

Perceptions and Acceptability of Male Circumcision in South Africa

Setswe G^{1, 2*}, Peltzer K¹, Majaja M¹, Matseke G¹ and Notshe Y¹

¹HIV/AIDS, STI & TB (HAST) research program, Human Sciences Research Council, Pretoria, South Africa

²Department of Health Studies, University of South Africa, Pretoria, South Africa

Abstract

Background: The aim of this study was to determine the perceptions and acceptability of male circumcision among the young, as well as older men and women in South Africa.

Methods: A total of eleven (11) focus group discussions were conducted in eight of the nine provinces of South Africa. Issues that were explored included (1) acceptability of male circumcision among different cultural groups, (2) perceptions about hospital versus traditional circumcision, (3) perceptions about safety of male circumcision, (4) perceptions about MC and protection against sexually transmitted infections including HIV, (5) misinformation about MC, (6) perceptions about MC and sexual pleasure, and (7) perceived barriers to male circumcision.

Results: The study found that male circumcision was acceptable to both men and women in various cultures in South Africa. Although traditional male circumcision was the most preferred method, concerns were raised about the safety, and for this reason some preferred hospital over traditional circumcision. There were mixed attitudes regarding whether male circumcision is protective from HIV transmission. Some participants said that male circumcision increased sexual pleasure and decreased sexual inhibition. There is a need for sexual and reproductive health promotion interventions in the context of male circumcision.

Conclusions: Male circumcision is acceptable to both men and women in various cultures in South Africa even though people have mixed perceptions regarding whether male circumcision is protective from HIV transmission.

Keywords: Culture; HIV/AIDS; Initiation; Male Circumcision; Tradition

***Corresponding Author:** Setswe G, Human Sciences Research Council, 134 Pretorius Street, Pretoria, South Africa; Tel: +27 12 302 2624; E-mail: gsetswe@hsr.ac.za

Background

Male circumcision is one of the oldest surgical procedures historically known to be undertaken for cultural, social, religious or medical reasons [1, 2]. It is a cultural practice which is done differently across cultures. It is widely practiced but predominant in Africa where it has been viewed as a rite of passage to manhood [3]. Though the practice differs across cultures, it essentially involves the removal of the foreskin [2].

The prevalence of traditional male circumcision was found to be 24.8% (compared to medical male circumcision rate of 13.2%). Connolly, Simbayi, Shammugam & Nqeketo [4] found in a national survey in South Africa in 2002 that, of 1067 men of 15 years and older who had been circumcised, the majority (57.2%) had been circumcised traditionally and 42.8% medically. The vast majority of Whites (97.8%), Indians (92.8%) and

Coloureds (87.4%) were circumcised medically, compared to only 21.8% of black Africans. The median age of circumcision for black South Africans was 18 years compared to 10 years for Coloureds, 2 years for Whites and 1 year for Indians. Traditional male circumcision was mainly practiced among the African Black population group (31.9%). However, there were stark differences among different African ethnic groups in traditional male circumcision rates, ranging from 71.1% among Venda, 60.5% Northern Sotho, 57.3% Xhosa, 57.0% Ndebele to 2.4% among Swati and 10.7% among Zulu [5].

In recent years, numerous observational studies have reported a significant protective effect of male circumcision against HIV and other sexually transmitted infections in men [6]. In addition to this, three randomized controlled trials from sub-Saharan Africa have shown that male circumcision reduces the risk of HIV incidence by approximately 60% [7]. According to Westercamp & Bailey, 2007 [6], ecological studies have shown that the countries in sub-Saharan Africa with the highest HIV prevalence are those in which male circumcision is little practiced. Based on epidemiological and experimental evidence to date, male circumcision could have a significant impact on the HIV epidemic in most highly affected areas.

A serious concern, however, is whether male circumcision can be provided to large numbers of adult males safely. While the beneficial effects of male circumcision are now widely recognized, those benefits must be weighed against the potential complications including bleeding, swelling, wound infections and removal of excessive skin. Male circumcision is a relatively simple, quick and safe procedure when performed in a clinical setting under aseptic conditions by a trained practitioner with proper instrumentation [8].

Perceptions about male circumcision

Perceptions about male circumcision differ markedly in different communities. Male circumcision has been perceived in different ways by different categories of people over the years. Some people have equated male circumcision with improved

hygiene, some have felt that it is a risky procedure and others had a widespread belief that circumcision leads to reduced incidence of STIs [6]. Furthermore, circumcision is associated with factors such as masculinity, social cohesion with boys of the same age who become circumcised at the same time, self-identity and spirituality.

In Zululand, King Shaka ordered that circumcision schools be abolished during the Zulu wars in the early 19th century [9], presumably because of the difficulty of holding the schools during the continual fighting or because young men will not be able to fight when they have wounds. For similar reasons, many other groups in southern Africa are thought to have abandoned male circumcision at that time, including the Swazi when King Mswati II banned the practice as it incapacitated men at times of war [10]. Two ecological studies have shown HIV infection rates to be highest in traditionally non-circumcising areas of sub-Saharan Africa [11, 12].

Acceptability of male circumcision

Acceptability of male circumcision has been studied in men and women in several countries in Sub-Saharan Africa, in men who have sex with men in China and the United States, in Indian mothers and expectant parents and men in Thailand. These studies show a wide variation in willingness to circumcise [7]. Westercamp & Bailey, 2007 [6] reviewed studies of the acceptability of male circumcision in Sub-Saharan Africa to assess factors that influenced male circumcision uptake in traditionally non-circumcising populations and they found that more than half of the men studied appear to be receptive if not eager to be circumcised.

Although circumcision is a cost-saving intervention in the long run, compared to lifetime HIV treatment costs [13, 14] there is a high cost to a rapid scale-up program. A study in Kenya revealed that a general lack of knowledge, training of practitioners, and instruments and supplies hampers the ability to provide safe circumcisions to large numbers of males [8]. The complications reported were evident not only for traditional

settings, but also for clinical settings. A study in Soweto, South Africa also indicated (even with limited demand) that resources to perform circumcisions were lacking [15].

Aim and Objectives

The aim of this study was to determine the perceptions and acceptability of male circumcision among the young, as well as older men and women in South Africa.

The objectives of the study were to describe:

- acceptability of male circumcision among South Africans
- perceptions about MC among South Africans

Methodology

Study design

This study was of a qualitative approach with eleven (11) focus groups discussions conducted with people from different cultural backgrounds, age and gender. This was designed as a formative research to design a quantitative questionnaire for the Human Sciences Research Council's third South African surveillance study on HIV and AIDS.

Qualitative research deals more with meanings than numbers. Mouton [16] refers to qualitative research as focusing on the natural attitudes of everyday life, within which the social cultural world is experienced by common thinking of people living their daily lives among their fellows [16]. The qualitative approach allows for the emergence of data that is specific socio-culturally [17]. According to Mason [18], qualitative research is grounded in a philosophical position that is concerned broadly with how the social world is interpreted, understood, experienced or produced [18]. Hence, the overall approach was appropriate for this study.

Data collection

A total of eleven (11) focus group discussions were conducted in eight of nine provinces (Western Cape, Northern Cape,

Eastern Cape, Free State, Limpopo, Gauteng, North-West and Kwa-Zulu Natal) in South Africa. Of these eleven focus groups, two consisted of both males and females (Gauteng and Limpopo province), and nine consisted either of male or females, selected using convenient sampling method. Each focus group discussion consisted of about eight to twelve participants chosen from various communities and institutional settings with the assistance of gate-keepers, depending on the province, region, location, and the target population. Total of 98 participants were involved in the study. Discussions were held in a language that was commonly used in that particular area.

A focus group guide was used during the interview process and also covered a wide range of themes that included participants' perceptions and acceptability of male circumcision and HIV risks. Focus group discussions were facilitated by trained HSRC research staff and external facilitators.

Both research staff and external facilitators attended a one day training session on how to conduct focus groups discussions. Focus groups were conducted in six provinces (WC, NW, Limpopo, Gauteng, KZN and FS). For each province, facilitators were placed according to the languages spoken in those areas to conduct focus groups. External facilitators were employed to participate in the data collection process on the merit that they have passed matric and also experience on data collection, particularly focus groups discussions.

All the focus group facilitators, who were Master's and Doctoral-level researchers at the Human Sciences Research Council (HSRC), were supplied with a focus group training manual comprising all the material available in the proposal, as well as more in-depth information on their responsibilities, qualitative methodologies, conflict mediation strategies, and background literature on social and cultural issues that are pertinent to the study.

Table 1: Characteristics of participants in FGDs

FGD	Province	Area	Participants	Ethnic group	Age range
FGD(A)	Gauteng	Soweto	Female and male teenagers	Sotho, Venda	16-20 years
FGD (B)	Limpopo	Sekhukhuni	Adult men and women	North-Sotho	25years and older
FGD(C)	North-West	Brits	Adult women	Tswana	25 years and older
FGD (D)	Free State	Botshabelo	Adult men	Sotho	25 years and Older
FGD(E)	Western Cape	Khayelitsha	Adult women	Coloureds, Xhosa	25 years and older
FGD (F)	Kwa-Zulu Natal	Umlazi	Adult women	Zulu	25 years and older
FGD (G)	Kwa-Zulu Natal	Ashdown	Adult women	Zulu	25 years and older
FGD (H)	Northern Cape	Galeshewe	Female teenagers	Tswana, Coloureds	16-20 years
FGD (I)	Northern Cape	Upinton	Adult men	Xhosa	25 years and older
FGD (J)	Eastern Cape	Mthatha	Young men	Xhosa	16-30 years
FGD (K)	Eastern Cape	Bisho	Male teenagers	Xhosa	16-20 years

During the focus groups discussions, the co-facilitator took field notes, which were later used to validate transcripts for accuracy. Some light refreshments were served during the focus group discussions.

Ethical considerations

Ethical approval to conduct the study was obtained from the HSRC's Research Ethics Committee (REC) and the Centre for Disease Control's Institutional Review Board (IRB). A study information sheet was made available to all participants. In addition, an informed consent form was available for youths and adults as well as parents/guardians of children aged 14-17 years, while an assent form was available for children aged 14-17 years. The original consent or assent forms which were in English, were both translated and back-translated (i.e., back into English) independently by professional translators into the other 10 official national languages used in South Africa. The back translation insured the accuracy of the translations.

In the field, gatekeepers granted permission to continue with the study. These included people ranging from the police, the village chief, village elders, municipality councilors, NGO

workers, members of Community-Based Organizations (CBOs), youth societies, and others. Parents and guardians of teenagers less than 18 years were asked to give informed consent for inclusion of teenagers in the focus group discussions. Informed consent and assent was first administered in groups before the actual focus group discussions were conducted. The facilitator went through consent form verbally, seeking feedback to ensure that participants understood all material that was on the form. All youth and adults who agreed to participate were required to provide written or verbal (where respondent was illiterate) consent.

The group discussions lasted for up to two hours in a language that was commonly used in that particular area. Sessions were recorded using a digital audio recorder. Consent was obtained from participants to record the discussion. The audio recordings of each focus group conducted were saved in a specific password protected file for transcription purposes.

Data analysis

Data were analysed using thematic coding [19]. This involved categorizing data derived from focus groups transcripts into

meaningful themes. In practice, themes serve to identify, label and interpret features of data [19]. The coding process for this study was complex and employed open, axial and selective coding. During open coding, all the data were categorized and broken down into pieces and within each category and subcategories emerged. Axial coding brought together related categories into themes. Finally, researchers examined the themes and determined if and how they related to one another.

Findings and Discussion

The following themes were revealed during data analysis; traditional versus hospital based circumcision, perceived sexual pleasure, perceived safety and complications, perceived protection from sexually transmitted infections and HIV/AIDS and perceptions on circumcision and sleeping with a woman immediately after being circumcised.

(1) Acceptability of male circumcision (traditional versus hospital circumcision)

Among the ethnic groups that traditionally performed male circumcision as a ritual the preference was on traditional than hospital circumcision and a concern was more on preserving the cultural practice than issues such as sexual pleasure, hygiene and safety. Traditional circumcision was preferred more among Pedi's than other ethnic groups. Among Pedi ethnic group, traditional circumcision is considered pride of the nation, meaning that the Pedi's grew up with this cultural practice and it must remain part of their lives. For most of the participants, compared with hospital circumcision, traditional circumcision is not only about the removal of the fore skin, it is also a place where one learns values on how to conduct himself in a community and also an initiation in to manhood. As expressed by some of the participants,

"Initiation is given approval by the chief. You can't just come from nowhere and start with the process," (FGD B).

"Initiation is a matter of gathering," (FGD B).

"It is a great thing to the family; everybody should be invited to celebrate the achievement," (FGD B).

Hence further expressed by one of the Xhosa participant that,

"I prefer the Xhosa method because I grew up among the Xhosa people knowing that method," (FGD E).

According to some of the more traditional and rural participants, to be circumcised in a hospital is an embarrassment to the community (FGD E), one will not get all the respect (FGD E) and again one will not be accepted in the community (FGD B). In many sub-Saharan countries such as South Africa, while there is a fair uptake of both traditional and hospital based circumcision there is a high HIV prevalence [8]. WHO [20] states that the secrecy surrounding traditional male circumcision, and some complications such as the amount of foreskin being removed, the encouragement of sexual intercourse immediately from "the bush" in some cultures, and at times some complications leading to death are some of the reasons that people are lately preferring hospital based or medical male circumcision. Wound infection and delayed healing are some of the reported complication associated with traditional male circumcisions which are better managed in clinical settings. Albeit the complications mentioned, traditional male circumcision seemed to hold a preferred cultural role mainly among traditional and rural communities.

(2) Perceived sexual pleasure and hygiene

Though traditional circumcision seems to be a cultural norm almost among all African ethnic groups, it is also seen by most of the participants as being about sexual pleasure.

"There is also a belief that men enjoy sex better after they have removed that skin" (FGD F)

"Most of the people believe that if the fore-skin is not removed, one will not get sexual pleasure" (FGD F)

"This might sound as a joke but a circumcised penis looks funny but it is enjoyable (laughs)." (FGD C) "The circumcised one is having more sexual pleasure. But when you are not circumcised your penis is cold." (FGD F)

"It might have a lot of pleasure but you can easily contract HIV without the foreskin and not using your condom." (FGD's I)

The positive spin-offs reported by women when their male partners were circumcised were improved hygiene, longer time for the partner to achieve orgasm and male partners wanting more sex. However, Brouard, [21] in his paper titled “Whose pleasure? Notes about male circumcision and female sexuality”, questions the world’s understanding and measuring of women sexual satisfaction associated with male circumcision. Brouard [21] argues that sexual ‘pleasure’ is a fluid concept which can depend on many issues such as whether the woman is menstruating, menopausal, exhausted, and has had foreplay and so on. Brouard argues that sexual pleasure is variable, contextual and unpredictable and therefore questions the recent findings that 40% of the women whose sexual partners were subsequently circumcised reported an improvement in sexual life. Therefore, according to Brouard, the issue of sexual pleasure in association with male circumcision needs more qualitative research because of its complication.

Male circumcision is now performed for a range of reasons, mainly social or health-related, in addition to religion and ethnicity. The desire to conform is an important motivation for circumcision in places where the majority of boys are circumcised. Brito et.al [7] found that the majority (73%) of individuals interviewed reported knowing that male circumcision improves genital hygiene. In Nyanza Province, Kenya, 96% of uncircumcised men and 97% of women irrespective of their preference for male circumcision stated their opinion that it was easier for circumcised men to maintain cleanliness [6, 10]. Although no differences were found in self-reported hygienic practices between circumcised and uncircumcised men, both men and women in a Ugandan study felt it was easier to maintain genital cleanliness in circumcised men [22]. Men participating in focus group discussions in Botswana, Kenya, Malawi, the United Republic of Tanzania, Zambia and Zimbabwe also believed that it was easier to keep the circumcised penis clean [10]. A survey by Brown and Brown, [23] in Denver, United States where circumcision occurs shortly after birth, found that parents, especially fathers, of newborn boys cited social reasons as the main determinant

for choosing circumcision, for example not wanting him to look different.

(3) Perceived safety and complications

There was a general feeling among the participants that compared to the past, currently, the initiates undergo medical checkup first before going in to the mountains to be initiated, and this is regarded as being safe.

“In the past, no medical doctors were allowed to go in to the initiation school, but of current, it seems to be a norm that initiates need to be checked by medical practitioners first,” (FGD B).

“I know that people are dying in the process of circumcision, but there are medical doctors who assist in the process to minimize the rate of deaths.”(FGD F)

Although most of the participants (FGD’s B & FGD’s F) believed that traditional circumcision is safe because of the safety measures that are being utilized currently, there were some concerns such as the desire to make money out of the practice. Majority (FGD’s D, J, E,I, G) felt that it has had some serious risks and complications. As expressed by some of the participants;

“It has turned in to money making scheme, and is also performed by people with no experience,” (FGD E).

“What is bad is when people do not make it up there in the bush, they die in the process,” (FGD D).

“When my partner went for circumcision, I would worry about the use of the instrument which was used on everybody,” (FGD D).

“The disadvantage would be that they might not change the blade they use to cut the foreskin. They use the very same blade that they have used in another person without cleaning it,” (FGD G)

Having to go to the bush, you put your child’s life at risk. I think we need to outgrow some of the things that we have been doing since in the past, we need to accept change,” (FGD H).

“I was circumcised in the mountain and let me tell you, it is a hell on earth. It is painful and it is cold there. And nobody cares when you are there. People say you are growing up so you must be strong” (FGD B).

Deaths, complications and penile botching associated with traditional male circumcision that normally are reported during the winter circumcision season in the Eastern Cape, elicit a lot of attention and concern about the safety of the traditional methods. In a study conducted by Bailey, et al [8] in Kenya, they state that there are concerns in traditional and non-clinical settings about the safety and efficacy of the process. They acknowledge that harm can be done by both traditional and clinical methods, especially in nonclinical settings where there are untrained practitioners and improper instruments. They identified bleeding and infection as the most common adverse effects, with excessive pain, lacerations, torsion and possibly erectile dysfunction as complications [8].

Circumcision undertaken by inexperienced providers with inadequate instruments or with poor after-care can result in serious complications [10]. Bailey et al., [8] found that many boys who were circumcised traditionally reported that they were unable to stop the bleeding after the procedure, and a parent either took them to hospital or, more frequently, called a health professional or “travelling nurse” to come to arrest the bleeding and provide bandaging. In traditional circumcisions, one blade may be used for several initiates, leading to cases of sepsis and HIV transmissions. Mass circumcisions are also common in some settings and can increase complication rates. Among the Xhosa in South Africa, an unsterilized, unwashed blade may be used on a dozen or more initiates in a single session [10].

It is estimated 40 to 50 young men die annually following ritual circumcision in South Africa, predominantly from infection and bleeding [24]. The Eastern Cape provincial Department of Health recorded 243 deaths and 214 genital amputations for circumcisions between 1995 and 2004. To address this, traditional surgeons are now required by law to be officially

recognized and registered with the provincial Department of Health [10].

(4) Perceived protection from Sexually Transmitted Infections (STI) and HIV

Among participants in the Limpopo and Northern Cape, both adult males and females, a perception was that when a person is circumcised, it means that, that person is protected from contracting sexually transmitted infections. As expressed by some of the participants:

“I support male circumcision because it helps males not to be at risk of being infected with sexually transmitted infections including HIV.” (FGD B)

“If you come from the mountain you are not at risk of being infected with STI’s.” (FGD B)

“Most of us believe that when you are circumcised, you will not contract sexually transmitted infections, it means if you want to be clean, you will go for circumcision.” (FGD I)

While some believed that by being circumcised they are protected from contracting sexually transmitted infections, on the other hand, some felt indifferent about the issue:

“It does not matter whether you are circumcised or not, if you have unprotected sex, you will contract HIV” (FGD I).

“It might have a lot of pleasure but you can easily contract HIV” (FGD G)

The notion that male circumcision could be protective against sexually transmitted diseases and HIV infection was first suggested over two decades ago. Since then, numerous ecological, observational and cohort studies have produced mixed findings. A meta-analysis of 27 studies from sub-Saharan Africa showed reduced risk of HIV in circumcised men compared with uncircumcised men [25]. The confusion on the protective effect on male circumcision against sexually transmitted diseases and HIV in our study is related to the mixed findings from observational studies.

(5) Perceptions on circumcision and sleeping with a woman immediately after being circumcised

From the focus group discussion, there was a mixed feeling among adult female Xhosas in Western Cape and male adults Xhosas in Northern Cape about sleeping with someone when a young man is just from the circumcision school. As expressed by the participants:

“If you are just from being circumcised, a believe is that, you are not supposed to sleep with someone as you will be discharging all that was used on your private parts on that person. And that is a sign of bad luck. That can bring to an end your sexual relationship.”(FGD E)

“I don’t know if this is true but it has been said that when you leave the mountains, you should sleep with someone that very same night to ride yourself off bad luck. In that night you have to sleep with a woman without a condom.” (FGD I)

Among the Xhosa communities in the Eastern Cape, there is a general perception and shared belief that when young men go to a circumcision school, they learn more about responsible manhood. The underlying assumption is that these lessons evolve to accommodate the current challenges such as the spread of HIV. However, these notions are challenged in a recent study conducted by Vincent [24], where he argues that there is an erosion in the role that used to be played by the circumcision schools in the Eastern Cape in that there is an increase in gender-based violence and the assumption that going through the circumcision school is a gateway to multiple concurrent sexual partnership.

During the traditional circumcision period, the initiate is tutored by the elders on cultural and health issues such as taking care of the genitals, sex education, and information on the dangers of promiscuity. Vincent [24] found that there is “an erosion of the role which circumcision schools once played in the sexual socialization of young men and the emergence of the idea that initiation gives men the unlimited and unquestionable right to

access sex rather than marking the point at which sexual responsibility and restraint is introduced into the lifestyle of young men” among the Xhosa in the Eastern Cape.

The determinants of male circumcision in traditionally circumcising populations, such as cultural identity, did not appear to be major barriers to circumcision in non-circumcising communities. According to Westercamp& Bailey, [6] cost, fear of pain and concern for safety appeared to be barriers to male circumcision and this differs across circumcising and non-circumcising communities. For example, for a circumcising community, families are expected to incur obligatory expenses regardless of the cost whereas in non-circumcising communities circumcision is regarded as a voluntary procedure and it would not take precedence over competing need. Sanctions against circumcision in traditionally non-circumcising communities tend to be much less severe than the converse i.e. not being circumcised in a circumcising community [1].

Conclusion

The study found that male circumcision is acceptable to both men and women in various cultures in South Africa. Although traditional male circumcision was the preferred method, concerns were raised about the safety and as a result some preferred hospital or medical to traditional circumcision. There were mixed opinions as to whether male circumcision is protective from HIV transmission. Participants felt that male circumcision can increase sexual pleasure and can increase sexual un-inhibition. There is a need for sexual and reproductive health promotion interventions in the context of male circumcision.

Although this and many other studies have investigated the acceptability of male circumcision (mostly in non-circumcising communities), more information is needed, especially pertaining to communities of mixed cultural backgrounds (including those housing migrant workers and in communities where most, but not all males are circumcised).

It is therefore important to investigate the readiness of communities and health care facilities to participate in the roll out of male circumcision. The circumcision programme will need to involve men of different ages to be successful, different decision makers need to be targeted. For example only circumcising babies would delay the preventive effect. Mothers of male children and adult males need to be involved rather than just the target ages of 12-30 years set by UNAIDS [6, 14]. All men need to be circumcised for the prevention to be effective for women. The age at circumcision is critical and the risks and benefits in the procedure at different ages (especially for young boys) are important to consider. Ethical and cultural barriers should be considered especially where access to medical care and aftercare is limited.

Acknowledgement

This study was supported by Cooperative Agreement Number U2G/PS000570-04 from Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

References

- UNAIDS (2007). Safe, voluntary, informed male circumcision and comprehensive HIV prevention **programming guidance for decision-makers on human rights, ethical and legal considerations**. UNAIDS: Geneva.
- Peltzer K, Kanta X (2009). Medical circumcision and manhood initiation rituals in the Eastern Cape, South Africa: A post intervention evaluation. *Culture, Health & Sexuality*, 11(1), 83 -97
- Mogotlane SM, Ntlangulela JT & Ogunbanjo BG (2004): Mortality and morbidity Among traditionally circumcised Xhosa boys in the Eastern Cape Province, South Africa. *Curationis*, 27(2), 57-62
- Connolly C, Simbayi LC, Shanmugam R & Nqeketo A (2008) Male circumcision and its relationship to HIV infection in South Africa: results of a national survey in 2002. *South African Medical Journal* 98 (10): 789-94.
- Peltzer K (2009). Utilization and practice of Traditional/Complementary/Alternative Medicine (TM/CAM) in South Africa. *African Journal of Traditional Complementary and Alternative Medicine*, 6(2):175-185.
- Westercamp N & Bailey RC (2007). Acceptability of male circumcision for prevention of HIV/AIDS in sub-Saharan Africa: a review. *AIDS and Behavior*, 11(3): 341-355.
- Brito MC, Caso LM, Balbueana H & Bailey RC (2009). Acceptability of male circumcision for the prevention of HIV/AIDS in the Dominican Republic. University of Illinois, Chicago. Section for Infectious Disease,
- Bailey RC, Egasah O, Rosenberg S (2008). Male circumcision for HIV prevention: a prospective study of complications in clinical and traditional settings in Bugoma, Kenya. *Bulletin of the World Health Organisation*, 86(9): 669-677.
- Scott BE, Weiss HA & Viljoen, JI (2005). The acceptability of male circumcision as an HIV intervention among a rural Zulu population, Kwazulu-Natal, South Africa. *AIDS Care*, 17(3): 304-313.
- UNAIDS, WHO (2008): Male circumcision and HIV/AIDS in Eastern and Southern Africa: Communications guidance. March 2008. UNAIDS: Geneva.
- Bongaarts J, Reining P, Way P & Conant F. (1989). The relationship between male circumcision and HIV infection in African populations. *AIDS*. 3(6):373-7.
- Weiss HA, Quigley MA & Hayes RJ (2000). Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS* 2000, 14(15): 2361-2370.
- Kahn JG, Marseille E, Auvert B (2006) Cost-Effectiveness of Male Circumcision for HIV

- Prevention in a South African Setting. PLoS Med 3(12): e517. doi:10.1371/journal.pmed.0030517
14. White RG, Glynn JR, Orroth KK, Freeman EE., Bakker R, Weiss HA, Kumaranayake L, Habbema JD, Buve A, Hayes RJ (2008). Male circumcision for HIV prevention in sub-Saharan Africa: who, what and when? AIDS, 22(14): 1841-1850.
15. De Bruyn G, Smith MD & Gray GE (2007). Circumcision for prevention against HIV: marked seasonal variation in demand and potential public sector readiness in Soweto, South Africa. Implementation Sci; 2: 2
16. Mouton J (1995): The state of methodology in South Africa. The analysis of research in the human sciences in South Africa. Pretoria: HSRC.
17. Cresswell JW (2003). Qualitative, quantitative and mixed method approaches. London: Sage publications,
18. Mason, J (1996) Qualitative Researching, London, Sage
19. Miles M. & Huberman A. (1994) Qualitative data analysis: An expanded sourcebook (2nd edn). London: Sage.
20. World Health Organization (2009). Traditional male circumcision among young people: A public health perspective in the context of HIV prevention. WHO: Geneva.
21. Brouard P (2010) Whose pleasure? Notes about male circumcision and female sexuality. Inter Press Service, 2009. <http://www.ips.org>
22. Engelbrecht A & Smith S (2004): Why do male patients request circumcisions?, South African Family Practice, 46:2, 25-28.. DOI: 10.1080/20786204.2004.10873042
23. Brown MS & Brown CA (1987). Circumcision decision: prominence of social concerns. Pediatrics, 80 (2): 215-219.
24. Vincent L (2008). 'Boys will be boys': traditional Xhosa male circumcision, HIV and sexual socialisation in contemporary South Africa. Culture, Health and Sexuality, 10(5): 431-46.
25. Mattson CL, Bailey RC, Muga R, Poulussen R, Onyango T (2005). Acceptability of male circumcision and predictors of circumcision preference among men and women in Nyanza Province, Kenya. AIDS Care, 17(2): 182-194.