UNCOVERING THE *DIRT* ON DEMAND CREATION FOR MEDICAL CIRCUMCISION

A Qualitative Study of Medical Male Circumcision Demand Creation in Gauteng Province, South Africa in 2012

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CONTENTS

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ABBREVIATIONS, TERMS AND ACRONYMS

Bophelo Pele	Reference to Orange Farm clinic, previously called the *Bophelo Pele Male Circumcision Project.* (see also Nelgate, below)
CHAPS	Centre for HIV and AIDS Prevention Studies
COF	Community Outreach Fieldworkers
DC	Demand Creation
FGD	Focus Group Discussion
ICT	Internet Communication Technology
IDI	In-Depth Interview
MOVE	Model of Optimised Volume and Efficiency, a WHO/UNAIDS prescribed best practise strategy, Developed in Orange Farm
NDOH	National Department of Health
'Nelgate'	Local community reference to VMMC clinic in Orange Farm
NGO	Non-governmental Organisation
NSP	National Strategic Plan for Prevention of HIV, STIs and TB
SANAC	South African National AIDS Council
SMS	Short Messaging Service
(V)MMC	(Voluntary) Medical Male Circumcision
WHO	World Health Organisation
Zola	Local community reference to VMMC clinic in Zola

EXECUTIVE SUMMARY

INTRODUCTION AND BACKGROUND: Given promising research on the HIV prevention benefits of voluntary medical male circumcision (VMMC), the South African National Department of Health together with the South African National AIDS Commission (SANAC) has adopted a target of having 80% of South Africa's adult males circumcised by 2016. Generating demand for VMMC is vital to achieving this ambitious target. The Centre for HIV and AIDS Prevention Studies (CHAPS) has been playing a technical advisory role in the establishment of high volume circumcision sites throughout the country and directly manages 14 such sites in Gauteng Province, one in North West province and one in Limpopo province.

This report highlights key findings from the first phase of a qualitative study designed to explore how the decision to seek VMMC or not is made in two Gauteng communities where CHAPS manages clinics. In May 2012, a total of 12 focus group discussions were conducted with circumcised and uncircumcised males of two different age groups. An additional six in-depth interviews were conducted with the female sexual partners of circumcised males to gain insight into their role in the decision-making process. The study explored factors that motivate and prevent males from seeking VMMC, ranging from individual knowledge to peer and gender norms.

RESULTS: What emerged from the study was a complex interplay of factors that impact on the decisional balance of males, both circumcised and uncircumcised. For example, both groups of males described fear of pain during and immediately after the actual procedure as a barrier. Both groups also demonstrated awareness of the HIV risk reduction benefits of circumcision. However, the actual decision to circumcise was more complex for most males. A consultative process with family, peers, outreach workers, and partners prior to seeking VMMC (or deciding against the procedure) was described. Community outreach fieldworkers (COF) as well as circumcised males within peer groups emerged as particularly strong supporters of VMMC, while family system are important influencers in terms of perpetuating (non)circumcising cultures, from requiring males to "go to the mountain" to eschewing the practice altogether.

Individual-level knowledge about the risks and benefits of VMMC varied. While most study participants knew about HIV risk reduction, they were not always clear about why. It appeared that many males, both circumcised and uncircumcised, associated the reduced risk of STIs and HIV with being better able to clean the "dirt" off of a circumcised penis. This has implications for how VMMC programmes communicate about the reduced risk of HIV.

Like many prior studies, structural level factors influenced the decisional balance of some males. Simply put, clinics that offer free and safe services are desired. Some males were hesitant to seek VMMC because they distrust government clinics or have had bad service experiences in other contexts, e.g. long queues or rude service. The distance to VMMC services was a factor for male requiring transport to return home after surgery and for follow-up visits, due to cost.

Concepts about what it meant to be male, from sexual virility to appearance, ran throughout the FGDs. The importance of the VMMC intervention was reinforced by male study participants who openly described sexual risk taking, alcohol abuse, and experiences with STIs, particularly 'drop'. Another gender issue that was raised was apprehension of being attended to by female nurses or doctors, which was mostly raised by younger males.

In addition to barriers and motivators for VMMC, the study explored communication preferences and new potential communication channels, such a mobile phones. These findings were highly contextual to existing demand generation activities and the social networks within which the study participants operate.

CONCLUSION AND RECOMMENDATIONS: The report ends with specific recommendations on what barriers to address and motivators to promote in ongoing demand generation activities in the two study communities. As an exploratory study, a number of new questions emerged that will need to be explored through further research and engagement with the communities of interest. While the findings cannot be generalised to South Africa, it is hoped that this study may lead communication practitioners to question some assumptions, such as increased knowledge leading to VMMC adoption, and to explore new ways of generating demand for this important HIV prevention intervention.

1. INTRODUCTION

In 2009, UNAIDS estimated that with more than five million people infected, South Africa is the country with the largest number of HIV-infected persons in the world. Intensive HIV education and prevention message delivery and even free antiretroviral treatment have thus far failed to substantially decrease HIV seroprevalence rates. Novel HIV prevention approaches are urgently needed in South Africa, of which voluntary medical male circumcision (VMMC) is one.

1.1 BACKGROUND ON VMMC DEMAND CREATION

Multiple observational studies have long noted an association between MMC and lower HIV infection rate (Reynolds et al., 2004, Siegfried et al., 2005, Quinn, 2000). In 2005, the first trial to randomize men to either circumcision or no circumcision (wait-list) showed that male circumcision was associated with a 60% reduction in the risk of HIV acquisition over the study period (Auvert et al., 2005). This trial took place in Orange Farm, South Africa. Soon thereafter, two other large randomized trials of MMC in Kenya and Uganda were closed early after interim analyses showed a greater than 50% reduction in HIV acquisition (Gray et al., 2007, Bailey et al., 2007).

Mathematical models have suggested that large-scale uptake of MMC in populations with high HIV prevalence and low circumcision rates could lead to very significant reductions in HIV incidence and prevalence, and constitute a highly cost-effective prevention strategy (Nagelkerke et al., 2007, Hallett et al., 2008, Hallett et al., 2011, Williams et al., 2006, Siegfried et al., 2009, White et al., 2008). Numerous factors have been raised in relation to achieving large scale uptake, including cultural variations in how circumcision is understood in relation to masculinity (Rain-Taljaard et al., 2003, Vincent, 2008), preferences for "traditional" versus clinical circumcision (Kepe, 2010), seasonality in demand and public health sector readiness to supply MMC (de Bruyn et al., 2007) as well as beliefs about circumcision's protective properties against HIV and other STIs (Bridges et al., 2011). In November 2011, the WHO and UNAIDS launched the *Joint Strategic Action Framework to Accelerate the Scale-Up of Voluntary Medical Male Circumcision for HIV Prevention in Eastern and Southern Africa, 2012–2016 (UNAIDS, 2011).* This document emphasises the importance of concentrated demand creation as part of the "catch up" phase of increasing the number of medically circumcised males to the level where population health benefits would be marked prior to countries entering a maintenance phase of regular MMC services.

1.2 VMMC DEMAND CREATION IN SOUTH AFRICA

Prior to the Orange Farm trial MMC was already being conducted in South Africa on a small scale to address penile health issues, e.g. phimosis, or for religious or cultural purposes. As a result of the 2005 study (Auvert et al., 2005), the government did not make any immediate policy to introduce MMC services. However, when the WHO and UNAIDS recommended the inclusion of MMC based on mounting scientific evidence in 2007, there was greater pressure to consider introducing MMC services for HIV prevention. The National Department of Health (NDOH) in South Africa has recognized VMMC as an important element in to South Africa's comprehensive package of HIV prevention services. The latest National Strategic Plan for HIV, STIs and Tuberculosis (NSP) includes specific mention of VMMC (SANAC, 2011). Encouragingly, a *Strategic Plan for the Scale up of Medical Male Circumcision in South Africa, 2012 -2016* is currently being drafted that aligns with the WHO/UNAIDS *Joint Strategic Action Framework (UNAIDS, 2011, SANAC, 2012).*

The focus of South Africa's strategy in the short term is to "catch up". In this phase, South Africa is seeking to achieve 4.3 million MMCs by 2016 (SANAC, 2012). This target is highly ambitious. From 2010-2011, the government supported a pilot project in partnership with the US government (USAID/CDC) with funding from the President's Emergency Plan for AIDS Relief (PEPFAR) which enabled models of VMMC to be tested in South Africa at a scale previously unknown. As a result, over 100,000 MMCs were conducted (SANAC, 2012). Following the pilot, between April 2011 and March 2012, MMCs have more than doubled. However, South Africa remains far off the mark of its 2016 target (SANAC, 2012).

An essential factor for reaching the MMC target is to ensure that services are widely available. To this end, the government has supported the establishment of multiple high volume sites using models for optimising volume and efficiency (MOVE), which is endorsed by the WHO. At present, there are also many high volume mobile sites operating in South Africa with the capacity to perform at least 30-40 circumcisions per day (SANAC, 2012). Some MOVE sites, such as the Zola clinic in Soweto managed by the CHAPS, have performed as many as 150 circumcisions in a single day during the high season (Taljaard, 2011).

Like availability, creating and maintaining strong demand for VMMC services is critical. While the axiom *"if you build it, they will come"* may ring true at the beginning, demand for services in the case of MMC always requires seeking new clients because it is a one-time service. The factors

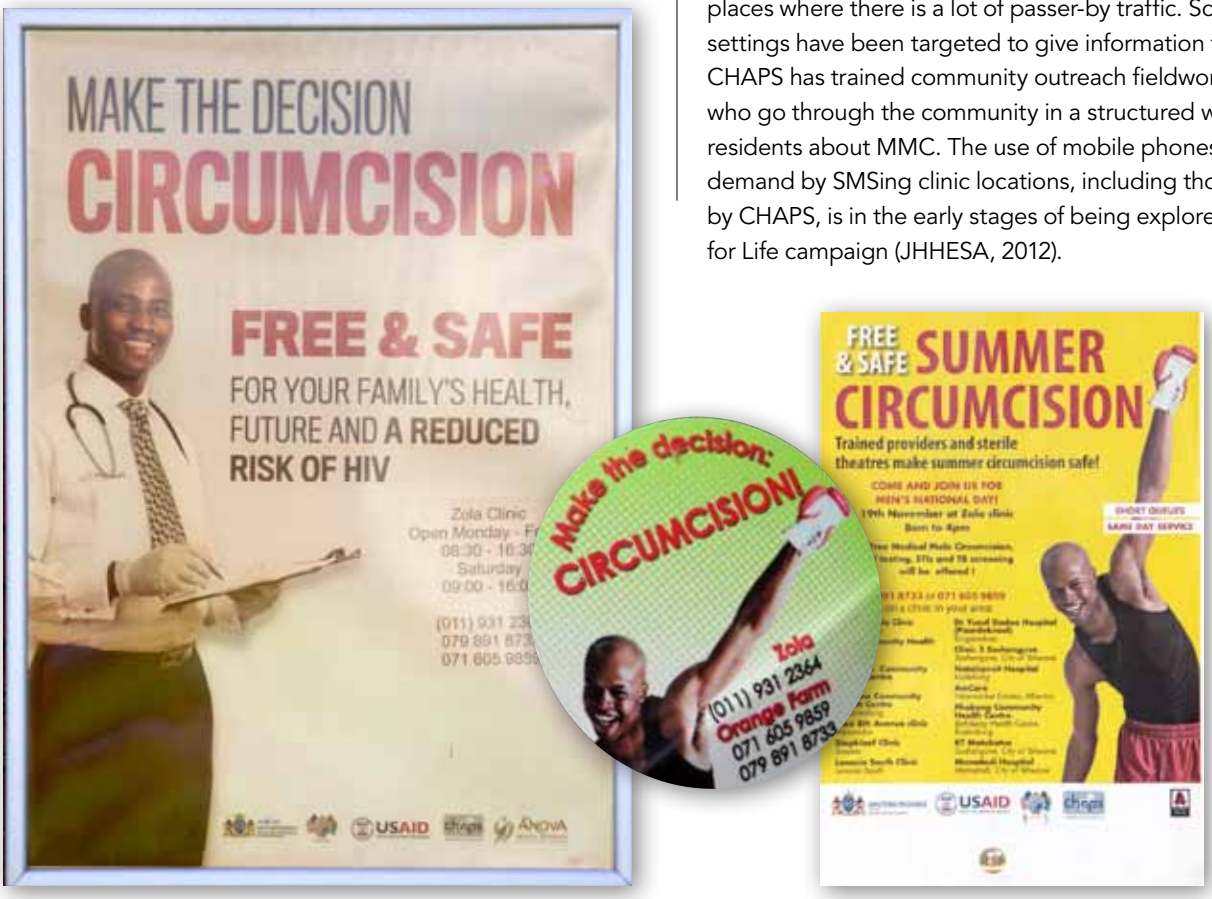
that motivate or inhibit uncircumcised males from seeking services are important to understand in designing outreach that will increase demand. This is particularly true as early adopters get circumcised and the programme seeks to engage with those more wary of circumcision.

Existing VMMC demand creation in South Africa has incorporated a number of communication strategies, relying heavily on interpersonal recruitment through a settings approach (schools and communities where there are clinics), mass media (particularly community radio), and print materials (pamphlets, posters). More recently, edutainment programmes such as Soul City Series 11, have addressed norms around VMMC. Various stakeholders have been engaged, including government health workers, community and traditional leaders, and the media. Mobile MMC services and short-term campaigns, e.g. MMC camps, have also been employed to increase uptake. The government has also convened a Technical Working Group comprised of government, civil society, private sector and academic actors to guide demand creation efforts.

1.3 VMMC DEMAND CREATION IN GAUTENG

Gauteng Province is the site of the Orange Farm study and was selected as a pilot province when the government decided to begin offering VMMC for HIV prevention. CHAPS, along with other service providers in Gauteng, have recruited clients to their services using a range of strategies, as described earlier. However, empirical evaluations of demand creation efforts in South Africa are limited.

Currently, CHAPS employs a number of strategies to create awareness and demand in the communities where it operates (Lissouba et al., 2010). Any demand creation activities usually start with engaging the community leadership. These include formal political structures like Ward counsellors through to very informal community structures like street committees. Consultation has also included traditional circumcisers who are active in the communities. From here a number of community workshop are scheduled with community organizations including non-governmental organizations (NGOs) working in the area. The activities also include distribution of informational pamphlets and a regular local call-in radio show that provides information and gets feedback from the community. To increase the visibility of MMC in community settings, CHAPS has also erected billboards and has distributed posters and stickers in popular places where there is a lot of passer-by traffic. School and clinic settings have been targeted to give information talks. Lastly, CHAPS has trained community outreach fieldworker (COF) staff who go through the community in a structured way to talk to residents about MMC. The use of mobile phones to generate demand by SMSing clinic locations, including those managed by CHAPS, is in the early stages of being explored by Brothers for Life campaign (JHHESA, 2012).



2. METHODS

2.1 STUDY DESIGN AND METHODS

A qualitative exploratory study design was selected to achieve the following objectives:

- To explore how young men and women understand MMC in the context of existing demand creation efforts in their communities;
- To explore communication dynamics around the MMC decision-making process;
- To inform the content of future MMC communication as part of comprehensive HIV prevention efforts; and,
- To generate ideas of how mobile phone technology and particularly short messaging services (SMS) could be leveraged for demand creation moving forward.

A total of 12 semi-structured focus group discussions (FGDs) with both circumcised and uncircumcised males and six in-depth interviews (IDIs) with female partners of circumcised men were conducted in Orange Farm and Soweto to meet these objectives.

The use of FGDs among males was selected to allow the research team to observe peer dynamics and norms in the context of discussing MMC. However, the investigators opted to conduct in-depth interviews (IDIs) with female sexual partners of circumcised males given the intimate nature of the questions being asked about relationship dynamics.

It should also be noted that this study is nested within an ongoing broader mixed-methods study that is exploring factors influencing demand creation initiatives and potential channels and content that could be used to scale up MMC as well as other health services targeting males.

2.2 STUDY SETTING

The study was conducted in Orange Farm and Soweto in Gauteng Province, South Africa. Both communities are sites with existing MMC clinics managed by the CHAPS. In Orange Farm the VMMC clinic is referred to by locals as "Nelgate" while the clinic in Soweto is often referred to as "Zola", the name of the public clinic in which it is housed.

2.3 STUDY SAMPLE

The study population were young men and women from the communities the organisation serves. Participants were recruited by outreach staff in both study sites based on predetermined criteria, with a total of 130 individuals contributing to the study sample.

For FGDs, circumcised and uncircumcised males were recruited purposively to achieve maximum variability. The groups were segmented into two age ranges and by circumcision status. Care was taken to ensure at least one FGD was conducted with each segment in each study location.

Table 2.1 Male focus group discussion sample by age, setting and circumcision status

Uncircumcised- OF	Uncircumcised - Zola	Circumcised - OF	Circumcised - Zola
15-24 age group individuals			
• 8	• 10 • 9	• 12 • 12	• 12
25+ age group individuals			
• 8 • 8	• 11	• 12	• 11 • 11
Total FGDs (individuals): 12 FGDs (124 individuals)			
3 (24)	3 (30)	3 (36)	3 (34)

In addition, six females were recruited for IDIs to explore how the decision to circumcise was made in the contexts of their relationships. In addition to age, they had to have been in a relationship with a circumcised male for at least three months *before* he was circumcised and he should have been circumcised for at least three months.

2.4 DATA COLLECTION & ANALYSIS

Data were collected by experienced professional researchers from Progressus, a local research company. The research team were trained on on the study protocol, ethics and data collection tools prior to data collection.

Data were collected over Fridays and Saturdays during the month of May, 2012. A female researcher interviewed all female participants and she was joined by a male researcher to conduct all FGDs. For a few FGDs, outside observers from the research team were present, always with the prior consent of the participants.

All FGDs and IDIs were conducted in the mix of local languages common to the study sites, following FGD or IDI guides. They were audio recorded to enable verbatim transcription and translation into English for analysis.

All transcripts were cleaned of all identifying information and then analysed with the support of NVivo 9. Both deductive and inductive codes were developed and categorised by theme, using a grounded theory approach.

2.5 RESEARCH ETHICS

The study received ethical clearance from the University of the Witwatersrand's Human Research Ethics Committee (HREC Certificate: M111019).

All individuals agreed to participate in the research of their own free will. Those eligible to participate under the age of 18 provided written parental consent as well as their own written assent to take part in the study. Those over the age of 18 provided written consent. Consent and assent forms were available in English, Sotho and Zulu. (See Appendix A for English versions) These were given to eligible participants prior to the FGDs or IDIs and also reviewed together with the researcher before data collection. The translations were assessed for clarity and consistency with the English forms prior to use. Separate consent forms for audio recording were obtained prior to data collection. Copies of all forms were given to the participants with the originals stored in a locked cabinet at CHAPS accessible only by Sasha Frade. These are stored, separately from audio recordings and transcripts.

All personal information for in-depth interviews has been kept confidential. The inability to ensure full confidentiality for FGDs was disclosed to participants prior to data collection, given that other FGD participants might disclose the discussion to outsiders. However, the facilitators and research team did not disclose any identifying information of the FGD participants. Each participant selected a pseudonym for use during FGDs or IDIs that could be used to link comments from the same individual together during the transcription process. Any references to real names or identifying information have been removed from the transcripts used for analysis and reporting by Sara Nieuwoudt.

Researchers were transparent about their roles (data collection) and did not provide counselling or advice during the data collection phase of the research.

3. FINDINGS ON DEMAND CREATION

The following chapter highlights the study results, integrating the responses of both male and female participants.

3.1 SOURCES OF VMMC INFORMATION

A key area of interest was where males and females in these two communities were getting information about VMMC. The researchers were trained to probe for both structured demand creation communication as well as less formal sources of information. The researchers also sought to understand whether the information sources were trusted. The findings are summarised in Table 3.1 below and expanded upon in the following section.

3.1.1 STRUCTURED SOURCES OF INFORMATION

Community Outreach Fieldworkers (COF) - important in helping clients overcome fear

Both circumcised and uncircumcised males described COF as being important sources of VMMC information. These COF, often referred to as "clinic staff" or "recruiters", were hired by CHAPS to generate demand for MMC services.

One common theme in relation to the COF was that they proactively sought out prospective clients, finding them at their homes or on the street. The following description was common among study participants, particularly circumcised males:

Table 3.1. Sources of VMMC information

Source	Mentions	Trust	Setting(s)	General Notes
COF	+++	High	Both	▪ Usually met clients at their homes or in the street, sometimes multiple interactions ▪ Usually provided pamphlets or appointment cards ▪ Some misgivings about talking with female COF ▪ Often previously known to *circumcised* males through family or other social networks
Peers	+++	Mixed	Both	▪ Circumcised males who share experiences (both positive & negative) highly influential in peer networks ▪ Peers key sources of information about VMMC as well as other health issues, especially among younger males (<25) ▪ Some peers thought to exaggerate either the positive or negatives of VMMC, affecting trust
Pamphlets	+++	High	Both	▪ Usually talked about in conjunction with COF ▪ Also taken from clinics, especially those providing STI or HIV testing services
Family	+++	Mixed	Both	▪ Like peers, those who had direct experience with circumcision most influential sources, e.g. an older brother
Clinic staff	++	High	Both	▪ Referrals most often after seeking treatment for STIs or HIV testing ▪ One case of referral for medical condition (phimosis)
Partners	++	Unclear	Both	▪ Girlfriends mentioned in context of discussing VMMC, but degree of influence unclear
TV	++	Mixed	Both	▪ Documentaries and news about study trusted ▪ LoveLife and Siyanqoba noted by females only ▪ Unplanned coverage, e.g. Zuma rape trial, less trusted
Radio	++	Unclear	Both	▪ Ukhozi and Thoka specifically mentioned
Billboards	++	High	Both	▪ Referral information and public presence to spark discussion specifically appreciated
Schools	++	High	Both	▪ Older males noted that they missed out on this
Car signage	+	Unclear	OF	▪ Make of car is noted as Avanza
Loudspeakers	+	Unclear	OF	▪ The loudspeaker was mounted on a vehicle

Key: +++ = raised in over half of FGDs; ++ = raised in 2-5 FGDs; + = raised in 1 FGD or IDI

"I got the information from the people who work at the clinic. They came to me at home. I was standing at the gate they explained to me what happens after circumcision, and that the risk of STIs and HIV is reduced." (Circumcised, Zola, 25+)

The female participants also described active COFs as being influential in their partners' understanding of VMMC and ultimate decision to get circumcised.

In multiple cases, circumcised males were in the same social networks as the recruiters, as described by these two study participants (emphasis added):

Participant 1: *"Luckily* ***a friend of mine that was working on the Nelgate project*** *told me that the following January the Nelgate center [local name for the VMMC clinic] would open and circumcision would be free. That was back in November of 2008."*

P2: *"I also heard from a friend and I had already been half-circumcised in the traditional way by the mountains within the township.* ***A neighbour of mine who also works on the project*** *encouraged me to go to Nelgate and finish it off." (Circumcised, OF, <25)*

These bonds of friendship or shared space may have influenced these particular males. At the very least, by being in the same social networks, the COF were able to share information that supported their peers to seek VMMC.

The type of information shared by COF appears to have focused primarily on risk reduction as well as what happens after circumcision. Respondents were consistent about this and often complementary of the recruiter's communication skills. The following quotes illustrate how interpersonal communication with COF helped support reluctant clients to make a decision to circumcise at the clinic.

"I was actually not keen, but after they explained to me and they gave me an appointment card. Then I went there." (Circumcised, Zola, 25+)

"I was scared in the beginning, but what then motivated me to go was the recruiters. My fellow guys had always tried to convince me to go, but I was scared. However, the recruiters are the ones who made me understand everything I needed to understand, such as the reduction of risks. That's when I decided that I can handle a six weeks waiting period." (Circumcised, Zola, <25)

Several males described how COF combined interpersonal communication with some kind of materials, e.g. appointment cards and/or information leaflets that reinforced key VMMC messages and provided information on where services were available.

"[A clinic staff] gave me information that circumcision also takes place at the Zola clinic. First time I was a bit scared. He gave me an information leaflet. After meeting him the second time, was then that I decided to go." (Circumcised, Zola, <25)

When asked about whether they trusted the information provided by COF, the study participants were generally positive. Even uncircumcised males expressed trust in the information provided by COF, as illustrated in this exchange in one FGD:

Participant 1: *"I think it's reliable, since it involves a professional thorough research."*

P2: *"Yes, to add on that, I think it's valuable since it tells about protection of the diseases taking place currently. Hence I say big up to that." (Uncircumcised, OF, <25)*

While this information was trusted, there were suggestions about additional information that could have been provided by COF, which is covered in the Recommendations section.

Health staff referrals – models of integrated services

In addition to CHAPS fieldworkers, some males described how clinic or hospital staff referred them to circumcision services. These health staff did not work at the VMMC clinic, but provided referrals. A key characteristic of these scenarios was that the clients were already using the health system to address sexually transmitted infections (STIs) or to get tested for HIV.

> *"In my case, I found out about the Nelgate centre at the local clinic when I was suffering from an STI after having had unprotected sex. The nurse there recommended that I go and get circumcised at the centre." (Circumcised, OF, <25)*

As with COF, a key feature of these interactions was that oral communication was reinforced with informational materials, e.g. pamphlets that the clients could take.

> *"Also when you go to the clinic, perhaps for HIV tests, the give you this information and also give you the leaflets." (Circumcised, OF, 25+)*

Uncircumcised males also reported hearing about VMMC from the clinics, particularly those in Orange Farm. While this source of information wasn't referred to as frequently as COF, it provides encouraging evidence of how integration of services in South Africa is bearing fruit.

Print and mass media – education, reinforcement and cues to action

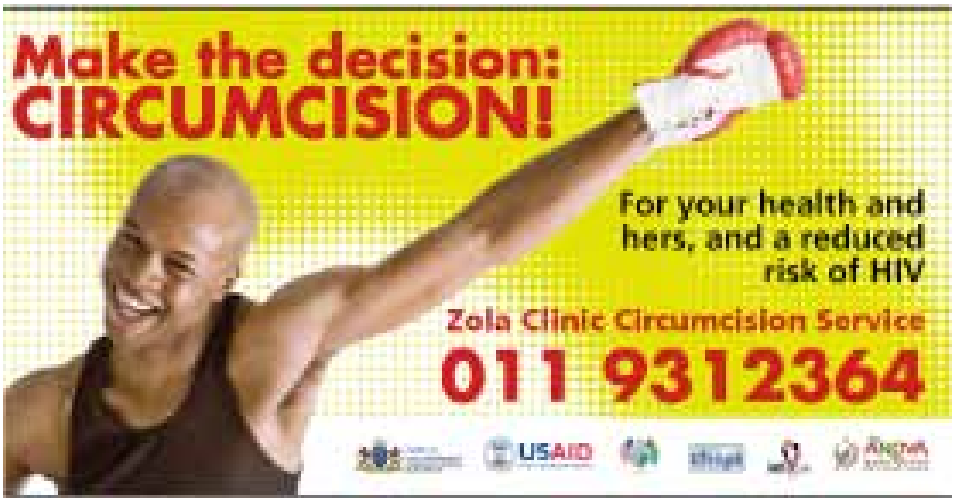
In FGDs, print and mass media were most often referred to as a supplement to interpersonal communication. With a few exceptions among uncircumcised males, they were rarely mentioned as sole sources of information. Although some described taking the materials to read on their own, several described the materials as tools to help explain MMC and clarify any misunderstandings, as highlighted in the following quote.

> *"[The COF] must explain everything in full and also because they have the pamphlets. He should read that pamphlets for you. He also needs to clarify where you don't understand. You also need to be free to ask questions rather than agreeing to everything as if you understand. He should explain everything step by step." (Circumcised, OF, <25)*

In Orange Farm, the use of advertisements on car trailers and loudspeakers mounted to vehicles was also noted. Magazines and newspapers were often named as sources of print information. The most cited mass media channels for VMMC were television and radio.

> *"On TV they usually advertise male circumcision that people need to circumcise: 'do the right thing'." (Uncircumcised, Zola, <25)*

In addition to pamphlets, billboards and posters were mentioned frequently.



"Even the billboards play a big role, because it's not easy to just meet the person in the street and start having that kind of conversation. The billboards and the flyers as well provide a lot of required information." (Circumcised, OF, <25)

The Internet emerged more strongly as a source of "general health information" for males.

There were some differences noted in terms of circumcision status. For circumcised males, an important role of these materials seemed to be the referral content they contained, such as the location of clinics or telephone numbers. They served as catalysts for discussion and a cue to action, beyond increasing knowledge. For uncircumcised males, print and mass media were described more as environmental factors that heightened their awareness of MMC.

Compared with circumcised males, uncircumcised males were more likely to talk about print and mass media as their main formal source of VMMC information.

> *"I read from [the pamphlets] that there's male circumcision. It reduces the chances of getting the sicknesses, though not 100%." (Uncircumcised, OF, <25)*

> *"The basic knowledge that we have we obtained from the media, such as radio news, magazines and so forth." (Uncircumcised, OF, 25+)*

Female partners also referred to pamphlets that their partners brought home or that they picked up from the clinics or COF directly. For them, beyond informing themselves, the pamphlet was a tool used to broach the topic of circumcision.

> *"I would hold the pamphlet [laughing] and pretending to be reading it and I would say to him, 'Do you see here? They say it is safe.'" (Female, Zola, IDI)*

> *"[The female recruiter] then gave me a pamphlet. I then showed it to my partner who then asked me where I got it. I then told him that I got it from A.M. He knew her. They knew each other before this. He also knew that she worked there. I then asked him if he had done it before. He said no. I then encouraged him to go." (Female, OF, IDI)*

The female study participants also mentioned VMMC being included in TV documentaries and soap operas.

> *"There was a documentary on TV where they were showing guys from Orange Farm. They were saying that they do circumcision and it is for free and it is not that painful because they give them painkillers, but you have to wait for six weeks before you could have intercourse. I saw that documentary. It is because of it that I thought it was safe to do it." (Female, Zola, IDI)*

> *"I used to watch Siyanqoba, and also LoveLife, so I had that information that they circumcise for free. I knew about that. And also they advertised I think last year on TV they showed Nelgate and the doctor was talking." (Female, OF, IDI)*

Most study participants seemed to trust the information in programme-generated materials, such as pamphlets or billboards. Reasons for trust included the link to research as well as overseas sponsorship.

> *"I think [the pamphlet] was written that it was from Orange Farm. So, I thought it should be from those people. That is what made me to trust the information. […] it was also written that there are people from overseas that are sponsoring it." (Female, Zola, IDI)*

> *"I trusted the information because we got the pamphlets from one of the recruiters and we called her, met with her and she explained the how the process is done." (Female, Zola, IDI)*

Some participants were less trusting of information from the mass media, such as television.

School presentations

One female interviewee with children explained that her sons got VMMC information in school. Her sons were later circumcised over school holidays, with the support of a COF. An uncircumcised male in Zola also referred to school presentations as a relatively new development that was making a difference.

> *"These days they send people who deal mainly with [VMMC]. They would send people dealing with HIV and AIDS to go to schools and teach about it. So we never had that chance of having people sent to the school." (Uncircumcised, Zola, <25)*

While none of the participants talked about being personally approached at school, it was recognized as a form of demand creation.

Other sources

Participants described additional sources of formal health communication, which had not been anticipated. For example, one participant talked about how his involvement in a local non-governmental organisation (NGO) introduced him to information on MMC.

> *"There was even an organization that I joined when at school, called Help Worldwide, funded by Olive Leaf Foundation. They somehow provided us with information that made me take a decision to get circumcised." (Circumcised male, Zola, <25)*

The work of other NGOs, such as LoveLife, was also mentioned as playing a role in sharing information about VMMC.

Finally, an uncircumcised male described how the media took unplanned news items and turned them into teaching opportunities, citing the coverage of Zuma's rape case:

> *"I also got the information through President Jacob Zuma's case about rape, where they were talking about who's more likely to get the infections between a man and a woman in terms of health reasons." (Uncircumcised, OF, 25+)*

Such news coverage would not have been in a formal demand creation strategy, yet it emerged as a source of VMMC information.

3.1.2 INFORMAL SOURCES OF VMMC INFORMATION

More frequently than not, males and females got information about VMMC through informal channels in their communities, including family and peers. Word of mouth was often described as a key conduit of health information, including VMMC. The most influential of these seemed to be males who had undergone VMMC who could share their experience. Other influential sources included sexual partners of uncircumcised males and family members. Friendships with people linked to the health system, e.g. nurses or COF, were also described.

Same-sex Peers

Circumcised and uncircumcised males in both communities described how they get much of their sexual and reproductive health information from peers or talking with "the guys".

> *"As guys, we advise each other about things like these. That for example, if you get a 'drop' today on the 11th of May, the same date next year the pain will come back because you are uncircumcised. I don't know exactly what causes that but I think it's because if you are uncircumcised, you are at the high risk of STIs and when removing the foreskin reduces the risk." (Circumcised, OF, <25)*

> *"So, [my peers] were advising me as a friend to get circumcised for my own safety, telling me that mistakes happen in life. So I tell the people that times change. So, what I'm here for today, I came for my own knowledge and my future." (Uncircumcised, OF, <25)*

Males who had undergone circumcision were particularly sought out as key sources of information. One circumcised male recalled:

> *"I needed to hear from someone with experience how the pain of surgery was. I wanted to know if it was something that I could handle or were they going to hurt me at the centre." (Circumcised, OF, <25)*

As noted earlier, with circumcised males there seemed to be blurred lines between friends and people working at the clinics or as COF.

> *"[I get information] also from the friends who are circumcised. I know of a friend who works at Bophelo Pele [Orange Farm VMMC clinic], they give out information and distribute pamphlets around the township. That's how we got the information." (Circumcised, OF, <25)*

However, information from peers was not always trusted, particularly in communication between circumcised and uncircumcised peers. One uncircumcised male complained that he was unsure about pain, distrusting what some of his circumcised peers told him:

> *"I do not trust it, because everybody will tell you a different story. Some will tell you that you will never feel any pain. Some will tell you that it is fine, everything is fine. So there is no information that I can trust." (Uncircumcised, Zola, <25)*

It may be that traditionally circumcised males do not always speak freely about their experiences with their uncircumcised peers. There are some taboos about discussing traditional

initiation experiences. The following quote suggests this might be the case, in describing how the experience of being circumcised created a bond that enabled young males to speak freely.

> *"If we all went the medical route then we can speak freely about anything. For example, all my friends did the medical one, so we can talk freely." (Circumcised, OF, <25)*

Males were not the only participants to seek information from peers. A few female interviewees talked about sharing information with female peers or family members.

> *"My sister and I communicate. She also sent her boyfriend to go and circumcise in 2008. They do not have a child, so she sent him there because he would refuse to use a condom. So, she said she doesn't know what he gets up to on the side, so it was better he go and circumcise. They still do tests. After three months they do tests. So she said he'd better be circumcise so he would not contract STIs fast, not that he would not get them but just that he doesn't get them quicker. So he went and did it so my sister said to me you must also speak to your partner to go and do circumcision at Nelgate."(Female, OF, IDI)*

Finally, during the discussions, uncircumcised males talked about peers who had negative VMMC experiences, which heightened their anxiety about seeking services. While a few serious adverse events were described during the FGDs, more often than not the negative experiences related to the pain experienced during the healing process, as is observed from the following quotes:

> *"I once had a friend. We lived together and he showed me his penis. It was like he was hurt, something like that, after he had circumcised. That is what scared me. […] I would like to go but I am afraid of such things." (Uncircumcised, Zola, <25*

> *"For me male circumcision is not safe because when I see people coming from the clinic they walk like I don't know what happened to their penises. They don't look fine. And when they tell me, they say they don't even sleep at night." (Uncircumcised, Zola, <25)*

The power of negative experiences to reduce demand for VMMC was illustrated by a circumcised male who had experienced an adverse event or "incident" in which the doctor "*cut the foreskin together with the tip of the forehead.*" According to him, uncircumcised males heard about his adverse event, resulting in them avoiding VMMC. He explained:

> *"In my township there are still the guys who remain uncircumcised, because of my incident. Even today as I was coming here, they were asking me if I was still coming to the same place of the incident." (Circumcised, OF, <25)*

Female partners

A few of the males noted that in addition to male peers, their girlfriends were supportive of circumcision.

> *"My girlfriend also advises me to go [get circumcised], but without any pressures." (Uncircumcised, OF, 25+)*

This was reinforced in IDIs, where all of the female partners talked about how they tried to influence their boyfriends with information about the benefits of VMMC. The information itself tended to come from pamphlets or COF, as described earlier.

Family

Family members' information about VMMC was also influential, both in terms of encouraging males to consider circumcision (or not) and to create a supportive environment.

> *"My understanding of Male Medical Circumcision is based on the fact that my younger brother underwent it. So he mentions the pain, just like what P have just said. Well I know they have the pain killers to give you so that you don't feel when they circumcise you, but my worry is the after-effects, especially for us as the adults." (Uncircumcised, Zola, 25+)*

In addition, many males talked about the importance of seeking family or parental advice before making the decision to circumcise.

> *"You can't just wake up and go for circumcision without telling the parents anything. So, you've a huge challenge to balance the peer pressure [to get circumcised] and the culture in the family." (Uncircumcised, OF, 25+)*

This dynamic were generally raised by those males who felt that medical circumcision was somehow out of line with their cultural identity, as will be discussed in a later section.

3.2 UNDERSTANDINGS(S) OF VMMC

For this study, it was important to understand how community members understand VMMC, both in terms of how demand creation messages are being interpreted and in identifying where communication may need to be adjusted or focused.

3.2.1 SCIENCE-BASED UNDERSTANDING

Most of the key science-based VMMC messages seemed to be known in both communities and among both males and females. These are summarised in table 3.2 below.

Most males seemed familiar with the idea that circumcision **reduces STI and HIV risk**. In a few instances, participants talked specifically about 60% reduced risk, as did this participant who received a round of applause from his group after sharing the following:

Table 3.2. **2008 Communication Guidance on Male Circumcision**

2008 Communication Guidance on Male Circumcision – important messages	Degree to which message was reflected in discussions or interviews		
	Circumcised	Uncircumcised	Female partners
Male circumcision reduces the risk of HIV infection for men, but only provides partial protection. It is additional to and not a substitute for other proven HIV prevention methods.	▪ Raised in all FGDs ▪ Some confusion around *how* it protects ▪ Not talked about as only reason for VMMC	See circumcised notes, ***plus***: ▪ Partial protection a reason some don't want VMMC ▪ Distinction between VMMC & traditional known	▪ See circumcised notes, ***plus***: ▪ Stronger focus on STI risk reduction ▪ Some incorrectly believe that circumcision directly reduces female HIV risk
Men should not resume sexual intercourse for at least six weeks after circumcision to ensure the healing process is complete. Ideally sex should only recommence after a medical assessment confirms the healing process is complete.	▪ 6 weeks raised in all FGDs ▪ Medical confirmation of healing not discussed in all FGDs	See circumcised notes	▪ 6 weeks raised in 5/6 IDIs ▪ One reported a 3 month waiting period
All males, whether circumcised or not, should seek to reduce the risk of HIV transmission through using condoms correctly and consistently and limiting their number of sexual partners.	▪ Importance of condom use discussed in all FGDs ▪ Single partners was discussed, but some fatality about "making mistakes" when out drinking, for example	See circumcised notes, ***plus***: ▪ Emphasis on using condoms to prevent HIV as an *alternative* to circumcision	▪ This was known, but there were still high levels of distrust in partner fidelity and consistent condom use
Whether circumcision takes place in a clinical or a traditional setting it is important to ensure safety.	▪ VMMC presented as safer option. ▪ Some did not think tradition could be safe.	▪ A bit more willing than circumcised to acknowledge traditional settings could be safe.	▪ Safety only assumed for clinics
For HIV positive men there is no demonstrated public health benefit for reduced HIV transmission to their partners and men with severe immunodeficiency are at an increased risk of complications following surgery. HIV positive men who become circumcised benefit directly from reduced genital ulcer disease.	▪ While HIV testing discussed in some FGDs, this message was not mentioned	See circumcised	**Not mentioned**

"According to my knowledge, which I think most of us also know, circumcision doesn't eliminate the risk of infection. It only reduces it by 60%, meaning that there is still a 40% chance that you might contract an STI, more especially if you have cuts or abrasions. You are more prone to infections when you are uncircumcised. It does happen that when you still have a foreskin and you have unprotected sex, you would perhaps notice some lumps, rashes and irritations on the foreskin which might later develop into infections." (Circumcised, Zola, <25)

Quite often males in the FGDs presented their understanding of STI and HIV risk reduction in situational contexts.

"If you are circumcised, the less you are to get infected by STIs. For example, if you are having sex with a virgin and you are still wearing a foreskin, chances of getting the viruses are very high because it's easy that your penis can get some scratches, which increases the risk. Being circumcised reduces the risk of contracting things like STIs and HIV/AIDS." (Circumcised, OF, <25)

The female sexual partners also talked about the reduced risk of STIs and HIV, citing this knowledge as being a reason they supported their partners' getting circumcised. One female partner explained:

"There is a pamphlet that talks about the advantages, like things that you should do especially when it comes to sex. You have to, like the pamphlet says, you have to use a condom. And between a circumcised person and a non circumcised person, the person who is not circumcised it's easy to contract diseases, because diseases are in this foreskin, things like STIs and so on. So that is what attracted me." (Female, OF, IDI)

The idea expressed in the above quote that **condoms are still required to prevent HIV and/or STIs** was raised in every interview and FGD and went unchallenged. However, this knowledge did not always translate into behaviour, as will be discussed later in the report.

Participants also noted the **hygiene benefits** of circumcision. Hygiene was referred to in terms of smell and the foreskin's proclivity to trap "dirt" or "germs". Many circumcised males described experiencing hygiene changes in terms of becoming less smelly:

"Hygienically, there is a huge difference now than before. It is now easier to maintain the penis clean. I can even skip a day without taking a bath and still not smell like fish, as previously." (Circumcised, Zola, <25)

While these types of experiences were noted often by circumcised males as a benefit of their decision, it was unclear how much the desire to smell better played into decisions to seek circumcision.

The desire to remove germs and dirt was more clearly a reason for seeking circumcision. In analysing transcripts, it was sometimes difficult to interpret whether the "dirt" participants were referring to in conjunction with circumcision related to actual dirt or was being used euphemistically for STIs or HIV, as illustrated in the following quotes:

"Getting circumcised was a good way of reducing chances of infections and disease since a foreskin also traps dirt during unsafe sex." (Circumcised, OF, <25)

"I have always known that when you have not yet circumcised your penis can easily get dirty." (Circumcised, Zola, 25+)

"I do not know much about STIs, but I hear it is about dirt. The dirt collects and causes an infection, and the infection goes into that thing and then there are things that cause you to get that disease. […] During intercourse when you do not use a condom and you go into a dirty person and then the foreskin grabs that dirt and that it collects together, then you get sick. What I am saying is that after intercourse you can wash your penis." (Uncircumcised, Zola, <25)

Often, though, it was clear that there was a belief that STIs could be washed off of a circumcised penis, as described by another male in the same FGD:

"What motivated me to get circumcised is that the presence of a foreskin isn't good. If you did not clean it thoroughly and you have sex, it takes all the germs from that girl and keep them to you, which will eventually develop into a drop." (Circumcised, OF, <25)

This suggests that the hygienic benefits of circumcision may be confused with how circumcision reduces STI risk. This is somewhat of a concern as there seems to be broader misunderstandings about this, such as President Zuma's description of taking a shower after having sex with a woman known to have HIV as a means of reducing his risk of infection (News24, 2006, Green and Gordin, 2006).

In only one FGD was the issue of **cervical cancer prevention** raised and, strikingly, only one female sexual partner from Zola talked about her reduced risk of contracting cancer as a benefit. All of the other females talked about their reduced risk of STIs or HIV as the way in which they benefitted medically.

Generally, differences in knowledge about MMC, particularly HIV/STI risk reduction, were not noted between circumcised and uncircumcised males. This challenges the idea that communication focusing on knowledge is enough to increase demand.

In addition to being able to repeat important VMMC messages, some study participants seemed to struggle with their understandings of how circumcision reduced risk of HIV or other illnesses. This may be attributed to a lack of understanding about the etiology of cancers or STIs.

> *"[The COF] do mention all the disadvantages of remaining uncircumcised, such as the risk of the foreskin holding the germs as you can't always be able to clean it thoroughly and* ***those germs can end up developing into prosphomic cancer****. That's at least what they told me." (Uncircumcised, Zola, <25)*

> *"According to my understanding, it›s like* ***when you are circumcised, things like STIs, you can treat it faster****. And maybe if you are not circumcised,* ***it can continue and end up as a drop, then HIV, and then you get sick****." (Female, OF, IDI)*

> *"I know that when you are circumcised you are not hundred percent protected from HIV, but* ***it protects you from a lot of things like STIs****, so that is what interested me about it." (Female, Zola, IDI)*

Finally, while some study participants mentioned circumcision as only partial protection from STIs and HIV, later comments from the same people suggested that they believed themselves to be fully protected, as in the following quote:

> *"I have benefited a lot, because I know that he had to circumcise. In me I am happy because I know now that I would not be infected by HIV, because we are now fine." (Female, Zola, IDI)*

This final point has been included to emphasize that being able to repeat information in messages does not always mean it has been fully understood or internalized.

3.2.2 CLINICAL PROCEDURES AND SERVICES

Another area of interest for the study was how men and women understood and experienced VMMC services. This includes issues of access and availability, e.g. cost, as well as experiences within the clinics that may be communicated to uncircumcised males. Some males, such as the following, wanted to know everything about the procedure prior to seeking VMMC:

> *"To me it was important to know what the whole procedure entailed. I needed to know if there was any after service or would I be on my own after surgery. It was comforting to know that there were scheduled check-ups at intervals afterwards." (Circumcised, OF, <25)*

However, this section has been broken down into different sub-themes that emerged.

Cost

The cost of VMMC was discussed by some males as important in terms of their uptake of VMMC. Generally, having free VMMC services available was described as a positive development, particularly by those who were already circumcised. Some males talked about how they had wanted to be circumcised for a long time, with cost being a barrier. For these males, once they knew it was free, they were quick to seek VMMC.

> *"I always wanted to circumcise and I had planned to go to a health institution and have the procedure done there, but luckily a friend of mine that was working on the Nelgate project told me that the following January the Nelgate center would open and circumcision would be free." (Circumcised, OF, <25)*

However, one circumcised male noted that making circumcision free caused some people to question the service.

> *"The other thing is that people don't believe that something so important could be for free. As black people, I cannot say we don't like free things. We do like free things. It's just that something dealing with the private parts is a very sensitive matter." (Circumcised, OF, <25)*

This was a minority concern, with most participants happy about having a free service.

Financial incentives

During the Orange Farm trial, males received financial compensation for their participation in the study. It is clear that some saw this as an incentive, as evidenced by a number of quotes from circumcised males in that community:

> *"What I can say is that the first thing that motivated us during the beginning of the…. Project was that we were given some money to get circumcised. We knew that if you go there you'd come out with R40." (Circumcised, OF, <25)*

> *"When we came for the first time we were given R40 each and when we went for the second time we were given R150 each. That really motivated us to do it." (Circumcised, OF, <25)*

> *"I was motivated by a friend. We were happy that we would get paid to circumcise and we were under the impression that we would also get some goodies that we intended to sell." (Circumcised, OF, <25)*

Others described the money as a bonus, not influencing their fundamental decision to seek VMMC.

> *"…the money was an unexpected bonus as we knew that at a hospital we would have to pay but at the centre, they helped us and still paid us." (Circumcised, OF, <25)*

The use of incentives, however, was a source of suspicion for some. One circumcised male shared that there were rumours in Orange Farm that the VMMC trials were spreading HIV.

> *"I only want add on what's also making the people feel scared. There are also bad rumours that, where have you ever seen the people providing you with service, thereafter give you money? It was said it means they are the ones spreading the HIV virus." (Circumcised, OF, <25)*

As money is no longer given, this finding is less relevant to ongoing VMMC demand creation, unless programmes are considering offering incentives or compensation in the future. Providing incentives is not part of the policies of any donor organisation at the moment. There are no plans or intention of providing any kind of incentive for VMMC services, other than providing the services for free.

VMMC in public clinics

The provision of VMMC within government health facilities was known, but the reaction was mixed. On the one hand, some reasoned that the provision of VMMC in clinics meant that the service had been vetted. As one Zola male reasoned:

> *"I knew that the government would not allow people who were not experienced, who didn't know anything about circumcision to open up a clinic. So, I knew from the start that they had to go through the government through a long process to get here to open up the clinic, so I had no doubts." (Circumcised, Zola, 25+)*

However, many males associated the clinics with sub-standard services.

> *"So, it looks like if I were to circumcise here at the clinic it would be suicide, because I am from the clinic and yet I still experience pain. And yet, I went to the clinic hoping to get help [for a STI] and now when I get out, like my brother has said, you have puss coming out of your penis. And yet, they have not explained anything about what you may experience afterwards. (Uncircumcised, Zola, <25)*

Some males perceived an opportunity cost of sitting at the clinic, missing out on opportunities to earn an income.

> ***Participant 1:*** *"At the clinic it's always full and you take time waiting for attention. We are just reluctant to spend the whole day there."*

> ***P2:*** *"And we don't have time to sit there. We have time to hustle and generate income. When you think of going to the clinic you just see that you'll lose the whole day of income."*

> ***P3:*** *"For me it's the nursing staff's tea time. They take the whole hour for tea break instead of only 15 minutes. I can't go there. If I don't get better I can only go when I'm worse and don't even see that they are taking me there." (3 Circumcised, Zola, <25)*

Many observations, such as those in the above exchange, seemed to be based on general observations about public clinics versus specific reference to the VMMC clinics. However, there were specific complaints about the VMMC clinics that were raised.

> *"I actually don't support the clinics. There are lots of confusing processes at the clinics. We are even stitched by women." (Circumcised male, OF, <25)*

Being seen at a public clinic concerned a few males, as they worried what people might say.

> *"The reality is that males are secretive, so it's hardly that we talk about things like these. […] Now even when someone is interested in coming for circumcision, but they consider what will people say if they see them coming here. So, if it was not a public facility like the clinic, I think they'd come." (Circumcised, OF, <25)*

Service providers' training

A key issue discussed among males was the training and capabilities of the people performing the circumcision, which was linked to the earlier theme of clinics having substandard services. A preference for private practitioners was expressed by some males, because they were perceived to have specialized training:

> *"If there's a need for me to get medical attention then I prefer the doctor than the clinic. I don't know because there are the doctors at this clinic, perhaps they specialize." (Circumcised, OF, <25)*

This distrust of clinic staff did not always translate to VMMC staff. Some males expressed how having qualified doctors eased their fears:

> *"I was not scared because I saw people who are known to be qualified, such as Dr G. It made me feel comfortable and looking forward to the process." (Circumcised, OF, <25)*

> *"One thing I'm sure of is that the clinic staff is professional, they cannot play that cruelty." [referring to the use of razors for traditional circumcision] (Uncircumcised, Zola, 25+)*

> *"For me it doesn't matter whether they are males or females. The fact remains that they're trained for what they are doing. They cannot just test their skills on you." (Circumcised, Zola, <25)*

However, it was exactly the fear of a doctor or nurse not having qualifications or training that was expressed by a number of males. This may be in part because the VMMC clinics managed by CHAPS are used for training, leading to rumours or confusion, as expressed by the following study participant:

> *"The other thing that scares the people is because they are not sure whether these doctors are qualified or there are still students." (Circumcised, OF, <25)*

> *"I needed to know if the surgeons were qualified or were they neophytes seeking to experiment on me." (Circumcised, OF, <25)*

This concern about safety may require further research to understand.

Safety

Not surprisingly, a key area of interest was the degree to which VMMC was safe. For most study participants VMMC was perceived to be safe or at least safer than traditional circumcision:

> *"I think most people decided to circumcise here in Nelgate because it is free and it is also safe." (Circumcised, OF, <25)*

> *"I absolutely do not have any complaint, none whatsoever about the service that I received. Everything was done professionally I also received medication and attention which I would have never received at a traditional initiation school." (Circumcised, OF, <25)*

> *"The fellow guys were telling us that at the initiation school it's not enjoyable of the treatment. They indicated that as they go there during winter and they spend the whole winter period undressed, the seniors also come to fight them. On the other hand the Sangomas challenge*

each other's powers through the attendees. If you are not strong then you'd fall a victim of that and eventually die. So, it makes that route unsafe. I was then informed by the other guys about the circumcision taking place here in at the centre, and so I told myself that it's better I do it the medical way because the traditional way is not at all safe." (Circumcised, OF, <25)

The only concerns about safety were linked to false rumours about scissors being used to circumcise in the clinics and staff qualifications, as already discussed.

Voluntary HIV testing

Voluntary HCT offered prior to circumcision emerged as a contentious issue, as many sought VMMC without knowing that HCT would be offered. In one FGD in Orange Farm the participants were quite emphatic about this point:

Participant 1: *"Most of the times they don't mention the tests during recruitment. It is very important for the person to know prior to coming here that there will be HIV and other related tests involved. Sometimes they will be in conflict with the people because they don't the people the whole truth. They only mention counseling and leave people to be surprised when they get here." (Circumcised, OF, <25)*

P2: *"The thing is that because these recruiters are at work so they are after the quantities of people showing up after recruitment. If they tell you about HIV tests you will also take your time to think before making your decision. Imagine you find out right there that your HIV positive whilst you did not even know the test that was going to be part of the procedure." (Circumcised, OF, <25)*

P3: *"I was also not told about the HIV tests, but about others such as sugar levels, blood pressure etc. Those are the two tests they did to me. They ask you if you want to get tested for those." (Circumcised, OF, <25)*

Several circumcised males claimed that they wouldn't have sought VMMC services had they known about the testing and insisted that males stay away because they do not want a HIV test.

"The biggest fear for most of the people is the involvement of HIV tests. They are willing to circumcise but are scared of blood testing." (Circumcised, Zola, >25)

Though HCT is voluntary and males are allowed to refuse, it is clear from the above exchange many felt compelled to get tested once they were at the clinics, having decided to get circumcised. There was then a concern that if someone went for HCT and was then sent to get a CD4 test, his status would be effectively disclosed to others. This was a particular concern as many males seek VMMC at the same time as peers.

3.2.3 NATIONAL POLICY

A few participants knew that the government was supporting VMMC. However the importance given to this was mixed. As noted earlier when discussing the provision of VMMC in public clinics, government support was seen as a red stamp as to VMMC's effectiveness for HIV prevention. In efforts to support the policy of VMMC promotion, the government has enlisted celebrity and traditional leader champions of VMMC. This approach to increasing awareness was problematical, as such champions described as being out of touch with the lives of those living in townships:

"I'm against the media when it comes to issues like their criteria. It doesn't mean that if something has been said by King Goodwill Zwelithini, perhaps that issue causes havoc in the house. And he's wherever he is enjoying life with his champagne." (Uncircumcised, OF, <25)

While it was unclear to what degree knowledge of government's policy of promoting VMMC as part of a combined HIV prevention strategy helps or hinders demand creation, the use of traditional leaders was more contentious than expected.

3.3 SOCIO-CULTURAL PERCEPTIONS OF SEEKING VMMC

Another key aim of this study was to understand what social and cultural factors might be influencing demand creation, particularly given the diversity of the South African population.

3.3.1 CULTURAL IDENTITY

Cultural identity, closely tied to family bonds, was an important aspect of seeking VMMC (or not). Ethnic identities were often juxtaposed in FGDs that contained a mix of Xhosa, Sotho and Zulu males. Xhosas and Sothos described themselves as being culturally circumcising, while Zulus still tended to define themselves as non-circumcising despite King Goodwill's support of circumcision.

For Xhosa and Sotho males with strong cultural identities, the decision to circumcise was about location: clinic or

"the mountain". Some believed that they could adhere to the family's (Xhosa) culture of circumcision without getting circumcised traditionally in a traditional setting:

> *"I was driven mostly by tradition. As a Xhosa speaking person, getting circumcised is part of our tradition. Although it is mainly done cultural by the mountains, I took a decision to have my circumcision clinically at Nelgate. This was based on the safety and organization of the whole procedure. I like the fact that HIV tests are conducted here, unlike in the bush. I also didn't want to go the traditional route as I was born and raised in Johannesburg and I knew nothing about the cultural procedure. Some initiates die in the bush and I chose the safer option." (Circumcised, OF, <25)*

However, for some Xhosa and Sotho males, if they were going to be circumcised, it would have to be in the traditional manner.

> *"We must only go the traditional route, straight into the mountain." (Uncircumcised, OF, <25)*

> *"I used to talk to him about it and he would never be convinced. It would just turn into a fight. He is Sotho he would say. […] He would tell me that it is his tradition and if he wants to circumcise he would have to talk to his family first and go there. They just don't tell about their secrets and go [to the mountain] and not the clinic. He has to do it the traditional way." (Female, Zola, IDI)*

One circumcised male summarized the tension that exists between traditionally versus medically circumcised males in communities of mixed cultural heritage.

> *"Another challenge is the issue of cultural diversity. Some go to the initiation schools. Some of us are not supposed to go that route. Then we come here. To those who went the traditional route, we'll always be the boys." (Circumcised, OF, <25)*

For Zulus the decision was more fundamental, with circumcision perceived to be turning their back on a cultural (and family) tradition. One uncircumcised male summarised the conflict he felt in considering VMMC:

> *"At home we are the Zulus and we normally discuss things before can be decided. You can't just wake up and go for circumcision without telling the parents anything. So, you've a huge challenge to balance the peer pressure [to get circumcised] and the culture in the family." (Uncircumcised, OF, 25+)*

> *"[Why we don't go] is the beliefs as well the myths you get from your parents that if you go [to the clinic] you will go insane, or you will have problems with your ancestors." (Uncircumcised, OF, <25)*

One Zulu male felt that it was important to explain that Zulu's are aware of the risks of STIs and HIV, but prevent these by using condoms, while maintaining the tradition of not circumcising.

> *"Since the Zulus, we are aware that since there are these pandemic diseases, condoms are there to be used. We recommend using a condom than circumcising because doing that is destroying my tradition." (Uncircumcised, OF, <25)*

Two Zulu males in separate FGDs mentioned King Zwelithini's support for circumcision. In both cases, they remained unimpressed, perceiving the King to be advising something against their culture. One explained:

> *"I've also heard from Ukhozi FM about King Zwelithini's opinion that people should get circumcised. According to my belief, a king is a leader but he's not God. It's the right thing involving them, but I'll give an example of Dingaan when he was confronted by the white people and bribed him to kill his brother. He should be advising people to follow their tradition, because as Zulus we believe that [circumcision] is Sotho and Xhosa's tradition, not ours." (Uncircumcised, OF, 25+)*

One strategy a female partner of a Zulu male took was seeking to de-link circumcision from his cultural identity.

> *"So I spoke to him and he kept refusing and saying we don't do that. We are Zulus. So I told him that Zulus also do it and it is not only Sotho and that every man does it, just to protect their partners. So he agreed to do it. (Female IDI, OF)*

Some males also had this perspective. While valuing their cultural identity, they saw circumcision as a health versus a cultural issue.

3.3.2 PEER STATUS

It was clear from the FGDs that peers play a very influential role both in terms of information sources as well as decision-making. As one young circumcised male from Orange Farm succinctly put it *"All my peers had been circumcised. I was left out and I had to do it."* Similar comments were frequent, such as:

> *"For me it was the stigma of being an outcast, as all my peers had been circumcised and I wasn't." (Circumcised, OF, <25)*

Uncircumcised males described being teased by circumcised males about their appearance. This was corroborated by circumcised males, who seemed proud of their efforts to shift norms. They talked about the pressure they put on their uncircumcised peers, often focusing on ideas of masculinity (see 3.4.5).

> *"We intimidate [uncircumcised peers], persuading them in a way. We tell them "Hey, you are not a man if you still have a foreskin." Some of them consider those words and eventually make the right decisions to go and get circumcised. So, it's just that, but at the end of the day it's not like we push them in a way of peer pressure. If you decide to go there and as a result get more information, despite the one we told you about, you'll start to see the truth in it." (Circumcised, Zola, <25)*

Many of the circumcised males also talked about how pressure from peers is what encouraged them to get circumcised.

> *"The guys who were circumcised by then were bragging about being safe, telling us that we'll always get sick because we hadn't circumcised by then." (Circumcised, OF, <25 FGD)*

While most discussion of peer pressure came from younger males, the FGDs with older males also suggested that there is a peer influence at work.

3.3.3 RURAL VERSUS URBAN

While both communities included in this study could be declared urban or peri-urban, the issue of living in an urban versus rural area was raised in three FGDs. This was always raised by Xhosa or Sotho participants in the context of getting circumcised medically versus traditionally. This distinction had to do with rural areas having strong cultural and family ties, with norms reinforced more strictly. One uncircumcised youth living in Zola explained:

> *"..in places like Joburg, to most people it is not tradition to them. But to us it is. So, when you get to the rural areas they will call you names for not circumcising. So I can say in the urban areas there is not much force, that if you are not circumcised they would not let you into their group or something like that. But in the rural areas, there is a big difference." (Uncircumcised, Zola, <25)*

This difference, explained another, might be that an adult male would not be offered meat or would not be allowed to marry if he had not been circumcised in the traditional way. Another uncircumcised male in the same FGD went on to explain how embedded this is, suggesting his rootedness in the rural area, despite living in Johannesburg.

> *"This is culture, and you can't stay [in Johannesburg] forever. I am sure there are certain things that you would have to do. You will have a child one day and you will have to go home to the rural areas because it will haunt you that you didn't go to the mountain. So nothing will be done for your child." (Uncircumcised, Zola, <25)*

Those with strong rural links described having less agency to make their own decision about VMMC.

> *"So, here in the urban areas people have rights, but not in the rural areas. Your father will tell you to leave those rights at the gate not in his house." (Uncircumcised, Zola, <25)*

Conversely, those with strong urban identities described circumcision along more individualistic terms, as follows:

> *"I was born and raised in Johannesburg and I knew nothing about the cultural procedure. Some initiates die in the bush and I chose the safer option." (Circumcised, OF, <25)*

Though less explicitly about rural and urban comparisons, other FGD participants described how various cultures are mixed together in Zola and Orange Farm, making it relatively easier to act counter to one's (rural) tradition.

3.3.4 RELIGION

Religion played a role in decision-making for some people, raised most often in discussions among uncircumcised males in the context of the Christian faith. One perspective was that God created men with foreskins, which should therefore not be removed.

> *"Circumcision is just suffering, because God created us as we are. Why should we now cut ourselves?" (Uncircumcised, Zola, <25)*

> *"My point of view is that if God was not wise, He was going to create us all without the foreskins. He gave us all the penises with a foreskin but you want to go and cut it. For me, it doesn't work." (Uncircumcised, Zola, <25)*

This argument was often countered by peers who argued that God created them with other things, like hair, which is cut. They also argued that with HIV now in the world, the context has changed from Biblical times and that God would understand:

> *"God would not have a problem with [circumcision]. If He sees that you are doing the right thing with his flesh he will not have a problem. […] that God gave us things for a reason, I am not denying that. There are people who have feet and God gave them for reason. You would find that the person had a problem and that foot got rotten so they removed it and give them an artificial leg. That is why they created these artificial legs. God will not be angry with you because you have an artificial leg. Just like the foreskin, because it collects dirt. That is why we remove it. He must just understand that there were diseases that were related to the foreskin, so it had to be cut off, not that we just did it out of the blue." (Uncircumcised, Zola, <25)*

Taken in the context of the broader study, there were not clear-cut patterns for or against circumcision among those identifying themselves as Christian. A quote from one of the female interviewees illustrates this well:

> *"My ex-boyfriend doesn't believe in it, because he says the Bible says when you are born you are already circumcised. And he was very cross with me for taking our son to circumcise. […] I said to him, you know what I am also a Christian and this is a medical procedure and I am also thinking of my son's health. […] Just like the Muslim, they believe totally in circumcision and they do it when the child is born." (Female, Zola, IDI)*

None of the participants talked about places of worship or religious leaders influencing their thinking about circumcision one way or the other.

3.3.5 RACE

A minor but noteworthy theme that emerged in the study was 'race', a social construct with deep roots in South Africa. At this point it should be noted that all of the study participants as well as the data collectors would be categorised as 'Black'.

The first theme that emerged was the perception that the presence or participation of Whites signifies a certain standard. One participant explained why he circumcised:

> *"I didn't have doubts, because I had heard when they talked that when white boys did it at the hospitals when they were young. So I didn't have doubts." (Circumcised, Zola, <25)*

Another circumcised male caused a debate in his discussion with the following statement:

> *"Upon my arrival there, when I see nurses, especially the white person, it made me feel better. We, the black people still have the perception that where there's a white person it means everything will go accordingly. […] The thing is that a lot of corruption already happened involving the black people. So at least where there is a white person, things tend to be believed to be better. […] We have the perception that the black staff might cut us the wrong way. So we believe that the white people will do the right things. Even when I was in there, I almost asked the nurse if nothing could go wrong, because she was going up and down during the process. But eventually when the white doctor was present, she completed the stitches." (Circumcised, OF, <25)*

While some of his peers agreed, not everyone shared his opinion:

> *"I don't care about the race, because these days **even the black people** are professionals. They won't take such chances in issues like removing the foreskins, knowing exactly that a penis is the most crucial part of the body." (Circumcised, OF, <25)*

A second (disturbing) theme was that negative characteristics were often attributed to being Black, indicating a certain degree of self-loathing.

> *"The strategy of giving people money after they circumcise would really work very well, **especially amongst black people**." (Circumcised, OF, <25)*

> *"And you know the black community is ignorant. When you think of the HIV test you think that if I'm positive it means I'll die. We don't care about knowing our health status. We only care about what people will say." (Uncircumcised, Zola, <25)*

> *"You know, we black people are stubborn. But if ever you put your health first, you will know that I need to do this thing." (Female, Zola, IDI)*

Presenting VMMC as something positive and proactive might be one way to counter this type of framing.

3.4 GENDER AND SEXUALITY

The role of gender and sexuality in seeking to understand why males do or do not seek VMMC services permeated all discussions and interview. They were infused with underlying norms around what it means to be a male or female, from professional roles to sexuality. This section draws out some of the most striking themes related to gender and sexuality as it relates to demand creation.

3.4.1 SEX OF SERVICE PROVIDERS

The sex of VMMC service providers, from COF to those performing the circumcisions, was raised in multiple FGDs of males under age 25.

The sex of COF was only noted in a few instances. However, given the employment of female COF and the importance of COF as sources of information, it bears noting that some males may feel initial reluctance in discussing STIs with female COF.

> *"Because she was a woman then we'd feel ashamed to talk to her about [STIs] and ask her what "drop" is. She was confident enough, so, she'd explain that a "drop" is a sickness which is formed when you have sex with a woman who is not clean enough." (Circumcised, OF, <25)*

In the case of the above quote, the COF' communication skills overcame this potential barrier. This was often the case in describing female COF. There was initial wariness followed by breakthroughs.

More frequently, males expressed fear or reluctance to be served by female nurses or doctors for the circumcision itself. Much of this had to do with discomfort of having females touch their genitalia, particularly younger females.

> *"Women usually work at clinics and most of us are usually shy to relate our problems to women." (Circumcised, OF, <25)*

> *"We are uncomfortable as men to expose our genitals to female nurses, if we had problems in that area. It would help if we knew in advance that the clinic had male nurses to attend to male problem regarding STIs. At times these nurses are young enough to be our younger sisters." (Circumcised, OF, <25)*

> *"I had to inquire on the gender of the surgeons. I was unsettled at first when I heard that there were both male and female surgeons. It sounded peculiar to have a female surgeon attending to a man." (Circumcised, OF, <25)*

> *"It would be better if it was the old ladies aged 45 upwards. It be better because we'd look at them with the respect of being the mothers and listen to what they are saying."(Circumcised, Zola, <25)*

In fact, some circumcised males said that they would not have sought services had they known there were female providers

> *"All I can say is that I do not trust a female person with male things, so most of the time I don't like it when a woman asks me to take off my trousers. I usually ask for a male nurse or a doctor." (Circumcised, Zola, 25+)*

> *"I wouldn't have gone and circumcised had I known that there would be female nurses attending me. I don't feel comfortable having female nurses touch my genitals." (Circumcised, OF, <25)*

> *"I also would have never agreed if I knew that female nurses lay you on a bed, naked and they fiddle with your penis, inject it and all that." (Circumcised, OF, <25)*

Given this context among circumcised males, it was not surprising that some uncircumcised males noted that female nurses were a barrier to them seeking services:

"We often hear from the guys who undergone it that sometimes the surgeons are females. Imagine a female holding my penis to circumcise me. That is my fear." (Uncircumcised, OF, <25)

"For me if they can change the staff and do away with female staff in the circumcision process, then I will go. This is because the guys who went for circumcision, they do tell us that those female staff are naughty; they start by playing with their penises first." (Uncircumcised, OF, <25)

It is important to note that this discomfort was not shared by all. A few males explained that they were more interested in the professional qualifications than the sex of the person attending to him.

"I would be uncomfortable having a friend of mine fiddle with my genitals. I am more than happy to have a professional nurse touch me there." (Circumcised, OF, <25)

"For me it doesn't matter whether they are males or females. The fact remains that they're trained for what they are doing. They cannot just test their skills on you." (Circumcised, Zola, <25)

Some males even expressed a preference for female providers. In such cases they often repeated the stereotype of women being gentler than men.

"I also have my own perception that men won't touch you gently. For example, when I go to the dentist I prefer the female one because I know they'll treat me with gentleness." (Circumcised, OF, <25)

Finally, on the topic of female service providers, some males seemed to enjoy showing off their confidence with women in front of their peers.

"The fact that the women are the ones stitching the penises can also be a problem ***to other guys****". (Circumcised, OF, <25)*

In some cases, this was sexualized. Rather than focusing on the professional qualifications of the female nurses, the service providers were described as objects of sexual fantasy or manipulation.

"Others had to queue to be attended by the white doctor and others by the black female nurse. I was happy to be on the side of that female nurse, imagining when she touches me down there. The ones before me were saying she can touch you softly. So I only wanted to be attended by her." (Circumcised, OF, <25)

It is unclear to what extent this was to impress others in the FGD and to what extent this was genuinely believed.

3.4.2 (PROSPECTIVE) SEXUAL PARTNERS

Some males felt that circumcision would make them more desirable to females, explaining that females in the area preferred circumcised males.

"…there's a belief by the girls in the township that a circumcised guy is more enjoyable than uncircumcised one." (Uncircumcised, OF, 25+)

"I was pressurized by my girlfriend. She always said sex without a foreskin is pretty much enjoyable." (Uncircumcised, OF, 25+)

Circumcised males seemed to enjoy reinforcing this message with uncircumcised peers:

"Most of the guys eventually went [to get circumcised] as a result of that, because we were telling them about the benefits of being circumcised, such as the fact that my girlfriend can now enjoy sleeping with me." (Circumcised, OF, <25)

It was notable that circumcised males were much more likely to talk about telling uncircumcised peer about female preference for sex with them more than the HIV risk reduction benefits.

For some, their cultures required circumcision in order to become a man, which seemed closely associated with sexual activity. There seemed to be an insinuation that one could not be sexually active until after circumcision. However, this would need more exploration in future studies.

3.4.3 THE SUPPORTIVE PARTNER

The role of female sexual partners in the VMMC decision tended to be one of support. Rather than having a deciding role, the female interviewees talked about the ways they tried to make the decision as well as the healing period easier for their partner. Women described themselves as more brave than men, particularly in terms of health seeking. In such cases, they accompanied their partners to the VMMC clinics.

3.4.4 BEING A MAN: MASCULINITY

For many males, circumcision is part of the process of becoming a man, both culturally, but also in the eyes of family and friends. This was particularly true for males of Xhosa or Sotho backgrounds.

> *"You are recognized as a boy until you circumcise." (Circumcised, OF, <25 FGD)*

> *"The first time I saw someone circumcised I think was in 2001; I saw my brother who was 5 years older than me. When I asked him, his response was that* ***he's now a man*** *by doing that. I consoled myself that I'll also be a man one day." (Circumcised, Zola, <25 FGD, emphasis added)*

> *"We do get a pressure because the guys like to tease one another and* ***they brag about being men*** *because they have their foreskins removed. That sometimes makes us feel bad and inferior. Some can even call you names and say "this thing with a foreskin." That makes us feel very bad." (Uncircumcised, Zola, <25 FGD, emphasis added)*

For a few males the way in which one is circumcised (medically or traditionally) was also important in the context of becoming a 'real man'.

> *"If you are circumcised the medical way, you are also not seen* ***the real man*** *to those who went to the mountains. So, it's still the same whether you remove the foreskin or not." (Uncircumcised, Zola, <25, emphasis added)*

The idea of becoming a man was emphasized frequently, particularly by circumcised men. It was used not only to refer to being circumcised, but also with regards to the courage needed to undergo circumcision.

> *"Of course some people can't even walk properly after surgery, but* ***it takes a man*** *to ignore the pain." (Circumcised, OF, <25, emphasis added)*

The concept of being a man was not isolated to circumcision status or going to the mountain. Some males talked about being a real man in the context of taking responsibility for oneself as well as loved ones:

> *"When I meet a girl, I ask her to get tested because I know mine. So, if she doesn't agree to it, then it means we'll use a condom. My friend knows that he brings me condoms and I really use them. I can now feel that* ***I am a real man****." (Circumcised, Zola, <25 FGD)*

> *"If you are able to support and maintain your children, you are a man. There a lot of males who are not circumcised, they have children and can maintain them;* ***they are real men****. Some are circumcised but do not care about their children; what makes them men? Do you get that? Some are circumcised but do not have partners." (Uncircumcised, Zola, <25)*

Finally, one participant emphasised that medical circumcision ('what they have done on the billboard'), is not about proving one's masculinity in contrast with traditional circumcision:

> *"…in the mountain it looks like you go there so that you become a man and not to be safe, to be safe and not get disease. But they go there so you could be a man. […] What they have done on the billboard, they did not do it so you can cut and be a man." (Uncircumcised, Zola, <25)*

It is important to understand the nuances of how males are defining what it means to be a man, in order to promote positive notions, shift harmful understandings of masculinity or to delink VMMC entirely from such rhetoric.

3.5 SEXUAL RELATIONSHIPS

This study explored the sexual experiences and behaviours of the participants, including behaviours addressed in VMMC counselling, such as abstaining from sex for six weeks, reducing partners, and consistent condom use. In addition, males who had been circumcised were probed about differences in sex before and after circumcision. So were the female sexual partners.

3.5.1 PAIN AND PLEASURE

Several males talked about pain they experienced while having sex with a foreskin, due to cuts and abrasions. This issue was usually raised by circumcised males when asked about changes they had experienced after circumcision. This pain was not raised as the central motivation for them to get circumcised.

More than pain, there was a great deal of curiosity about how sex would improve after circumcision, with a particular emphasis on how many rounds one could go and giving pleasure to the female partner.

> *"We wanted to test the difference between sex with the foreskin and then without. It was just the element of curiosity." (Circumcised male, Zola, <25)*

As a side note, this curiosity was often described as being shared with their partners.

Circumcised males uniformly confirmed that sex was more pleasurable after circumcision.

> *"I know sometimes they believe that there's no difference, but I do tell them that when you come back there's a huge difference on your sexual pleasure." (Circumcised male, Zola, <25)*

> *"I was mostly motivated by the fact that sex would feel better than what I had experienced. They told me that circumcision improves the whole package and I was sold. I am living proof that it really does improve." (Circumcised male, OF, <25)*

> *"I can say sex is great. … It is because of the circumcision, because now I get a good feeling that I never did before. Like, I was being robbed. It was being withheld and now it can come out... Even the rounds are now longer…" (Circumcised male, Zola, 25+ FGD)*

The female partners also described more pleasurable sex after circumcision, although this was not their main reason for supporting their partner's to get circumcised.

3.5.2 PARTNER COMMUNICATION

There was not enough data on partner communication to determine which patterns were more or less prevalent. A number of communication dynamics were noted in relation to couples discussing circumcision.

Among the study participants, both male and female, there appeared to be a great deal of distrust about the fidelity of their partner.

> *"I do trust him. **The thing is, things happen**. Even now I don't know what you do. You go to work alone and so do I. We do not know what is happening between us. So I encourage him to go to the clinic to circumcise. And he said I do not trust him and I said no I trust him, like I did back then. I just want him to go." (Female, OF, IDI; **emphasis added**)*

While fear of STIs seemed to underlie much of the couple communication around seeking VMMC, this was a delicate topic for many, as is clear from the previous quote. That said, some study participants described more direct communication, from advice to mandates.

> *"So, they were advising me as a friend to get circumcised for my own safety, telling me that mistakes happen in life. […] My girlfriend also advises me to go, but without any pressures." (Uncircumcised, OF, 25+)*

> *"So he said he was afraid to circumcise and that they do not do it from his family. So I said to him he does not have a choice, because I want him to do it." (Female, OF, IDI)*

Not all partner communication was described as positive. One female interviewee talked about how her desire for him to circumcise was dismissed and how she was sidelined from that decision.

> *"Eish... that person is too difficult and he does not like to talk about male issues, especially when it comes to circumcision. He would just be angry and would say leave me alone, things like that." (Female, OF, IDI)*

3.5.3 CHANGES IN TYPE OR NUMBER OF SEXUAL PARTNERS

To describe changes in sexual behaviour, one must first understand the types of behaviours young males in these communities were involved in before. Some insight can be gained both from uncircumcised males current activities and the reflections of circumcised males.

One of the most striking patterns in this regard was how many males talked about girlfriends in the plural, suggesting multiple concurrent partnerships.

> *"Before I was circumcised I was just doing sex just because I had to do it. But now that I am circumcised there is a huge difference in such a way that even **the girls** do say it that they enjoy it." (Circumcised, OF, <25)*

Often they distinguished between casual partners and more stable girlfriends by status, e.g. "girl" versus my "main" partner.

There were also multiple references to the use of alcohol in conjunction with casual sex. Such partnerships carried high risk, as their status would be unknown and alcohol was usually involved, as illustrated by the following quote from a young uncircumcised male:

> *"My concern is one; we are not growing up in same times as [the old men with the foreskins]. They were not the children who* ***wake-up in the morning and hit the road to the tavern where they can meet any woman****. We are living in the bad times with indigenous diseases. During their times they only knew sicknesses such as sugar diabetes, toothache etc. The ones we know are very dreadful." (Uncircumcised, Zola, <25)*

Many circumcised males described themselves as engaging in drinking as well as multiple partnerships prior to VMMC. Post-circumcision there remained a prevailing attitude of "mistakes" happen while drunk, such as unprotected sex.

However, many circumcised males felt that the consequences had changed now that they were at lower risk of contracting STIs:

> *"I remember one time I was with a girl whom most of the guys slept with caught "drop". So, when the guys see me with her they told me I'd experience the same. But because I'm circumcised, nothing happened to me. I slept with her but even today I'm still okay." (Circumcised, OF, <25)*

This perception was attractive to an uncircumcised male, who seemed to want multiple partners without upsetting his girlfriend:

> *"I don't want my girlfriend to leave thinking that I'm fast when it comes to girls, when I suffer from STIs. I want to remove the foreskin because it used to bother me with infections before." (Uncircumcised, OF, 25+)*

Some males also seemed obsessed with having sex with virgins, describing how circumcision made this easier:

> *"There is a huge difference, especially where virgins are concerned. Sex is smoother and better now without the foreskin. You would get cuts and abrasions on the foreskin after sleeping with a virgin." (Circumcised, OF, <25)*

The value placed on having sex with virgins may be an area for future research.

Nobody spoke of having fewer partners after circumcision.

3.5.4 POST-SURGICAL ABSTINENCE

The six week period of abstinence after circumcision was discussed in all of the FGDs. This was an important factor for some at the stage of deciding whether or not to circumcise.

> *"Of paramount importance to me was the healing period. I needed to know how long after circumcision would I be able to use my penis again." (Circumcised, OF, <25)*

Some circumcised males talked about the fears or difficulties they faced during the six weeks of abstaining from sex.

> *"So there was this one girlfriend of mine that I liked too much and mind I'm still within my six week waiting period after circumcision. […]I'm worried about the chick and the six weeks. The very same night I told myself that, that guy will not get sex from my girl. But I became very vigilant of the guy and made sure the guy doesn't win, up until I finish my "detention"." (Circumcised, OF, <25)*

However, it seemed that the vast majority of males abstained as they had been instructed.

This period of healing was also discussed by female partners, as they had a more active role to play. They all described how they supported their partners to abstain, although some with more difficulty than others.

> *"I knew he had to wait for six weeks, and we did wait for six weeks." (Female, Zola, IDI)*

> *"It was difficult when he told me that we have to stay for six weeks without sex, because we used to have sex for at least twice a week. So it was difficult, but I respected that because I wanted him to get better. But it was difficult to accept, it was difficult." (Female, OF, IDI)*

3.5.5 POST-SURGICAL CONDOM USE

As discussed earlier, both males and females were aware that circumcision only reduces HIV risks and that condoms are still recommended. During this study, we were interested in whether those who were circumcised used condoms more,

less or the same as before. This was of particular interest given fears of sexual disinhibition raised by critics of VMMC.

Many males in the study talked about low levels of condom use before circumcision, either directly or indirectly by describing themselves as frequent sufferers of STIs. Therefore, it was not very surprising to find that some continued to use condoms sporadically. Low condom use was most often described in conjunction with drinking alcohol. While technically these males would be at reduced HIV risk compared to when they were uncircumcised, they were describing high risk behaviours.

Others described using condoms less, particularly with their "regular" or "main" girlfriends.

> *"You know unlike girls, we guys sometimes don't want to use it, but the girls always insist on condom use. Especially to my regular girlfriend, I sometimes remove a condom in the middle of the game and she can't feel that I removed a condom because she enjoys a great deal now that I removed a foreskin."*

Still others described using condoms more than before circumcision as a result of VMMC.

> *"Most of the time he didn't want to use a condom and if I ask him to use a condom he would ask me whether I do not trust him anymore. And using condoms is the best, because it prevents a lot. So, that is why I wanted him to circumcise, because he does not want to use a condom. […] So I was afraid of things like drop. […] I was also avoiding other things, but since he got circumcised we use a condom. [...] So it happened that after he was circumcised he then said no, we have to use a condom. I tried to ask him what made him change his mind but he didn't explain. He just told me that from now we have to use a condom, because I am avoiding certain things." (Female, OF, IDI)*

> *"I also have a problem that when I meet a girl I ask her to get tested because I know mine. So, if she doesn't agree to it, then it means we'll use a condom. My friend knows that he brings me condoms and I really use them. I can now feel that I am a real man. Currently my girlfriends live elsewhere and they trust me; we got tested together." (Circumcised, OF, <25)*

In this second quote, it was interesting to find a pro-health spin on the idea of being a man.

Interestingly, the fact that condoms were recommended for circumcised males was a key reason uncircumcised males gave for not seeking VMMC.

> *"I personally don't see the necessity need to get circumcised, because condoms are there to protect us. So I don't see the necessity to get circumcised." (Uncircumcised, OF, <25)*

Since the Zulus, we are aware that since there are these pandemic diseases, condoms are there to be used. We recommend using a condom than circumcising because doing that is destroying my tradition. (Uncircumcised, OF, <25)

However, one uncircumcised male described how females are less likely to request condoms with circumcised males:

> *"… when I look at it, about four to five years to come when you try to sleep with a woman she will ask you if you are circumcised. When you say no she will ask you to use a condom. That is why I say somewhere somehow [circumcision] is growing." (Uncircumcised, Zola, <25)*

This was an instance of a male stating his dislike of condoms outright and seeing VMMC as a strategy to fulfill that preference (not disinhibition, per se).

3.6 DEMAND CREATION RECOMMENDATIONS

Study participants shared their ideas on how to generate demand for VMMC, either based on their own experiences or by observation. These have been organised by constructs commonly used in behavioural and communication theory.

3.6.1 KEY BARRIERS TO ADDRESS

Numerous barriers to VMMC were identified and described in the context of discussions, both by circumcised males in the context of overcoming barriers and remaining barriers for uncircumcised males. Females also described barriers to their being able to support VMMC.

The barriers that emerged most consistently and powerfully in the analysis can be placed in three categories. These have been summarised in table 3.3. (see opposite page)

Logistical barriers were raised by males only, who claimed that all they lacked was time and money. With regards to time, both the season and work leave were mentioned. Transportation was also raised as a concern, particularly for those living far from the clinic who were not sure how they would get home after circumcision.

Seasonality

For some males, circumcision is meant to be done (or not) in particular times of the year. Part of this comes from the traditional times of going to the mountain (winter), while for others it was more out of preference. For example, one participant described how he did not want to get circumcised in the festive season as it would interfere with his drinking.

> *"Because it was during December when he recruited me, I told him that during the festive season I drink alcohol most of the times so it was not the best time for me to commit to that. But I promised him I'd definitely do it in January and I sure did it in January." (Circumcised, OF, <25)*

One of the female partners noted that a benefit of VMMC, unlike traditional circumcision, is that it could be done in summer as well.

Work

Unemployment in both Orange Farm and Zola are high. For employed males, finding a time to go on leave to get circumcised was important.

> *"My reason [for not circumcising] is because of work. Anytime I would go, but it's for now I can't go on leave, because I am going on leave in June." (Uncircumcised, Zola, <25)*

With the above quote, either this male was not aware of weekend clinic hours or he may have been working on Saturdays.

Transportation

A few males mentioned lack of transportation as a barrier, particularly for the return home after surgery. This concern relates to deeper issues of poverty, where males did not have enough money for public transport.

> *"I think if everyone had that chance where there could be a transport from one place to the other so that one would not fall when they come from circumcising. You would find that some people don't have transport money and they haven't eaten." (Uncircumcised, Zola, <25)*

The obvious suggestion was to provide transport to clients, especially after circumcision.

Short-term discomfort comprised a second set of barriers for both males and females, with some key differences. For males, this most often related to the pain of the surgery and the potential for adverse events in the healing process.

Fear of pain was by far the most frequently stated reason for not seeking or delaying seeking VMMC. This was raised by both circumcised as well as uncircumcised males. The following quote is typical of the fears voiced:

> *"So what I wanted to know is that after you have done it do you experience pain or is there anything that they give you for pain? Because when you wake up in the morning the penis gets an erection. So, immediately when you get an erection the stitches get torn. So, those are some of the things that scare me." (Uncircumcised, Zola, <25)*

Table 3.3. The three barriers that emerged most consistently and powerfully.

Barriers	Male barriers to seeking VMMC	Female barriers to supporting VMMC
Logistical	▪ Seasons – summer or festivals ▪ Transportation (cost) ▪ Work – no leave	*None mentioned*
Short-term discomfort	▪ Pain ▪ Discomfort of interacting with female COF/clinic staff ▪ Possibility of adverse events ▪ 6-week waiting period	▪ Not sure how to raise issue ▪ Insinuation of lack of faithfulness ▪ Partner anger/violence ▪ 6-week waiting period
Identity	▪ Zulu ethnicity ▪ Traditional circumcision requirements for Xhosa, Shona to be "a man" ▪ Religion – not altering God's creation	▪ Gender role – not to question male ▪ Not a family tradition

Identity comprised the final and much more complicated set of barriers linked to masculinity, femininity, sexuality, and in some cases culture and/or religion. Much if this has already been covered in the earlier findings and is not repeated here.

3.6.2 KEY MOTIVATORS AND FACILITATORS TO PROMOTE

Part of demand creation requires communication that builds on and reinforces the positive factors that motivate males to seek services.

As already reported, the communication of VMMC's medical benefits seems to be bearing fruit in terms of knowledge and should continue.

Furthermore, the actual reduction in STIs was described as sources of relief and pride by both males and females. Such testimonials could encourage males currently on the fence.

Finally, the sexual pleasure described by both males and females should be communicated.

3.6.3 COMMUNICATION CHANNELS AND MIXES

COF with pamphlets seem to be the most influential combination of programme initiated demand creation, allowing for immediate questions to be answered by the recruiter and the pamphlets giving potential clients a tool to discuss it with others, e.g. sexual partners or family.

There is scope to involve circumcised males as formal (or informal) COF. This was specifically suggested.

Print media

The study participants were strong advocates of using pamphlets and even expanding their distribution points, with a few words of warning about format.

> *"Pamphlets would also be very useful especially in school, although they use cartoons to depict humans which at times makes us lose interest in reading the whole thing altogether. […] Pamphlets would also work well if distributed in selected target areas like schools, taverns, community halls and shopping centers." (Circumcised, OF, <25)*

Some of the uncircumcised males had ideas about additional content for pamphlets, with an emphasis on visuals, such as follows:

> *"[The pamphlets] must display uncircumcised penises with different sicknesses, like I said, to show people the disadvantage of being uncircumcised. They can show the uncircumcised ones with their problems and also show the circumcised ones, to show the people how they will end up being if not circumcised. […] It must include the pictures for the benefit of illiterate people." (Uncircumcised, OF, <25)*

Both circumcised and uncircumcised males were also positive about the use of billboards and posters, both for cost reasons and for raising public awareness about VMMC. Below is an exchange in one of the FGDs.

> *"I feel we did not do justice to the billboard issue; these could be very powerful tools as they appeal to most people especially in the townships where circumcision is still relatively a new topic." (Circumcised, OF, <25)*

> *"I would also like to emphasize the power of billboards and posters, these would really appeal to a lot of people and many would read these notices perhaps thinking that it could be a notice about a party only to find out that it's the very information on circumcision that they have been looking for. There still are people out there that don't know how they can get information on male circumcision." (Circumcised, OF, <25)*

> *"I think that billboards save money as compared to fieldworkers that have to be paid and have to travel from place to place. Billboards can be planted at strategic positions and achieve the same purpose in a timeless manner." (Circumcised, OF, <25)*

One suggestion on how to improve existing billboards would be to use indigenous languages.

Mass media

Males also emphasized the role of radio in the day to day life in their areas, suggesting specific frequencies with good coverage.

> *"Let us not forget the power of radios and how much a part of our everyday lives they are. Even if you might not have a radio yourself, you might still get the information from your neighbour." (Circumcised, OF, <25)*

> *"I second the thought of using radio. Most people in this part of the country listen to **Thetha FM**." (Circumcised, OF, <25)*

Interestingly, in response to the above suggestion, someone pointed out that Thetha FM only covered the Vaal area. This is a good reminder to research coverage prior to airing demand creation programmes.

Edutainment

A few edutainment programmes were mentioned in the context of VMMC as well as HIV. One uncircumcised male suggested edutainment as a way to increase awareness of HIV and VMMC:

> *"They can also [raise awareness] on TV, as a soapie like Generations. They can get people to act and disguise their appearances into different stages of HIV/AIDS, from when the person is still normal and fresh up to the final stage. While we don't see that, we are still taking things for granted. Now they just show their own programs that are useless." (Uncircumcised, OF, <25)*

However, there was some skepticism that such programmes can change perspectives in the communities. One participant highlighted the danger of using celebrities to promote health, as they may later mislead people. He also pointed out that there are already a number of programmes using edutainment techniques.

> *"The communities don't care. Think about people like Nkosi Johnson, Khabzela, how their conditions were before they died, the people who announced their HIV status publicly. The same celebrities who you say should be utilized for advertising HIV issues, one of them was commenting that the ARVs are not effective. They mislead the people who will in turn die in large numbers. The HIV shows have always been there. There's been many shows and programs regarding it, even in Generations there's someone sick with HIV/AIDS. There's currently no soapie where there's no character of the person infected by HIV." (Uncircumcised, OF, <25)*

This distrust of celebrities was reinforced by the muted response of Zulu males to the King's support of circumcision, as reported earlier.

Mobile telephones

Mobile phones were explored as a potential channel for demand creation. There was a specific question on the topic in both FGD and IDI guides. Both networks and phone use patterns were explored. **Table 3.4, below**, summarises the networks and phone use patterns discussed in each setting.

In both settings, cost was raised as a major issue, with many people relying on mobiles to receive calls and SMS only. Some of the younger males described using their mobiles for accessing the internet and for social networks, particularly those in Zola.

When asked about receiving health information via their mobiles, a few described having already used their mobiles for health purposes, though not in the context of demand creation:

> *"I was bleeding profusely after my circumcision after a suture had come off as a result of an erection. I sent a "please call me" to the dedicated line and I was assisted accordingly over the phone." (Circumcised, OF, <25)*

Table 3.4 A summary of the networks and phone use patterns discussed in each setting

Setting	Popularity	Network	Network Notes	Mobile use notes
Orange Farm	+++	MTN	Works better than other networks; Talk for free	▪ Most critical factor is free services. Youth, in particular, are unwilling to spend airtime. ▪ Phones used mostly for calls & SMS ▪ Social networks used: FB, Mxit ▪ Please call me is popular ▪ Many are using fake brand handsets
	++	Vodacom	Sometimes no signal	
	++	CellC	Free internet; Free minutes; Chat free; Best for those using social networks, e.g, Facebook	
	+	8ta	*Reason not given*	
Zola	+++	MTN	Sometimes can't receive calls on weekends	▪ Social networks used: FB, Mxit, Twitter, WhatsApp ▪ Please call me is popular ▪ Access Internet ▪ Listen to music on phones
	+++	Vodacom	Fine in JHB, but problems in rural areas	
	++	CellC	Internet free; Popular with youth	
	++	8ta	Free SMS	
	-	Virgin Mobile	*Reason not given*	

When probed specifically about the use of mobiles for demand creation, a number of concerns were raised. One of those concerns was cost:

> *"Most of us would not have been keen on using an SMS feature dreading the fact that we might lose valuable airtime or we might not even have enough airtime for the service." (Circumcised, OF, <25)*

The cost of airtime seemed to be a particular concern among young males in Orange Farm. This led to some recommending the use of free SMSes to share VMMC information.

> *"It would have worked if it was on TV or billboards and if the SMS feature was free. Using mass media devices would reach out even to elders who might SMS and get information for their kids." (Circumcised, OF, <25)*

In the above quote it was interesting that the use of SMS was associated with elders. The content of the SMS was also raised as an important consideration, as this is already being used to convey messages about related health topics.

> *"It also depends on what the SMS speaks about, because sometimes when it you see that it talks about the HIV/AIDS, you just delete it and so on. But if it's a relevant SMS, like the SMS about the STIs and the number to dial if you have queries, it could be useful." (Circumcised, OF, <25)*

When asked about popular networks in their areas, study participants raised a fear that some people would miss out if only one or two networks was used to disseminate messages.

Despite these concerns, there was also enthusiasm about using phones to reach a greater number of people. Advantages mentioned included that the message could be saved, it could provide referral information, and could be shared with others.

Social networks, e.g. Facebook and MixIt, were also being used by younger participants, particularly those in Zola. One cautioned against the use of social networks and when probed explained that males do not use them:

> *"I don't necessarily think that it would be a good means of disseminating information as these social platforms are predominantly used by girls. If the information is intended for boys, then the whole thing would be a miss.' (Circumcised, OF, <25)*

More specific ideas of how social networks might be leveraged to improve demand creation were not shared.

4. LIMITATIONS

This study used qualitative methods to explore a range of experiences and perceptions related to VMMC demand creation. Given the qualitative nature of the design, the findings cannot be generalised to the entire communities of Orange Farm and Soweto, let alone South Africa.

In writing this report, the author has sought to reflect the range of voices and perspectives present in the discussions and interviews. Some nuances may have been missed in the translation from local languages to English. However, conducting the data collection in local language supported participants to open up more fully, offsetting the potential loss of meaning in translation. Most FGDs lasted at least 1.5 hours.

It should be noted that the FGDs themselves were influenced by group dynamics, with some individuals dominating. In some ways, these dynamics mirror the ways in which peers interact in the community and was part of the observation process. Indeed, this is one of the advantages of using FGDs as opposed to IDIs. That said, while the facilitators actively sought out the perspectives of all participants, it is possible that some males did not feel comfortable to share their thoughts.

There were few instances of the facilitators changing the words of participants or introducing new ideas during the discussions, which could have introduced bias. Quotes from participants following such instances do not feature in this report, as it is possible that the ideas or words reflected more the researcher than the study participant perspectives.

Finally, the coding and analysis of data was conducted by a single individual. While the analysis was subjected to collegial input and feedback, the validity of the codebook itself was not tested. As such, there is a danger that the personal bias of the researcher has influenced the presentation of findings. To offset this bias, as much as possible, the verbatim quotes have been included to substantiate claims of the author.

This study highlights the complexity of demand creation communication as it is playing out in two communities in Gauteng Province. To make sense of the findings, a theoretical construct called decisional balance, the way one weighs the pros and cons of VMMC, is helpful. In this case, decisional balance describes the multiple factors males weigh against each other to decide whether or not to get circumcised medically.

Communication guidance and strategies for VMMC demand creation have indicated a need to for multi-level approaches (UNAIDS). According to this guidance, although demand creation commonly is measured as individual behaviour (numbers of individuals seeking VMMC), demand creation efforts need to go beyond addressing individuals directly. To increase effectiveness, they should also consider peers, partners, and families at the interpersonal level as well as community and social levels, as these directly and indirectly influence the behaviour of uncircumcised males. This was reinforced with the findings of this study.

The study confirmed that information about STI and HIV risk reduction was a powerful motivator for many males to seek circumcision. This was undoubtedly an important factor for females to support uncircumcised partners as well. Potential barriers to VMMC, such as the six week abstinence period following the procedure, were understood and had not stopped many males from seeking VMMC, suggesting that other factors outweighed this barrier.

However, a key finding was that knowledge, while important, did not automatically translate into an intention to seek VMMC for everybody, as evidenced by the uncircumcised males. Similarly, an ability to repeat key information about risk reduction did not mean that it was fully understood, as highlighted by the female partner who talked about risk reduction but then expressed her relief that she was safe from HIV now that her partner was circumcised. This suggests that while evidence regarding VMMC needs to remain a key feature of demand creation, it functions only as one element of individuals' and couples' decisional balance when considering VMMC. While this may seem obvious,

5. DISCUSSION

many communication programmes focus on increasing knowledge without measuring other critical factors.

5.1 PROGRAMMATIC RECOMMENDATIONS

The following discusses potential programmatic approaches at different levels in an ecological model in which uncircumcised males are at the centre.

Individual and Interpersonal Approaches

The primary target audience for VMMC demand creation is uncircumcised males as it is by their actions that the fruit of demand creation is ultimately measured. The study found that this is not a homogenous population in Gauteng. While certain barriers and motivations were noted across this target group, e.g. fear of pain and a desire to avoid STIs and HIV, important differences also emerged along ethnic lines, age, relationship status and around conceptions of masculinity.

Enlisting **proactive COF** to establish rapport with uncircumcised males in the community emerged as an important strategy regardless of segment. These COF are most effective when they have print material that they can provide to potential clients or family members. The content of the print materials should provide facts about the benefits and limitations of VMMC. There was also a desire to know more about the process that happens in the clinic.

The COF may need additional communication training to ensure that misunderstandings to not occur. Although female COF have been effective, this study suggests that COF who share peer characteristics with the target audience may be even more effective if properly trained, e.g. a Zulu circumcised recruiter may better understand and speak to the apprehensions of an uncircumcised Zulu peer.

Tapping into the **peer networks of circumcised males (and their female partners)** is another strategy for both one-on-one conversations as well as organising discussions in group settings. The data showed that peers exert an enormous amount of influence on each other. As such, it is critical that they are fully informed to avoid misunderstandings. While some can be formally engaged as COF, there is also an opportunity to enlist circumcised male's support in contacting their uncircumcised peers for structured sessions with trained communicators.

Print materials that can be viewed by individual as a source of information, e.g. pamphlets, posters, and billboards, should continue to be employed. However, the content should be revisited to:

- Address misunderstandings about STI/HIV risk reduction that emerged in the study
- Explain the clinic procedures, e.g. sex of providers, voluntary nature of HIV testing, etc.
- Include more visuals and/or local languages to address those who cannot read English
- To address barriers around circumcision itself, the following approaches are recommended:
- Recruit circumcised males to share their experiences of VMMC, specifically addressing the issue of pain and healing
- In messages, acknowledge that there may be pain, emphasizing that it is short-term and off-set by the benefits of circumcision
- Highlight the professional qualifications of service providers, ensuring that both male and female providers are depicted in a positive and professional light
- Sensitise clinic staff to be more aware of how experiences in the clinic are communicated to other potential clients in the community

These materials should be pre-tested in their own right before distribution.

Community-level Approaches

In addition to addressing individual uncircumcised males, this study suggests that a number of norms are at play within social and cultural networks as well as within the communities of interest. Addressing norms would require another set of approaches.

Addressing cultural norms

It was clear that the cultures and traditions of potential VMMC clients should be treated with respect to avoiding alienation of key populations. At the same time, a clear threat to South Africa achieving its VMMC targets is the idea that certain groups, e.g. Zulus do not circumcise or Xhosa's should not be circumcised in a clinic. While such ideas had some currency in Orange Farm and Zola, especially among uncircumcised males, they will be even more important as demand creation shifts to rural areas where traditional circumcision is practiced. Engagement with traditional leaders and further research should inform communication in such settings. However, one of the female participants in this study presented a concrete idea of how communicators can begin to address this issue by de-linking cultural identity from the physical marker of circumcision.

To address barriers related to identity, the following is recommended:

- Tailor messages to address the different factors being weighed by different cultures (medical vs. mountain setting for Xhosa and Sotho; circumcision for health vs. changing a cultural behaviour for Zulus)
- Promote a version of masculinity or being a "real man" that emphasises taking responsibility for oneself and ones loved ones, including sexual partners

5.2 RESEARCH RECOMMENDATIONS

This study was exploratory. In the process of analysis, several areas for further qualitative and quantitative research were identified.

Further observational studies could be conducted on the following:

- Perceptions of the safety of medical versus traditional circumcision
- Mapping of VMMC seeking by ethnic make-up of catchment areas
- Positive deviance: pro-health conceptions of masculinity
- Understandings of disease progression
- COF recruitment messages

Operational research could be conducted on:

- Tailoring of messages by ethnic identity and measuring changes in uptake

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