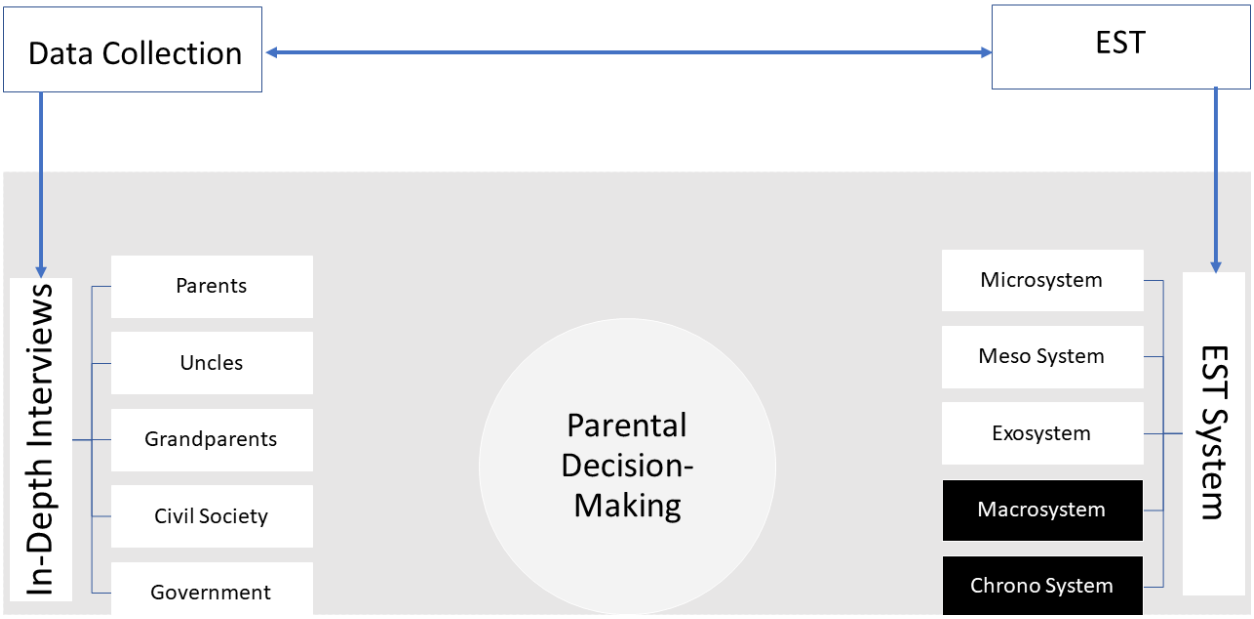

Figure 5.1 Ecological Systems Theory integrated with the data collection process (Own construction)

5.3.7 Ethics approval and consent to participate

Participation was voluntary. Written informed consent was obtained from all participants and identifying information was excluded from the analysis. The Ethics Committee of the Faculty of Health Sciences, University of the Free State, provided ethical clearance (UFS HSD 2018). The National and Gauteng Departments of Health (South Africa) authorised the study.

5.4 Findings

The researchers analysed the factors that influenced parents' decisions about infant and child male circumcision, according to the three systems of the EST.

5.4.1 Microsystem factors

The participants had close relationships with family members, and this affected the decision-making process. The parents who accepted infant and child male circumcision emphasised health and hygiene in their decision-making. They mentioned two health benefits: lowering the risk of sexually transmitted infections over the long term and good genital hygiene. One father said: *"It*

helps with not getting infections like STIs [sexually transmitted infections] and even HIV, as you are getting older and having sex." Another father said: *"If you are clean, you will not get sick easily and that is important for young children."* These parents' beliefs in the medical benefits of circumcision were an incentive to accept infant and child male circumcision. They weighed up the short- and long-term health benefits and decided on behalf of their sons.

The circumcision status of the father was very influential in the decision-making process. One mother said: *"His father was young when he did it and we decided to do it for our son when he was young."* Furthermore, one of the mothers linked the father's circumcision status to sexual performance: *"My son's father was circumcised, and we always heard that men that are not circumcised are not good in bed."* A father's circumcision status could therefore seem to confirm a mother's beliefs about masculinity (sexual performance) and influence her decisions for her sons. This mother attached a meaning to circumcision beyond the surgical procedure.

Our interviews pointed to the dominant role of men in the decision-making process. One member of a civil society organisation said: *"Fathers influence this thing big time; they are the ones that decide."* Fathers carry authority and status and have power in decision-making. It was clear that circumcision practices are embedded in the participants' conceptualisations of masculinity and what it means to be a man. One father said: *"When you are not circumcised, we do not look at you as a man, so, if you are not circumcised, we look at you as if you are half a man."* Boys therefore learn to associate circumcision with notions of manhood at an early age.

As parents navigate through their own cultures, they perceive the circumcision decision-making process as a delicate balancing act. The cultural expectation will be that they will favour traditional male circumcision (TMC) over infant and child male circumcision. One male member of a civil society organisation, who is also a father, said: *"Family members expect parents to send their children to the mountain [initiation school]."* This comment demonstrates the effect of a family history of TMC. One parent said he reconsidered and changed his mind about *"sending my child to the mountain".* He felt that the expectation of pursuing TMC was unfair, and he described the consequences he suffered by not accepting TMC: *"I was told I was no longer respecting my family and they were not very happy about that."* His concern was the nature of the teachings about women at the initiation schools. He said*: "It's useless"* and *"I do not like what they are saying about women and abuse and how they teach there."* The comment points to a dislike of the domestic violence teachings and the exclusion of women during TMC.

Most of the parents faced family criticism and pressure when they opted for infant and child male circumcision. Their decisions sometimes caused conflict. One father said: *"When they know we are going to the hospital for circumcision, people are angry, so they say bad things to us."* Because parents found deciding difficult, they consulted their uncles to resolve the conflicts that arose, because of their decision. One child's uncle said: *"The parents come to us to resolve family issues as a result of the circumcision, so we discuss with other family members as to why they are taking the direction of child circumcision."* This quote shows a broader decision-making process in adopting infant and child male circumcision. Knowing that uncles are there to support them, helps parents to resolve conflict, promote peace and provide stability in the family. It demonstrates respect for family values and practices.

Some parents regarded their children's autonomy as important. They felt that circumcision was a personal decision, affecting their sons. One single mother remarked: "*The way I see it is that he should decide for himself because, after all, it is his body."* Another mother said: *"This thing is not easy – my son should decide for himself, because I don't want him to blame me when something goes wrong. It is his choice."* A married father echoed this sentiment: *"As much as we are his parents, we cannot decide for him, it's something that he has to figure out when he is ready."* While some of the participants agreed that the health and HIV prevention benefits later in their sons' lives are equally important, they were adamant that the child should ultimately decide for himself. One married father said: *"Our boy was the first child, and when my wife was pregnant, we decided not to circumcise, because he should decide what he wants to do. We will be there to support him."* Despite being aware of the health and HIV prevention benefits of male circumcision, the need to respect the child's autonomy was a priority for many participants.

Parents' perceptions about pain and safety were factors inhibiting a decision in favour of infant and child circumcision. The parents who did not accept infant and child male circumcision held strong beliefs about their children's pain during the circumcision procedure. One married mother said: *"When he is too young, like now, he is two years old, it might be too painful, and he can't speak properly",* and another said: *"It is such a delicate part of the body, I don't want to see my child in pain − will he be able to handle it? I really don't know."* Some parents also cited safety concerns as a reason for deciding not to circumcise their male infants and children. One father said: *"For now, I'm not comfortable with cutting my son. He can't protect himself against the pain and that I think is not safe at all. We will wait for now."* It was evident that the pain fathers went through who experienced MMC or TMC, influenced their decision not to circumcise their male infants and children. One father said: *"It was a painful process; the healing took very long. I know*

they will numb it, but after the medicine wears off, it will be painful. I don't want him to go through that."

The intergenerational connectedness of grandparents and uncles and the parents' particular situation contributed to the parental decision-making process. Grandparents and uncles were a source of support and information for families who accepted infant and child male circumcision. Grandparents seemed to be particularly influential. For example, one father said that grandparents "*inform you about everything – how long it takes to heal, how to take care of the wound, the surgery at the hospital and when you get home, what to do for the baby."* A grandmother described her role as follows: *"We get involved as grandparents. That is our role – we advise and give support to the family to make sure that they can go through with the circumcision without too many problems."* Comments like this showed that the grandparents felt valued and insisted on transmitting their family traditions and solidifying their central role in the family. The parents actively sought information from the grandparents before the infant or child was circumcised. One grandparent remarked: *"They ask us, and we provide everything, like home remedies, how to care for the baby and everything."* This illustrates the value of intergenerational voices and shows that some parents acknowledge the ideas and value grandparents' opinions. This is an example of an intergenerational foundation of trust and dialogue between the parents and grandparents.

5.4.2 Mesosystem factors

Some parents considered post-operative support important. Since the parents in the sample who accepted infant and child male circumcision were employed, their children attended ECD programmes. One father said the staff at the ECD centre: "*know what they are talking about, because we wanted full information about how they take care of the kids, the services they offer and how they work with the clinics."* This comment demonstrates that some parents were comfortable with the services provided by ECD centres. A grandmother said: *"the information parents got, helped them decide, because they were comfortable placing their children at the centre when they went back to work".*

Some mothers said that the information provided was pre-packaged, so that they could take it home. One mother felt that this indicated that the centre was prepared and said: *"We received pamphlets to take home about what to expect, with contact information we could use for additional information."* This shows that some mothers researched, planned, and deployed strategies to

inform their decision. The ECD practitioners dealt with mothers' concerns about caring for the children, therefore mothers had trust in the centre, and it facilitated their decision-making.

5.4.3 Exosystem factors

Policy development and the availability of financial resources influenced parental decision-making. The public health system does not offer infant and child male circumcision services for HIV prevention. Therefore, parents who decided to circumcise their sons used private health services, either paying themselves or using medical aid. A father explained: *"We had medical aid, but it doesn't cover everything, we had to pay for the doctor's consultation and medicines afterwards."* For parents without a medical aid, the issue of affordability was burdensome*: "For us, it meant saving up and checking prices of doctors, so we could decide to proceed with it."* One parent said: *"Where I work, there is no medical aid, we waited until we had the money."* The availability of financial resources was a major barrier for some parents.

Some single mothers said the decision not to circumcise their children resulted from their inability to afford the procedure. One mother said*: "Because I am not working, I won't be able to pay for the circumcision, so I can't do it."* Another single mother said: *"It is difficult. I do not have an income to pay for things. You have to decide what's more important for your family."* These comments suggest that circumcision may be an afterthought for single mothers, because of unemployment and competing household demands.

Some interviewees expressed concern about the lack of a policy for infant and child male circumcision. One female member of a civil society organisation was not enthusiastic about an infant and child male circumcision programme. She said: *"I have issues with rolling out infant and child male circumcision within the current public health system, because where I work, there is no medical aid."*

A government official linked the policy issue to health system problems: *"Our health system is under pressure; we have no policy to guide us."* Another participant said: *"I can't see how we can move forward with this before we sort out the policy, funding and what we face in our clinics and hospitals."*

5.5 Discussion

Our findings showed that some parents think that deciding to proceed with MMC for their son, would benefit the child later in life. However, the parents who had not accepted infant and child

circumcision, had carefully considered several ethical issues linked to the decision-making process.

5.5.1 Reasons for not accepting infant and child male circumcision

Because of the risks associated with the medical procedure, deciding whether to circumcise infants and children, raised concerns that influenced parental decision-making, such as the risk of infection and the ethical question of performing an irreversible procedure on a child who cannot give consent (Di Pietro et al., 2017). Some parents spoke of the need to respect a child's autonomy. Two early infant male circumcision studies, in Eswatini and Zimbabwe, also found that some participants rejected the procedure, arguing that the child should decide for himself (Mavhu et al., 2012; Jarrett et al., 2014). In a large quantitative South African study, some parents said that they would not make this decision on behalf of their sons, because their sons can make the decision themselves when they are older (Spyrelis et al., 2013).

In an Eswatini study, women identified pain and complications, associated with the procedure, as barriers to the uptake of early infant male circumcision (Jarrett et al., 2014). According to Spyrelis et al. (2013), some parents are scared to circumcise their infants at a young age, noting that they would be scared for their safety and whether the child would experience pain or discomfort. Mavhu et al. (2017) supported this finding, stating that fathers who experienced pain during VMMC, were more likely not to accept early infant male circumcision. Although all the participants would have liked their sons to be circumcised, one of the major factors against it was fear of complications and pain. Although death from medical circumcision is unlikely, a particular concern among the participants was excessive bleeding, as infants were perceived to be at higher risk of death (Jarrett et al., 2014).

In the present study, the lack of financial resources available to unemployed single mothers negatively influenced their ability to pursue infant and child male circumcision. Single motherhood in South Africa is common, with 43.1% of young children living with their mothers only (Hall & Sambu, 2018). In a South African study, single mothers indicated that they felt excluded, lonely and rejected and made significant decisions (healthcare, education, housing) independently (Boecker et al., 2021). In a longitudinal study, De Wet-Billings (2021) found that single mothers are becoming the primary decision-makers in South African households, increasing from 4.63% in 2008 to 34.34% in 2017.

A study conducted in Zimbabwe, showed that the participants expressed concern about the affordability of circumcision, because they would have to balance the cost of the procedure against other household priorities (Mavhu et al., 2014). This is in line with the findings from the present study, as single mothers bear the economic brunt of providing for their households and exercising the option to circumcise their male child becomes an afterthought. HIV prevention policies should keep pace with the reality of single female parents' circumcision choices and priorities. Therefore, single parent female voices should receive recognition in circumcision policies.

5.5.2 Reasons for accepting infant and child male circumcision

The study highlighted the significance of the father's circumcision status in the decision-making process and supported studies done elsewhere (Waters et al., 2012; Amuri et al., 2016).

Our study found that TMC practices construct masculinity and masculine norms in the decision-making process. A man becomes established in male circumcision practices. Traditional perceptions of masculinity and masculine norms are reinforced at the EST micro level, where the father plays a dominant role in the decision-making process (Shen-Miller et al., 2011). This finding is consistent with a study in Zambia (Bailey et al., 2017).

Many parents are under pressure from their extended families to adopt TMC practices, instead of infant and child male circumcision. We found that trade-offs lie at the heart of the decision-making process. The concept of trade-offs in healthcare decision-making involves weighing different options and considering the gains and losses already experienced or expected in the future (Case et al., 2015). Being aware of the trade-offs sensitised the parents to consider the conflicts they faced in dealing with competing alternatives and family relationships.

The extended family's voices (grandparents and uncles) played a pivotal role in conflict resolution, providing information and support in the decision-making process. This finding supports the finding of Spyrelis et al. (2013) and Phili and Karim (2015) that parents view consultation with the extended family as necessary and empowering. The influential role of the extended family in the parents' decision-making process fits in with EST constructs.

At the mesosystem level, ECD centres are crucial instruments supporting parents in the decision-making process. The parents who accepted infant and child circumcision, engaged in sessions with personnel at the ECD centre to gather information on the type of support received from these centres. The information mainly included the level of care provided for children and the

relationship with community health services. This consultation built the confidence of the parents and contributed to the decision-making process. Parents in our study said the ECD centres earned their trust by demonstrating their competence, knowledge and track record of problem-solving and support for parents' decisions. Our findings align with research on ECD experiences by Shertiel (2018) and Azzi-Lessing and Schmidt (2019) pointing to the long-term benefits of trust, solidarity, and agency. Due consideration should be given to ECD programmes that combine parental support with mainstream ECD services.

Currently, infant and child male circumcision services are not offered as part of the standard HIV prevention services in South Africa. Despite deciding to adopt infant and child male circumcision, some participants noted the high cost of the procedure and the non-availability of the service in the public health sector. Some parents pursued infant and child male circumcision through the private sector and covered the cost of the procedure through a medical aid and financing it themselves. Our study findings are consistent with those of Rediger and Muller (2013) and Sardi and Livingston (2014) who found that policy guidance, including accurate health information and ethical considerations, are important elements that help parents to make an informed decision.

Based on the findings, Figure 5.2 depicts the contribution of the study.

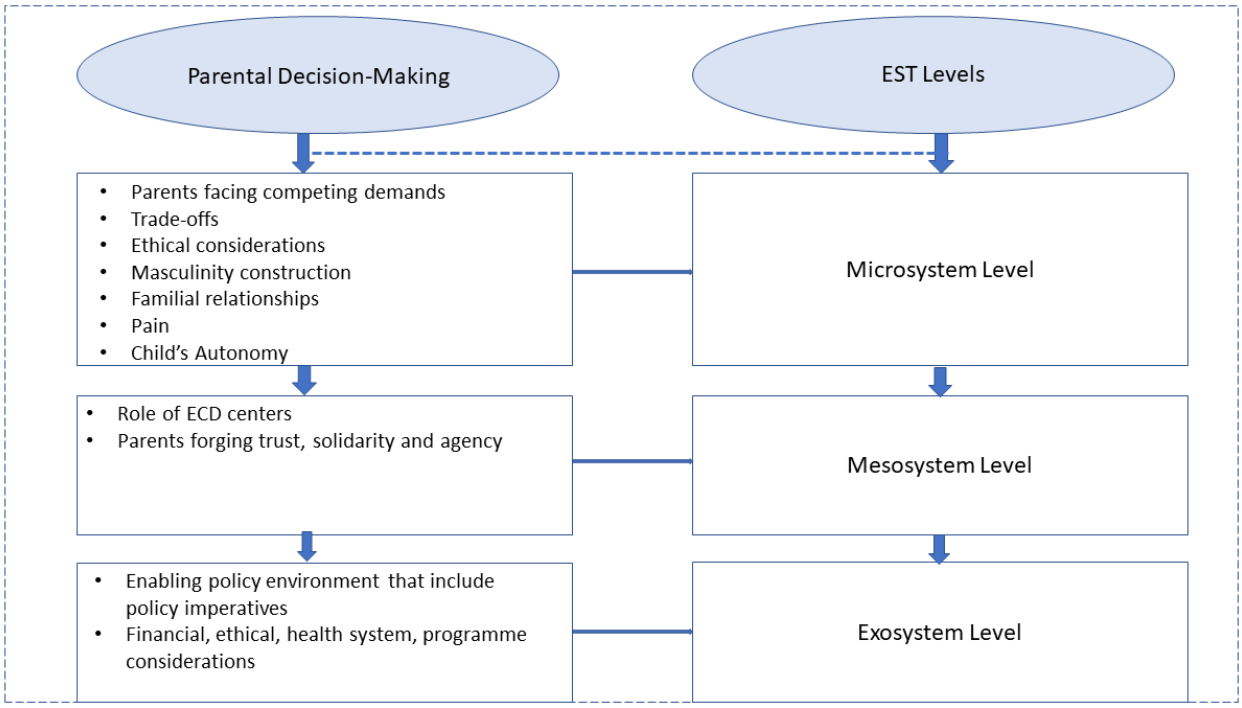

Figure 5.2 Parental decision-making framework (Own construction)

5.5.3 Limitations

This study had limitations. Identifying parents, grandparents and uncles for the study was challenging. The lead researcher is a South African female who had to interview men about infant and child male circumcision. Issues related to infants (0−12 months) and children (1−12 years) could differ considerably, but the study combined the two groups together. The interviews were conducted in English, which may have affected the quality of the study findings, as some participants may have encountered difficulties with English.

As the study sample comprised of predominantly black African families, the findings are not generalisable to other communities.

5.6 Conclusion

We found that making a decision about circumcising infants and children is a challenge that many parents face. The link between parental decision-making and a lack of policy was clear. Some parents made the decision based on the cost of the procedure. We argue that health policymakers should expand the current MMC programme to include infant and child male circumcision. A potential infant and child male circumcision programme in South Africa could have benefits, such as the financing of the procedure, accurate medical information, approved circumcision techniques and post-operative care. Furthermore, fathers can be targeted to support health promotion activities as effective agents of change through communication, seeking updated, accurate information and engaging in relevant forums and structures (Hlongwa et al., 2020). Our study proposes a parental decision-making framework to facilitate the discussion on developing and implementing an HIV prevention policy related to infant and child male circumcision, in line with the latest WHO recommendations.

Abbreviations

ECD: Early childhood development
EST: Ecological Systems Theory
HIV: Human immunodeficiency virus
MMC: Medical male circumcision
TMC: Traditional male circumcision
VMMC: Voluntary male medical circumcision
WHO: World Health Organisation

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Chapter 6
Analysing Black Women's Perceptions Towards Infant and Child Male Circumcision in Two South African Townships

Article 3

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Analysing Black women's perceptions towards infant and child male circumcision in two South African townships

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Abstract

Perceptions affect behaviour and influence decisions about infant and child male circumcision (ICMC). Using qualitative interviews, this study investigated twenty-five Black women's perceptions of ICMC decision-making in South Africa. Black women who had opted not to circumcise their sons, were selected through purposive and snowball sampling. Underpinned by the Social Norms Theory, their responses were analysed through in-depth interviews and a framework analysis. We conducted the study in the townships of Diepsloot and Diepkloof, Gauteng, South Africa. Participants were selected through purposive and snowball sampling. Three major themes emerged: medical mistrust, inaccurate knowledge leading to myths and misconceptions, and cultural practices related to traditional male circumcision. Building Black women's trust in the public health system is important for ICMC decision-making. Policies should address misinformation through platforms that Black women share. There should be an acknowledgement of the role that cultural differences play in the decision-making process. This study proposes an ICMC theoretical perceptions framework to inform policy.

Keywords: medical male circumcision, Social Norms Theory, traditional male circumcision

What is already known on this subject: Male circumcision decision-making is complex because multiple, interrelated factors influence it. Deciding about circumcising infants and children is a challenge that many parents face.

What this study adds: This study found that social pressure from the social network, myths and misconceptions resulting from inaccurate knowledge, medical mistrust and traditional male circumcision practices influence the decisions of Black women not to circumcise their sons. The study proposes a perceptions framework to demonstrate consideration for Black women's voices in the male circumcision discourse.

6.1 Introduction

Globally, male circumcision has gained momentum as a strategy for preventing HIV transmission. Randomised controlled trials found that adult medical male circumcision (MMC) reduces the risk of HIV infection in heterosexual males by approximately 60% (Auvert et al., 2005; Bailey et al., 2007). Several African countries rolled out infant and child male circumcision (ICMC) programmes (Jarrett et al., 2014; Keetile & Bowelo 2016). South Africa has implemented its MMC programme in 2010, although the government only published the *South African National Guidelines for Medical Male Circumcision* in 2016 (South Africa, Department of Health 2016). In contrast to South Africa, countries like Botswana and Eswatini have implemented ICMC programmes since 2014 and 2009, respectively (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (U.S.), 2014; Swaziland, Ministry of Health & World Health Organization [WHO], 2014). However, ICMC, as an HIV prevention strategy, requires acceptability from caregivers, including female caregivers or mothers. This, raised questions among families of infants and children about how caregivers can make decisions about ICMC as it is not yet known how female caregivers think or how they make decisions in this regard (Jarrett et al., 2014; Keetile & Bowelo 2016). With 37.9% of all households in South Africa being headed by females, it is particularly important to involve women in ICMC decision-making (Stats South Africa, 2019). For ICMC to be an effective HIV prevention strategy, the perceptions and thinking of women decision-makers are therefore important.

The role of women in circumcision decision-making was emphasised in a joint strategic action framework by the Joint United Nations Programme for HIV/AIDS and the World Health Organization (UNAIDS/WHO 2011). However, in Eastern and Southern Africa, the focus has been on targeting men to increase the uptake of MMC. Governments ignored the advice of the UNAIDS/WHO about the role of women in providing support for men and adolescent boys in deciding about MMC (Nxumalo & Mchunu 2019; Semeere et al., 2016). Diverse gender perspectives in male circumcision programmes are limited (Segalo 2015), with a narrow focus on men remaining dominant. The views of Black women seldom feature in policy documents. This probably results from multiple subordinate identities of Blacks and females (Harman, 2016; Serrant, 2020). Therefore, male circumcision policies should consider the voices of Black women (Coles & Pasek 2020).

The research on the role of women in the decisions about ICMC points to the role of multiple factors, such as the father's circumcision status, health and hygiene, the cost of the procedure and religious practices (Justman et al., 2013; Mavhu et al., 2014; Spyrelis et al., 2013). In a study in Eswatini, women described their consultation with their fathers as an important step in decision-making (Jarrett et al., 2014). The father's circumcision status was also a positive

decision-making factor among women in Botswana (Keetile & Bowelo 2016). Moreover, masculinity and traditional male circumcision (TMC) practices influenced women in South African and Zimbabwean studies to reject ICMC (Mavhu et al., 2014; Rech et al., 2014). Social networks (peers and family members) both positively and negatively affect the circumcision decision-making of women. Acceptance occurs when the extended family (in-laws) agree to the procedure (Amuri et al., 2016). Social norms shaping gender roles were evident in a Zambian study where women required permission from their husbands to pursue early infant male circumcision (EIMC) (Waters et al., 2012).

In South Africa, various cultural groups practice TMC. TMC takes place at puberty as a rite of passage from boyhood to manhood (Ntozini & Abdullahi 2018). Within the traditional practice of male circumcision, masculinity is central to the teaching at initiation schools (Douglas & Maluleke 2018; Siweya et al., 2018). These teachings include culturally grounded expectations for men's behaviours, roles, and relationships, linked to male dominance, power over women, and that only males should decide on circumcision (Sedibe 2019).

Social norms influence how women make decisions about ICMC. However, little is known about the social perceptions of women regarding ICMC. Dempsey et al. (2018) stated that social norms are unwritten individual expectations or rules about acceptable (and unacceptable) interactions. Against this background, this article analyses women's perceptions of ICMC and proposes a perceptions framework for ICMC decision-making to inform ICMC policy.

6.2 Theoretical framework

This study uses the Social Norms Theory (SNT) developed by Perkins and Berkowitz (1986), who addressed the problem of student alcohol consumption. The SNT provides an understanding of the environment and interactive influences that modify individual behaviour (Dempsey et al., 2018). In the SNT, behaviour depends on individual beliefs and perceptions of other social group members' practices and behaviour (Scholly et al., 2005). Social norms are "rules and standards that members of a group understand, and that guide or constrain social behaviours without the force of law" (Cialdini & Trost 1998:152) and link to a perceived social pressure to participate or not participate in a particular behaviour (Ajzen 2019). Social norms influence individual behaviours because they depend on people's personal beliefs and decisions in specific situations.

The SNT assumes that individual behaviour is influenced by perceptions of what other people accept and expect. Generally, people think that others engage in more negative behaviours than they do. Correcting these misperceptions will strengthen individual feelings that their

desire to resist negative behaviours is normal. In turn, this will increase a sense of social support for positive behaviours (Hahn-Smith & Springer 2005).

In public health research, the SNT has been applied in the context of HIV prevention. For example, one study of sexual behaviour practices and perceptions found that students held misperceptions about their peers' levels of sexual activity and condom use (Scholly et al., 2005). Specifically, students significantly overestimated the number of partners, the level of sexual activity, the frequency of unintended pregnancies and the incidence of sexual transmitted infections among their peers, while underestimating the level of condom use. The SNT can help understand the perceptions and socially constructed meanings attached to circumcision, which influence acceptance and rejection of ICMC (Fleming et al., 2016). Therefore, policymakers can integrate the SNT perspectives into designing interventions to provide information that challenges social norms and misperceptions about ICMC. Using the SNT as a theoretical framework, this study uses women's voices to inform the development of a perceptions framework for ICMC decision-making.

The SNT has been criticised for promoting positive health behaviours and not acknowledging the complexities of human behaviour because social norms evolve (Rachlinski 2000). Furthermore, Berkowitz (2003) advised that when employing the SNT, researchers should ensure robust data collection techniques to ensure reliable data and the development of strong normative education, information and communication messages. Failure to do so can lead to reinforcing misperceptions and misrepresentation. Davis et al. (2015) argued that although the SNT is an extensive theory, it fails to illustrate implementation processes.

6.3 Methods

6.3.1 Setting

The study took place in Diepkloof and Diepsloot in Johannesburg, Gauteng, South Africa, with a population that is generally exclusively Black South Africans. The sites were selected because the City of Johannesburg is a central metropolitan municipality with a sizeable HIV-positive population and one of the priority districts funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (Van Schalkwyk et al., 2021). PEPFAR supports the voluntary MMC programme at the local public health clinics in the two townships.

Located in the north of Johannesburg and within the borders of the Gauteng province, 28.6% of households in Diepsloot are female-headed, and in the township of Soweto, where Diepkloof is located, the percentage of female-headed homes is 40.3% (Statistics South Africa 2013). The South African national HIV prevalence, incidence, and behaviour survey (Simbayi

et al., 2019) reported that the Gauteng province has an HIV prevalence rate of 17.6% among 15–49-year-olds. However, the prevalence among pregnant women is 32.2% (Moyo et al., 2020; Simbayi et al., 2019).

The WHO (2009) indicated that the median age for undergoing TMC in the Gauteng province is 17. Furthermore, 10% of the males aged 14–24 years and 22% aged 19–29 years were medically circumcised, and 58–65% of males underwent TMC (Lagarde et al., 2003; Rain-Taljaard et al., 2004). In a male circumcision study conducted in Gauteng, participants self-reported a three-week healing period for TMC (Lagarde et al., 2003).

6.3.2 Research design

A qualitative descriptive research design guided this study. This design was apt because it generates an understanding of the perspectives of people through obtaining the meanings people attach to them (Caelli et al., 2003). It enables the collection of rich, detailed descriptions about the phenomenon where limited information is available (Bradshaw et al., 2017).

6.3.3 Sample

Purposive and snowball sampling was used to select Black women who had chosen not to circumcise their sons as infants or children. A research pamphlet was distributed in Diepkloof and Diepsloot communities to recruit prospective participants. Women who expressed interest contacted the first author who arranged the interviews. The snowball sampling technique helped to identify additional Black women. This process continued until we recruited 25 participants. The snowball sampling method depended on referrals from the first participant to other participants who met the selection criteria. This sampling technique is useful when studying specific populations and discussing sensitive issues (Magnani et al., 2005). Data saturation was attained when no additional data were apparent from the in-depth interviews (Trotter 2003).

The study sample consisted of 25 Black women. The participants were between 21 and 52 years old. All the participants had sons who they chose not to be circumcised medically. Fourteen women obtained their high school qualification, nine completed vocational training and two women had a tertiary qualification. Seventeen women were unemployed, and eight were employed part-time in the services sector. The sample represented Zulu, Venda, Tsonga, Sotho, and Xhosa ethnic groups. The majority of the women were in relationships, and some were married. Most women lived with their intimate partners, while some lived with their parents.

6.3.4 Data collection

The in-depth interviews were conducted with Black women at the two study sites. One strength of an in-depth interview is that it provides answers to the research question and a conversational mode of interaction, enabling participants to engage spontaneously to express their views (Damons 2008). The SNT and the research questions related to ICMC information, TMC and public health experiences guided the interviews. The participants agreed that the discussions, which took place in English, could be audio recorded. Informed consent was obtained through administering a written consent form and an information leaflet containing an overview of the study. The participants signed the consent form, and all the interviews were at a venue identified by the participants. Interviews took 40-60 minutes. Follow-up discussions were arranged to answer questions that required further explanation.

6.3.5 Data analysis

A framework analysis approach was used to analyse the data. Framework analysis is appropriate because it involves a comprehensive and systematic data analysis process based on the initial responses of participants (Satyanarayana & Srivastava 2010). Additionally, framework analysis is a flexible tool that allows for a comprehensive and detailed analysis of themes (Richie & Spencer, 1994). The SNT analysis of the data focused on personal and social factors influencing the perceptions of ICMC. First, we familiarised ourselves with the data. Second, a coding framework was developed and third, we extracted and synthesised the data to develop the final coding framework, a process termed charting (fourth). Finally, mapping and interpretation was done in which all themes were represented and the relationships between the themes analysed (Figure 6.1).

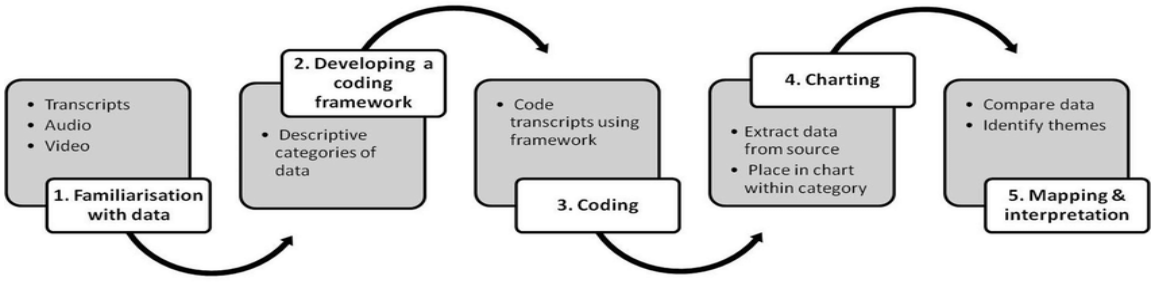

Figure 6.1 Five-step process in framework analysis (Source: Ritchie and Spencer 1994)

Ethical considerations

The Human Sciences Research Ethics Committee of the Faculty of Health Sciences, University of the Free State (UFS HSD 2018/1443), provided ethical clearance. The National

and Gauteng Departments of Health, South Africa, authorised the study. Furthermore, the study excluded information that could identify participants in the analysis and followed all standard ethics procedures of written informed consent, voluntary participation, and confidentiality**.** Pseudonyms were used to identify the participants in the study.

6.4 Findings

We identified the following themes: perceptions of medical mistrust, cultural perceptions regarding traditional male circumcision, and inaccurate information leading to myths and misconceptions.

6.4.1 Mistrust of the public health system

The participants believed that the public health care system was unreliable. First, there is the historical health care experience that informs current decision-making. Perceptions of mistrust resulted from women hearing, watching, and sharing historical problems. Zama (aged 42) remarked, "*I heard from my grandmother about how they were treated as women and my mother saying nothing has changed. So, I'm thinking, how can you listen and trust what they [government] say."* This quote shows the historical roots related to the poor treatment of Black women in health care settings. Based on this experience, women expect their grandmothers experience to repeat itself. Therefore, women in the study did not accept ICMC because they did not trust the advice from the public health officials.

Second, observing problems in the public health care system created mistrust. Thandi (aged 27) said: *"I saw women giving birth in the lines and toilets because nurses are rude. So, imagine coming with a baby with problems from circumcision? I'm scared."* This quote implies that some women perceived that public health care professionals do not care about patients, which sparked a sense of indignation among the participants. Being scared to be a victim of poor health care services is a real inhibiting factor for women deciding about ICMC.

Third, the women were scared that help might not be available when requested. Vicarious experiences of another women's negative experience with her son's circumcision were evident. Pinkie (aged 32) described her experience: *"My neighbours' son was circumcised when he was young, it was a nightmare, she said, he had an infection, he was sick, and it took a long time to heal."* The exposure to negative circumcision stories of others that produced undesirable surgical results could lead to higher levels of medical mistrust in the circumcision procedure.

The discussions with the women triggered intense emotional reactions and feelings of frustration, anger, and fear when two women shared their personal experiences about the health care system. They perceived free health care services as inferior because of the post-operative complications related to their sons' medical circumcision procedure.

6.4.2 Cultural perceptions

The cultural practice of TMC may influence women's perceptions of ICMC. Many participants said that ICMC goes against their beliefs and values of practising TMC. Consequently, they did not accept ICMC. Santo (aged 37) voiced her strong cultural beliefs: "*We cannot just wake up in the morning and say that we will go for the child circumcision, what about our culture, we send boys to the mountain for circumcision in our culture [Tsonga]."* This quote shows that the cultural practice of TMC forms the foundation of some women's male circumcision views. The need for cultural expression resonates with Dineo (aged 31), who indicated that her son will be going to initiation school: "*I still believe in the old ways of doing things the right way, culturally and I don't see anything wrong with that – my son will be going to the mountain soon."* These quotes show that TMC perpetuates traditional knowledge transfer within their cultures. Many participants subscribed to conventional structures and authorities, which reject ICMC. Not deviating from TMC practices, therefore not challenging culture, traditional practices could be seen as a safe space as there is no need for alternative practices to TMC.

The women shared that ICMC altered many social values and traditions while reiterating their acceptance of and commitment to TMC. Palesa (aged 52) mentioned that her sons underwent TMC: *"Let me tell you straight, our people must be careful and not just follow new things [ICMC], they try to cut culture out of everything, we must not be forced to do things that other people do.*" The quotes reiterate the women's suspicion towards ICMC and reinforce the fear that MMC practices are advanced at the expense of TMC because African beliefs and practices are often viewed as problematic. Furthermore, the fear of cultural erosion and potential conflict between traditional practices and Western health care interventions is evident. Women perceive ICMC negatively because of cultural decline in the value of TMC. The foundations of TMC teachings and cultural norms are passed down between generations to reaffirm women's perceptions.

Two women were concerned that accepting ICMC could lead to social sanctions in the community if they decided to pursue ICMC. Such sanctions would ordinarily be exercised without impunity and lead to social rejection and ultimately isolation. Fulu (aged 31) said: "*When you circumcise in the hospital, they [other boys in the community] make fun of them and don't treat them well. They treat them horrible."* Sara (aged 23) supported this by saying:

"They call them 'a man-woman'; it means a man by name and because he is not from circumcision school, he is called a woman. I don't want my son to be treated like that".

The SNT predicts that interventions designed to correct misconceptions will benefit some individuals. They may participate less in potentially harmful behaviour (TMC) or be encouraged to engage in protective, healthy HIV prevention behaviours such as ICMC. Social norms develop through women's perceptions that they are not living up to the socially accepted practices of TMC. If their sons do not undergo TMC, they could face social interaction difficulties, judgement, and ill-treatment. The perceived negative labels constructed and assigned to boys and men who have not undertook TMC negatively shape women's ICMC perceptions and decisions about ICMC.

6.4.3 Inaccurate information about infant and child male circumcision

Information is a prerequisite for health care decision-making processes. Some women said their unfavourable stance emanated from their lack of information about ICMC. The women received limited information about ICMC from health care providers and held the least decision-making power, fuelling their misconceptions about the procedure. These women often regarded their friends as a major source of information. Fernández (2013) found that women may not always receive sufficient information. Decisions may depend on the long-standing generational norms that may impact the availability of ICMC to women and the expectation of women to participate in ICMC decision-making.

Significantly evident from women's experiences is that societal rules often govern the availability of ICMC information. For Hlami (aged 36), it is socially unacceptable for women to participate in family discussions about male circumcision: *"I do not know much about circumcision of babies, because it's not something that is talked about with women in our family, only the men will talk if it comes up."* Echoing her sentiments, Dineo (aged 30) described the exclusion and invisibility of women and fathers "managing" the information that is shared: "*We don't feature when it comes to the circumcision of our sons, so you end up not knowing much; their fathers are in charge, they make decisions, so you only get information here and there."* These quotes magnify gender-related social norms and power relations in spaces where circumcision decisions are made. Cultural beliefs related to TMC consider it taboo for women to participate in discussions about male circumcision.

The women mentioned that their ICMC decision-making practices were informed by their perceptions of other women's ICMC choices and expectations through connections with members of their social networks. Martha (aged 26) described that her friends played a significant role in her decision to reject ICMC, as she explained: *"Our friends have a lot of*

power, if they are against it [ICMC], you will also not do it [ICMC]." Although the women regarded friends as a source of ICMC information, they also complained that their friends expected them to reciprocate their ICMC decisions. Anele (aged 22) said: *"It's small, but it's there. When you ask [friends] and they say they don't support ICMC, it's going to be awkward for you if you change your mind later."* These women considered ICMC information from proximal reference groups such as friends, signifying subtle, in-direct pressure to conform with the group decision (ICMC rejection). Social proofing is evident due to the normative social influence of friends, as women often conform (by rejecting ICMC) to gain acceptance by their social networks. Therefore, this social acceptance demonstrates that peers can profoundly influence women's perceptions of norms related to ICMC. Furthermore, the women described the information they gathered from social networks. For example, Nandi (aged 34) indicated that she received subjective, negative, and superficial detail on ICMC. She said: *"They [friends and family] tell you that you won't sleep; they [children] cry a lot and there's a lot of pain, so obviously, I'm not going that route."* Even though the women receive inaccurate, misleading information from friends and family, they regard it as reliable because it rejects ICMC. Furthermore, the inaccurate information could also be consistent with pre-existing negative perceptions of the social network.

6.5 Discussion

The negative perceptions of Black women towards ICMC circumcision presented in the current study resulted from medical mistrust, cultural practices related to TMC and lack of information about the procedure. These perceptions could represent significant barriers to seeking ICMC services for HIV prevention.

Multiple generations of women shared their perceptions of the public health care system. Intergenerational mistrust of the public health care system eroded trust. Many of the problems in the South African health care system result from the apartheid period (1948–1993). The health care system was highly fragmented, with discriminatory effects between different racial groups (Baker 2010). Despite the democratic South African government introducing significant amendments in health policy and legislation, compliance, safety, efficiency and quality concerns remain a challenge (Mogashoa & Pelser 2014; Moyakhe 2014).

The South African history of racist policies, the legacy of abuse and government misinformation regarding the HIV epidemic has fuelled mistrust in health care services (Nattrass 2013; Tun et al. 2012). Sacks (2021) noted that health care decision-making in Black communities depends on intergenerational experiences, mistrust, marginalisation and abuse. South Africa has experienced a high disease burden and an increased patient load, which

negatively impacts the availability of health care services (South Africa, Department of Health 2017).

Maphumulo et al. (2019) stated that the South African health care system needed repair. Despite efforts of the government to improve the quality of health care services, the standards of care and patient expectations remained largely unmet (Visser et al., 2012). The public has lost trust in the health care system, leading to a decline in the use of public health care services by a population dependent on these services (Malakoane et al., 2020).

Furthermore, despite the limited political intention to improve health care services for women in the public sector, it is clear that the participants have not received adequate information, counselling, and options about medical procedures and testing regarding maternal and child health (Campbell & Nair 2014). Mavhu (2014) highlighted the need to address social norms to improve the acceptability of EIMC because of mistrust based on experiences from MMC programmes. This is consistent with an MMC study in Eswatini that highlighted concerns related to the mistrust of HIV programmes (Adams & Moyer 2015).

In addition to the perceptions of poor service quality of the public health care system, personal and anecdotal experiences of adverse events experienced by children negatively influenced women's decision-making. This finding confirms a neonatal male circumcision study in Zambia that highlighted that the most cited reason among mothers who did not accept neonatal circumcision was the lack of trust in the medical personnel (Waters et al., 2013). Consistent with prior research on the acceptability of neonatal male circumcision in Zambia, the women in this study highlighted their fears related to the negative outcomes of the procedure (Waters et al., 2013). A global review of neonatal and child male circumcision highlighted that the rate of adverse events increases when health care providers lack experience and adequate training and there is a lack of supplies (Weiss et al., 2010). According to Rech et al. (2014), rapid upscaling of the male circumcision programme in South Africa has decreased the quality of circumcision services related to adverse events, infection control, post-operative counselling, and external supervision. If South Africa should consider ICMC as an HIV prevention strategy, the perception of medical malpractice and service quality requires attention.

Strong cultural beliefs related to TMC profoundly influenced the women's perceptions regarding ICMC. TMC represents a celebrated cultural practice that symbolises the transition from a boy to a man by constructing masculine identities (Gwata 2009; Mavundla et al., 2009). TMC practices operate within social and cultural settings as cultural expression and identity. Women in this study believed that ICMC interfered with their cultural beliefs and practices and were concerned that their culture was under threat. This finding is consistent with two

independent studies of neonatal male circumcision conducted in Zambia and eSwatini. Mothers indicated that ICMC was not part of their cultural and traditional beliefs and therefore rejected the practice (Jarrett et al., 2014; Nyoni 2015). In a South African study, women indicated that ICMC excluded important traditional rights practices embedded in their cultural beliefs (Phili & Karim 2015). Black women's male circumcision objections were influenced by their perceptions that male circumcision programmes could lead to cultural erosion and destruction of customary practices (Kelly et al., 2013; Spyrelis et al., 2013).

TMC practice contains notions of masculinity linked to affording rights, privileges and social benefits attached to access to resources and inclusion in community and family rituals (Ntombana 2011). The social construct of manhood and masculinity has been deemed a challenge as medically circumcised men are viewed as inferior to traditionally circumcised men (Mavundla et al., 2009; Mavundla et al., 2010; Peltzer & Kanta 2009). Our study confirms this reality. In one acceptability and feasibility study conducted in Malawi, women identified cultural considerations as a barrier to accepting the procedure due to traditional beliefs related to TMC that dictate that a mother should not see her son's circumcised penis (Chilimampunga et al., 2017). Our findings show that the women resisted ICMC because it would erode African cultural values and traditions. Kalichman (2010) argued that in high HIV prevalence settings, African cultures reject neonatal male circumcision because of TMC's strong perceptions of masculinity and maturity. This shows scepticism about ICMC in Africa because of the dominating biomedical approaches followed in Western cultures (Niang & Boiro 2007).

Black women feel disempowered in the ICMC decision-making process due to limited information and the fathers' leading role in the decision-making process. This is consistent with Chilimampunga et al. (2017), who found that women's perceptions of EIMC were influenced by fathers making the circumcision decisions. The dominance of fathers constrained the participation of women in the decision-making process. In a Zimbabwean acceptability study of EIMC, it was considered taboo for "outsiders", which included women and children, to access information about medical circumcision (Mavhu et al., 2012). Furthermore, the study showed that women also conform by not challenging ICMC decisions because they are from a different clan from their husband and are not familiar with the clan's circumcision practices (Mavhu et al., 2012). Therefore, women conform to social expectations of silence and reinforce male dominance in decision-making. Thus, restrictive gendered social norms cement the collective belief of the dominant role men should play in the decision-making process. This, in turn, reinforces women's exclusion, ostracisation and marginalisation in the decision-making process. Furthermore, social constructions of masculinities characterised by male dominance, strength, power, giving permission and leading women are the main feature in decision-making (Shefer et al., 2007).

The relationship between the social network and women's negative perceptions was significant for women in this study. The social context shapes perceptions at the interpersonal level. Women use a network of social relationships (friends and family) to access information about ICMC that created subtle social pressure among women to conform. Conforming to what other members of the social reference group (friends and family) expect maintains social norms because of the fear of rejection or sanction if you do not comply (Cislaghi & Shakya 2018). Social proofing is evident due to the normative social influence of friends, as women often conform (by rejecting ICMC) to gain acceptance by their social networks. Therefore, this social acceptance demonstrates that peers can profoundly influence women's perceptions of norms related to ICMC. The concept of social proofing is considered a social, psychological phenomenon whereby individuals copy the actions of others to inform decision-making (Cialdini 2001). Therefore, social proofing influences the ICMC decisions because Black women follow the steps and decisions of their friends and conform because of fear of being rejected or disliked, promoting perceptions of ICMC rejection.

Women in both a South African and a Zimbabwean study indicated that friends play an important role in women deciding to accept or reject EIMC (Mavhu et al., 2012; Spyrelis et al., 2013). Despite using social networks as sources of information, they often do not have accurate medical information about neonatal male circumcision (Pruenglampoo 2015). Therefore, recognising the powerful role of social networks underscores the need to provide real, targeted, credible risk-benefit ICMC information to parents vital to support the decision-making process (Waters et al., 2012).

Based on the findings, Figure 6.2 depicts the contribution of the study as captured in the recommendations below:

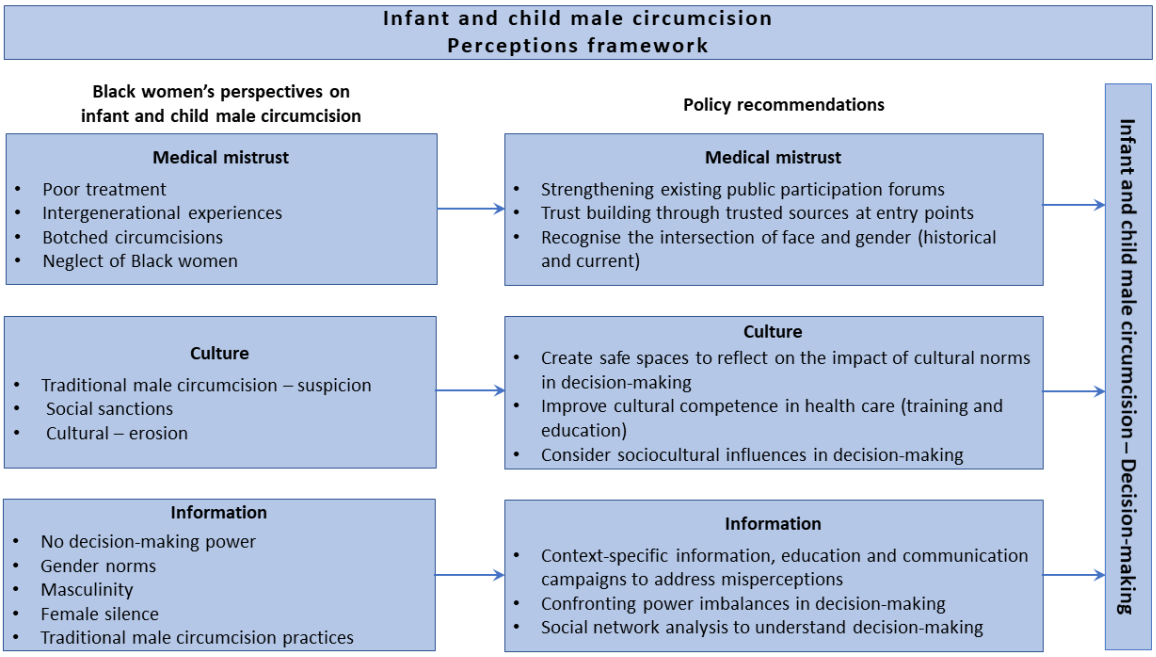

Figure 6.2 Infant and child male circumcision perceptions framework (Own construction 2022)

6.6 Recommendations

We make the following recommendations to inform medical male circumcision policies and programmes:

- **Understand stakeholders and context:** To implement ICMC policy, a social network analysis can be a tool to map and measure the relationships between stakeholders involved in ICMC decision-making. Such analysis could identify the main network actors and describe the interactions involved to provide the context to understand the social norms that influence the ICMC decision-making process.
- **Revise gender applications and approaches to ICMC decision-making**: Advancing gendered approaches in male circumcision policy frameworks sets the scene for a contextual understanding of the role of women in ICMC decision-making and widens the scope for social inclusivity. This requires emphasising gender dimensions related to power imbalances and equal participation of women in ICMC decision-making processes. The focus should be on addressing the domination of men in decision-making. This should include increased representation and participation of women in decision-making.
- **Consider women's access to health care service needs:** Embed and recognise the role of social norms in ICMC decision-making within male circumcision policy domains. Additionally, the needs of women should be recognised in the delivery of health care

services, with a specific focus on cultural sensitivity in the context of the diversity of values, beliefs, recognising the organisational, clinical, structural, and sociocultural barriers women face in health and health care.

- **Promote trust in public health care systems:** Policy frameworks that acknowledge the complexities of trust in the South African public health care system can go a long way in addressing medical mistrust. Initiatives that address social norms and maintain trust in the context of patient-centred care for women is important. Furthermore, interventions should be responsive and respectful to inform male circumcision policies to improve the health care and health outcomes for women and their sons.
- **Mobilise communities:** Utilising community leaders as entry points for community mobilisation and participation in interventions related to social norms. Promoting dialogue through reflection about ICMC decision-making barriers that women face, linked with concrete actions, can facilitate addressing social norms related to ICMC decisions.
- **Encourage continuous dialogue**: Cultivating safe places for reflection through constructive dialogue to understand the social norms that negatively impact ICMC decision-making, specifically related to TMC practices, medical mistrust, and misinformation. Moreover, there should be a focus on building environments where women can be emotionally safe to share their experiences and concerns and ask questions.

6.6.1 Limitations

This article used responses limited to Black women who did not opt for ICMC in Diepsloot and Diepkloof, Gauteng, South Africa. Therefore, the findings are contextual and may not necessarily apply to other communities in Gauteng and the broader South African society. Nonetheless, the results offer insights into Black women's perceptions of ICMC that could inform ICMC policies and programmes. Even though women were the primary focus of the interviews, additional information could come from fathers and other influential family members. The quality of the study findings may have been affected because all the interviews were in English, and some participants may have faced language barriers.

6.7 Conclusion

Social experiences, historical and cultural contexts influence the way women make ICMC decisions, which influence the effectiveness of ICMC as an HIV prevention strategy. Social norms distort Black women's perception of ICMC negatively. This study makes several

contributions to the literature on ICMC decision-making. First, the study demonstrates that Black women in this study experience ICMC negatively because they experience social pressure from their social network of friends to conform to the negative views of ICMC. Furthermore, men lead ICMC decision-making within the family context, reinforcing historically unequal gender relations and limiting equal participation. Second, the study highlights the need for evidence-based and theoretically grounded policies to guide interventions that effectively influence social norms. This will require addressing the negative perceptions of ICMC directly by understanding women's ICMC beliefs, unique experiences, and complex decision-making processes. Third, this qualitative descriptive study provides several empirical findings for MMC policy and programmes within the complex sociocultural context of TMC practices. Policies and programmes that address social norms in disfavour of some of the harmful practices of TMC as it relates to Black women could be implemented and evaluated, recognising that this remains a topic of contestation. Fourth, the study demonstrates the importance of considering gendered perspectives in the MMC discourse and the need for an inclusive knowledge base that amplifies Black women's voices in HIV prevention.

Abbreviations

ICMC	Infant and child male circumcision
SNT	Social Norms Theory
HIV	Human immunodeficiency virus
MMC	Medical male circumcision
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
TMC	Traditional male circumcision
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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Chapter 7
Findings, Recommendations and Conclusion

7.1 Introduction

This thesis investigated ICMC decision-making in South Africa and provided the different perspectives of parents, grandparents, government officials, members of civil society organisations and extended family members. This chapter provides an overview of the main findings, recommendations, the study's contribution, and areas for future research.

Parents make decisions about their children's health. The decision about circumcising their male children is one example. Circumcision decision-making is influenced by culture, religion, social networks, social norms, and HIV prevention (Morgan et al., 2021; Phili & Karim, 2015; Waters et al., 2012). Yet ethical considerations are central to a child's right in the medical decisions regarding his body (Di Pietro et al., 2017).

The South African government's policy position regarding ICMC is vague and clear policy guidelines remain absent. Affordability and access are central policy issues. Prior studies have examined ICMC decision-making mainly in acceptability and feasibility terms. Furthermore. gendered perspectives of ICMC decision-making have received limited attention. This study investigated ICMC regarding the social and cultural contexts of masculinity, culture, gender and how such intersections influence the beliefs, perceptions, and experiences in the decision-making process.

A qualitative research approach was used. The study was conducted in two townships (Diepsloot and Diepkloof) in Gauteng, South Africa, and the participants were purposively selected. This approach provided a richly layered analysis and understanding of the social phenomena influencing ICMC decision-making. Creswell (2013a) explained that a qualitative research approach helps to understand and explore the meaning that individuals or groups attribute to a problem. The research design for each of the three articles included a single case study (Chapter 4), an exploratory case study (Chapter 5) and a descriptive approach (Chapter 6).

The participants from the three articles included a young Pedi male in (Article 1), who switched his point of view from supporting and undergoing TMC to advocating for MMC. In Article 2, 48 participants, including grandparents, uncles, government officials, and members of civil

society organisations, provided unique insights into the factors influencing parental ICMC decisions of acceptance and non-acceptance. Article 3 investigated 25 Black women's perceptions of ICMC. The data were collected through in-depth interviews utilising interview guides. Most interviews took place at participants' homes, but some were conducted telephonically for 40–60 minutes each. The data were analysed through thematic analysis in Articles 1 and 2, and a framework analysis was used in Article 3.

7.2 Chapter summary

Chapter 1 delineated the relevance and significance of the thesis. This included background information about ICMC, and an outline of the theories and methods applied in the study. Furthermore, the introduction provided the problem statement, the aim and objectives, problem statement, and the research gap. Much information is available on MMC feasibility and acceptability, ethics, human rights, documenting of best practices, meeting MMC targets and creating demand. Although there is an emphasis on lessons learned to inform ICMC programming, limited literature examined the perceptions and experiences of young men, parents, and Black women. The study investigated ICMC decision-making in South Africa and engaged with the different perspectives and debates to fill this gap.

Chapter 2 presented a scoping review of the ICMC and MMC decision-making literature. The review used two online electronic databases – Scopus and PubMed – and adopted the PRISMA-Scr guidelines to overview the available literature and identify knowledge gaps to inform policy and practice. The scoping review of the ICMC and MMC decision-making literature showed the limited application of theoretical frameworks to understand ICMC decision-making. There is only a limited set of behavioural theories used in MMC (Social Cognitive Theory, the Integrated Behavioural Model, and Stages of Change Theory) and ICMC (Theory of Planned Behaviour, Theory of Reasoned Action, and the Integrated Behavioural Model), which dominated the research studies.

Chapter 3 provided an analysis of the South African MMC guidelines. This analysis was needed to identify gaps, reflect new research and updated information regarding ICMC decision-making. For example, the guidelines should consider mainstreaming gender to address women's and men's interests and concerns.

Chapter 4 (Article 1), titled *Changing cultural practices: A case study of male circumcision in South Africa,* used a single case study to analyse MMC decision-making and its sociocultural perceptions of gender and masculinity, which influence male circumcision decision-making. The article used Social Constructivism to explain Simon's experiences and how knowledge is produced through social interaction. It illuminates a decision-making process shaped by the

social interactions and cultural dimensions of TMC. Deep-rooted norms, beliefs, and practices related to TMC, direct the roles that men play that directly influence decision-making towards male circumcision.

Chapter 5 (Article 2), *Parental decision-making in infant and child male circumcision: A case study in two townships in Gauteng, South Africa,* used an exploratory case study approach to analyse the multiple factors that influence parents' ICMC decisions. The study applied constructs from the Ecological Systems Theory to assess parents' experiences regarding the acceptance or non-acceptance of ICMC. Parents' concerns about affordability and availability of the procedure in the public sector influence decision-making. Among the parents who accepted ICMC, health and hygiene factors and the extended family played a vital role in decision-making. The study showed a relationship between parental decision-making and the lack of ICMC policy for HIV prevention because the cost of the procedure played a role in some parents' circumcision decision-making.

Chapter 6 (Article 3) analysed *Black women's perceptions of infant and child male circumcision in two South African townships.* This article is a descriptive, qualitative study of *Black* women who had opted not to medically circumcise their sons. The article explained the role of social norms in influencing Black women's social perceptions of ICMC, which impacted their circumcision decision-making. The SNT provided an in-depth understanding of the social environment and interactive influences that shape the ICMC decisions Black women make. The study pointed to the underrepresentation of Black women in ICMC decision-making. MMC policies and programmes will be inclusive if they include Black women in decision-making.

7.3 Main findings

This section provides an overview of the main results of the study as well as the main theoretical and empirical contributions of the research.

7.3.1 Social dimensions of infant and child male circumcision decision-making

The social aspects of ICMC decision-making remain a challenge to MMC policy and implementation. The study offered new insights into the social relations of ICMC decision-making. ICMC decision-making is complex and dynamic and should be understood within the social context. Previous studies on MMC decision-making practices often focused on acceptability and feasibility. This study investigated the social context of ICMC decision-making and highlighted how the social context influences decisions. The social context is defined as the sociocultural forces that shape people's everyday experiences, which directly or indirectly affect health-seeking behaviour (Pasick & Burke, 2008). By depicting the social

realities of ICMC decision-making, the study expanded the current understanding of social realities and experiences of the main actors (men, parents, and women) and how it affects decision-making. This study argued for understanding the complexity of the social context of ICMC decision-making. As the findings in the articles (Chapters 4, 5 and 6) reflect, the following dimensions can be identified in which the social context of ICMC decision-making can be situated:

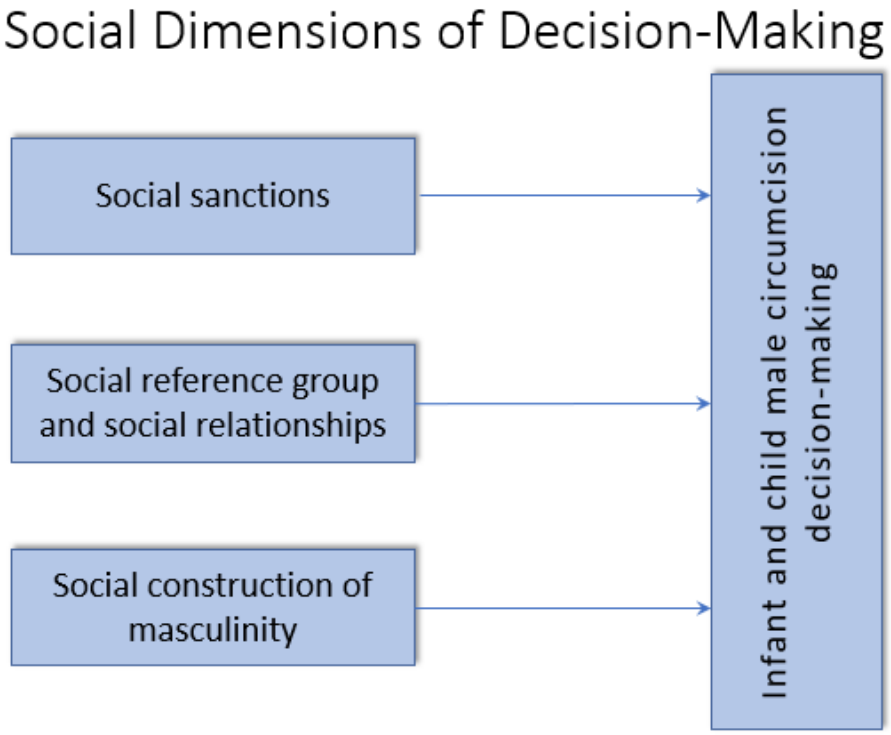

Figure 7.1 Social dimensions of decision-making (Own construction)

7.3.1.1 Social sanctions

The study highlighted the social realities and consequences of ICMC decision-making. The evidence in Chapter 4 demonstrates the influential role that TMC played in Simon's life and how his TMC experience has shaped his perception of ICMC. Simon's experience illustrates how silence about TMC can often negatively influence male circumcision decision-making. The social consequences of the secretive practices of TMC include judgement, isolation and ostracisation, thus men co-opt to silence. The TMC practice expects from initiates not to publicly share intricate details about the practice to maintain rules, authority, and tradition (see Chapter 4). Men's failure to comply with the secret practices of TMC are met with threats of external sanctions, executed in the form of exclusion, violence, and the humiliation of being brandished as non-male. The implication is that sharing your pain and fears openly is taboo and deserving of punishment for breaking the silence. Parents' ICMC decisions of acceptance were linked to the social consequences and impact of their subsequent decisions at family

level (see Chapter 5). Parents' decisions to accept ICMC instead of TMC led to conflict and judgement and was viewed as disrespectful to the family's TMC cultural traditions. Parents described disrespecting the family as affronting to their TMC culture. The disrespect is something to be ashamed of as parents were raised in the TMC culture and expect that they should *do the right thing* (see Chapter 4).

The evidence in Chapter 6 shows that Black women confront social sanctions not to accept ICMC. Within the social context of judgement, Black women can and do experience negative interactions with friends and extended family members. Social norms are active in Black women's ICMC decisions, which inadvertently maintain the negative social reactions to ICMC. Black women's conformity avoids negative sanctions and penalties of rejection by their social reference group (friends and family) (see Chapter 6).

7.3.1.2 Social reference group and social relationships

This study showed how the interaction with the social reference group of family and friends influences the attitudes, perceptions, and insights guiding ICMC decision-making. The study further demonstrated how the decision is constructed through information sharing and experiences while relying on the support of the reference group. Parents retained their decision-making capacity by identifying intergenerational supporters (their sons' grandparents and uncles) to help them make decisions (see Chapter 5). These supporters were influential and demonstrated an understanding of their situation. This reinforced parents' value of their relationships with grandparents and uncles, who pledged their unwavering support for the ICMC decision-making process.

The study provided insights into how social norms affect ICMC decision-making (see Chapter 6). Through the perceived risks involved in ICMC, Black women were making non-acceptance decisions within their informal support networks. Chapter 6 showed how social norms often function as unspoken *rules of the game*, governing women's negative perceptions of ICMC. Women reinforce the social expectation that they conform when they do not challenge ICMC decisions. Women conform to social expectations of silence and strengthen male dominance in decision-making to maintain social approval. Simon's support from his mother in his decision to reject TMC and accept MMC is pivotal (see Chapter 4). Despite excluding women from TMC discussions, Simon's mother was considered a hero. Women's interactions reinforced the contribution of women in male circumcision decision-making and Simon's ultimate decision to reject TMC. Therefore, it is crucial to recognise the powerful role of women and the immediate social relationships that have an impact on the decision-making process. In contrast, Simon made a different decision by not subscribing to the normative expectations of

authority that affect individual choices. Not following the prescription of the TMC practice and deviating from TMC and accepting MMC, he ran the risk of publicly undermining TMC. The fact that Simon was not amenable to TMC practice may have been driven by the desire not to seek social approval, especially when other initiates upheld the veil of secrecy.

7.3.2 Social construction of masculinity

TMC practices contribute to the construction of masculinity and masculine norms in decision-making. The cultural practice of TMC ties masculinity to power, silence, and social secrets. The factors reinforce patriarchal notions that men are superior and have dominance over women (see Chapter 4). TMC is a means of demonstrating masculinity as a rite of passage to manhood. Failing to achieve masculinity can lose social influence, increased stigma and ostracisation and loss of social benefits. Black women associated the cultural practice of TMC with social constructions of manhood in their decisions of non-acceptance of ICMC (see Chapter 6). This afforded their sons' masculine identities and privileges in the social context, that includes social status, respect, and dominance.

Despite this, the findings showed that, even when Black women are excluded and forced out of dialogue and vocality in TMC practices, they played an active role in keeping alive a vision of masculinity through TMC practices. This becomes central in how women interpret the meaning behind TMC practices.

7.3.3 Infant and child male circumcision policy myopia (short-sightedness)

The study highlighted the policy gaps related to ICMC decision-making. In South Africa, the MMC policy has not considered ICMC decision-making factors. Furthermore, the government has failed to implement an ICMC policy to prevent HIV. ICMC is not free in the public sector and is only available through the private health care sector. The *South African national guidelines for medical male circumcision* should recognise and address the legal and ethical aspects of ICMC decision-making (see Chapters 3 and 5). Furthermore, the guidelines fail to recognise the role of women in MMC. Their experiences, needs, barriers, and more importantly, their role in the circumcision decision-making are not recognised and can present challenges in reaching HIV prevention targets (see Chapter 6). A policy position of the South African government as it relates to women and male circumcision decision-making becomes important. Improved knowledge of ICMC decision-making would help to identify policy measures to correct gender imbalances while minimising their social consequences.

7.3.4 Multimethod qualitative approach to infant and child male circumcision decision-making

This study is one of the first multimethod qualitative approach studies conducted on infant and child male circumcision decision-making. The study employed more than one qualitative research method to explore ICMC decision-making. The choice of a qualitative approach across the three independent articles illuminated ICMC decision-making from various methodological stances. The study united different qualitative methodological approaches to describe, explain and analyse the complexities of ICMC decision-making. The study collected the voices of a young man, parents, single mothers, extended family, civil society, government officials, and Black women regarding their ICMC decision-making perspectives. The multimethod nature of the study presented a wealth of qualitative evidence of how ICMC decision-making is a complex, multifaceted experience firmly rooted in the social context. Therefore, the analysis presented was multi-dimensional, in line with the multi-layered, complex social world of everyday life experiences of the research participants. Furthermore, the different qualitative approaches allowed for different nuances in ICMC decision-making. The qualitative work provided a foundation for understanding ICMC decision-making as a process rather than an outcome.

The nature of MMC research has focused primarily on acceptability and generating demand for male circumcision services, while instrumentalising women in creating a demand for MMC. Since MMC and ICMC are male-focused HIV-prevention interventions, the perspectives of men are often prioritised. However, this study investigated the experiences and perceptions of Black women. The focus on the male perspectives in MMC limits women's voices, leading to women not being seen as knowledge producers in HIV prevention. This study foregrounds women in the MMC discourse by making their voices visible. MMC programmes often reference gender and the role and value of women in MMC. However, the silent assertions in MMC discourse are often driven from a patriarchal perspective.

However, the role of women in circumcision decision-making is minimised. As a result, there have been lost opportunities related to MMC and ICMC. Through meaningfully engaging women and bringing their voices to MMC and ICMC discourses, the focus must be on altering women's negative perceptions regarding trust, self-worth, respect, and dignity as women. Additionally, this study gave a voice to women's experiences. It illuminated the need to consider the participants' cultural autonomy and exposed their negative interactions with the public health care system.

Moreover, the study challenged hegemonic knowledge production because it presents new insights into the intersection of knowledge production and gender representation enacted in

male circumcision scholarship literature, policies, and programmes. Chapters 4, 5 and 6 revealed that these new insights may be viewed through the following lenses:

- *Integrating diverse narratives into the ICMC decision-making literature* provides a fuller, more inclusive view of ICMC decision-making that is rooted in the social context.
- *Emphasising the role of women* in male circumcision-decision-making, not only as commodities and instruments in support of generating demand for medical male circumcision. This approach contributes to new understandings of the inequalities of knowledge production with the traditional strong focus of the male voice.
- *Expanding women's role in knowledge production* in the context of gendered domains of knowledge production provides a deeper understanding of their world. It gives them access to domains they were not previously allowed to explore. It confronts the masculine knowledge construction in ICMC decision-making by amplifying Black women's voices. Employing qualitative approaches, the study reduced the disparity in knowledge production that has yielded incomplete masculine experiences and perceptions (Heberlein et al., 2016).
- *The focus on Black women's voices (married and single)* highlights their needs and concerns. It illustrates the complicit nature of their decision-making related to patriarchal masculinity. Therefore, the role gender plays in the decision-making process provides a voice that can empower women. While the inclusion of women's voices is important, it is critical to analyse what characterises and shapes these voices. For example, it helps to understand why they are invisible and unseen in the discourse and what can be done to address it.

7.3.5 Contribution to theory by including gendered ICMC decision-making dimensions

The Social Constructivism, ecological systems, and Social Norms Theory explains how individual behaviour is shaped and structured by environmental and interactive influences. According to these theories, the emphasis is on giving meaning to actions and experiences, based on interactions, influences, relationships and how they make meaning of their actions and experiences. It demonstrates the complexities of decision-making linked to multiple levels of influence within the wider social context, including the beliefs, values, and perceptions of the broader society.

In essence, the theories used in this study do not consider ICMC decision-making domains through a gender lens. Practically, the theories pay limited attention to the underlying decision-

making conditions of Black women living in township contexts. The importance of considering ICMC decision-making through a gender lens within the social construction of reality, Ecological Systems Theory, SNT was underscored in this study. While scholars have done a good job at investigating the foundations of behaviour, such as norms, rules, culture, and policies, they have paid less attention to how Black women make decisions within these structures (see Chapter 3). Additionally, there has been no clear reflective research programme that focuses on the lived experiences of participants within such decision contexts (Black women in a township) (see Section 7.3.3). As indicated in Chapter 1, the Social Constructivism, Ecological Systems, and Social Norms theories are based on interactions, connections, and influence within social relationships, often neglecting to reflect important representational aspects of the Black female identity and gender. Chapters 4 and 6 argued that social norms impact women's perceptions and participation in MMC decision-making. The sociological and psychological theories presume that ICMC decision-making is free of the complexities of vested interest and the gendered social realities of ICMC decision-making. It does not raise questions about the exclusion and marginalisation that underpin the ICMC decision-making realities faced by Black women. Additionally, this deliberate social exclusion mirrors the invisibility of Black women's voices in the broader MMC discourse.

This invisibility of women in the ICMC decision-making process has been shown to work in combination with women's position in the decision-making process. The study demonstrated that Black women's experiences of ICMC decision-making has resulted in silence, fear, and trade-offs in decision-making (see Chapters 4, 5, 6). In the context noted earlier, this study emphasised gendered perspectives because of the MMC policies and programmes that do not consider the context noted earlier. ICMC decision-making impacts women differently due to gender norms.

7.4 Study contribution

To date, there are limited studies that investigated ICMC. In South Africa, no studies focused on the ICMC decision-making process from the perspectives of multiple stakeholders, including parents, Nongovernmental institutions (NGOs), government officials, Black women, and young men. Furthermore, MMC is largely a masculine field where women are excluded and enjoy marginal participation in decision-making processes. The study used Black women's experiences as a mirror to view the evolving gender dynamics of ICMC decision-making. For example, Kaufman et al. (2018) highlighted that females' peer influence on adolescent males plays an important role in circumcision decision-making.

This study explored their experiences in two townships in the Gauteng province. This research study is significant to public health as it expands existing knowledge in the field. Furthermore, the study results could inform policymakers to review and evaluate the existing MMC programme and policies.

This section focuses on the contributions of the thesis. The study contributed two published articles:

- Palmer, E., Rau, A., & Engelbrecht, M. (2021). Changing cultural practices: A case study of male circumcision in South Africa. *American Journal of Men's Health*, *14*(4). https://doi:10.1177/1557988320927285
- Palmer, E., Marais, L., & Engelbrecht, M. (2022). Parental decision-making in infant and child male circumcision: A case study in two townships in Gauteng, South Africa. *The African Journal of AIDS Research*, 21(1), 32–40. https://doi.org/10.2989/16085906.2022.2038645

Furthermore, at the submission of this thesis (Chapter 6, Article 3) was submitted to the *Journal of Maternal and Child Health*. Chapter 2 and 3 (scoping review and document analysis) will also be prepared for publication.

7.4.1 Contribution to methodology

The thesis demonstrated various qualitative methods. The three articles paid attention to male circumcision decision-making in a social context. The literature review indicated that among the 83 ICMC research studies conducted, the largest proportion were quantitative studies (45), followed by qualitative studies (13) (see Chapter 3). This demonstrates that ICMC decision-making literature is primarily focused on quantitative studies, employing mainly questionnaire-based surveys within a health-facility-based context.

While there is a growing body of literature in ICMC decision-making, limited attention is paid to how gender, masculinity, social norms, social context, and broader societal factors influence decision-making. Bossio et al. (2014) argued that ICMC literature is limited and does not clearly outline the parents' course when making these decisions because male circumcision is a controversial subject. The study conducted in-depth interviews to provide insight into the complex decision-making process. Furthermore, it presented a single case study of a young male's TMC experience shaped by gender, social construction of masculinity and the positioning of men, women, and young boys relative to each other and the local context. The study fills this gap by extending the ICMC decision-making literature beyond parents by engaging multiple perspectives on decision-making, which includes Black women and single

mothers to provide a comprehensive understanding and paints an inclusive picture of the gendered nature of circumcision decision-making. The gendered dimension of decision-making that the study presents contrasts with the current MMC literature related to Black women's negative experiences of ICMC. These experiences are often rooted in social pressure, men dominating decision-making, mistrust of the public health system, and TMC cultural practices that highlight how historical, unequal gender relations are reinforced. Furthermore, the contribution lies in the empirically rich insights provided by the single case study, exploratory case study and descriptive qualitative methods. The study illuminated the dynamics of voice and choice as critical elements that can contribute to a better understanding of the decision-making process. Additionally, frameworks to understand the multiple influences in acceptance and non-acceptance decision-making, which can guide policy and programme development processes, were presented.

7.4.2 Contribution to medical male circumcision policy

The study provides policymakers with a rich, contextual understanding of ICMC decision-making for MMC policies. Researchers have paid much less attention to women's perspectives in male circumcision decision-making. This thesis contributes to the knowledge base by offering a uniquely South African perspective on ICMC decision-making.

The *South African national guidelines for medical male circumcision* have not been reviewed and updated since 2016. The objectives of providing safe, affordable circumcision services as set out in the guidelines will not be met if the guidelines are not reviewed to include updated policy guidance from the WHO (2020) and PEPFAR (2020). This may provide policy direction to clients, parents, families, health care workers and nongovernmental institutions (NGOs) offering male circumcision services in the community. Moreover, a review of the *South African national guidelines for medical male circumcision* is recommended to ensure updated compliance with legislation, regulations and guidance from donors and international agencies to avoid litigation stemming from medical malpractice actions related to the circumcision procedure.

There is limited empirical evidence in the literature on women's involvement in MMC programmes. The study found that the needs and concerns of single women are not included in male circumcision policies and programmes. The findings showed that women consider that the child has a right to be involved in the decision-making process and their unemployment and competing for household needs make ICMC unaffordable (Chapter 5). Therefore, policies and practices should not be one-dimensional because women exist at the intersection of multiple identities and thus can experience and interpret the same policy in distinctly diverse

ways. Furthermore, this work highlighted how women experience ICMC decision-making and its influence on their everyday experiences within their social contexts.

7.4.3 Contribution to the theory

A focal point of the contribution of this thesis was the scoping review of the ICMC and MMC literature and theory. The scoping review highlighted that the ICMC and MMC research literature is well established (Chapter 2). Furthermore, the analysis confirmed that ICMC research lacks a theoretical orientation. Most literature studies have not utilised theoretical frameworks to guide their research; hence, the current research addressed the gap in applying theoretical constructs to understand ICMC decision-making. Despite a plethora of research on MMC, this is the first scoping review combining ICMC and MMC literature and theory. This absence of a theory to explain ICMC decision-making is surprising, given the extreme decision-making context faced by many parents, young men, and adolescents. The present research contributes to theory because it generates original insights into the ICMC decision-making phenomena that will be useful for policymaking to improve and understand ICMC decision-making. This is done by making the use of theories (Social Constructivism, Ecological Systems Theory, and Social Norms Theory) (Chapters 4, 5 and 6) explicit to guide the study. Social Constructivism added value to the study because it highlighted the role of the social context in the construction of knowledge and experience. Employing the three constructs of the Ecological Systems Theory in the study analysis provided access to the multiple meanings that parents attach to ICMC decision-making. Furthermore, SNT helps in understanding that ICMC perceptions of acceptance and rejection are embedded in the socially constructed meanings attached to circumcision.

Furthermore, the study advanced theoretical knowledge by generating new insights into unexplored ICMC decision-making domains. Noticeable was the domain related to Black women (married and single) because it extended the ICMC literature as a new aspect in the ICMC decision-making literature. This study illuminated Black women's invisibility in ICMC decision-making due to gender dimensions, the social context, and masculine constructions, as well as depictions of Black women's roles in the male circumcision discourse. The study produced a theoretical contribution by providing new and inclusive ICMC decision-making viewpoints that could open up creative dialogue in MMC research, policy, and programme development.

Additionally, the study analysed and forged connections among the empirical evidence and the theoretical framework to understand ICMC decision-making. The two-way relationships between empirical data and various levels of theory contribute to the advancement of

knowledge. This study adds to the body of knowledge by expanding theoretical knowledge about ICMC decision-making in theoretical grounding. This was achieved by applying sociological and psychological theories to expand the analysis of ICMC decision-making processes and how they play out in social environments. Furthermore, the study employed empirical data to advance conceptual knowledge of the field by applying theoretical constructs to explore ICMC decision-making.

Moreover, the central contribution of the study lies in applying different theories combined in one qualitative study to analyse ICMC decision-making in a developing country context. Therefore, the theoretical focus provided strength to the study. The theories provided a context for this thesis and connected ICMC decision-making to the social construction of reality, Ecological Systems Theory, and Social Norms Theory. These theories are used as a framework to understand ICMC decision-making from the perspective of a young man, parents, extended family, and Black women. The study elevated the role of the theory in qualitative research by applying theoretical constructs to provide coherence and depth to the research and data interpretation, therefore allowing new ways of seeing and understanding ICMC decision-making.

7.4.4 Framework for infant and child male circumcision decision-making

The thesis presented an ICMC decision-making framework for understanding the complex layers of ICMC decision-making (see Figure 7.2). This ICMC decision-making framework spans several disciplines, including public health, human rights, sociology, psychology, law, and human rights. This study's contribution is unique because it investigates ICMC decision-making from a different angle, highlighting parental factors, Black women's perceptions and the perspectives of a young Pedi male who changed from supporting and undergoing TMC to advocating for MMC. This contributed to developing an ICMC decision-making framework presenting decision-making domains that should be considered in MMC policy and programme formulation.

Figure 7.2 Infant and child male circumcision decision-making framework (Own construction)

7.5 Key recommendations

This section illuminates specific areas that policymakers, health care workers and NGOs responsible for performing and delivering MMC services may consider addressing. The following recommendations are proposed:

❖ **More attention should be paid to understanding the impact of social beliefs**

Sanctioning strategies that maintain social norms can be addressed through active community mobilisation by ensuring that the norms are transparent and measuring their impact on ICMC decision-making. Furthermore, research is needed to understand how social sanctions for compliance or non-compliance differ by setting, and how it affects men and women in the decision-making process.

- **Expanded thinking about the social dimensions that influence ICMC decision-making and the potential impact on women**

Policy interventions on social dimensions of ICMC decision-making should recognise that the individual is part of a larger social system that influences decision-making. Policies should recognise and acknowledge how social norms shape ICMC decision-making in TMC practices related to patriarchal masculinity and gender inequality in decision-making. The following elements can be included; manhood, gender attitudes and gender norms to understand how these may influence ICMC decision-making. Partnerships with NGOs such as the Centre for Communication Impact in Pretoria, South Africa, could engage communities to influence positive social norm changes and address gender dimensions to ensure women's active participation in ICMC decision-making.

- **Social network interactions through family, friends and peers play a significant role in the ICMC decision-making process**

Policy directives should consider a social network analysis to investigate the relationships and map the decision-makers and the role of network actors related to ICMC decision-making. Employing a social network analysis may help illuminate the complex social interactions between the social network actors that shape the ICMC decision-making process, providing context and understanding to policy improvements that could be made to strengthen male circumcision services. The Centre for AIDS Development, Research and Evaluation (known as CADRE) in Johannesburg, South Africa, could do research to expand their understanding of ICMC decision-making through evaluating the significance of the social network actors in their roles and identifying how their interactions influence ICMC decision-making. This will help to establish policy priorities to improve MMC programmes.

- **There should be recognition of the social constructions of masculinity as it relates to male circumcision decisions**

The significance of recognising that masculinity is complex requires multiple perspectives and viewing masculinity as an evolving social process that is not bound by rigid stereotypes. Policy imperatives should target all levels of the ecological system (including the microsystem, mesosystem, exosystem, macrosystem, and chronosystem) to emphasise reciprocal relationships in the decision-making process (see Chapters 4 and 5). There is an urgent need for male circumcision programmes to challenge the negative conceptions of manhood and consider transforming gender-based cultural practices such as TMC to include sensitivity to all genders and to acknowledge women's participation in male circumcision decision-making. This could be achieved through working with NGOs such as Sonke Gender Justice in

Johannesburg, South Africa, through community education and mobilisation programmes that engage men and women in programmes that address negative masculinities and gender roles in ICMC decision-making.

- **There should be a concerted effort to update the medical male circumcision policy**

The *South African national guidelines for medical male circumcision* was released in 2016 and has not been reviewed since its inception. In Chapter 3, this study proposed that the guidelines should be reviewed and updated to incorporate the recent, related policy guidance. In 2020, the WHO updated their guidelines for VMMC for adolescent boys and men in generalised HIV epidemics. The recommendations and considerations should include attention to ethics, human rights, and safety for boys under the age of fifteen. Furthermore, the ethical and legal decision-making dimensions related to consent and the autonomy of the child to make decisions should be incorporated to reflect decision-making difficulties comprehensively. Additionally, the policy should acknowledge the sociocultural factors and shift from gender-neutral policy positions, while incorporating policy directives that are gender-sensitive and acknowledges the role of women in ICMC decision-making. The Centre for the AIDS Programme of Research in Durban, South Africa (known as CAPRISA), has immense potential to contribute to the review of the guidelines to inform MMC policymaking and produce guidance for the programme because of their extensive experience in undertaking local and international health policy research.

- **There should be further qualitative research in ICMC decision-making to improve policy provisions**

This study highlighted women's features in the decision-making process, despite their low visibility in the literature. Further research into understanding gender equality in ICMC decision-making should be explored to address the poor representation of women. Gendered norms and inequalities are entrenched in ICMC decision-making. It is important to ensure women's equal representation and meaningful participation in MMC decision-making policy and programme planning. Evidence across the three articles implicitly demonstrated that women are not consulted or included in the decision-making arena, leaving them at the periphery of the decision-making process. Over and above the involvement of individual women, women's organisations should be engaged and represented in policy review processes. Qualitative research should be expanded in ICMC decision-making to improve the policy mandates related to the inclusion and representation of women in MMC decision-making. Organisations such as the Centre for HIV/AIDS Prevention Studies (known as CHAPS) in Johannesburg, South Africa, are ideally placed to conduct qualitative research

based on their extensive MMC research experience and their active role in the MMC policy and programming development processes in South Africa.

- **To expand on the existing body of knowledge, more studies should use theoretical constructs**

This study's scoping review underscored the underutilisation of theoretical frameworks when analysing MMC decision-making (see Chapter 2). Furthermore, theoretical perspectives on decision-making were applied to explain ICMC decision-making, providing context to ICMC decision-making situations to create a more comprehensive picture of how male circumcision choices are made, given the availability of circumcision alternatives (see Chapters 4, 5 and 6). Additionally, further research studies should comprehensively explore ICMC decision-making by applying relevant theories to understand ICMC decision-making processes comprehensively. This will provide a detailed picture of the processes, stakeholders involved, and influences on decisions of male circumcisions. Research organisations, such as the Centre for Communication Impact, could play an instrumental role in expanding the understanding of ICMC decision-making by putting together the experiences and perspectives involved, based on sound theoretical foundations.

Table 7.1 provides a summary of the main study findings and recommendations.

Table 7.1 Summary of the main study findings and recommendations

Main findings	Chapters	Main recommendations
Social sanctions are imposed when parents deviate from what is perceived as the prevalent infant and child male circumcision (ICMC) decision-making behaviour in their community.	4, 5, 6	• Medical male circumcision (MMC) programme interventions should pay attention to understanding the impact of social beliefs and how these beliefs influence sanctioning strategies in the decision-making process • Policy guidelines should include social dimensions that influence ICMC decision-making and the potential impact on women.
The social network interactions through family, friends and peers play a vital role in the ICMC decision-making process.	4 ,5, 6	• The government should explore social network approaches to inform MMC policies and practices to demonstrate how social norms influence beliefs and decisions. • Attention should be given to intergenerational decision-making studies. Policies and programmes should focus on shared decision-making models that consider the role of the extended family.
The social construction of masculinity influences male circumcision decisions.	4, 5, 6	• Engaging traditional leaders through dialogue to change social norms related to masculinity and traditional male circumcision. • Integrate gender transformative approaches in policy analysis and policy implementation.
The MMC policy is short-sighted.	3, 4, 5, 6	• MMC policies should clarify the uncertainly related to the inclusion of ICMC as part of the MMC programme. • Review of the MMC policy guidelines to reflect updated ICMC information. • MMC policies should be more gender-responsive to address women's exclusion in ICMC decision-making.
This is one of the first multimethod qualitative approach studies conducted on ICMC decision-making.	2, 3, 4, 5, 6	• There should be research into a gender analysis of MMC policy documents to expand and improve the policy mandates related to the gendered decision-making dimensions of ICMC.
The study contributes to theory through expansion of the literature.	4, 5, 6	• More research studies should apply theories to understand ICMC decision-making to provide a comprehensive picture of a complex decision-making process in the context of gender, culture, and social dynamics.

7.6 Further research

The study offered unique perspectives of family involvement in the decision-making process. The nuclear model of the family is not an accurate representation of many Black South African families. Therefore, incorporating the views of other family-based relationships to depict the reality of the representations of the extended family in ICMC decision-making could benefit from future research.

The MMC policy is outdated because it does not reflect recent WHO and PEPFAR guidance. The core guiding principles of the MMC policy include quality, safety, informed consent, confidentiality, human rights, and privacy confidentiality. Moreover, these principles could be analysed concerning the perceptions of the current male circumcision programme service delivery.

The study was theory-driven because it identified, applied, and integrated a strong theoretical foundation throughout the thesis. Further research could use theoretical constructs to contextualise and explore the complexity of ICMC decision-making through additional decision-making scenarios, such as exploring decision-making perspectives in policy and lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual contexts.

Furthermore, this study pointed to the unaffordability of ICMC as a major consideration in the decision-making process. Out-of-pocket costs for parents to pursue ICMC, especially given competing household priorities for single mothers, were prohibitive, creating access barriers. The study did not provide evidence on the cost considerations at household level and costs to the public health care system. However, further research could investigate these associations (affordability, availability, acceptability) to inform ICMC policy and programme interventions. Given the structural and fiscal reforms under the National Health Insurance Fund that the South African government is considering, the cost of implementing ICMC as an HIV prevention strategy becomes an important consideration.

Throughout the study, the need to amplify Black women's voices in male circumcision is underscored. Further research in this area is needed to ensure an inclusive knowledge base that gives identity to the intersecting voices of Black women, elevating their visibility in the MMC discourse.

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Appendix A
Ethical Clearance Letter

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

09-Jan-2019

Dear **Ms Eurica Palmer**

Ethics Clearance: **Early Infant Male Circumcision in South Africa**
Principal Investigator: **Ms Eurica Palmer**
Department: **Centre for Health Systems Research and Development Department (Bloemfontein Campus)**

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is:**UFS-HSD2018/1443/2901**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00006240; REC 230408-011; IORG0005187; FWA00012784
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa
www.ufs.ac.za

Appendix B
Informed Consent Document (Adopters)

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
ECONOMIC AND MANAGEMENT SCIENCES
EKONOMIESE EN BESTUURSWETENSKAPPE
CENTRE FOR DEVELOPMENT SUPPORT
SENTRUM VIR ONTWIKKELINGSTEUN

October 2018

Study title: Early Infant Male Circumcision (EIMC) in South Africa[1]

Dear participant,

I am a PhD (Development Studies) student in the Faculty of Economic and Management Sciences, University of the Free Sate. The title of my study is as above. The aim of the study is to explore key aspects and trajectories of EIMC in South Africa and critically engage with the different perspectives around the issues.

The protocol for the study was approved by the Faculty of Health Sciences Research Ethics Committee, University of the Free State. The study will be conducted under the direction of Dr Michelle Engelbrecht and Dr Asta Rau from the Centre for Health Systems Research and Development, University of Free State.

You were selected to participate in this study as a parent whose child was circumcised within the first two months following the birth of the child. Your participation is entirely voluntary and you have the right to withdraw at any stage in the process without any consequences. Furthermore, the data you share will be destroyed should you choose to withdraw from the study. The researcher will issue you with a signed copy of your agreement for your records.

As researchers we will do everything in our power to protect your confidentiality. You will be requested to provide your name, contact number and sign this consent form. This will allow the researcher to contact you in the case of any follow up questions. An audio recording will be made of the interviews.

The signed consent form will be kept safely in a locked cabinet and no one outside of the research team will have access to it. Your responses will not be linked in any way with your name or appear in any reports.

[1] The title of the thesis was amended in 2021 to read: Early childhood male medical circumcision.

Procedures of the study:

- You will be expected to participate in three one hour in-depth interviews with the researcher over a three month period. Together with the researcher, you will choose a venue for the interviews.
- You will be expected to participate in follow-up interview sessions. At the end of each interview session, the venue and date of our next interview session, as well as your contact details, will be confirmed by the researcher.
- If your contact details have changed, please indicate this to the researcher.
- If you do not understand, or feel uncomfortable answering any of the questions, please indicate this to the researcher.
- Specify the language you would prefer to use during the interviews.

Risks

Due to your direct/indirect exposure to early infant male circumcision you might feel some emotional distress when answering some of the questions. If for some reason you feel this way, please inform the researcher. We can discuss referring you to an appropriate service provider for counselling.

Service providers:

- Lifeline – Ekurhuleni at 3 Russel Street, Benoni, Gauteng (011 421 0384).
- Lifeline –Soweto Clinic at Corner of Braam Fischer and Dobsonville Roads, Dobsonville, Soweto, Gauteng (011 926 3230).

Benefits

The information you will share with me may not benefit you personally. For future purposes, however, the information may be helpful to others who are considering early infant male circumcision for children. Therefore, I sincerely invite you to join this study because you will have an opportunity to share your views and experiences.

Please note that you will receive no remuneration for participating in the study nor will there be any costs payable by you.

Should you require any additional information concerning this study at any time, please contact the principal investigator.

Eurica Palmer on phone number: 061 210 9814

If you have complaints/problems, please contact:

HSREC Chair, Ms M Marais on 051 401 7794 (office hours 07:45–16:30)

HSREC Secretariat, Mrs J du Plessis on 051 401 7794 (office hours 07:4–16:30)

I, _____

[FULL NAME OF PARTICIPANT IN BLOCK LETTERS]

Have read and understood all the above information; was given the opportunity to discuss this information and ask questions; volunteer to take part in this study; and confirm that I have received a copy of this consent form.

Signature of participant: **Date:**

_____ _____

Appendix C
Informed Consent Document (Non-Adopters)

October 2018

Study title: Early Infant Male Circumcision (EIMC) in South Africa[1]

Dear participant,

I am a PhD (Development Studies) student in the Faculty of Economic and Management Sciences, University of the Free Sate. The title of my study is as above. The aim of the study is to explore key aspects and trajectories of EIMC in South Africa and critically engage with the different perspectives around the issues.

The protocol for the study was approved by the Faculty of Health Sciences Research Ethics Committee, University of the Free State. The study will be conducted under the direction of Dr Michelle Engelbrecht and Dr Asta Rau from the Centre for Health Systems Research and Development, University of Free State.

You were selected to participate in this study as a parent whose child was not circumcised within the first two months following the birth of the child.

Your participation is entirely voluntary and you have the right to withdraw at any stage in the process without any consequences. Furthermore, the data you share will be destroyed should you choose to withdraw from the study. The researcher will issue you with a signed copy of your agreement for your records

As researchers we will do everything in our power to protect your confidentiality. You will be requested to provide your name, contact number and sign this consent form. This will allow the researcher to contact you in the case of any follow up questions. An audio recording will be made of the interviews.

The signed consent form will be kept safely in a locked cabinet and no one outside of the research team will have access to it. Your responses will not be linked in any way with your name or appear in any reports.

[1] The title of the thesis was amended in 2021 to read: Early childhood male medical circumcision.

Procedures of the study:

- You will be expected to participate in three one hour in-depth interviews with the researcher over a three month period. Together with the researcher, you will choose the venue for the interviews.
- You will be expected to participate in follow-up interview sessions. At the end of each interview session, the venue and date of our next interview session, as well as your contact details, will be confirmed by the researcher. If your contact details have changed, please indicate this to the researcher.
- If you do not understand, or feel uncomfortable answering any of the questions, please indicate this to the researcher.
- Specify the language you would prefer to use during the interviews.

Risks

Due to your direct/indirect exposure to early infant male circumcision you understand that:

- Due to your direct/indirect exposure to early infant male circumcision you might feel some emotional distress when answering some of the questions. If for some reason you feel this way, please inform the researcher. We can discuss referring you to an appropriate service provider for counselling.

Service providers:

- Lifeline – Ekurhuleni at 3 Russel Street, Benoni, Gauteng (011 421 0384).
- Lifeline –Soweto Clinic at Corner of Braam Fischer and Dobsonville Roads, Dobsonville, Soweto, Gauteng (011 926 3230).

Benefits

The information you will share with me may not benefit you personally. For future purposes, however, the information may be helpful to others who are considering early infant male circumcision for children. Therefore, I sincerely invite you to join this study because you will have an opportunity to share your views and experiences.

Please note that you will receive no remuneration for participating in the study nor will there be any costs payable by you.

Should you require any additional information concerning this study at any time, please contact the principal investigator.

Eurica Palmer on phone number: 061 210 9814

If you have complaints/problems, please contact:

HSREC Chair, Ms M Marais on 051 401 7794 (office hours 07:45–16:30)

HSREC Secretariat, Mr J du Plessis on 051 401 7794 (office hours 07:45–16:30)

I, _____

[FULL NAME OF PARTICIPANT IN BLOCK LETTERS]

Have read and understood all the above information; was given the opportunity to discuss this information and ask questions; volunteer to take part in this study; and confirm that I have received a copy of this consent form.

Signature of participant: **Date:**

_____ _____

Appendix D
Informed Consent Document (Government)

October 2018

Study title: Early Infant Male Circumcision (EIMC) in South Africa[1]

Dear participant,

I am a PhD (Development Studies) student in the Faculty of Economic and Management Sciences, University of the Free Sate. The title of my study is as above. The aim of the study is to explore key aspects and trajectories of EIMC in South Africa and critically engage with the different perspectives around the issues.

The protocol for the study was approved by the Faculty of Health Sciences Research Ethics Committee, University of the Free State. The study will be conducted under the direction of Dr Michelle Engelbrecht and Dr Asta Rau from the Centre for Health Systems Research and Development, University of Free State.

You were selected to participate in this study as a national/provincial government official from the Department of Health because of your direct knowledge and experience of HIV/AIDS, Maternal Neonatal Child and Woman's Health (MNCWH) programmes and policymaking in South Africa.

Your participation is entirely voluntary and you have the right to withdraw at any stage in the process without any consequences. Furthermore, the data you share will be destroyed should you choose to withdraw from the study. The researcher will issue you with a signed copy of your agreement for your records.

As researchers we will do everything in our power to protect your confidentiality. You will be requested to provide your name and sign this consent form. This will allow the researcher to contact you in the case of any follow up questions. An audio recording will be made of the interviews.

The signed consent form will be kept safely in a locked cabinet and no one outside of the research team will have access to it. Your responses will not be linked in any way with your name or appear in any reports.

[1] The title of the thesis was amended in 2021 to read: Early childhood male medical circumcision.

Procedures of the study:

- You will be expected to participate in a one hour in-depth interview with the researcher over a period of one month. Together with the researcher, you will choose a venue for the interviews.
- You will be expected to participate in follow-up interview sessions if required. At the end of each interview session, the venue and date of our next interview session, as well as your contact details, will be confirmed by the researcher. If your contact details have changed, please indicate this to the researcher
- If you do not understand, or feel uncomfortable answering any of the questions, please indicate this to the researcher.
- Specify the language you would prefer to use during the interviews.

Risks

Due to your direct/indirect exposure to early infant male circumcision you might feel some emotional distress when answering some of the questions. If for some reason you feel this way, please inform the researcher. We can discuss referring you to an appropriate service provider for counselling.

Service providers:

- Lifeline – Ekurhuleni at 3 Russel Street, Benoni, Gauteng (011 421 0384).
- Lifeline –Soweto Clinic at Corner of Braam Fischer and Dobsonville Roads, Dobsonville, Soweto, Gauteng (011 926 3230).

Benefits

The information you will share with me may not benefit you personally. For future purposes, however, the information may be helpful to others who are considering early infant male circumcision for children. Therefore, I sincerely invite you to join this study because you will have an opportunity to share your views and experiences.

Please note that you will receive no remuneration for participating in the study nor will there be any costs payable by you.

Should you require any additional information concerning this study at any time, please contact the principal investigator.

Eurica Palmer on phone number: 061 210 9814

If you have complaints/problems, please contact:

HSREC Chair, Ms M Marais on 051 401 7794 (office hours 07:45–16:30)

HSREC Secretariat, Mrs J du Plessis on 051 401 7794 (office hours 07:45–16:30)

I, _____

[FULL NAME OF PARTICIPANT IN BLOCK LETTERS]

Have read and understood all the above information; was given the opportunity to discuss this information and ask questions; volunteer to take part in this study; and confirm that I have received a copy of this consent form.

Signature of participant: **Date:**

_____ _____

Appendix E
Informed Consent Document (Civil Society)

October 2018

Study title: Early Infant Male Circumcision (EIMC) in South Africa[1]

Dear participant,

I am a PhD (Development Studies) student in the Faculty of Economic and Management Sciences, University of the Free Sate. The title of my study is as above. The aim of the study is to explore key aspects and trajectories of EIMC in South Africa and critically engage with the different perspectives around the issues.

The protocol for the study was approved by the Faculty of Health Sciences Research Ethics Committee, University of the Free State. The study will be conducted under the direction of Dr Michelle Engelbrecht and Dr Asta Rau from the Centre for Health Systems Research and Development, University of Free State.

You were selected to participate in this study as a member of civil society because you have direct knowledge and experience in human and child rights, HIV prevention, Maternal Neonatal Child and Woman's Health (MNCWH) programmes and policymaking in South Africa.

Your participation is entirely voluntary and you have the right to withdraw at any stage in the process without any consequences. Furthermore, the data you share will be destroyed should you choose to withdraw from the study. The researcher will issue you with a signed copy of your agreement for your records.

As researchers we will do everything in our power to protect your confidentiality. You will be requested to provide your name and sign this consent form. This will allow the researcher to contact you in the case of any follow up questions. An audio recording will be made of the interviews.

The signed consent form will be kept safely in a locked cabinet and no one outside of the research team will have access to it. Your responses will not be linked in any way with your name or appear in any reports.

[1] The title of the thesis was amended in 2021 to read: Early childhood male medical circumcision.

Procedures of the study:

- You will be expected to participate in a one hour in-depth interview with the researcher over a period of one month. Together with the researcher, you will choose a venue for the interviews.
- You will be expected to participate in follow-up interview sessions if required. At the end of each interview session, the venue and date of our next interview session, as well as your contact details, will be confirmed with the researcher. If your contact details have changed, please indicate this to the researcher.
- If you do not understand, or feel uncomfortable answering any of the questions, please indicate this to the researcher.
- Specify the language you would prefer to use during the interviews.

Risks

Due to your direct/indirect exposure to early infant male circumcision you might feel some emotional distress when answering some of the questions. If for some reason you feel this way, please inform the researcher. We can discuss referring you to an appropriate service provider for counselling.

Service providers:

- Lifeline – Ekurhuleni at 3 Russel Street, Benoni, Gauteng. (011) 421 0384).
- Lifeline –Soweto Clinic at Corner of Braam Fischer and Dobsonville Roads, Dobsonville, Soweto, Gauteng. (011 926 3230)

Benefits

The information you will share with me may not benefit you personally. For future purposes, however, the information may be helpful to others who are considering early infant male circumcision for children. Therefore, I sincerely invite you to join this study because you will have an opportunity to share your views and experiences.

Please note that you will receive no remuneration for participating in the study nor will there be any costs payable by you.

Should you require any additional information concerning this study at any time, please contact the principal investigator.

Eurica Palmer on phone number: 061 210 9814

If you have complaints/problems, please contact:

HSREC Chair, Ms M Marais on 051 401 7794 (office hours 07:45–16:30)

HSREC Secretariat, Mrs J du Plessis on 051 401 7794 (office hours 07:45–16:30)

I, _____

[FULL NAME OF PARTICIPANT IN BLOCK LETTERS]

Have read and understood all the above information; was given the opportunity to discuss this information and ask questions; volunteer to take part in this study; and confirm that I have received a copy of this consent form.

Signature of participant: **Date:**

_____ _____

Appendix F
Interview Guides

Early Infant Male Circumcision Adopters

1. **Where did you hear about EIMC?**

2. **Why did you decide to have your son circumcised? Probes:**
   - What role did health benefits, health care providers, religion, culture, final appearance, timing, father's circumcision status play and why?
   - What are the cultural, religious, family meanings attached to the roles of men and women in the decision?
   - What are the community and family structures that supported the decision? How do they operate?
   - Can you tell me as a partner, do you feel that you had an equal say in the decision? Explain

3. **What influenced your decision? Probes:**
   - What role did (family, partner, peers, health facility, mother-in law) play in the decision-making on EIMC and why? How were they involved? Did some have more power than others
   - What process did you follow to make the decision and why?
   - Who was involved? Who was the primary decision-maker? What were his/her/their reasons? Were they supportive of your involvement in the decision? Has this always been the case? Please explain.

4. **How did your family respond to your decision to circumcise your son? Probes:**
   - From your experience, can you tell me about any differences you have noticed in how men and women perceive EIMC?
   - From your experience, can you tell me about any differences you have noticed in how older and younger people see EIMC?

5. **What made it easy/difficult to take your son for EIMC? Probe:**
   - Access to EIMC services, health benefits, fear of complications, cost, culture, safety, timing of the procedure, community, family/partner. Why?

6. **Would you recommend EIMC to other parents? Probes:**

- Why or why not?
- What learning experiences would you like to pass over to parents and why? Positive and negative

7. **Can you tell me more about how discussions of future EIMC will be handled?**
   Probe:
   - Will it be negotiated, a family decision, father's decision, how will this be managed? Explain more.

8. **Is there anything more you would like to add?**

Thank you very much for your time.

EIMC Non-adopters

1. **Where did you hear about EIMC?**

2. **Why did you decide not to have your son circumcised? Probes:**
   - What role did fear of harm, death, injury, deformities, excessive pain, safety of procedure, access to health services, not being able to have children, female service providers, age, timing, father's circumcision status, culture, religion play and why?
   - Who was the primary decision-maker? What were his/her/their reasons?
   - What are the cultural, church, family meanings attached to the roles of men and women in the decision?

3. **What influenced your decision? Probes:**
   - What role did (family, partner, peers, mother-in law) play in the decision-making and how?
   - What was the process of reaching consensus with partner/family? How were they involved? Did some have more power than others?
   - As a partner, do you feel that you had an equal say in the decision? Why/why not?

4. **Would you recommend EIMC to other parents? Probes:**
   - Why or why not? Explain.

5. **How did your family respond to your decision not to circumcise your son? Probes:**
   - Were you able to challenge the decision as a partner/ family member?
   - What was the role of the female partner in the decision?

6. **From your experience, can you tell me about any differences you have noticed in how men and women perceive MMC and EIMC?**

7. **From your experience, can you tell me about any differences you have noticed in how older and younger people see male circumcision and EIMC. Probes:**
   - As needed probe: gender, culture, religion, community, health facility.

8. **What needs to change for you to decide to opt for EIMC? Probes:**
   - Information, cultural and religious beliefs and practices, partner/family influences, community, gender, public health system.

9. **What specific information do you think is essential in helping people decide to have their sons circumcised:**

   Probes:
   - Why and how would it help them?

10. How did your family respond to your decision to get circumcised?

Probes:

- From your experience, can you tell me about any differences you have noticed in how men and women responded to you being circumcised?
- From your experience, can you tell me about any differences you have noticed in how older and younger people responded to you being circumcised?

11. Is there anything more you would like to add?

Thank you very much for your time.

Men who were circumcised as infants/ adults over 18 years of age

1. **At what age were you circumcised:**

   Probes:

   - How did you feel? Positive and negative feelings.
   - Was this what you expected? Explain.
   - How did you find out about medical male circumcision?

2. **Why did you decide to get circumcised?**

   Probes:

   - What role did fear of harm, death, injury, deformities, excessive pain, safety of procedure, access to health services, not being able to have children, female service providers, age, timing, father's circumcision status, culture, religion play and why?
   - Who was the primary decision-maker? What were his/her/their reasons?
   - What are the cultural, church, family meanings attached to the roles of men and women in the decision?

3. **What influenced your decision?**

   Probes:

   - What role did (family, partner, peers, mother-in law) play in the decision- making and how?
   - What was the process of reaching consensus with partner/family? How were they involved? Did some have more power than others?
   - As a partner, do you feel that you had an equal say in the decision? Why/why not?

4. **Can you tell me anything about where your circumcision was performed, and who did the procedure?**

   Probes:

   - Why?
   - Was this what you expected? Explain.

5. **Did your parents/guardians discuss the circumcision procedure with you?**

   Probes:

   - Who informed you and how? Processes they followed.
   - What were the reasons they gave for you undergoing circumcision?
   - Was this what you expected? Positive and negative.

6. **As an adult, how do you feel about being circumcised?**

   Probes:

   - Please describe your thoughts, feelings, experience. Positive and negative.
   - How do you feel about your parents/family in making the decisio ? Positive and negative, any complications.

7. **Can you tell me anything about the positive and negative effects of medical male circumcision (MMC)? Explain.**

   Probes:

   - What was positive for you and why? What was negative for you and why?

8. **Would you circumcise your son? Explain**

   - How would you go about making that decision and why?
   - Who would you involve in the decision-making and why? Explain.
   - What age do you feel would be most appropriate to circumcise your son and why? What else would you consider and why?

9. **Tell me about the cultural meanings attached to the roles of men and women in the decision to take their sons for MMC?**

10. **From your experience, can you tell me about any differences you have noticed in how older and younger people see MMC?**

11. **Can you tell me about your learning experiences of MMC that you would like to pass over to others?**

    Probe:

    - Which ones and why?
    - Would you recommend EIMC to other parents?
      Probes:
    - Why or why not? Explain.

12. **Is there anything more you would like to add?**

Thank you very much for your time.

Government

1. **What are your views on EIMC?**
2. **What is the Department of Health's view on EIMC?**
3. **Should the Department of Health include EIMC? Probes:**
   - What are the issues that are of key interest to the community and civil society and why?
   - Can EIMC be integrated into initiatives/programmes? How and why? (MNCH, MMC, other)
   - How are MMC and MNCH providers trained to counsel on EIMC if it is requested by patients?
4. **What would you like to see from the SA VMMC programme, in five years?**

   Probes:

   - As needed for demand creation, EIMC, reaching targets, stakeholders, funding, research, gender.
   - Civil society role and involvement how and why?
5. **Can you tell me anything about the potential barriers/opportunities for EIMC from a community, individual, couples, family, policy perspective?**

   Probe:

   - To what extent will this hinder/help EIMC?
6. **Have you ever undertaken any special programmes to try to reach men, families, partners, extended families in MMC?**

   Probes:

   - How was the decision made and why?
   - How can women to get involved in decision-making?
   - How can the sociocultural aspects be addressed?
7. **What would facilitate EIMC?**

   Probe:

   - As needed – Policy change, programme leadership, advocacy, engagement with communities, health system, funding (local, donor, private sector), addressing socio-cultural aspects, civil society.

8. **Can you tell me anything about the role of gender in formulating/not formulating EIMC policy and strategic planning?**
    - If there is a policy and strategy, how was it designed, at what level?
    - Has it been adopted, and how is it supposed to be implemented?
    - Is there a plan to include gender in formulating/not formulating EIMC policy further on? How?
    - What could be the benefits of stronger gender perspectives in the EIMC/MMC programme?
    - In the given context, what other stakeholders have gender on their agenda? In what way could their expertise and resources be used to inform EIMC?
9. **What have you learnt from programme implementation in relation to gender issues?**

    Probe:
    - How could the organisation work further towards addressing norms and practices in order to decrease gender inequality?
    - How can we go about to consider issues around masculinity/masculine perspectives?
10. **Is there anything more you would like to add?**

Thank you very much for your time.

Civil Society

1. **Describe your experience with government and with other CSOs with regards to EIMC?**

   Probes:

   - Gender, rights of the child, parent(s).

2. **What is the view of civil society on EIMC?**

   Probes:

   - Rights of the child, rights of couples/parent(s), role of DoH, role of policy, gender, culture, religion, public health system, community.

3. **Can you tell me anything about the power of civil society and its organisation to make EIMC happen in SA?**

   Probes:

   - What power do they have and why?
   - How can this power be harnessed?

4. **Can you tell me anything about the role of gender, child and parental rights, civil society, culture, religion in formulating/not formulating EIMC policy for SA?**

   Probes:

   - What are the rights issues relevant to parents/families making the choice of EIMC? Why?
   - What are the gender issues relevant to parents/families making the choice of EIMC? Why?
   - What are the social and family structures relevant to parents/families making the choice of EIMC? Why?
   - What could be the benefits of stronger gender perspectives in the EIMC/MMC programme?
   - How can we address the gender implications of EIMC? Decision-making power, masculine power and norms, intergenerational power, gender equality?

5. **How do we deal with the barriers of EIMC?**

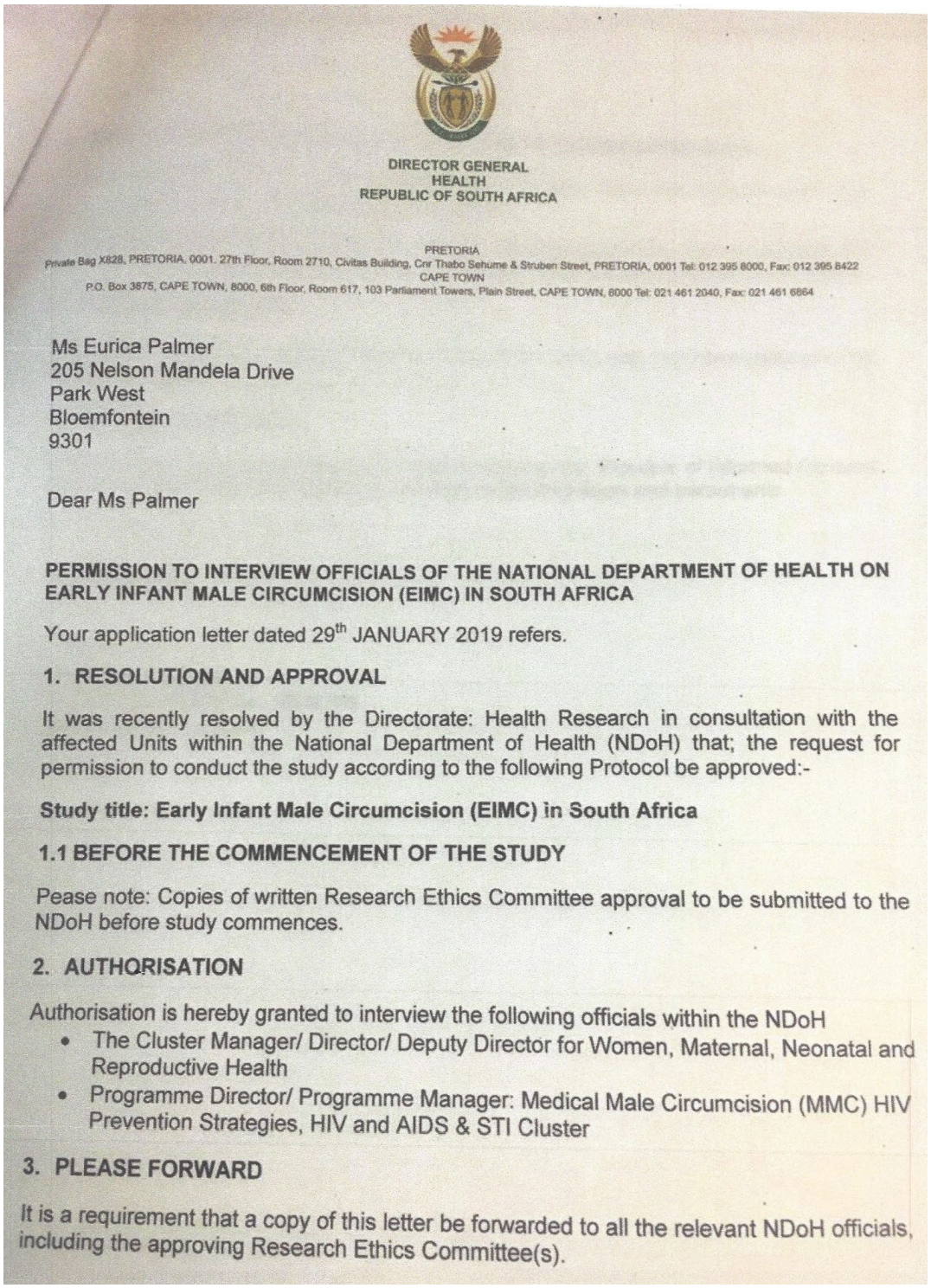
   Probes:

   - What role can communities, individuals and social networks play and why?
   - What can we do to better promote women's voices within this discussion and why?

6. **What would you like to see from the public health services in rolling out EIMC?**
    - What are the public health considerations in neonatal circumcision in your view?
    - Also ask the key informants for their recommendations or solutions in addressing the problem.
7. **Is there anything more you would like to add?**

Thank you very much for your time.

Appendix G
Permission to Interview Officials of the National Department of Health



DIRECTOR GENERAL
HEALTH
REPUBLIC OF SOUTH AFRICA

PRETORIA
Private Bag X828, PRETORIA, 0001. 27th Floor, Room 2710, Civitas Building, Cnr Thabo Sehume & Struben Street, PRETORIA, 0001 Tel: 012 395 8000, Fax: 012 395 8422
CAPE TOWN
P.O. Box 3875, CAPE TOWN, 8000, 6th Floor, Room 617, 103 Parliament Towers, Plain Street, CAPE TOWN, 8000 Tel: 021 461 2040, Fax: 021 461 6864

Ms Eurica Palmer
205 Nelson Mandela Drive
Park West
Bloemfontein
9301

Dear Ms Palmer

PERMISSION TO INTERVIEW OFFICIALS OF THE NATIONAL DEPARTMENT OF HEALTH ON EARLY INFANT MALE CIRCUMCISION (EIMC) IN SOUTH AFRICA

Your application letter dated 29th JANUARY 2019 refers.

1. RESOLUTION AND APPROVAL

It was recently resolved by the Directorate: Health Research in consultation with the affected Units within the National Department of Health (NDoH) that; the request for permission to conduct the study according to the following Protocol be approved:-

Study title: Early Infant Male Circumcision (EIMC) in South Africa

1.1 BEFORE THE COMMENCEMENT OF THE STUDY

Pease note: Copies of written Research Ethics Committee approval to be submitted to the NDoH before study commences.

2. AUTHORISATION

Authorisation is hereby granted to interview the following officials within the NDoH

- The Cluster Manager/ Director/ Deputy Director for Women, Maternal, Neonatal and Reproductive Health
- Programme Director/ Programme Manager: Medical Male Circumcision (MMC) HIV Prevention Strategies, HIV and AIDS & STI Cluster

3. PLEASE FORWARD

It is a requirement that a copy of this letter be forwarded to all the relevant NDoH officials, including the approving Research Ethics Committee(s).

4. **THIS AUTHORISATION IS SUBJECT TO THE FOLLOWING PROVISOS**

(a) The NDoH shall be notified of any decision to discontinue the research study. The reason for such cancellation shall be stated.

(b) The research study shall be conducted in accordance with the Protocol submitted to the NDoH. Any Amendment(s) to the protocol, shall first be submitted to the NDoH.

5. **PROGRESS REPORT**

Submission and presentation of the final report of the study with recommendations to the NDoH is required.

6. **INFORMED CONSENT**

It is the NDoH requirement that in all research projects the 'Principle of Informed Consent' should be adhered to. This applies to research study volunteers and participants.

Yours sincerely

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH
DATE: 12/2/2019