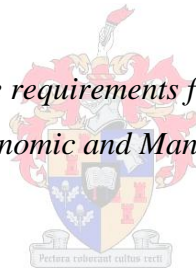


What is influencing male participation in medical male circumcision as preventive intervention for HIV transmission in Windhoek, Namibia?

by

Ndasilohenda Katangolo

Assignment presented in fulfilment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) in the Faculty of Economic and Management Sciences at Stellenbosch University



Supervisor: Dr Thozamile Qubuda

April 2014

DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The purpose of this study was to identify what influencing male participation in medical male circumcision as preventive intervention for HIV transmission in Windhoek, Namibia and make recommendations, according to the findings, on how circumcision mobilization can be improved in Windhoek, Khomas Namibia.

A descriptive cross-sectional study was used to identify factors contributing men not participating in the MC services. Data was collected using a structured questionnaire administered with 35 participants. SPSS was used to analyze and interpret the data. The main objective of the study was to identify factors contributing to decision of whether to circumcise or not medical male circumcision Windhoek city. The study revealed that traditional beliefs and norms on circumcision , low knowledge on male circumcision , Distance to the health centre where MC services rendered and pain are major factors contributing to men not participating in MC services. It further revealed that community, patients and health care workers are the major determinants in MC programs. Recommendations were made and the researcher is urging the government to increase fund raising activities in order to make MC services free and available to all health centres countrywide.

OPSOMMING

Die doel van hierdie studie was om te bepaal wat beïnvloed manlike deelname in die mediese manlike besnyding as voorkomende intervensie vir MIV-oordrag in Windhoek, Namibië en aanbevelings te maak, volgens die bevindinge oor hoe besnyding mobilisering kan in Windhoek, Khomas Namibië verbeter word.

‘n Beskrywende deursnee- studie is gebruik om faktore wat bydra mans nie deelneem aan die MC dienste te identifiseer. Data is ingesamel met behulp van 'n gestruktureerde vraelys geadministreer met 35 deelnemers. SPSS is gebruik om die data te ontleed en te interpreteer. Die hoofdoel van die studie was om faktore wat bydra tot besluit of te besny of nie mediese manlike besnyding Windhoek stad te identifiseer. Die studie het getoon dat die tradisionele oortuigings en norme op die besnydenis, lae kennis oor manlike besnyding, Afstand na die gesondheids-sentrum waar MC dienste gelewer en pyn is belangrike faktore wat bydra tot die mense nie aan MC dienste. Dit het verder aan die lig gebring dat die gemeenskap, pasiënte en gesondheidswerkers is die belangrikste determinante in MC programme. Aanbevelings is gemaak en die navorser is dring die regering fondsinsameling aktiwiteite ten einde MC dienste gratis beskikbaar aan alle gesondheid -sentrums landwyd te maak , te verhoog.

LIST OF ACRONYMS

AIDS-Acquired Immune Deficiency Syndrome

ART-Anti-retroviral Therapy

DHS-Demography Health Survey

HIV-Human Immune –deficiency Syndrome

HPV-Human Papilloma Virus

MC-Male circumcision

MOHSS-Ministry of health and social services

PMTCT-Prevention of mother- to- child transmission of HIV

PEPFAR-President emergency plan for AIDS relief

RCT-Randomized control trial

SPSS-Statistical package for social science

STI-Sexual transmitted infection

UNAIDS-United nation programme on HIV/AIDS

VTC-Voluntary counselling and testing for HIV

WHO-World health organisation

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CHAPTER I

INTRODUCTION

1.1 Background

The HIV epidemic has claimed life of million people around the global and put a heavy burden on public health challenge worldwide. However, there are also comparable evidences that circumcision of men reduces the chance of contracting HIV through heterosexual intercourse by one half at least. The Global AIDS update report that the estimate of round about 33.4 million of people were living with HIV and 2.7 million people are estimated to be newly infected for the update of 2012 (Joint united national programme on HIV/AIDS [UNAIDS], & World health organisation [WHO], 2012). Furthermore, Statistic update has revealed that Sub-Saharan Africa has 68% of HIV infection are occurring in the region and most of the transmission in adult men is contracted thru unprotected vaginal intercourse.

The Human Immunodeficiency Virus (HIV) statistic varies between countries within Sub-Saharan Africa is significantly in both scope and scale. According to the report of National sentinel survey of Namibia, HIV prevalence among expecting mother is estimated to be about 20%, while the national prevalence of HIV in Namibia is estimated to be 13.5% (2011), among the highest in the world (MOHSS, 2012). The annual report show that HIV responses mechanism in place for the epidemic reduction, included are major funding for HIV programs. In order to slow down the HIV infection, there is a need to refocus on some other mechanism such as Male circumcision are diverse evidenced base intervention which can be effective on reducing HIV infection among men and in national range. The result from Namibia Demographic and Health survey (2006-2007) has indicated that 21% of men within the age of 15-49 years are circumcised. But, these have varies from region to region, because in Ohagwena region is having 1% of circumcised men while Omaheke region has 57% circumcised men.

Namibia is among the top Southern Africa country which affected by HIV/AIDS epidemic (UNAIDS & WHO, 2012) with heterosexual activity as a major factor contributing to the spread of HIV (MOHSS, 2012). In additional, 39 average new cases of HIV infection in Namibia per day has been estimated on The estimates and Projection of the impact of HIV/AIDS in Namibia report (MOHSS, 2008). among these statistic figures, there are children under the age of 15 while more, are for adult within the age of 15-49 and most of the infection occur thru heterosexual intercourse.

In 2007, WHO and UNAIDS give a recommendation to countries with high HIV prevalence to consider and include MC as part of the package services of HIV prevention (WHO, 2007).

The recommendations were given based on the evidence given on the study findings the three studies trial in African countries, which show that circumcised men, has up to 60% less risks of contracting HIV compare to the uncircumcised men. Other biomedical intervention Namibia has adopted in reducing HIV transmission are; Prevention of Mother to Child transmission (PMTCT), Treatment of sexual transmission infection properly with correct diagnoses, encourage consistent use of condom, provision of Anti-retroviral Therapy as well as Male circumcision.

The Namibia AIDS Executive Committee has established a National male circumcision to engage in the study in order to find the situation assessment tools. The committee setup knowledge, attitudes, behaviours and practices a (KABP) in order to access the men willingness to accept circumcision services in the public health facilities. The finding from the survey has indicated approximately 21% of men in Namibia has been circumcised. With these committee in place, Namibia has recorded up to up to 350 men has been circumcised since the scale up of recommended medical male circumcision as a HIV prevention strategy(WHO,2010).However, low male circumcision has been identified as one factor influencing HIV epidemic. Therefore, Namibia has adopted the strategy of biomedical intervention in September 2009 and the services has been rolled out to 3 main public health facilities for MC (Global report, 2010).this study was therefore design to find the factor that hinder men not to take part in medical MC which offer in most public health facilities as strategy of HIV prevention and reduction among men. The result of the study will assist to implement and motivate men to partake in MC as a prevention of HIV infection in Namibia (MOHSS, 2011).

1.2 Problem statement

Namibia is among the countries which accepted the WHO recommendation on medical male circumcision as strategy in reducing and prevention of HIV infection among men, because Namibia has high HIV infection rate and low Male circumcision prevalence. Male circumcision is common in Otjiherero speaking community in Namibia, but the country is made up 14 regions which consist of 10 ethnic groups. Namibia has reported total number of MC conducted from 2008-2011 estimated at 8,110 men (WHO, 2011).

Despite the multiple prevention programs being implemented in the country, Namibia records 39 new cases of HIV infections on a daily basis, as reported in the Namibia Male circumcision for HIV prevention Policy, (2010). Following the scaling up the services of male circumcision in the country as per recommendation by

UNAIDS and WHO, there are still little in men to uptake and use the service of medical male circumcision, especial in men whose circumcision is not traditional accepted and allowed. The report further stated that, in 2007, the government of Namibia has announced the intention to introduce safe male circumcision as part of the national strategy for HIV prevention, following the trial research result which done in Kenya, Uganda and South Africa that suggested the effectiveness of medical circumcision in reducing the spread of HIV. This is a good reason to motivate men to go for voluntary male circumcision, as the service is rendered for free of charge at Windhoek Central Hospital in Windhoek and other part of district hospitals countrywide. The problem around this is low turn up of men for the MC procedure, there might be some factors affecting uptake of MC in Windhoek, Namibia.

These has raised a need to conduct a study that will assess factors that influence men not to partake in the MC services among men in Windhoek aged 18-49 and what can be done to attract men especial whose traditional circumcision is not part of their culture. In additional, male circumcision is popular among traditional circumcising communities but it has raise a matter of concern on hygiene and safer ways of conducting male circumcision. It is of importance to find a way of linking traditional circumciser and medical services in order to ensure that all procedures are done safety and correctly to reduce HIV infection among men.

1.3 Significance of the study

In order for the MC services to run smoothly, the need for community involvement to understand the benefits of up taking in the services. Therefore, it is important to conduct information sharing in the community to give more information on goals ad mission of MC services in HIV prevention which can benefit the whole community. This study was designed to study and investigate more about the perspectives of adults in the community that may facilitate and hamper uptake of voluntary medical male circumcision services, particularly service uptake among sexual active men. The results from this study will be used to inform the male circumcision program in Windhoek in order to increase the number of clients and improve community understanding of the relevance of voluntary male circumcision for clients.

The results of the study can also provide baseline information that will assist in program planning for HIV prevention as well as identification of implementation gaps and development of training manuals, policies and guidelines. Medical male circumcision on HIV prevention study will benefit men as the procedure is done on them to reduce HIV infection and again before the procedure is performed, the clients are undergo session of HIV counselling and testing which will benefit those who do not know their HIV status and HIV/AIDS information in general. In additional, once they are tested positive they are being refer for

enrolment of Anti-retroviral treatment (ART) which is life saving medication. While for their sexual partner especial women, study has shown that women who have their men circumcised have lower chances of cervical cancer, as the finding of the study (Pappas-Deluka, Simeon, Kustaa & Halperin, 2009).

1.4 The aims of the study

To identify the factors that influence men to uptake voluntary medical male circumcision and find new ways of motivating male participation on the service as HIV prevention intervention.

1.5 Objectives of the study:

- To establish men knowledge on medical male circumcision
- To assess men perception toward medical male circumcision
- To identify factors contributing to decision of whether to circumcise or not medical male circumcision.
- To document suggestion and proposal for improving male participation in medical male circumcision service as a HIV prevention method while adhering to the WHO, UNAIDS, and other accepted guidelines.

1.6 Research question

What is influencing male participation in voluntary medical male circumcision as a preventive intervention for HIV transmission in Windhoek, Namibia?

1.7 Methods of the study

The study was a cross-section, descriptive study, whereby both quantitative and a qualitative methods of collecting data was used to address the study objectives on low uptake of male circumcision among men in Windhoek. The data obtained from the study were analysed using SPSS Package Version 20 and convenient sampling was used to select the participant in the study.

1.8 Structure of the study

Chapter One: this part of the study content gives a brief on study introduction which contain the problem statement and describe the significance of study. Within thus chapter, the whole content of research study has been discussed which include the outline of objectives and aims of the study.

Chapter Two: The part covers the information of literature reviews of past authors who study the same topic. The literature study has detailed the recent findings and conclusions of the previous studies done on the same topic and more depth knowledge concerned the research topic.

Chapter Three: The chapter has indicated the outlines of methods and designs use in the study to obtain data and how the data has analysed. Within this chapter it also explains the population of study.

Chapter Four: This chapter give more of the discussion report of data analysis of the study and the results from data analysis.

Chapter Five: this chapter contain the detailed discussion of study results from the Chapter Four.

Chapter Six: This chapter form part of conclusions and recommendations of the study.

1.9 Limitations of the study

This study's findings cannot be generalised to the whole population of Namibia as a country, because it covers only male circumcision as one of the prevention strategy on HIV infection not other HIV prevention methods. Due to time and resources the data collection was done in some Windhoek residents who were found at three state clinic at the time of the study been conducted. A convenience method of study has use in sampling the study population at specific selected sites.

No clinical examination has performed during the interviews to confirm the status of circumcision that is a reason that false self-reported status on male circumcision cannot be detected as well as the respondents has filled their questionnaire. This study was based on self-reporting circumcision status. Some of the responded appeared like hesitating to give honest response to some question as they might felt being intimidated to give information out of the purpose of the study; probably they think that it could be unlawful. To minimise this reaction among participants, the purpose of the study has explained to each and every respondent as well as their informed consents pertaining their rights has discussed with them in terms of participating in the study.

1.10 Meaning of terms

Acceptability is indicated as respondent willingness to be circumcised for HIV prevention or encouraged their son or male relative to circumcise.

Barriers to MC: Reported reason not to circumcise.

Circumcision status: Self-reported circumcision status, age when circumcised, reason for circumcision, person who performed circumcision.

Employment: is categorized as employed if the respondent is full time, part time or self-employed an unemployed if the respondent is unemployed or student

MC preferences: is indicated as respondents preferred age of circumcision, person who would conduct the procedure, and cost of the MC procedure.

Marital status: defined as married if the respondent is married or living together as if married and unmarried if they are single, widowed, divorced or separated.

Level of education: Will be categorized as primary and lower for none or lower primary (up to grade 7) and secondary and higher for secondary and tertiary education.

Religion: is categorized as Christian if the respondent belonged to a Christian faith such as Roman Catholic, Lutheran or Anglican and other if they reported other religions apart from Christian.

1.11 Summary

This chapter has discusses in detail the background of MC, states the problem and highlights the significance of the study. It also focuses on the objective and aims of the study, question of the research, research methods, study structure as well as limitations of the study.

CHAPTER 2

LITERATURE REVIEW

Review of the literature defines as process of researcher familiarizing with available information on the study topic (Christensen, Robinson & Turner, 2011). Objective of the study will be narrated more on this chapter.

2.1 Introduction

Male circumcision is procedure done by cutting of the part or the whole outer side skin which covers the penis head through surgical methods (Cichocki, 2008). This can be done for varies reason such as cultural, religious beliefs or medical reason (Aggleton, 2009). There are evidences showing that in countries where male circumcision is done there are less HIV prevalence compare to the places where circumcision of men is not practiced. According to Western Camp and Bailey (2006), male circumcision has minimized HIV infection among male, which can help their partners not to contract HIV if the protective effect has been maintained among men. In Namibia, male circumcision services are low while the HIV prevalence rate remains high. In the country MC practiced among two regions which are Omaheke with 52% and Otjozondjupa with 42% because they are cultural practicing male circumcision in men. Namibia has low rate in male circumcision whereby the figures show an estimated at 21% less compared to other southern countries (MOHSS, 2009).

2.2 Background of MC

There are different ways and types of MC worldwide. However, the most common one is there the foreskin which covers the head of the man penis are cut out completely, which leaves the whole penis glands out (Doyle, 2005). In the world, approximately 30% of men who aged 15 years and older have been circumcised (WHO & UNAIDS, 2007). Among these are Muslim who made up around two thirds of the percentages. Most of these Muslim are from Asia, North and Middle East Africa 13% are non-Jewish and non-Muslim residing in the United State of America. Historically, male circumcision is practice because of the culture and religious beliefs (Rizvi, Nagvi, Hussain & Hassan, 1999). In some parts of society male circumcision is performed to prevent STI, Cancer of the penis, Urinary Tract infection and Genital Hygiene has been associated factor with some health benefit of MC in some communities (Cichocki, 2008 & Morris, 2007). In addition, female partners have also benefited from male circumcision, because female partners of circumcised men have been reported with low cases of getting Human Papilloma Virus HIV and Curial Cancer (Morris, 2007).

According to the DHS in Namibia, the prevalence of MC in the country is approximately 21% among adult males within the age of 15-59, which is different from one region to another (MOHSS, 2008). According to the DHS,(2007) regions in northern part of the country, MC services have been reported lower than 14% in Oshana, Omusati, Oshikoto and Ohangwena were most of the people who are residing there are of Oshiwambo tribes and MC is not culturally supported while central regions such as Omaheke, Otjozondjupa and Kunene regions where most Ovahimba and OvaHerero tribes are residing, the MC prevalence has increased from 41% to 57% because MC is performed traditional and it is culturally acceptable although it was not for HIV prevention among men and now is also being performed at medical facilities.

The great difference in MC prevalence in most African countries has been observed and noted. In Namibia it is partly because there are some ethnic groups or tribes who are traditionally not circumcised and do not know the benefits. There is also the reason that there are different ethnicities living in different areas around Africa (WHO & UNAIDS, 2007).

According to WHO (2007), a report has revealed that the prevalence rate of MC among adult men in Southern African countries is rather low and the estimations given show that in countries like Swaziland, Zambia and Zimbabwe, MC is at 15% (WHO & UNAIDS, 2007). The report further states that there are countries with higher MC prevalence rates such as Madagascar (80%), Angola (66%), Mozambique (60%), Lesotho (46%), South Africa (35%), Botswana (25%) and Malawi (21%) among adult male.

Nnko, Washija, Urassa and Boerma, (2001); have done a study which gives evidence that in a community of Sukuma, an ethnic group in Tanzania, the MC Service is relatively high among traditionally non-circumcising group because of an HIV preventive program which has been introduced and implemented in the area. Furthermore, the study has found health related conditions have reduced for instance, enhanced penile hygiene and reduction in STI risk because the men are circumcised in that particular area.

In some parts of the world, male circumcision is associated with wealth and high economic status of certain individuals and among traditionally non circumcising communities for example men with high level of education tend to partake in male circumcision and it is most practiced by men who live in urban areas than rural areas (Halperin, Fritz, Mc Farland & Woelk, 2005, Nnko et al., 2001). To add to this there is evidence that high levels of education tend to interact more with individuals from different backgrounds, mix of religious and ethnic groups. These social behaviour interactions are likely to give an individual a better understanding of MC services (Urassa, Todd, Boern, Hayes, 1997).

The age preference has varies from ethnic and religious belief of different population around the globe. In Judaism society MC is done on eighth day after the birth of a male child while Muslims there are no age limitations attached with MC (Rizvi, Naqvi, Hussain & Hasan, 1999).Ome African tribes, MC is performed as part of early adult life or changing to puberty stage, adulthood and marries (Doyle, 2005). The author has given example that in Xhosa tribe in South Africa and Masaci tribe of Kenya is performed by way of indicating and entitling men hood (Doyle, 2005).

2.3 Benefits of male circumcision

There are several advantages in MC and there are enough evidence that MC is minimizing chances of HIV infection in men, if it is combined together with the comprehensive package of HIV protection, because MC alone cannot prevent a full protection from HIV infection (MOHSS, 2007). Pappas-Deluka, Simeon, Kustaa & Halperin, 2009, study has defined that Male circumcision as a complete removal of the penis foreskin by cutting it out. The procedure is believed to reduce HIV transmission between men and women when having unprotected sex. Recent studies have revealed that medical male circumcision also reduces the transmission of HIV between men who have sex with other men. The PEPFAR support voluntary medical male circumcision when it done by trained and qualified medical personnel.

The programme also contains a full HIV package such as promotion of female and male condom, screening and treatment of Sexual transmitted infection, counselling and testing for HIV as well as referral for treatment for all HIV positive clients. The study further explained that, scientists have shown interest and conclude that there is a link between HIV infection and lack of circumcision. Because they found out that the internal foreskin of the penis contain a cell called Langerhans that is normal targeted by HIV when it enters the body for the first time. If these tissues break or tear they increase the chance men to acquire HIV and other sexual transmitted infections during unprotected sexual intercourse. But when the penis foreskin has removed through circumcision procedure, the penis develops a hard layer which reduces the Langerhans cells. The report also emphasize that circumcision of the penis can change the bacteria environment around it and that how it cut down the HIV infection. However voluntary medical male circumcision does not only benefit men, but it also provides advantages to women, because if more men are circumcised then few men will get HIV and HIV transmission will be reduced, (WHO & UNAIDS,2011).

Parrerson, Landay, Seigel, Flener, Pessis, Chaviano and Bailey, 2002, found out in a biological study that the foreskin of uncircumcised penis contains a high concentrated cell which is highly susceptible to HIV infection. The biological explanation stated that, this has potentials of carrying HIV infection that why

circumcision is need to reduce HIV acquisition and other sexual transmissions infection and reduce the foreskin damage or tears during sex.

There are also benefits for women with circumcised men. WHO & UNAIDS, (2012) has report that women who are HIV negative are directly benefiting from MC in many ways, such as; reduction in acquiring HIV if their only tested male partner is circumcised and HIV negative status. Studies has shown that, circumcised men has low chances of getting genital ulcers, gonorrhoea and Chlamydia diseases, these will work in the advantages of women as they will have low risk chances of getting infection from their male partners,(WHO ,2012).

2.4 Risk associate with MC

There are negative effects associated with male circumcision procedure although it has benefit package. Like any surgical procedure, there are associated risks with circumcision. The risks involved with circumcision found to be low in areas where the procedure is done by well trained, equipped with resources and experience personnel (Auvert, Taljaard, Lagarde, Sobngwi-Tambekou, Sitta & Pauren, 2005, Barclay.L.2006).

However, circumcision has not been shown to directly protect women or female from acquiring HIV infection from HIV infected men who are circumcised (Wawer, Makumbi, Kigozi, Serwadda, Watya, Nalugoda, Buwembo,Ssempijja, Kiwanuka, Moulton, Sewankambo, Reynolds, Quinn, Opendi, Iga, Ridzon, Laeyendecker, & Gray ,2009).

Some studies has revealed that MC minimizes the sensitivity of the penile which negatively affect the sexual performance in men this appear to be among some complication come with MC but most of the circumcised men reported that there are no change at all (CDC, 2008). However, there are some complication associated with MC such as feeling of pain on circumcised part, risk of infection on the wound, whereby in some cases where circumcision is performed at less hygiene sites, there are cases of mutilation bleeding, interference in healing process and even death reported (de Vincenzi & Mertens,1994). Early sex activity without proper healing wound can increase the risk of contracting HIV. Sometimes, complications that arise after male circumcision may be more than benefit of circumcision (Kanghudie, 2007).

Studies have revealed that circumcised men are likely to engage in risk sexual behaviour which can fuel the HIV infection (WHO, 2012). In some cases, circumcised men tender to refuse the use of condom consistent

and correctly, while others fall in habit of having multiple sexual partner which can influence the transmission of HIV in the society.

Moreover, male circumcision is believed to be one of the factors that lead to gender based violence against women in some cases because, if a man is circumcised, they tender to believe that they have lower chances of contracting HIV. These can force a woman not to inform them to put on the condom when engaging in sexual intercourse or adhere to other safer sexual practices (WHO, 2012).

Furthermore, circumcision services are helping to reduce HIV infection in men (from a woman to a man), some HIV positive women might feel stigmatised or discriminated upon as been seen source of HIV infection in the community. In some insistence, could lead to women been abused or labelled that they brought HIV infection in the relationship because, circumcised men may think that they are safe from getting HIV because they are circumcised (WHO,2012).

Due to limited recourses and manpower in some parts of the country, MC programme are receiving more support in terms of funding, these can lead to compromising other important HIV prevention programs which can benefit the whole society at large (WHO, 2011). The condom use has proven to help in alleviate problem and discomfort associated with circumcision and condom is import in reducing HIV infection, inflammation of penis tip and injury to the penis.

2.5. Medical male circumcision and HIV infection

As discussed in chapter one, medical male circumcision has shown a remarkable reduction in HIV infection caused by unprotected sexual intercourse. Male circumcision is defined as a complete removal of penis foreskin (the skin on the head of penis that can be rolled in front or backward) (WHO, 2012). Three random trial studies have been conducted on different places, whereby the participants have randomly selected and assigned whether to be circumcised or not, follow up has been made after period of calculated time to compare the HIV infection between the two group to see which one has higher rate of the infection. The results have showed that the risk was about 60% which means that those who were circumcised has low rate of HIV infection because they were minimised by circumcision (Auvert, Taljaard, Lagarde, Sobngwi-Tambekou, Sitta & Pauren, 2005, Bailey, Moses, Parker, Agot, Maclean, Krieger, Williams, Campbell &Ndinya-Achola, 2007, Gray, 2007). Moreover, because of these results from different studies confirm the benefits; medical male circumcision must be considered as potential intervention in prevention of sexual transmitted HIV infection, although the procedure has implication on service provision and cultural reasons (WHO, 2007).

The study of meta-analyses of observational in 1999 and 2000 has reported that there is reduction in HIV infection risk in circumcised men, as high as half of the men who are not circumcised (Van Howe, 1999, Weiss, Quigley & Hayes, 2000). It also found out that some countries allocate a low budget toward medical male circumcision while other increases their expenditure toward male circumcision activities. Therefore, community participation and mobilization plays major role in expanding and increase medical male circumcision in any community. The study has reported that there was an experiment which was done on a device to be used in medical male circumcision which is nonsurgical replacing the sutures. This exercise is done in Zimbabwe and Rwanda with a device called PrePex. While in Kenya and Zambia they have Shang Ring which help health professional with limited training to provide and perform male circumcision. There is another device in Botswana which is used on male infants (WHO, 2012).

According to the WHO report in 2010, more than 550 000 men has circumcised for HIV prevention purpose but still the target to reach 80% is still low among priority countries for men aged 15-49, according to the report released by (Global HIV/AIDS Response Progress report ,2011). In South Africa, Kenya and Uganda three clinical trials have found that men who received medical male circumcision and adhere to the instruction of health professional, on their follow up and wound care have reduced chances of acquiring HIV during unprotected sexual intercourse as emphasised (Pappas-Deluka, Simeon, Kustaa & Halperin, 2009). There is biological evidence that has showed that there are more Langerhans cells concentration, which is target of HIV in a foreskin of mucosal layer and these make men more susceptible in contracting HIV infection if indulged in unprotected sexual intercourse with HIV infection partner (Patterson, Landay Sagel & Flener, 2002). The keratinized stratified the epithelium layer of skin which covers the head of the penis and outer layer of foreskin provide the barrier or protection against HIV infection (Szabo & Short, 2000). The authors further explain the evidence that, argues that the penile shaft and outer skin are well keratinized while the inside mucosal layer of the foreskin is not keratinized. These will give chance to micro abrasion during sexual intercourse because of the sensitivity of the foreskin; these will give a chance of entrance for STIs and HIV (Szabo et al, 2000).

2.6. Medical MC acceptability as an HIV prevention strategy

Pappas-Deluka, Simeon, Kustaa and Halperin, (2009), has revealed a notable negative findings of the above linear regression analysis is that circumcision did not correlate with the change in HIV incidence in women. This may be explained by a notable number of cases of the direct effect of circumcision on men contracting of HIV and has not been shown to slow transmission to women as slower, indirect effects through lower prevalence among men may still be likely. Moreover, Namibia did not see any substantial roll out of male circumcision programs during the 2000s decade. The workshop examined data on male circumcision from

the 2006-07 DHS and the more recent report of Teacher Survey. There are noticeable changes in the pattern of circumcision among men, this might be due to health reasons, mixed social behaviour between non-circumcised communities and circumcised one, faith based reasons like wide spread of Muslim faith and desire to enjoy sexual pleasure (Weiss, Quigley & Hayes , 2008).

According to the Health Policy initiative “The potential cost and impact of expanding Male circumcision in Namibia in (2009) has found that, approximately 1 in 5 men to be circumcised in Namibia overall. This is relatively low compared to other countries according to the report. Moreover, based on expert input during the workshop, most of the male circumcision in Namibia is within the Ovahimba and Ovaherero communities those perform male circumcision traditionally (Namibia health sentinel survey, 2009). Although male circumcision in Namibia is low compared to other African countries, participants did perceive some ecological effect. The regions of Kunene, Omaheke, and Otjozondjupa have the highest levels of male circumcision in Namibia (52.2%, 56.7%, and 41.6%, respectively) and have a lower HIV prevalence than the national HIV prevalence among 15 – 49 year women at ANC clinics (10.9%, 13.1%, and 15.1%, respectively, compared to 17.1% nationally) according to the report of the Namibia Triangulation Project: Synthesis of Data on the National HIV Prevention Effort and Trends in the Epidemic (2010).

MC is believed to increase sexual pleasure of both partners in a couple, because it reduces the friction during sexual intercourse and this believed to enhance the woman sexual arousal. If the men penis is having a foreskin, it is like wearing a condom (Nnko, Washija, Urassa & Boerma, 2001). A survey done by Bailey, Moses, Parker, Agot, Maclean, Krieger, Williams, Campbell and Ndinya-Achola, (2007), has reported that during the study on acceptability of medical male circumcision in non circumcised communities, nearly all participants have reported willing to take their sons for medical male circumcision if the procedure is to be performed at the health facilities and if they will be informed on advantages and disadvantages of circumcision. This suggests that men prefer medical circumcision than traditionally performed circumcision. To add to this, it indicated that communities have low knowledge on MC and there is need for community education on the importance of MC on HIV reduction. In a separate study it shows that more women have knowledge on male circumcision than men this could be due to the fact that women tend to be the ones taking children to health facilities and listening to mass media such as TV and radios for information (Bailey, Muga, Poulussen & Abicht, 2002).

2.7 Barriers to Male circumcision

In some studies, uncircumcised men have views that the removal of the penis foreskin will expose them to health risks because the covering of the penis is acting as protective shield. Some perceive that MC is

associated with a lot pain where in some case death can occur from bleeding (Pappas-Deluka, Simeon, Kustaa & Halperin, 2009). The authors further explained that ,some men identified that the use of same blade at traditional circumciser increases the risk of HIV transmission because the blade is use on several people without proper cleaning. However, male circumcision can lead to behaviour change where men who are circumcised may think that condom use is no more necessary and these can lead to HIV infection (Pappas-Deluka et al, .2009).

According to the study done by Pappas-Deluka et al,. (2009), discusses that some of the barriers to MC are thoughts that can limit the uptake of the service. The identified factors are such as fear of male circumcision complication which could lead to death, fear of pain on the site which has to be cut and other health related factors as well as the cost involve in procedure to be performed. On health related reason are infection and bleeding associated with the procedure and in some society where the procedure is conducted by traditional circumciser, risk of HIV transmissions if one blade use in different men for the procure without proper and sterile cleaning (Halperin, Fritz, McFarland & Woelk, 2005). There are some studies which show that the public a strongly prefer the procedure to be done in health facilities by well-trained health personnel (Westeren & Bailey, 2007). In the communities where circumcision is not part of norms and culture, the barriers to the procedure are pain during and after the procedure has been perceived in most communities as a barrier to MC acceptability too (Lukobo & Bailey, 2007; Ngalande, 2006). While in societies where circumcision is done as part of traditional, the pain is not a barrier to the procedure, because the procedure has made to be painful, as way of showing that a men has transformed into adulthood and pain is associated with a sign which indicate that one become an adult(Westeren & Bailey,2007; Ngalande,2006).

2.8 Summary

The chapter discussed previous recent studies on the researched topic in more detail. The literature has explained the advantages and disadvantages of male circumcision, although most of the studies have revealed the benefits of male circumcision on HIV prevention. The acceptability of medical male circumcision in non-circumcising community has showed interest especial if the procedure is done safely, this make most community to show willingness and positive attitudes toward circumcision. Some of the known reasons that contribute to low participation rate of men in male circumcision are culture, religious and pain associate with the procedure. This can be some of the contributing factors that hamper positive outcome toward MC. However, for the program of male circumcision to be utilised and successfully, cultural and religious beliefs have to be considered when implementing the program as additional strategy for HIV prevention.

CHAPTER III

METHODOLOGY

3.1 Introduction

Methodology is defined as different ways of designing the study accordingly to proved techniques of the research (Christenesen, Johnson & Turner, 2011). On this section will explain the methods use in the study according to the design of the research, setting of the study, study population, sample size, sampling procedure, data collection, validity, reliability, instrumentation and data analysis. However, ethical consideration has discussed in this chapter also.

3.2 Research design

This is a cross-section, descriptive study, whereby both quantitative and a qualitative methods of collecting data will be used to address the study objectives on low uptake of male circumcision among men in Windhoek. The study designs has use both methods of collecting data in order to the knowledge of men MC, their perception and barriers to MC. Respondents has answered an anonymous close ended questionnaire and interviews has conducted to the key formats participants. Interviews and questionnaires have used to collect data for the study. The tools used to collect data were selected based on the study aims and objectives.

3.3 Study setting

The study was conducted in Windhoek district which has a multi-cultural and diverse way of living. Windhoek is a capital city of Namibia, which situated at centre of the country in Khomas region. Due to the minimal resources, the study was conducted in Windhoek, at the selected three state clinics which are; Hakahana, Khomasdal and Robert Mugabe clinic. The study was carried at three government clinics, which render Voluntary HIV Testing and counselling services. The researcher has chosen these sites for the study because it represents the population in Windhoek, Hakahana clinic is located at informal settlement, Khomasdal clinic is located in the middle class group and Robert Mugabe clinic is located in Town.

3.4 Study population

The study was targeted towards all adult males aged 18-49 years, found at the VTC (Voluntary HIV Testing and Counselling) HIV counselling and testing room at selected clinics around Windhoek (Hakahana, Khomasdal and Robert Mugabe clinic). The study population was narrowed to 35 participants in total due to time and resources. Among the study population are 5 health workers and 30 adult males.

3.5 Sample size

The study sample size was 30 adult males who were attending VTC at three identified health centres and 5 health workers working at these clinics during the study period.

3.6 Sampling procedure

To select the participant of the study, convenience sampling was used. Every adult male who met the criteria of the population targeted qualified to participate in the research. The research was conducted in the selected clinic around Windhoek to make sure there are cross-section and representative from each community around Windhoek district. The clinics where the study was conducted are: Hakahana, Khomasdal and Robert Mugabe clinic. All male adults who visited the VTC clinics between 01 November and 20 November 2013, were approached to voluntarily participate in the study if they met the requirements of selection for the study, until the required size of the study was met.

3.7 Data collection

The researcher adopted and edited questionnaires from previous studies done on medical circumcision by other researchers. The semi interview questionnaire was adopted from analysis for male circumcision in Tanzania by national institute for medical research and ministry of health and social welfare in, final report September 2009, the researcher edited and added some questions so that it can suit the researched topic. The questionnaire is an instrument used to obtain responses from a person and it contains both closed and open ended questions (Leedy & Ormand, 2005). The researcher has chosen questionnaire and semi structured interviews because these tools are time saving and participants are willing to give their inputs.

The researcher has conducted individual face to face semi structured interviews (purposeful sample) with health workers one from each clinic and two male circumcision programme officers on their experience and complaints they get from the public about male circumcision as HIV prevention intervention. The researcher has a medical background which involves doing surveys and researching on specific diseases; the researcher is a nurse by profession but not at the clinics where the study takes place. The major study the researcher has participated in was a survey on assessing nutritional needs for HIV patients in three regions in Namibia which are Khomas, Hardap and Karas, this study sponsored by USAIDS and PERFAR in 2011. The researcher has conducted personal interviews using attached semi-formal interview schedule. Interviews were conducted in both English and Oshiwambo depending on the participant language preferences.

3.8 Validity

The sample has drawn from the same district and different ethnic groups. The interviews and questionnaires were pretested on 10 men before data collection who happen to share similar characteristics with the study sample. The data collection tools were translated from English to Oshiwambo which well understood by both the researcher and participants. The checking of data quality was done before and during processing of data for data consistency and completeness.

3.9 Reliability

To address the issue of reliability of the study, the same questionnaire was used to collect data from all participants in the study and all interviews were conducted by a trained interviewer. Due to time and resource constrained, no further assessment of feasible of study on reliability.

3.10 Instrumentation

The researcher has adapted and edit questionnaire from previous studies done on medical circumcision by other researchers. The semi interview questionnaire has adopted from analysis for male circumcision in Tanzania by national institute for medical research and ministry of health and social welfare in, final report September 2009, the researcher has edited and add some question so that it can suit the researched topic. The English version questionnaire was translated in Oshiwambo which is one of the common languages spoken in Namibia. The questionnaire structure included the age, gender, education status, ethnic group and personal information on medical male circumcision, barriers to MC and acceptability of MC as preventive strategy for HIV infection.

3.11 Data analysis

The data was analysed with SPSS software version 21. Multiple-choice questions were coded and entered into the SPSS database. Non-numeric responses were analysed and categories were identified. Frequency distributions tables, graphs, percentages, proportion and pie charts were constructed and displayed factors contributing to low MC participation. Questionnaires have been thoroughly checked for completeness and verified by the researcher, before being coded and entered into SPSS. Descriptive statistics of the demographic characteristics, knowledge, attitudes, beliefs and barriers will be presented using absolute numbers, simple percentage, range and measure of central tendency (mean, mode). To present the finding, tables and graphs were used for interpretation of data.

3.11.1 Data management

Statistical Packages for social science software version 21 was used, after data has collected, the study question were entered in the system one by one. The questionnaires were checked for any missing data, inappropriate responses and inconsistency of the responses.

3.11.2 Data recoding

The process of data recording began by creating outcome variables. The outcome of this research was to see what encourage medical male circumcision amongst the locals basing also on their traditional backgrounds, religious affiliations, educational levels and general basic knowledge. Knowledge and perceptions were decoded from answers given to questions that did not directly ask about the participant's point-or-view.

3.12 Ethical consideration

The research proposal was given ethical permission from the Ethical Committee at Stellenbosch University and Namibia research committee before the research commerce for approval. The Ministry of Health and social services (Permanent Secretary) granted permission for the study to be carried out in the three selected health facilities. The main components in research ethics have been adhered to during the course of study. Confidentiality and anonymity will be applied to all data collected during the study. All male at selected sites of the study were having equal chances to participate in the study with full informed consent. All participants has been entitled to full and given informed consent before involve in the study and were given a chance to read the full descriptive of study process and objectives. Furthermore codes were used instead of names to avoid linkage and direct identity of the participants respond. Throughout of the study, a participant has a right to withdraw from the study any time. The participants did not receive any payment and were informed that data collected was for research purposes. The data has kept in the database in a computer that has a protected password.

3.13 Summary

The chapter has explained in detail methods which have used to collect data from the study participants. The way in which data was analysed and the work plan of the step to follow including research design has been discussed here. The work plan includes study population, sample size and methods, data analysis as well as ethical consideration in the study. The following chapter is four which describe the find of the study.

CHAPTER IV

STUDY ANALYSIS AND RESULTS

In this chapter findings of the research are presented. The analysing of data will be done in form of interpreting data and presentation of the finding. It has two sections: one section for exploration of data and second section is data analysis and observation findings. The results are presented in form of tables and charts.

4.1 Description of sample

In this section there is socio-demographic information, extent of education, economic standing and knowledge, attitudes and perceptions of men towards the exercise, reasons and perception of male circumcision.

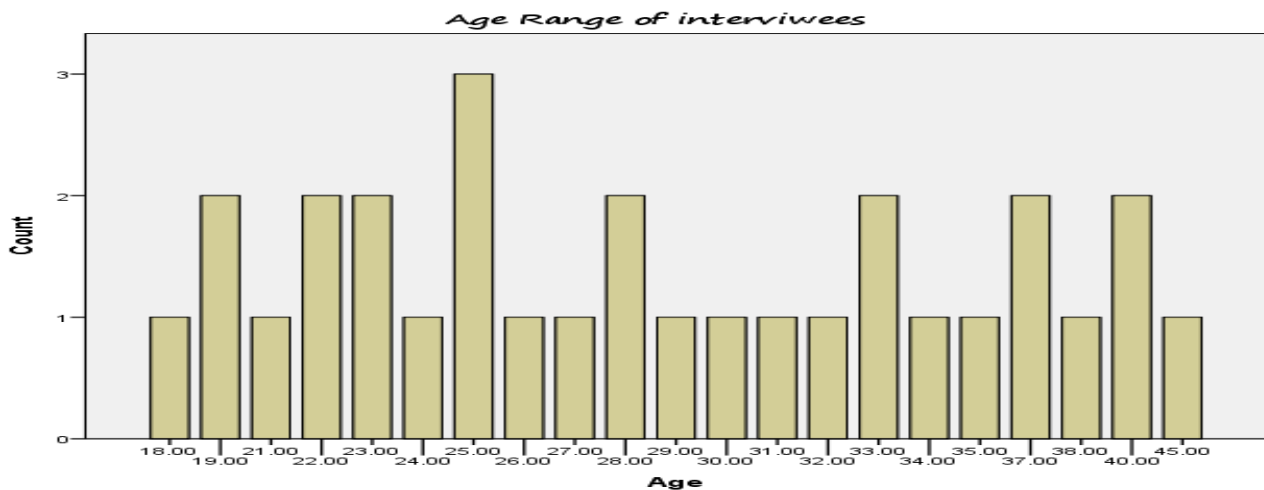


Figure 1: Age of interviewees

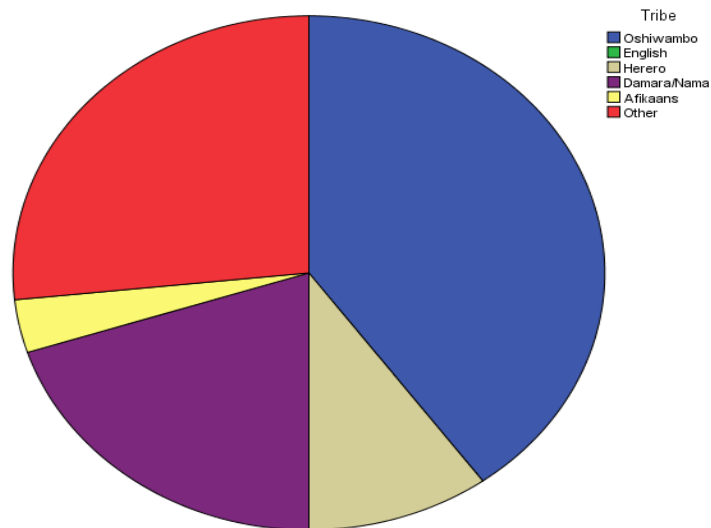
The men interviewed were between 18 and 49 years old. Thus the range was fair. Though most early to mid-twenties (21-29) dominated the group with a total of 14 participants of that age range. They were of different economic standing as some are employed; others unemployed and the rest were students.

Table 1: Distribution by religion

Religious	Study sample	Percentages
Lutheran	8	26.7%

Roman Catholic	6	20%
Anglican	4	13.3%
Apostolic	3	10%
Other	9	30%

As presented on the table1 above, most of the participants were Christians. With the majority number were from other religious 30% while the few one from Apostolic.



The above pie chat represents the ethnic backgrounds of all males which were interviewed. The Oshiwambo being 40% of the group, Herero with 10%, Damara>Nama with 20%, Afrikaans with 3, 3% and other ethnic groups were 26.7% of the group. It is more or less a true picture of the overall societal distribution of tribes in the Windhoek area where the interviews were conducted.

Figure 2: Distribution by languages

Distribution by education

Table 2: Education Level * Circumcised Cross tabulation

		Circumcised		Total %
		Yes	No	
Education Level	Primary	2	4	6(20%)
	Secondary(8-12)	5	12	17(57%)
	Tertiary(university/college)	2	5	7(23%)
Total		9	21	30 (100%)

Seventeen (57%) of the respondents had secondary education, while seven (23%) of them had tertiary level in education and six (20%) of the participants had primary education.

Table 3: Distribution by Marital Status * Circumcised Cross tabulation

		Circumcised		Count
		Yes	No	Total
Marital Status	Never Married	1	5	6(20%)
	Married	3	10	13(43%)
	Separated/Divorced/Widowed	5	6	11(37%)
Total		9	21	30(100%)

Table 2 presented the marital status of the participants in the study. It showed that nearly 43% were married, Eleven (37%) were separated, divorced or widowed and Five (20%) were never married.

4.2 Prevalence of Male Circumcision

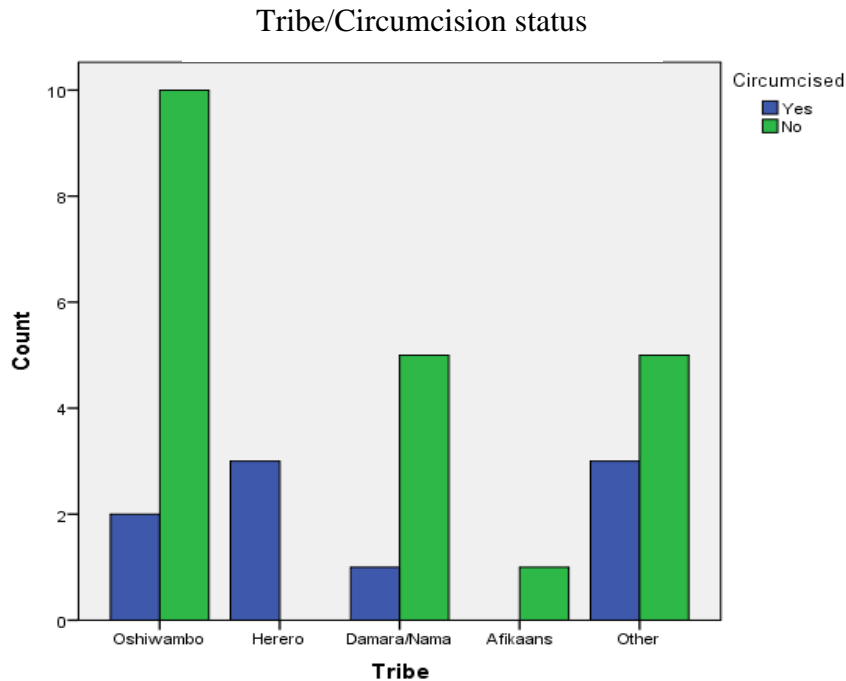


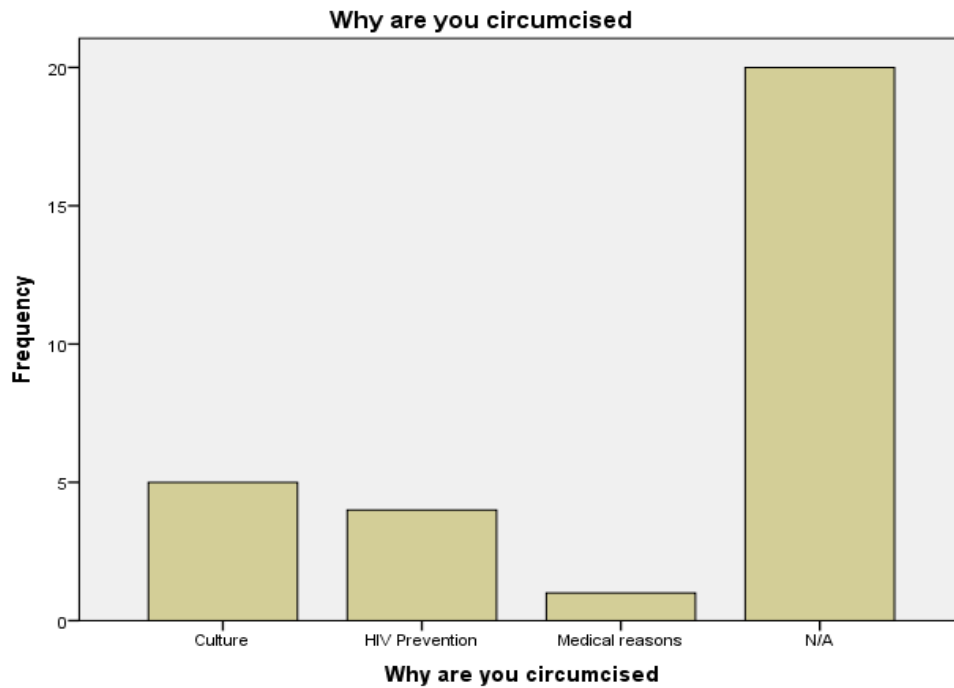
Figure 3: Tribe/Circumcision statuses

Note in the graph above (Fig. 3) that all three (100%) Herero respondents were circumcised, two (7%) of Oshiwambo respondents were circumcised while 10 (33%) were not circumcised. In Damara>Nama tribe one (3%) were circumcised while 5 (17%) were not circumcised. However, in Afrikaans (3%) speaking who participants in the study none of them were circumcised while other tribes has three (10%) circumcised and five (17%) men were uncircumcised.

Table 4: Why are you circumcised?

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
Culture	5	16.7	16.7	16.7
HIV Prevention	4	13.3	13.3	30.0
Valid Medical reasons	1	3.3	3.3	33.3
N/A	20	66.7	66.7	100.0
Total	30	100.0	100.0	

The table 3 above and the bar graph below shows the number of responses from participants who were already circumcised. When asked reasons for circumcision, 16.7% in the table represents the percentage of the total group of the circumcised men who did that culture is still the major reason MC is practised. While 30% has indicated they were circumcised for HIV prevention and 33.3% has responded that circumcision



has done on them for medical reasons.

Figure 4: Why are you circumcised?

Table 5: Age of Circumcision

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
Valid Infant <2yrs	5	16.7	50.0	50.0
Valid Young child 2-12yrs	1	3.3	10.0	60.0
Valid Adult >20	4	13.3	40.0	100.0
Valid Total	10	33.3	100.0	

Missing	System	20	66.7	
	Total	30	100.0	

The majority of participants, 5 (50%) were circumcised during their infant age of under 2 years while 1(10%) circumcised at young child age of 2-12 years and 4(40%) were circumcised during their adulthood age of 20 and above.

4.3. Male knowledge on medical circumcision

In order to establish how far the respondents understood the point behind circumcision all the respondents were asked why male circumcision was carried out. The data collected is shown in the table below:

Table 6: Reason associated with circumcision

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
Traditional	15	50.0	60.0	60.0
Medical	3	10.0	12.0	72.0
Hygiene	1	3.3	4.0	76.0
Valid all three above reasons	4	13.3	16.0	92.0
No response	2	6.7	8.0	100.0
Total	25	83.3	100.0	
Missing System	5	16.7		
Total	30	100.0		

Most of the respondents (60%) have indicated that MC is done as a traditional and for cultural reasons. Furthermore, 12% believe that MC is done for medical reasons while 4(13.3%) Give both above reasons as to why circumcision is done. However, 2 (8%) participants did not respond to the question on reasons of circumcision.

4.4 Male perception towards medical circumcision

Table 7: Why not circumcised?

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
No time	3	10.0	10.0	10.0
Hospital is too far	5	16.7	16.7	26.7
Do not know where to go	4	13.3	13.3	40.0
Not in my culture	5	16.7	16.7	56.7
Valid N/A	10	33.3	33.3	90.0
Fear of pain/low sex drive	3	10.0	10.0	100.0
Total	30	100.0	100.0	

In order to assess the male perception toward circumcision, question was asked to those not circumcised. Most 5(16.7) of the participants has indicated that health facilities are fall from them where circumcision performed while the same number 5(16.7%) of men in the study has indicated that MC is not part of their culture.futher,4(13.3%) has responded that they do not know where MC procedure done at health facilities, while 10((33.3%) did not respond to the why not circumcised question.lastly,3(10%) of the respondents has fear of pain or low sex drive.

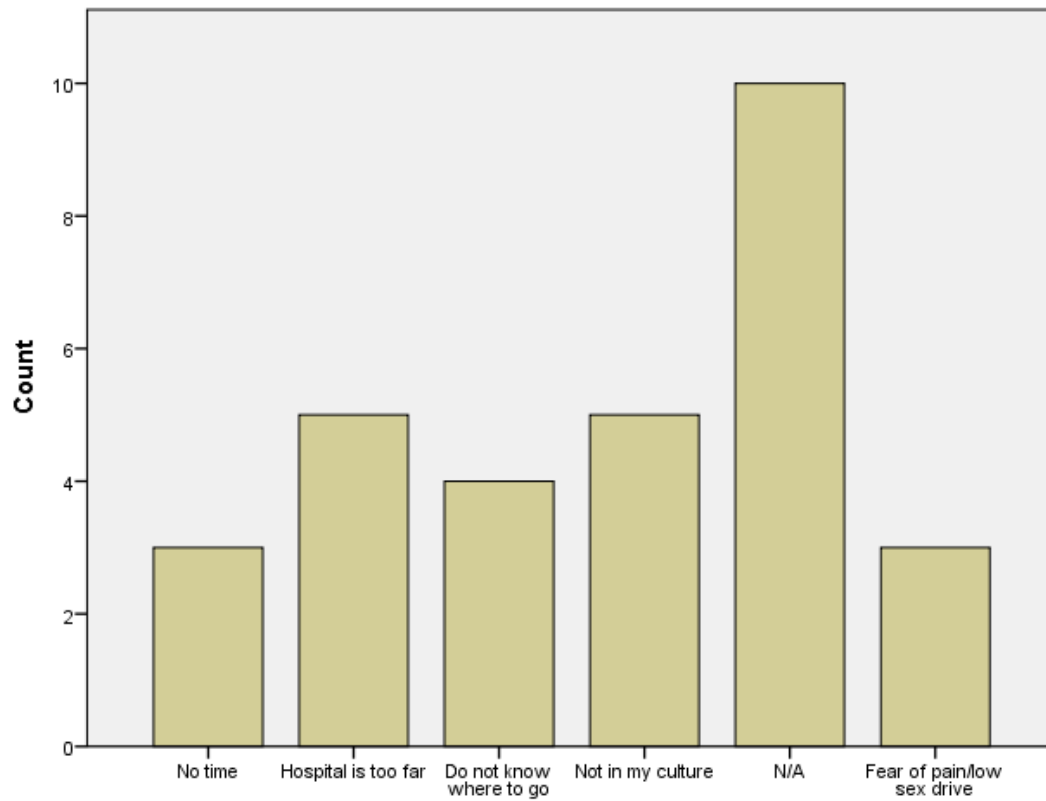


Figure 5: Why not circumcised

this bar graph of Figure 5 illustrate a clear picture on why men who are not circumcised not coming to the health facilities to be circumcised. Although, most (33.3%) of men indicated that they has not reasons.

4.5 Benefits and risks of medical male circumcision

All participants were questioned as to what they thought there are benefits in MC. The question was open-ended yet the general answers which were obtained showed that they were aware of the HIV prevalence reduction benefits of MC.

Statistics

Benefits

N	Valid	28
	Missing	2
Mode		43
Range		17
Minimum		43
Maximum		60

Table 8:
Benefits

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
HIV Reduction	14	46.7	50.0	50.0
Better Hygiene	2	6.7	7.1	57.1
Both Hygiene & HIV reduction	7	23.3	25.0	82.1
Valid Better Sex performance	1	3.3	3.6	85.7
Don't know	3	10.0	10.7	96.4
Traditional respect	1	3.3	3.6	100.0
Total	28	93.3	100.0	
Missing System	2	6.7		
Total	30	100.0		

To assess if the participants linked their knowledge of reasons behind circumcision and its benefits, the researcher co-tabulated the data and deduced that to a fair extent, most, (23participants) knew reasons and appreciated benefits of MC particularly the HIV prevalence reduction and hygienic purposes.

Table 9: Reason for Circumcision * Benefits Cross tabulation

		Benefits					Total
		HIV Reduction	Better Hygiene	Both Hygiene & HIV reduction	Better Sex performance	Don't know	
Reason for Circum-cision	traditional	6	1	2	1	3	13
	Medical	1	0	2	0	0	3
	hygiene	0	0	1	0	0	1
	all three above reasons	4	0	0	0	0	4
	No response	0	0	2	0	0	2

Total	11	1	7	1	3	23
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The participants were asked a question regarding to benefits of circumcision which cross-tabulated to find out whether this differ from reason of male circumcision. 13 respondents indicated that most reasons for circumcision in traditional way is for HIV reduction 6(26%) one (4.3%) of the respondent believe circumcision preformed for better hygiene while 2 (8.6%)responded has indicate that MC has benefits for both hygiene and HIV reduction as well as one (4.3%) responded that it enhance better sex performance and 3 (13%) responded do not know.

Those whose who give medical as a reason for circumcision are 3(13%) with one respond that MC play a role in HIV reduction and 2(8.6%) indicated that the benefits are both hygiene and HIV reduction. However, 4(17.4%) have indicated that all reasons such as HIV reduction, better hygiene and better sex performance are benefits of Male circumcision.

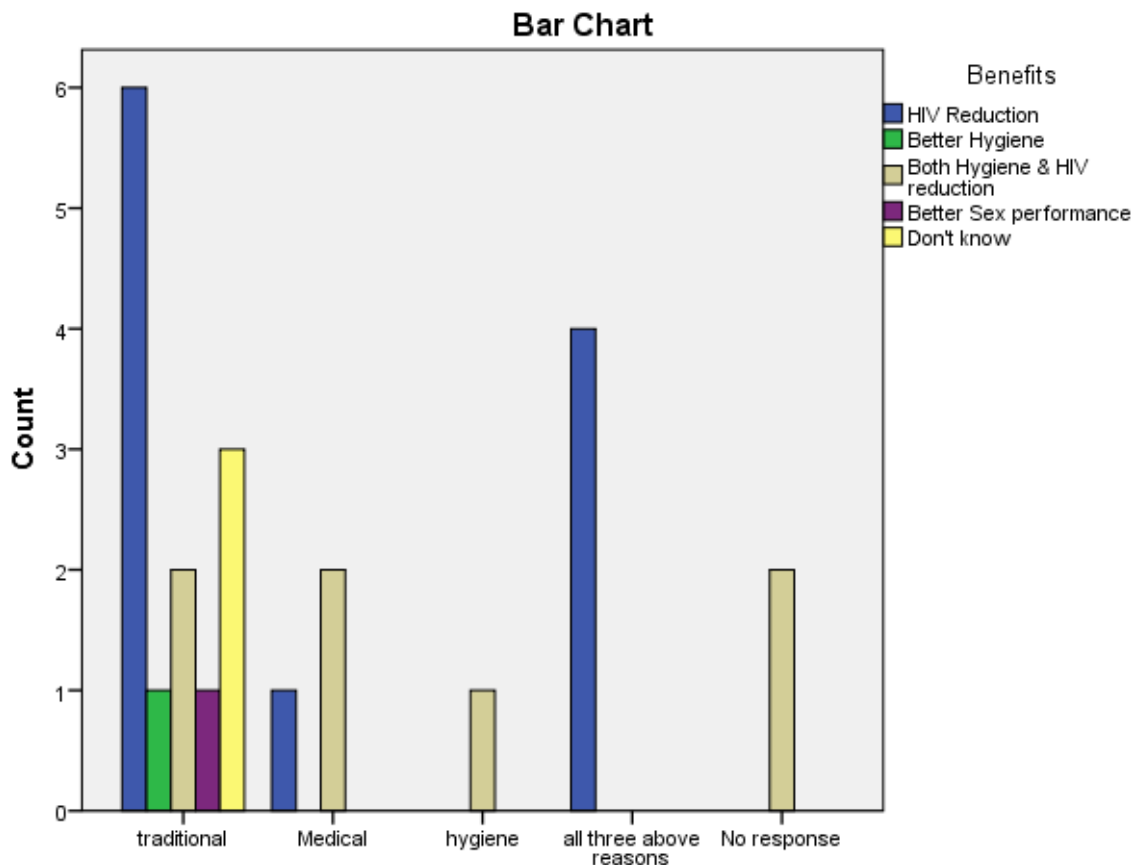


Figure 6: Reason for circumcision

This figure indicated that those who has circumcised traditionally have heard of benefits of MC that is reducing HIV, most 6 (26%) of the respondents 5 (22%) believe it for both reasons HIV reduction and

hygiene while other 2 (9 %) responded that they have no reasons on question asked and few of 2 (9%) has responded that it improve hygiene in men and enhance sexual performance. Lastly, 2 (9%) has not responded to the question on the benefits and reasons for circumcision.

Table 10: Venue of Circumcision

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
Valid Health Facility	20	66.7	100.0	100.0
Missing System	10	33.3		
Total	30	100.0		

Among the uncircumcised men 20(66.7%) participated in the study has indicated that they prefer circumcision procedure to be performed at the health facilities. The respondents show willingness to participate in the MC if it performed at the hospital or any health facilities.

Table 11: Consequences of Circumcision

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
Valid I don't know	6	20.0	21.4	21.4
Valid Low sex drive	6	20.0	21.4	42.9
Valid Pain and swelling	16	53.3	57.1	100.0
Valid Total	28	93.3	100.0	
Missing System	2	6.7		
Total	30	100.0		

Partici pants were again asked in an open-ended manner

of questioning what they thought were negative consequences of MC. Majority 16 (57.1%) stated pain and swelling, the rest either thought it reduces sex drive and performance 6 (21.4%) or they said they did not know at all 6 (20%).

4.6 Capacity of health facility to provide medical male circumcision

The table below show the figures of circumcised men and places where circumcision has performed.

Table 12: Where were you Circumcised?

	Frequency	Percent %	Valid Percent %	Cumulative Percent %	
Valid	Traditional	4	13.3	40.0	40.0
	Health Facility	5	16.7	50.0	90.0
	I don't know	1	3.3	10.0	100.0
	Total	10	33.3	100.0	
Missing	System	20	66.7		
Total		30	100.0		

There are total of 10(100%) circumcised men who participated in the study. Four (40%) of the responded has circumcised at traditional facilities while 5 (50%) has done at health facilities and 1(10%) respondent do not know the venue where the procedure has performed

4.7 Male circumcision acceptability

To deduce if MC is becoming an acceptable practice, the participants who were not circumcised were asked whether or not they would like to be circumcised.

Table 13: Would you want circumcision

	Frequency	Percent %	Valid Percent %	Cumulative Percent %
Valid	No	1	3.3	4.3
	Undecided	1	3.3	4.3
	Yes	7	23.3	30.4
	Strongly yes	7	23.3	82.6
	N/A	4	13.3	100.0
	Total	20	67	100.0
Missing	System	10	33.3	
Total		30	100.0	

From the table 14(60.8%) participants in the study has indicate desire to be circumcised at the health facilities, 4(13.3) participants has not answer the question of decision on circumcision. While 1(3.3%) do not want to be circumcised and 1(3.3%) did not decide on responding to the question of circumcision. Four (13.3%) did not respond to the question. This shows that the MC is increasingly becoming acceptable, even with males whose culture does not have MC as a practice. This was further confirmed when asked if they would like to have their sons circumcised.

Table 14: Would you want circumcision/would you want your son circumcised cross tabulation

		Would you want your son circumcised				
		Strongly No	Undecided	Yes	Strongly Yes	
Would you want circumcision	No	0	0	0		1
	Undecided	1	3	0		0
	Yes	0	0	5		2
	Strongly yes	0	0	1		6
	N/A	0	0	1		0
Total		1	3	7		9

One (5%) of the participants in the study indicate “no” willing to be circumcised, three (15%) of the participants did not decide to be circumcised now, 7 (35%) responded that they are willing to be circumcised while 9 (45%) of the respondent strongly say “yes” to male circumcision and had no problems with having their sons circumcised.

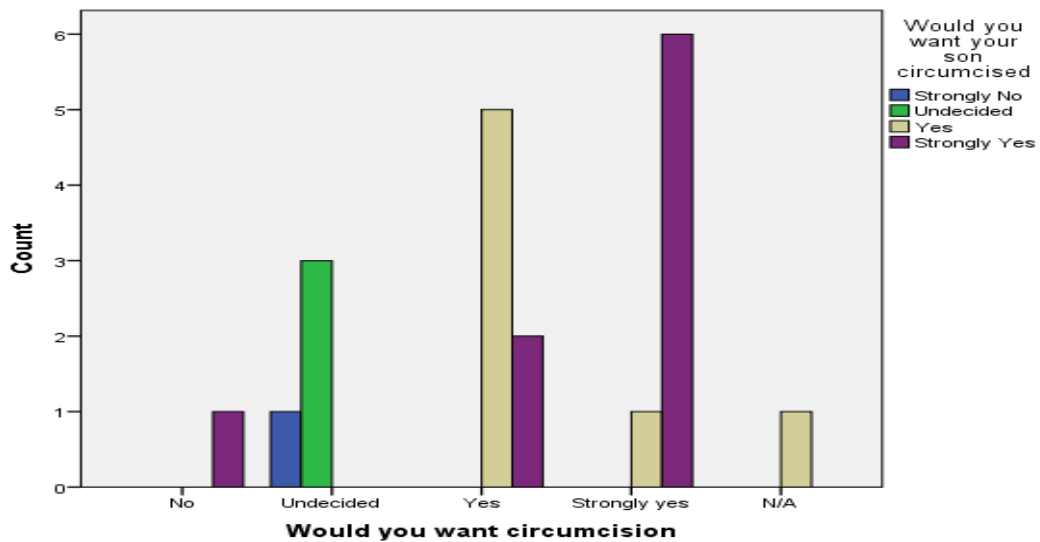


Figure 7: Why you want circumcision

From the total number of 20 men who are not circumcised during the study, One (5%) of the participants in the study indicate “no” willing to have his son circumcised, three (15%) of the participants did not decide to give their son for circumcision now, 7 (35%) responded that they are willing consent their son to be circumcised while 9 (45%) of the respondent strongly say “yes” to male circumcision and had no problems with having their sons circumcised

Table 15: Would you want your son circumcised/Best time to get your son circumcised

Cross tabulation

		Best time to get your son circumcised		Total
		Infants(under13)	Adult (over19)Own decision	
Would you want your son circumcised	Strongly No	1	0	1
	Undecided	1	2	3
	Yes	4	3	7
	Strongly Yes	9	0	9
	Total	15	5	20

Most 15 (75%) of the participant believe that the best age for circumcision is during infant stage (under 13years of age).While 5(25%) believe that the best age for circumcision is over 19 years old and above.

4.8 Barriers to male circumcision

Table 16 below illustrates worries among study participants against male circumcision.

Table 16: Worries against circumcision

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
Safety	2	6.7	6.7	6.7
Pain and swelling	10	33.3	33.3	40.0
Cost	2	6.7	6.7	46.7
Far Facilities	7	23.3	23.3	70.0
Low Sex Drive	3	10.0	10.0	80.0
Other	1	3.3	3.3	83.3
Most of the above	5	16.7	16.7	100.0
Total	30	100.0	100.0	

All 30 participants in the study have given some reason to certain worries against circumcision. Ten (33.3%) express the pain and swelling experienced during and after the procedure. Seven (23.3%) respondents indicated that health facilities that render MC are far from them, 2 (6.7%) stated that safety is a concern while the same number 2(6.7) of participants also stated the cost of the procedure is worrying some. However, 3(10%) of the respondents indicated that MC can low sex drive.

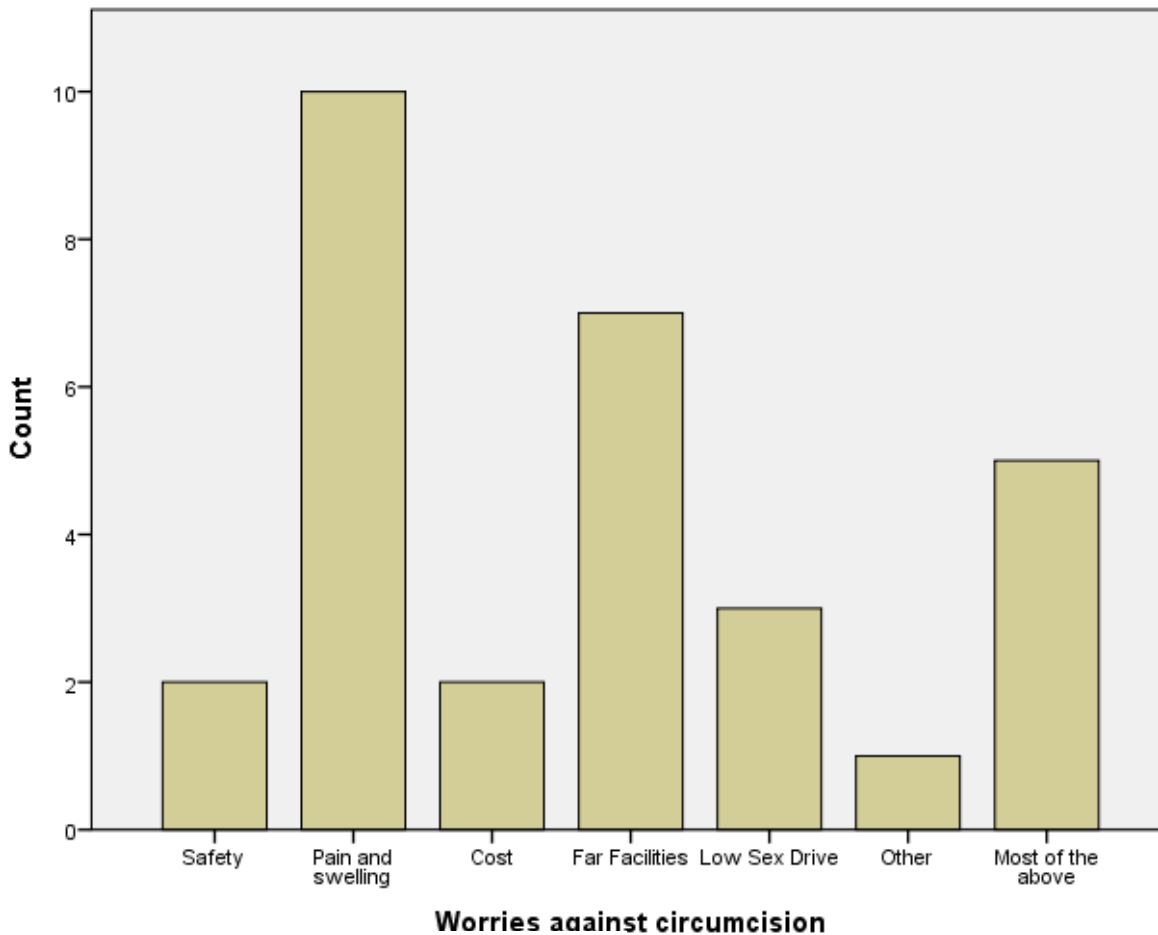


Figure 8: Worries against circumcision

It is evident that pain or the distance to go to a health facility may really have a hindering effect towards MC. The assessment of data in the figure 8 shows that those two factors are prevalent with the participants of the research of which 56, 6 % of the group pointed them out.

4.9 INTERVIEW SCHEDULES ANALYZED THEMATICALLY

Registered nurses and health program administrator were interviewed

Theme 1- In your opinion, what are the main factors influencing Male Circumcision in your area?

Registered nurse: Reduce HIV with 60% in men and minimise cervical cancer in women.

Health program administrator: Reduce Sexual Transmission Infections and penis hygiene as well as cultural beliefs especial among Otjiherero speaking community.

Theme 2- What do you consider as disadvantages of Male Circumcision?

Registered nurse: Painful, reduce sex drive in circumcised men and swelling on the wound

Health program administrator: Some believe that it only done in Herero culture while some religious condemn it as an evil procedure.

Theme 3 - Is there any stigma attached to a man being circumcised or uncircumcised?

Registered nurse: That MC belong to a certain tribe for instance Otjiherero people. Some people view a circumcised man as weak in bed and labelled to have small penis.

Health program administrator: Some believe that uncircumcised men got bigger penis than circumcised while some culture belief that uncircumcised men are dirty.

Theme 4. What do you know about the relationship between HIV infection and Male Circumcision?

Registered nurse: MC reduce HIV with 60%but, if a men is circumcised and HIV positive ,he can still transmits the HIV to the woman if no protection used during sexual intercourse.

Health program administrator: Circumcised men who are HIV negative have low chances of contracting HIV than uncircumcised men with 60%. And an uncircumcised man has a foreskin which can contain other STI s that facilitates HIV transmission easily because the skin tender to have sores or wounds.

5. If we wanted to increase the provision of health facility–based Male Circumcision, what do you think are the most important factors we should address?

Registered nurse: Train all health workers on MC and make the service available to all health facilities.

Health program administrator: Allocation of more funds so that the circumcision services can be demarcated countrywide. The program must be integrated in all crucial services such family planning.

6. If we wanted to increase demand for male circumcision among adults and children, what sort of things should we do?

Registered nurse: Involvement of all stake holders such as parents, traditional authorities, schools and constituencies councillor to mobilise the message of free male circumcision services rendered at some government health facilities.

Health program administrator: Making men understand the importance of circumcision thru television, radio and other social Medias such as Face book, Twitter and so on in order to clear all myth around MC.Training all traditional circumcisers on safety and hygiene when performing male circumcision in their communities.

Theme 7 At health facilities providing male circumcision, what other services (apart from post-operative care) do you think would be beneficial to provide to the circumcised?

Registered nurse: HIV counselling and testing thru VTC in order for people to know their HIV status, Tuberculosis screening and Family planning thru condom distribution.

Health program administrator: Provision of Antiretroviral drugs to those tested HIV positive

4.10 Summary

This chapter presented the results of the findings of the study. It also reported on the statistical analysis that determined the factors that hinder men not to participate on voluntary medical male circumcision rendered at public health facilities for HIV preventative intervention. The analysis also highlighted the correlation of these outcome variables

From the data analyses done within this chapter it can be safely concluded that the greatest hindrance to male circumcision is neither culture, religion, education level or even denial but that the facilities are not adequate or easily accessible. This has been expressed by all health workers who participated in the study as major factors that influence male participation in circumcision at the health facilities. Men who are not circumcised are willing to get circumcised and are even willing to pass on the practice to their sons. It can also be said that more information about the process of medical male circumcision still needs to be disseminated and explained to men especially concerning the reasons behind MC regardless of their social standings; educationally or economically. It would also be vital to note during the information spread how HIV prevalence would be reduced greatly with male circumcision services.

CHAPTER V

DISCUSSION

In this chapter, the study results will be discussed in comparisons with study objectives, aims and literature which has been reviewed. The study provides information on what is influencing men not to participate in medical male circumcision as a preventive intervention for HIV transmission in Windhoek, Namibia.

5.1 Demographic Information

The participant's age ranged from 18 and 49 years from Windhoek. According to the study done by Bailey, Muga, Poulussen, and Abicht, (2002), has single out that, majority of the respondents in the study were young people, and this is the same finding with this study. Their education levels ranged from primary school to tertiary education. Therefore we can conclude that all participants were literate. They were of various Christian beliefs with 26.7% Lutherans, 20% Roman Catholic, 13.3% Anglicans, 10% Apostolic and 30% were not specific. Thus the group had a diverse view in terms of spirituality and beliefs. This was also the case with tribal differences where 40% were Oshiwambo, 10% Herero, 20% Damara>Nama, 3.3% Afrikaans and 26.7% of other tribal backgrounds. The Namibian population is dominated by the Oshiwambo speaking group and this study is currently reflecting on it. Majority of the Herero men are circumcised because it is part of the traditional culture (MOHSS, 2008). However this study can be compared with a research study done by Kebaabetswe, Lockman, Mogwe, Mandevu, Thior, Assex, (2003) & Shapiro (2001) in Botswana with 605 participants from different cultural and geographic area to represent in the study.

Of the respondents, 43.3% were married, 36% were separated, divorced or widowed and 20% were never married. The researcher noted that male circumcision status does not have bearing on marital status because circumcision is not a pre-requisite for marriage.

5.2 Men knowledge on medical male circumcision

According to the UNAIDS Global report,(2008)on the knowledge of circumcision among men has showed low, but in a case of current study 64% of the men showed that they are aware that circumcision can reduce the prevalence of HIV contraction.28% said they did not know whilst 8% did not respond. This goes to show that there is still need for the dissemination of information about the practice of male circumcision. As there are still some respondents that said they do not know about the reduction of HIV prevalence as a benefit of MC, it goes to show that they have less knowledge about the concept of MC, thus more social mobilization and education needs to be done. However, the current study has reveal that 64% men have good knowledge on male circumcision despite the fact that not everyone willing due to factor mention in the study report.

This study is supported by two other studies done by Kebaabetswe, Lockman, Mogwe, Mandevu, Thior and Assex, (2003) in Botswana and Halperin, Fritz, McFarland and Woelk (2005) in Zimbabwe that also concluded that more than 65% of the male to have good knowledge on male circumcision. However, UNAIDS report, (2008) on the knowledge of MC among men was below 40% of the respondents.

There is need for dissemination of information on male circumcision practices as there are still some respondents that do not know about the reduction of HIV prevalence as a benefit of the procedure. This shows that respondents have less knowledge about the concept of MC, thus more social mobilization and education needs to be done. However the study revealed that 64% of the men showed that they are aware that circumcision can reduce the prevalence of HIV contraction, 28% said they did not know whilst 8% did not respond. The study has not found link between religious and knowledge on male circumcision. This indicates that, low level of knowledge in men about male circumcision cannot be matched with participant's religion affiliation.

5.3 Men perceptions towards medical male circumcision

Sixteen percent of the participants interviewed still perceived that male circumcision is a cultural act generally practiced by the Herero tribe in Namibia. Moreover, negative perceptions toward male circumcision could be due to the lack of adequate knowledge about the benefits of circumcision, as the study has found out a link between the two. Once one has positive perception toward circumcision benefits, they might also show more interest and willing to participate on the procedure. In another view, it can be hard for people to show good perception if they do not have more knowledge and not fully informed on the benefits of MC. Therefore, as the Herero are only about 10% of the total population within Namibia, this may well explain why the rate of circumcision of men is still low within the country.

10% feared pain and swelling during and after the procedure. This may be a contributing aspect as to why they will not voluntarily go for circumcision. Because of the little information they are receiving, they also have not made it a priority thus we can still find 10% saying they do not have time for it. There is power in knowledge to influence one perception. Out of 30 respondents, five men who were having negative attitude toward MC has change their perception after information sharing on benefits of male circumcision and show willingness to partake in the procedure. There are similar findings with a study done by Shapirol, (2001) that most men change their perceptions toward male circumcision after information session sharing and are likely to be circumcised.

Enhanced sexual performance is a perception that men who has done circumcision say is a positive aspect. However, male circumcision does not reduce sexual drive level or pressure, even performance which come with sexual satisfaction (Gray, Kigozi, Serwandda, Makumbi, Watya & Nalugoda, 2007).

5.4 Benefits and Risks of Medical male circumcision

The study has found out that, the two major benefits of male circumcision are; the reduction of HIV prevalence and better personal hygiene, with 25% of the respondents naming both as benefits. Fifty percent of respondents explain the benefits of circumcision are to reduce HIV prevalence and only whilst 7% said it is good for traditional respect. These findings are indicating low knowledge among some men who still perceive circumcision as cultural norms. However, some responded that male circumcision can enhanced sexual performance, 3.6% of the participants stressed their opinions. The same finding that some men fear that circumcision will interfere with their sexual desire as found in the study of Pappas-Deluka, Simeon, Kustaa and Halperin, (2009) that some respondent believe that MC can enhance they sexual performance. From this analysis it shows that though men may not be aware of the details of the male circumcision procedures, they were aware of the benefits to be gained from circumcision for instance reduction of HIV. These finding that there is lack of knowledge among men about male circumcision are in congruency with (Westercamp & Bailey, 2006).

5.5 Capacity of health facilities to provide male circumcision

The participants were asked why they were not circumcised, 16.7% of the respondents who had said they are not circumcised mentioned that the health facilities where the male circumcision procedure is carried out are far from them, whilst 13.3% said they do not know where to go. This proves two major concerns: there is need for more service integration of Male Circumcision into health facilities which currently do not render the services and there is also need for advertising and demarcating where the services are available. Pappas-Deluka, Simeon, Kustaa and Halperin, (2009) has found the same challenges that, facilities in Namibia and manpower are contributing factor to low MC prevalence in the country and the services are only rendered at selected health facilities in the country. The study has found out that more men are willing to participate in the procedure if the services will be provided for free. The same result was found in the study by Shapirol et al, (2001) that among 238 uncircumcised men, 145 (61%) has indicated that they are willing to go for male circumcision procedure at the hospital if the service rendered for free of charge; the number has increase to 192 (81%) after information session. These further demonstrate the association of health facilities and men perceptions on advantage of male circumcision.

Health care workers such as nurses need to be trained also on how to perform the male circumcision procedure so that there is no need to wait for trained doctors when they are not available or in shortage, this was expressed by health workers who participated in the study. The same concerns of shortage of health personnel in the state facilities has been reported in MOHSS report (2011) and Pappas-Deluka, Simeon, Kustaa and Halperin, (2009) has found the same concern and recommendation was given for speeding up the process of job shifting and additional in scope of practise for professional nurses.

5.6 Acceptability of male circumcision

According to the respondents, who were not circumcised, 60.8% expressed interest in being circumcised, 17.4% were undecided and only 4.3% said they did not want. These percentages show that male circumcision is becoming increasingly acceptable regardless of cultural background. According to Pappas-Deluka, Simeon, Kustaa and Halperin, (2009) Ngalande, Bailey, Levy, Kaponda, Kawala, Mhango and Chitsulo, (2004) and Mavhu, Buzdugan, Rech, Dermaux-Msimsng, Legeai, Lewis, Singh, Puren and Auvert, (2011) studies finding has found the same results as the currently study that, medical male circumcision is on demand despite some barriers toward it.

According to the health workers who participated in the study, they stated that most men still believe that circumcision is for a certain cultural group, which shows that more information on male circumcision that it reduce HIV in men with 60% need to be disseminated around. Eighty-one percent of men are willing to get their sons circumcised, though they emphasized that they would prefer that the procedure should occur in a health facility and whilst the sons were still in their infancy to avoid the fear of pain. Similar results were found from the study in non-circumcising community in Botswana (Kebaabetswe, Lockman, Mogwe, Mandevu, Thior, Assex, & Shapiro, 2003).

5.7 Barrier to male circumcision

The fear of pain, safety and distances from health facilities are the majorly stated barriers to male circumcision. Of which 33.3% of the participants believed that the process of circumcision is a painful experience and that their penises would swell after the procedure. The same concerns has been picked raised from previous studies by Pappas-Deluka, Simeon, Kustaa and Halperin,(2009), Westercamp and Bailey,(2006) the men express concerns on pain experience during the procedure and safety associated with MC. Twenty-three point three percents showed interest but said that the health facilities they knew provided the services are too far from their reach. 10% feared that after circumcision they would experience a low sex drive and/or reduce their sexual performance and pleasure. Safety and cost of the procedure has 13.4% as

barriers of men not getting circumcised. The assumption can be made that, uncircumcised men with positive perceptions toward male circumcision can accept voluntary medical male circumcision if all factors which hinder access to the services such as lack of surgical facilities and man power has been address as raised by the facilities health workers who participated in the study. According to the health workers who participated in the study, they express the some men complain of pain associated with the procedure, other has assumption that male circumcision can interfere with their sexual performance. Health workers recommend that more information sharing is needed in the community to clear the myths.

5.8 Study Limitation

On this study, there are several limitations. Firstly, the use of Voluntary Testing and Counselling clinic limit the population which did not use VTC services this can be taken as external validity. The general population on this study group has been represented as this indicated by the study group who are seeking HIV prevention program. Secondly, sampling process could have lead to selection bias due to time delimited during the study. The study was based at health facilities, that only adult male who attended VTC at 3 selected clinics during the study periods have participated.

Thirdly, the study has relied on self-report from the participant on the male circumcision status. However, according to Risser, Eissa, Cromwell, Barratt and Bortot, (2004) reported that 4-7% of self-reports on male circumcision has found not to be precisely. The prevalence rate reported on this study on male circumcision should be interpreted with caution, since no clinical examination has been conducted during the study to confirm the circumcision status.

Fourthly, most of the circumcised male cannot remember their age when they were circumcised, who performed the procedure and the locality where procedure has done. This type of information has not routinely collected during the study.

CHAPTER VI

Conclusion and Recommendation

6.1 Conclusion

This study aimed to find out the factors that hinder men not to partake in medical male circumcised services offered at the public hospital in order to reduce HIV infection. The study has sought the views of adult males who were attending VTC services at the three selected state clinic during the study period whereby their participation was voluntarily. Thirty adult males and four health workers participated in the study around Windhoek public health facilities. On this study, it found that men are not participating in the male circumcision due to health facilities are far from them, pain associated with a procedure. However, most of the participants prefer medical male circumcision because it done by professional personnel and safe place which is the hospital.

The study has found out that majority of men has knowledge on medical male circumcision, particularly on its advantages of reducing HIV infection, STIs and enhance genital hygiene among the respondents in the study. Most of the men are aware that circumcision provides only partial HIV infection and make a point on emphasising condom use during sexual intercourse. However, percentages are still has low knowledge on male circumcision activities and its partial protection against HIV acquisition, whereby they need more information on the procedure, for the country to reach its target rate on MC services.

Most of the adult men prefer to be circumcised at the health facilities than at traditional circumcisers especially, in communities where male circumcision is not traditional practiced. The fact that health facilities are far from the community has been pinpointed out as one of the barriers to MC services. Moreover, some respondents expressed concerns over the safety cost and infections associated with male circumcision. Voluntarily medical male circumcision has accepted more than tradition circumcision especial on reduction of HIV infection among men.

6.2 Recommendations

The study finding has recommended the following:

- Information on Voluntarily medical male circumcision services and HIV infection should be made available at places where young people likely to gather or hang around. The MC information should be disseminated thru Social Medias such as Facebook, Twitter and other social network where most people nowadays spend their most time. The organisation dealing with campaign about MC services

must try to link with political personnel so that they can give motivational speech and celebrities who are most people look upon as their role model in order to pass message and encourage every uncircumcised men to partake in the procedure for HIV infection reduction purpose.

- MOHSS together with other closely related ministries such as Ministry of youth and information should engaged in massive campaigns to create awareness among youth and adults especial those residing at far places where information on MC services does not reach them on time.
- Information on male circumcision must be printed in all indigenous languages and if awareness and information sharing is done on radio, it has to be translated to all local languages.
- Crucial training of all health workers to conduct the male circumcision procedure to ensure that the procedure is done safely and risks are been minimised. This will help male circumcision services acceptability and reduce barrier to MC services because the procedure will be done at all public health facilities countrywide.

Voluntary medical male circumcision services to be integrated in all public health sectors, for every man to be catered for at their nearby health facilities.

- MOHSS and other stakeholders involved in MC services mobilisation must encourage traditional circumcisers participation by providing necessary training and recourses such as training on safety, hygiene and ways of performing a procedure in order to include men who prefer to be circumcised at traditional that medical procedure due to their cultural beliefs and norms. Regulating all registered traditional circumciser by proving direct monitoring on regular basis and keep them updated with new changes regarding medical male circumcision and HIV infection, this will facilitate the circumcision procedure to be performed safely according as required by health standard.
- MOHSS must initiate the direction of performing medical male circumcision to infant male at birth for parents who can give consent; this will help to increase MC especially in none circumcised communities in the country.

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APPENDIX 1



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner
STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH (PARTICIPANT)

Topic: what is influencing male participation in voluntary male circumcision as preventative intervention for HIV transmission in Windhoek, Namibia?

You are asked to participate in a research study conducted by Katangolo Ndasilohenda from Africa Centre from HIV and AIDS Management at Stellenbosch University. The result of research will contribute toward the researcher's master level thesis as part of a requirement for completion of MPhil in HIV/AIDS Management programme. You were selected as a possible participant in this study because of your position as client at VTC (voluntary testing and counselling) clinic where the research will take place.

1. PURPOSE OF THE STUDY

To identify the factors that influence men to uptake voluntary medical male circumcision and find new ways of motivating male participation on the service as HIV prevention intervention.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

You will be asked to participate in an individual interview with the researcher. Kindly be honest in answering questions as possible. The interview will take place at the clinic during the working hours and will last not more than 30 minutes. Confidentiality, anonymity and privacy of data will be maintained all times.

3. POTENTIAL RISKS AND DISCOMFORTS

There is no risk involved with the research interview and apart from some question you might find sensitive or uncomfortable to answer. Time to spend on the interview might cause inconvenience to some people.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will not gain any personal benefit from this study, but your participation will benefit others by enabling policy makers to strategize ways that will improve male circumcision services as a measure of HIV/AIDS prevention while in the process, reducing the impact of HIV/AIDS in the country. Your responses will enable the researchers to understand the community's perceptions on male circumcision

5. PAYMENT FOR PARTICIPATION

There will be no payment in participating in the study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of real name not use in order to prevent linkage to the data provided. Information will be kept safe at the researcher office e only be made available to the study leader. Data will be stored in a safe place at all times. The researcher and her supervisor will be the only persons having access to the data. All data collected will be destroyed after successful completion of the thesis, for the purpose of which it was collected. The anticipated period is after one (1) year. As mentioned previously, all interviews will not be tape recorded and the interviews will be transcribed verbatim, without making any reference to your name or personal identifiers. Confidentiality and anonymity will be maintained throughout.

The purpose of the study is to promote the incidence of male circumcision in Namibia. In the writing of the thesis, confidentiality, anonymity, and privacy of participants will be maintained at all times.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact (Katangolo Ndasilohenda +264812169513 and if you have any questions or concerns regarding the research, please feel free to contact the study leader: Dr Thozamile Qududa +27218083999.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Ms. Katangolo Ndasilohenda in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant*] and/or [his/her] representative _____ [*name of the representative*]. [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [**English/*Oshiwambo/*other*] and [*no translator was used/this conversation was translated into* _____ by _____].

Signature of Investigator

Date

APPENDIX 2

MAIN QUESTIONNAIRE FOR MALES

All eligible males are to be interviewed using this form.

“Thank you for agreeing to help us with our survey. My name is **Katangolo Ndasilohenda**. I am a student from Africa Centre for HIV/AIDS at Stellenbosch University. I am talking to men in an effort to find out more about male circumcision. Your contribution will be of great importance to us. The interview will last about 10 minutes. There is no right or wrong answers to the questions; we would just like to learn about your personal thoughts and attitudes. If you don’t understand a question, please tell me, and you can add further information at any stage.

Your answers will, of course, be kept confidential. Your personal responses will be seen by only a very few of my colleagues and your name will not be used in relation to the answers you give.”

Place of interview..... District:Region...

Interviewer’s code:

Date:

1. DEMOGRAPHICS AND SOCIO-ECONOMIC INFORMATION

1.1 Age /____|____|

1.2 What’s your tribe? Oshiwambo, English, Herero, Damara>Nama, Afrikaans, Others _____

1.3 What is the highest education level you have attained?

1=None; 2=Primary (1-7); 3=Secondary (8-12); 4=Tertiary (university/college)|____|

1.4 What is your marital status?

1=Never married; 2=Married; 3=Separated / Divorced / Widowed;|____|

1.5 Religion 1=Lutheran; 2=Roman catholic; 3= Anglican 4=Apostolic 5=Other religion (including traditional); 4=No religion;|____|

1.6 Employment status: Employed/Unemployed/Student

I.MEN KNOWLEDGE ON MEDICAL MALE CIRCUMCISION

1.7 Are you circumcised? 1=Yes; 2=No; if yes go to question 17

2. Do you know that circumcision reduce the risk of contracting HIV/AIDS? YES/NO

3. Why do you think male circumcision is carried out?

Traditional reasons: 1=Yes; 2=No; |____|

Medical reasons: 1=Yes; 2=No; |____|

Hygiene reasons 1=Yes; 2=No; |____|

Other reasons (*please state*)

If the respondent answered 'Uncircumcised' to Question 5, USE THE QUESTIONNAIRE FOR

UNCIRCUMCISED MALES

Questions for uncircumcised Males ONLY

II.MEN PERCEPTION TOWARD MEDICAL MALE CIRCUMCISION

4. Why aren't you circumcised?

5. Would you want to be circumcised? |____|

1=Strongly 'No'; 2=No; 3=Undecided; 4=Yes; 5=Strongly 'Yes'; 8=NA;

6. What are your reasons for this answer?

7. If you have or had a son, would you want him to be circumcised? |____|

1=Strongly 'No'; 2=No; 3= Undecided; 4=Yes; 5=Strongly 'Yes'; 8=NA;

8. What are your reasons for this answer?

9. When would be the best time for him to be circumcised?

Infants (less than 13 years)

Adolescents (14-19 years)

Adult (more than 19 years)

10. Where would you like him to be circumcised? |____|

1=At a traditional circumciser; 2=At the health facility; 3=At other places; 8=NA;

Specify if 'at other places':

III. BENEFITS AND RISKS OF MEDICAL MALE CIRCUMCISION

11. What do you think the benefits of male circumcision would be?

12. What do you think the problems or negative consequences of male circumcision might be?

13. If you had to pay for the operation, what is the most you would be prepared to pay in N?

14. What would be the source of this money?

End of survey for uncircumcised male respondents

Questions for circumcised Males ONLY

15. Why are you circumcised?

16. How old were you when you were circumcised?

IV. CAPACITY OF HEALTH FACILITY TO PROVIDE SAFE MEDICAL MALE CIRCUMCISION

17. Where was it done? |____|

1=at a traditional circumciser; 2=at a health facility; 3=some other place; 8=NA; 9=Don't Know;

Specify if 'some other place':
.....

18. Can you estimate the financial cost to your family of the male circumcision?

19. What was the source of this money?

20. What do you think the benefits of male circumcision are?

21. What do you think the problems or negative consequences of male circumcision are?

22. Are you pleased that you are circumcised? |____|

1=Strongly 'No'; 2=No; 3=Undecided; 4=Yes; 5=Strongly 'Yes'; 8=NA;

23. Would you recommend male circumcision to others? |_____|

1=Strongly 'No'; 2=No; 3=Undecided; 4=Yes; 5=Strongly 'Yes'; 8=NA

If NO-Why would you not recommend male circumcision?

VI. MEDICAL MALE CIRCUMCISION ACCEPTABILITY

24. If you have or had a son, would you support his circumcision?

1=Strongly 'No'; 2=No; 3=Undecided; 4=Yes; 5=Strongly 'Yes'; 8=NA;

25. Do you know if male circumcision services are available at the nearest health facility?

(Government)

V.BARRIERS OF MALE CIRCUMCISION

25. What worries people most to accept male circumcision? |_

1=safety 2= pain 3=ancestors permission 4=cost 5=far away surgical facilities 6=fear of unsatisfactory sexual performance 5=other

26. On your view, what can the government does to motivate men to participate on medical male circumcision?

THANK YOU FOR YOUR PARTICIPANTION, ANY QUESTION ON MALE CIRCUMCISION

APPENDIX 3

EKONAKONO LYOKUTALA NKENE AALUMENT YOMOVENDUKA ITAYA LONGITHA OMAYAKULO NGE EKENKO ONGOMUKALO GWOKUSHUNITHA PEVI ETAANDELO LYOMBUTO YO-HIV.

Oto pulwa nesimaneko opo u kuthe ombinga momapekaapeko taga ningwa kuNdasilohenda Katangolo (onomola yongodhi 081 2169513) ngoka e li omunasikola koUniversiti yaStellenbosch ti ilongele onkatu yopombanda mekonjitho lyomukithi gwo-HIV/AIDS. Omapekapeko ote ga ningi pamwe nomulongi gwe Omundohotola Thozamile Qubuda (Onomola yongodhi +27 21 808 3999). Iizemo yomapekaapeko ngaka otayi ka longithwa moku mu pethitha onzapo monkatu yopombanda. Oto indilwa nee ngeyi opo u kuthe ombinga molwashoka owu na omauyelele ngoka taga pumbiwa opo omuntu a vule okukutha ombinga.

1. ELALAKANO LYOMAPEKAPEKO

Okweeta po euveko kombinga yontseyo, omikalo, omaitaalo kombinga yekeno lyaalumentu, osho wo iikateki mbyoka tayi etitha enkundipalo mokutaambiwa ko kwekenko lyaalumentu ongomukalo gwokushunitha pevi etaandelo lyombuto yo-HIV. Omapekapeko otaga ka kwathela wo okuulika mo omaunkundi ngoka ge li mokutula miilonga omilandu ndhoka dha totwa nale dhi na sha nomauyelele kombinga yekeno, notaga ka kwathela wo aanduluki yomilandu ya kwatele mo oshizemo shomapekaapeko, nosho wo okukondjitha omikundu ndhoka dha monika. Omapekapeko ngaka otaga ka kwathela wo mboka inaa uva nando onale ekenko lyaalumentu kutya oshike, ye li tseye.

2. OMILANDU

Ngele owi iyamba u kuthe ombinga momapekaapeko muka otatu ke ku pula iinima tayi landula: Oto ka pewa elandulathano lyomapulo ngoka wa pumbwa okuyamukula to udhitha mombaapila ndjoka to pewa, notashi ke ku kutha konyala ominute omulongo nantano sigo omilongo ndatu. Kambadhala wu gandje uuyelele wu li mondjila ngaashi tashi vulika.

3. OMAUPYAKADHI NGOKA HASHI VULIKA GA HOLOKE

Kapu na naanaa uupyakadhi wa sha wa tegelelwa wu ka holoke molwokukutha ombinga kwoye momapekaapeko muka, ashike otashi vulika omapulo gamwe wu ga mone ko ga fa omawinayi unene noitoo vulu oku ga yamukula. Otashi vulika aantu yamwe ya ka kale ye wete okuyamukula omapulo taku ya manene po ethimbo lyawo.

4. OMAUWANAWA KAAKUTHIMBINGA NENGE KOSHIGWANA

Omayamakulo ngoka to ka gandja itage ku kwathele ongoye awike, ashike omayamakulo ngaka otaga ka kwathela oshigwana ashihe notaga ka kwathela wo aalongekidhi yomilandu opo ya hwepopaleke omulandu ngu gwa tulwa po nale gu na sha nekenko lyaalumentu ongoshitopolwa shokukondjitha nokushunitha pevi etaandelo lyombuto yo-HIV. Ekuthombinga lyoye ota li ka kwathela wo aaningi yomapekapeko yu uve ko omayiuvu gaakwashigwana kombinga yekenko lyaalumentu.

5. ONDJAMBI MOLWEKUTHOMBINGA MEPEKAPEKO NDIKA

Ondjambi yoye mepekapeko ndika oyo ontseyo ndjoka to ka likola kombinga yekwatathano pokati kenkeko nombuto yo-HIV. Omayamakulo ngoka to gandja otaga ka kwathela aapekapeki ya tothe mo omaunkundi ngoka ge li momilandu ndhoka dhi li po dhi na sha nekenko

6. OKWAAHOLOLA UUYELELE WOYE MBU TO GANDJA

Uuyelele auhe to ka gandja momapekapeko ngaka otawu kala oshiholekwanima thiluthilu noitawu ka gandjwa nande okulye, kakele owala kungoye mwene nenge papitikilo lyoye, nenge ngele owa pumbiwa kompango. Itatu ka longitha nando edhina lyomuntu mombapila ndji wa yamukula, otatu longitha owala oonomola. Kapu na nando ogumwe ta ka tseya kutya owa yamukula shike. Oombapila adhihe ndhi dha yamukulwa otadhi kala dha patelwa mokaskopa koshitenda mombelewa yanakupekapeka. Nakupekapeka oye owala e na oshipatululo shombelewa ndjoka, osho wo shokaskopa mu mwa patelwa oombapila. Iizemo yomayamakulo otayi ka shangwa momushangwa ngu tagu ka tuminwa komundohotola Qubuda, ashike itamu ka shangwa nando edhina lyomuntu.

7. OKUKUTHA OMBINGA NENGE OKUTINDA

Oto vulu okukutha ombinga nenge okutinda okukutha ombinga momapekapeko ngaka. Ngele owi iyamba okukutha ombinga, oto vulu okwiikutha mo kehe ethimbo nopwaa na nando egeelo lyasha. Oto vulu wo okutinda okuyamukula omapulo ngoka u uvite inoo hala oku ga yamukula ndele e to tsikile okuyamukula ngoka wa hala. Omupekapeki ota vulu okukwiindika waa tsikile we nokugandja uuyelele ngele oku wete sha pumbiwa.

8. OMAUYELELE GOONAKUNINGA OMAPEKAPEKO

Ngele owu na omapulo nenge omagwedhelepo gasha, oto vulu okudhengela konomola tadhi landula: Ms Ndasilohenda Katangolo kongodhi yosheendelela 0812169513 nenge wu dhengele Omundohotola Thozamile Qubuda konomola +27 21 808 3999.

9. UUTHEMBA WOYE NAKUKUTHOMBINGA

Oto vulu wu hulithe po okugandja uyelele pwaa na egeelo lyasha. Ito vulu okuningilwa nando oshipotha shasha shaashi wa tokola kutya ino hala we okukutha ombinga momapekapeko ngaka. Ngele owu na omapulo gasha ge na sha nuthemba woye onganakukuthombinga momapekapeko ngaka, oto vulu okuninga ekwatathano naMee Maléne Fouché koiimeila nenge kongodhi ndjika [mfouche@sun.ac.za; 021 808 4622] koshitopolwa shomapekapeko.

ESHAINOKAHA LYANAKUKUTHOMBINGA NENGE LYOMUKALELIPO GWE

Uyelele auhe onde u yelithilwa, _____ kuNdasilohenda Katangolo mOshiwambo, elaka ndyoka ndu uvite. Ondapewa wo ompito opo ndi pule omapulo nonda yelelwa lela komayamukulo ngoka nda pewa.

Otandi gandja epitikilo lyandje lyokukutha ombinga momapekapeko ngaka. Onda pewa wo okopi yombaapila ndji.

EDHINA LYANAKUKUTHOMBINGA

ESHAINO LYANAKUKUTHOMBINGA

ESIKU _____

ESHAINOKAHA LYANAKUNINGA

OMAPEKAPEKO

APPENDIX 4

OSHIWAMBO QUESTIONNAIRE

EKENKO LYAALUMENTU

Tangi sho wakutha ombinga momapekapeko.edhina lyanje ongame KatangoloNdasilohenda.omunasikola kendiki lyo HIV/AIDS mwaAfrica,moshiputudhilo shopombandaStellenbosch.otandi ningi omapekapeko kombinga yashoka otashi ngambeke aalumentukaaholoke koshipangelo opo nya kenkwe.ekudhombinga lyoye olya simana.omapulapulo otaga kwata ethimbo lyominute 15.kapuna epulo lili monjila nenge lyapuka,lombwelanje shoka wuvite.holola ngele owahala okugwedhapo uuyelele wontumba kwashika topulwa.omayamukulo goye otaga sikililwa nawa.

Ehala mpoka tapu pulilwa..... oshikondo..... Oshitopolwa.....

Onomola yanakupulwa:

I.OMAYELE KOMBINGA YUUKWATYA WONAKUPULWA

1.1 Omvula dhoye

1.2 Uukwahoko woye

1.3 Ondondo : Uulongelwa (1-7)

(8-12)

(ondondo yiiputudhilo yopombanda)

1.4 Uukwatya wonjokana: owahokamwa,inohokamwa,owatopoka, omusilwalume,owakala pamwe inamuhokana

1.5 Uukwambepo : kaatolika,angalicana,apostolic,eitalo limwe

1.6 Iilonga: oholongo/iholongo, omunasikola

II.ONTSEYO, OMIKALO, EITALO NOSHOWO IIKATEKI KOMBINGA YEKENKO LYAALUMENTU

1.7Owa kenkwa : eeno/aawe

Eeno,tsikila kepulo 11

2. Owatseya kutya enkenko lyaalumentu otali shonopalenke ompinto yokukwatwa kombuto yo

HIV? Eeno/aawe

3. Omolwashike ekenko hali ningwa malumentu: Omuthigululwankalo

Uunamiti

Uunjolowele

Kandithimbulukwa

III.OMAPULO GAALUMENTU MBOKA INAA YAKENKWA

4.Omolwashike kenkwa?

5.Owahala okukenkwa 1=ino itayela noonkondo, 2=ino itayela,3=ino ninga etokolo ,4=owitela ,

5=owitela noonkondo,8=ino ninga etokolo

6.Tumbula etompelo kepulo etiteno

7.Ngele owuna aanona yoye yamati owahala yakenkwa 1=ino itayela noonkondo, 2=ino

itayela,3=ino ninga etokolo ,4=owitela , 5=owitela noonkondo,8=ino ninga etokolo

8. Ekenko ngele otaliningwa lyoshali koshipangelo oto vulu wukakuthe ombinga? 1=ino

itayela noonkondo, 2=ino itayela,3=ino ninga etokolo ,4=owitela , 5=owitela noonkondo,8=ino

ninga etokolo

9.Epipi lini lyawapala okukenkwa :Lyuunona okuza pevalo sigo ominvo 13

Lyoopokati okuza pominvo 10-19

Lyuukuluntu okuza pominvo 19 wuuka pombanda

10.Owahala okukenkelwa peni :1=onganga dhopashiiludhe

2=Koshipangelo

3=Pomahala galwe

4=Kandishiwo

Ngele owahogolola onomola 3,gandja etompelo

11.Tumbula omauwanawa gokukenkwa?

12.Tumbula omauwinayi gokunkekwa?

13.Ngele oto kenkwa owa hala okufut ingapi?

14.Iimaliwa otoy kutha peni?

Tangi showayamukula omapulo,owuna epulo lyasha kombinga yokukenkwa?

IV.OMAPULO GAALUMENTU MBOKA YAANKENKWA

15.Omolwashike wakenkwa?

16.Owali wuna omvuula ngapi show a kenkwa?

V.OKWIIHWAPO KOSHIPANGELO MOKUNINGA EKENKO LYOPAUNJOLOWELE

17. Openi wankenkelwa 1=onganga dhopashiiludhe

2=Koshipangelo

3=Pomahala galwe

8=inashi pumbiwa

9=Kandishiwo

Ngele owahogolola 3,nganja omatompelo

18.Tengeneka kutya owafuta iingapi?

19.Openi wakutha iimaliwa?

20 Tumbula omauwanawa gokukenkwa

21.Tumbula omauwinayi gokukenkwa

22.Owu vite nawa sho wakenkwa? 1=ino itayela noonkondo, 2=ino itayela,3=ino ninga etokolo ,

4=owitela , 5=owitela noonkondo,8=inashi pumbiwa

23.Oto vulu okulombwela yaakweni ya kuthe ombinga mokukenkwa : 1=ino itayela noonkondo,

2=ino itayela,3=ino ninga etokolo ,4=owitela , 5=owitela noonkondo,8=ina shi pumbiwa

Ngele ino itayela ,omolwashike?

VI.ETAMBULOKO LYEKENKO LYAALUMENTU MOSHIPANGELO

24.Ngele owuna aanona yaamati oto ya tsu omukumo opo yakakenkwe koshipangelo?1=ino

itayela noonkondo, 2=ino itayela,3=ino ninga etokolo ,4=owitela , 5=owitela noonkondo,8=ina

shi pumbiwa

V.IIKATEKI YEKENKO LYAALUMENTU

25. Oshike hashi etele aantu uumbanda wokutanbulako ekenko lyokoshipangelo?1=okukenkwa

kwaali paunjolowele, 2=uuwehame,3=etaambiko kaakuluyonale,4=ondando,5=uukule womala

gokukenkelwa, 6= uumbanda wokunkekwa, 7=yilwe

26. Pamadhiladhilo ngoye oshike epangelo lina okuninga opo litse omukumo aalumentu ya kudhe ombinga mekenko lyokoshipangelo?

Tangi showayamukuna omapulo,owuna eepulo lyasha kombinga yokukenkwa?

APPENDIX 5

SEMI-STRUCTURED INTERVIEW SCHEDULE

(QUESTIONS FOR KEY INFORMANTS-HEALTH WORKER)

1. In your opinion, what are the main factors influencing Male Circumcision in your area?

Prompt: [What are the possible benefits/advantages related to health, culture, religion, etc.]

2. What do you consider as disadvantages of Male Circumcision?

Prompt: [What are the possible disadvantages related to health, culture, religion, etc.]

3. Is there any stigma attached to a man being circumcised or uncircumcised?

Prompt: [What is the possible stigma related to culture, religion, etc. regarding to both MC statuses in both traditionally circumcising and non-circumcising communities]

4. What do you know about the relationship between HIV infection and Male Circumcision?

Prompt: [What is the protective effect in percentage of male circumcision against HIV infection]

5. If we wanted to increase the provision of health facility–based Male Circumcision, what do you think are the most important factors we should address?

Prompt: [Availability and allocation of funds and resources?]

Prompt: [Do you think staff in health facilities knows how to carry out male circumcision to the satisfaction of the local population? Please explain].

Prompt: [What role would your organization be able to play in increasing male circumcision services?]

6. if we wanted to increase demand for male circumcision among adults and children, what sort of things should we do?

Prompt: *[Who do you think would have the most influence on people, if we were to ask someone to publicly support a programme?]*

Prompt: *[What messages do you think would have the most influence on people, to encourage male circumcision among adolescents or adults? What about for the parents of newborns or children?]*

Prompt: *[At what age do you think parents would like to have their male children circumcised: as infants (less than 1 year old); as children (between 1-5 years old), as children (between 6-10 years old), as adolescents (between 11-17 years old), or as adults (18 years old and above)? Why?]*

Prompt: *[How much money and payments in kind (non-monetary) would adults and parents in your area would be able to pay for male circumcision services?]*

7. At health facilities providing male circumcision, what other services (apart from post-operative care) do you think would be beneficial to provide to the circumcised?

Conclusion:

Thank you very much for your time. It has been a very interesting and useful discussion.

Do you have any other comments or questions for me regarding male circumcision?

APPENDIX 6



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice

Stipulated documents/requirements

10-Oct-2013

KATANGOLO, NDASILOHENDA

Dear Ms NDASILOHENDA KATANGOLO,

Your **stipulated documents/requirements** received on **09-Oct-2013**, was reviewed by members of the **Research Ethics Committee: Human Research**

(Humanities) via Expedited review procedures on **09-Oct-2013** and was approved.

Sincerely,

Susara Oberholzer

REC Coordinator

Research Ethics Committee: Human Research (Humanities)

Proposal #: HS998/2013

Title: What is influencing male participation in voluntary medical male circumcision as preventive intervention for HIV transmission in

Windhoek, Namibia?

APPENDIX 8



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: (061) 2032562
Fax: (061) 222558
E-mail: tkakili@yahoo.com

Enquiries: Ms. T. Kakili

Ref: 17/3/3

Date: 18 July 2013

OFFICE OF THE PERMANENT SECRETARY

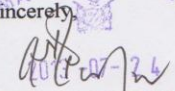
Ms. N. Katangolo
P. Box 26324
Windhoek

Dear Ms. Katangolo

Re: Voluntary free medical male circumcision for HIV prevention in Windhoek, Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for the completion of your Master of Philosophy in HIV/AIDS management;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,


MR. ANDREW NDISHISHI
PERMANENT SECRETARY

