



**UNIVERSITY of the  
WESTERN CAPE**

**Acceptability of Medical Male circumcision among men in Engela  
district of the Ohangwena region, Namibia**

**By**

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## ABSTRACT

This study focused on acceptability of medical male circumcision (MMC) in Ohangwena region, Namibia. Since the scaling up of this program in public hospitals, no study was done with a specific focus on men who are the target population for this intervention. This study aimed at exploring the role of masculinities in MMC acceptance and specifically focused on circumcised men. To understand this context, I initially focused on general constructions of masculinity as well as the historical background of ritual circumcision which used to be practiced in this region. I spent three months at Engela District Hospital working with the male circumcision (MC) regional coordinator who is also the MC Nurse at the same hospital. Data collection process utilised an ethnographic study design involving qualitative research methods namely participant observation, formal and informal interviews and the use of field notes. Participants included men who visited the hospital for circumcision procedure, health workers and community elders.

Findings indicate that, circumcision that is now offered in hospital settings is not a recognised marker of masculinity in Ohangwena. There is also paucity of information regarding traditional circumcision. Since its abolishment in the eighteenth century, little is known about the history of this practice. Contemporary means of being a man in this setting are situated in everyday circumstances and include work, being strong, independent and ability to fulfil family responsibilities. Thus, in this context notions of masculinity do not determine men's responses to MMC. Instead, men are motivated by health benefits in accepting MMC. MMC's proven ability to reduce HIV transmission by 60% is the primary reason why most men are willing to be circumcised. Other reasons include genital hygiene and correction of medical conditions related to the foreskin such as ulcers and lacerations. Men's knowledge and understanding of the relationship between MC and HIV prevention also plays a role in MMC acceptance. Some concerns that were raised by men in relation to this intervention are pain and discomfort, fear of complications, decreased penile sensitivity,

transfer of untruthful information and gender of circumciser. I regard these concerns as barriers to MMC acceptance. This thesis also argues that, the manner in which MMC is performed out in public health facilities is not gender sensitive since it is mostly done by women. This act in my view is likely to make men feel emasculated and thus discourage other men from taking up this voluntary service. This study therefore recommends similar research in other contexts to challenge speculations made about the likely impact of MMC on masculinity, because, in my research, uptake of MMC has nothing to do with constructions of manhood. I further recommend provision of standardised equipments and resources including human resources for efficient provision of this program countrywide.



## KEYWORDS

Acceptability

Circumcision

Engela

Ethnography

HIV/AIDS

Men

Masculinity

Namibia

Ohangwena

Sexuality





## **DEDICATION**

This thesis is dedicated to my wonderful parents Gabriel and Selma Nepaya as well as the Nepaya girls - my lovely little sisters Tuwilika, Ndinelago, Ndatega and Nelago. THIS IS FOR YOU!



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## DECLARATION

I, Magdalena Ndapewa Nepaya hereby declare that this thesis; “*Acceptability of Medical Male Circumcision amongst men in Engela district of the Ohangwena region, Namibia*”, is my own original work and it has not been submitted for a degree or examination in any other university nor any other parts of it, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Signed: .....

Date: November 2012



## ACRONYMS

**ABC** - Abstinence, Be Faithful, Condomise

**AIDS** – Acquired Immune Deficiency Syndrome

**ART** – Antiretroviral Therapy

**AVAC** – AIDS Vaccine Advocacy Coalition

**HIV** – Human Immune-Deficiency Virus

**MC** – Male Circumcision

**MMC** – Medical Male Circumcision

**MOHSS** – Ministry of Health and Social Services



**NBC** – National Broadcasting Corporation

**NDHS** – Namibia Demographic Health Survey

**NPC** – National Planning Commission

**STIs** – Sexually Transmitted Infections

**UNAIDS** – Joint United Nations Programme on HIV and AIDS

**VCT** – Voluntary Counselling and Testing

**WHO** – World Health Organisation

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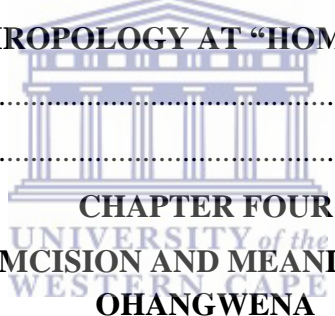
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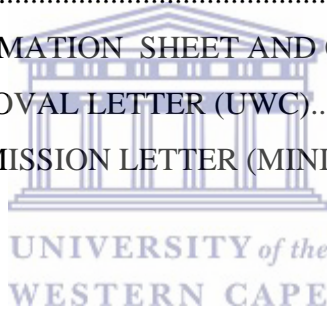
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# CHAPTER ONE

## GENERAL INTRODUCTION

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) World AIDS Day report, total number of new Human Immune-Deficiency Virus (HIV) infections has dropped from 2.2 to 1.9 million by end of 2010. This (World AIDS Day) report further reveals that an estimated 34 million people are living with HIV worldwide (UNAIDS 2011). Sub-Saharan Africa is the hardly hit region, where 68% of people living with HIV reside. This status quo still calls for effective HIV preventive interventions. Efforts to reduce the spread of HIV and its impacts continue to be explored and strengthened. More attention is given and more resources are being availed for testing biomedical interventions to curb the HIV pandemic. Antiretroviral therapy<sup>1</sup> (ART) continues to be rolled out and existing ABC (Abstain, Be Faithful and Condomize) prevention methods are being maintained and emphasised as part of the HIV prevention strategies.

To complement HIV prevention strategies, male circumcision<sup>2</sup> (MC) was first proposed in 1986 that it might reduce risk of HIV acquisition (Alcena 1986). This proposal was followed by ecological and biological studies which suggested that male circumcision reduces the risk of HIV acquisition during heterosexual intercourse (McCoombe and Short 2006). Later, three Randomized Controlled Trials (RCTs) were conducted in South Africa, Uganda and Kenya to prove the suggestion that emerged from ecological studies (Bailey *et al.* 2007). Previously, MC has been practiced for medical reasons in the West while in Africa it was performed for cultural and religious reasons and it is still practiced in some parts of the continent.

Randomised Controlled Trials (RCTs) established that male circumcision reduces HIV transmission by 60%. In March 2007, the World Health Organization

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<sup>1</sup> ARVs are being used for prevention purposes for example in Prevention of Mother-to-child Prevention (PMTCT) and Post-Exposure Prophylaxis (PEP).

<sup>2</sup> Male circumcision is the surgical removal of all or part of the foreskin of the penis. It is one of the oldest and most common surgical procedures worldwide, undertaken for religious, cultural, social or medical reasons.

(WHO) and UNAIDS recommended that MC now be recognised as an additional intervention to reduce the risk of acquiring HIV infection heterosexually (WHO and UNAIDS 2007). Countries in Sub-Saharan Africa where HIV prevalence is high were urged to scale up services offering MC. Namibia is one of the countries in Sub-Saharan Africa that currently provide MC as a prevention measure against HIV. According to National HIV Sentinel Survey report (2010), Namibia's HIV prevalence rate was estimated to be 18.8% - one of the highest in the world. In response to WHO call the Namibian Government, through the Ministry of Health and Social Services (MOHSS) in July 2007, announced that circumcision should be included and treated as a potential preventative measure against HIV (Sibeene 2007). However, The Minister of Health later reported the need to mobilize resources and prepare health facilities (Sibeene 2008). Thus provision of MC for HIV prevention only commenced in 2010. MOHSS has set a target to circumcise 80% of all males by 2025 (Mietzner 2011) and at least 45% (450 000) of the male population by 2015 (Kafidi and Nyatondo 2012). More than 9000 men have so far been circumcised nationally by June 2012 (*ibid*).

The study explored acceptability of MC as a preventive medical intervention in a currently non-circumcising community. It also looked at how men understand and perceive MC as part of the preventative package against HIV transmission. Furthermore, this research attempted to investigate the role that masculinities play in the context of MC acceptance. The study was conducted among men in Ohangwena region, Namibia. As a researcher, I was based at Engela State Hospital where I recruited some of the participants (men and health workers – running MC program). Male participants were recruited in the study as they came to the hospital to undergo circumcision, and later followed at their homes for formal interviews. Few elders in Engela and its surrounding community also participated in the project.

Research on men has evidently shown how masculinity is increasingly being used as a framework for analysis of men's health behaviour. This includes an analysis of the ways men respond to HIV messages in African societies (Mfecane 2010;

Barker and Ricardo 2005). These ways include – and not limited to sexual behaviour and acceptance or rejection of HIV prevention programmes or interventions. Incorporating masculinity in this research means a focus on men and how they construct their identities as applied to acceptability of MC for HIV prevention. Although constructions of masculinity do not always determine men's behaviour, it helps in understanding such behaviour in a social context (Barker and Ricardo 2005). Masculinity is thus a significant and central analytical concept in this study.

The key argument in this thesis is that masculinity has no impact on men's acceptance of MC for HIV risk reduction. Instead, men are motivated by medical benefits to uptake this intervention. I also argue that, although circumcision practice formed part of the transition from boyhood to manhood, presently circumcision status is not a recognised marker of real manhood in Ohangwena. My findings therefore differ from previous studies that emphasise the importance of considering notions of masculinity when dealing with medical circumcision (Vincent 2008, Aggleton 2007, Mfecane 2010). Most studies determined acceptability of MMC on basis of men's willingness and not actual action, without considering that willingness does not always translate into action (Dowsett and Couch 2007); hence my focus on men who were taking up this service at Engela hospital.

## **1. BACKGROUND/RATIONALE**

Male circumcision is one of the oldest and most common surgical procedures worldwide, undertaken for religious, cultural, social or medical reasons on neonates, adolescents and adult males. Gairdner's (1949) study states that the foreskin is devoid of function, but various literatures argued that it protects the glans penis from injury and contact with clothes or napkin. Although the origin of MC remains uncertain, several authors claim that the practice dates back to about 5000 BC (Hinz and Hangula 2010). In Egypt, it was a belief or rather a ritual for every man to be circumcised before entry into the priesthood, while the Jews were

circumcised to maintain their covenant with God (Aggleton 2007). Circumcision was introduced in Europe with Christianity, but later Christians took a strong stand against it. But it remained a strong custom among the Jews. MC then continued to be a medical practice in Western societies (Gairdner 1949).

To date, Gollaher (1994) appears to be one of the scholars who have produced a significant and constructive medical history of circumcision in America (United States). It began in 18<sup>th</sup> century with a leading orthopaedic surgeon who discovered circumcision to be curing health conditions like paralysis, hip-joint disease and to quieten nervous irritability in young children. Because of his reputation and professional standing in American medical practice, his discovery was not rejected despite doubts surrounding the originality of his findings. This led to active promotion of circumcision and further discovery of other benefits. MC was then seen as a solution to a wide array of other illnesses such as enuresis, hernia, and stricture of the bladder, constipation, convulsions and epilepsy amongst others (*ibid*). Despite the occasional setbacks and the fact that no scientific studies were carried out to determine the efficacy and safety of circumcision prior to its introduction into medical practice, circumcision became a frequently performed surgery in American medical practice for hygiene and disease prevention purposes (*ibid*).

Gollaher (1994) also revealed that before the 18<sup>th</sup> century and the aforementioned unexpected discoveries; the primary indications for circumcision were cancerous lesions and phimosis<sup>3</sup>. Further, he stated that acceptance of MC as a sanitary precaution in societies can be compared to the way ‘cleanliness’ has been accepted and understood during the years of its inception. Gairdner (1949) referred to MC as a way of preventing later development of a variety of conditions such as paraphimosis<sup>4</sup> venereal diseases (for example HIV), penile cancer and

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<sup>3</sup> Phimosis is a condition where the foreskin cannot be fully retracted over the glans penis (Munnariz *et al.* 2002) or an abnormal constriction or tightening of the foreskin interfering with normal function (Gollaher 1994).

<sup>4</sup> Paraphimosis is an uncommon medical condition where the foreskin becomes trapped behind the glans penis and cannot be pulled back to its normal flaccid position covering the glans penis.

cervical cancer in women. In indigenous populations of the deserts (central Australia, Mexico, Kalahari and Saudi Arabia) men were circumcised to prevent the occurrence of balanitis<sup>5</sup> because in a hot, dry and sandy environment where they lived, it would be easy for the sand to get under the foreskin (Short 2006). It is now evident that the primary motive for circumcision in most societies has been medical. But I am interested in exploring its social aspects. My focus is on how medical MC is accepted by men considering their social and cultural standings and their understanding of what it means to be a man. The next section shows that circumcision in African societies is a culturally-charged event.

### **1.1 Male Circumcision in African societies**

Male circumcision has deep roots in Africa where it is practiced by diverse cultural groups mainly for cultural and religious reasons as part of initiation rituals. These initiation rituals symbolize a rite of passage from boyhood to manhood (Wilcken 2010). Ncayiyana (2003) compares initiation rituals to the modern military training - hard but intended to nurture because the 'school' is toughening, training and initiating male adolescents into warrior status. These ceremonies are undertaken in non-clinical, isolated places (Ncayiyana 2003).

For Namibia in particular, the 2006–2007 Namibia Demographic Health Survey (NDHS) indicates that 21% of 15–49-year-old men are circumcised, varying by region from 1% in Ohangwena to 57% in Omaheke. According to Pappas-DeLuca *et al.* (2009), original inhabitants of Namibia, the Khoi-San people, did not engage in ritual circumcision. But for centuries, circumcision was an integral cultural practice among Bantu-speaking communities who migrated from Central African regions and settled in Namibia (Pappas-DeLuca *et al.* 2009). In her study of ritual and ritual change in Ovamboland, Namibia, Salokoski (2006) found that amongst Ovakwanyama 'tribe' of Ohangwena region, circumcision was performed as part of male initiation (*epitotanda*) in camps erected in secluded places and lasted from

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<sup>5</sup> Balanitis is the infection of the glans (head of) penis, which could lead to other diseases of the male genital organs such as urethritis (infection of the urethra).

four days to two months. A circumcised man was held in great esteem; he was given tasks of honour; he could marry and attend men's meetings because he was no longer a 'boy' (Salokoski 2006). Early Ovambo kings were also circumcised, but this ritual was later abolished in Oukwanyama in the years 1885-1890. The reasons for this abolishment remain vague but believed to be related to military concerns and kingship (*ibid*). Today ritual MC is only practiced in Omaheke, Kunene and Kavango (among the *Vanyemba*) regions (Pappas-DeLuca *et al.* 2009).

However, as with any surgical procedure, there are risks involved. Bailey *et al.* (2008) did a comparative study of complications between traditionally and medically circumcised men in a traditionally circumcising community in Kenya. Pain, bleeding and infection were the most common complications recorded in all settings, but traditional circumcision registered high rates of complications than in clinical settings. Other complications reported from traditional circumcision include lacerations, pain upon urination, and incomplete circumcision. In South Africa, increased complications and risks of traditional circumcisions have been at the core of media coverage. This is shown by Kepe (2010) in his analysis of materials around the health crisis and tensions between government and traditional leaders, rejecting government's efforts to make the rituals safer. Complications recorded include infections, penile amputations and death which can result from shock due to dehydration or excessive bleeding (*ibid*).

Nonetheless, MC is now promoted in the fight against HIV/AIDS and its safety even in clinical settings cannot be disregarded. This study focused specifically on 'Medical Male Circumcision' (MMC), defined as complete removal of the foreskin of the penis by a trained health professional (Aids Vaccine Advocacy Coalition - AVAC 2010) and performed in a health facility (Bailey *et al.* 2008).

## **2. RESEARCH PROBLEM**

Namibia has high incidence(s) of HIV (18.8%) and low circumcision rate (21%). The 2011 National Policy on MC for HIV Prevention, reported a series of surveys which have been commissioned by MOHSS to estimate potential cost and impact of scaling up MC services (USAID 2009), to assess attitudes and perceptions of the general public, stakeholders and health care personnel toward MMC in Namibia (Pappas-DeLuca *et al.* 2009). These surveys were followed by implementation of MC for HIV prevention in health facilities in 2010. However, none of the abovementioned studies focused on the acceptability of MMC amongst medically circumcised men and the role that masculinity can play in the context of MMC acceptance. Cultural and social factors were explored from a general stance and not specifically from men's perspectives. With MC now being promoted and performed medically for HIV prevention, I regard it of importance to investigate its acceptance particularly amongst men in a presently non-circumcising community - and also to explore how constructions of their masculinity impacts on MMC acceptance.

### **3. AIMS OF THE STUDY**

Fundamentally, this study seeks to make a contribution to the medical anthropological debates on issues of health, specifically MC and HIV/AIDS studies. It will do so by exploring the role of masculinities (including issues of sexuality) in MMC knowledge and acceptance, as well as social and cultural factors impacting man's decisions to be circumcised. Another aim is to examine strategies employed by health workers for advocacy purposes to promote and educate the nation about this recently endorsed medical intervention.

### **4. RESEARCH QUESTIONS**

1. What does it mean to be a man in a non-circumcising community (constructions and experiences of masculinity)?
2. What is the meaning of sexuality (in relation to MC) to men in a non-circumcising community?



3. What is men's knowledge about medical MC?
4. What role does masculinity play in the context of medical MC acceptance?
5. What impact does medical MC have on men's meanings and constructions of masculinity?
6. What strategies are used by health workers to promote MMC?
7. How do elders and community leaders generally understand and respond to MMC intervention?

## **5. SETTING THE SCENE**

### **5.1 Namibia – “Land of the brave”**

The Republic of Namibia is a vast, sparsely populated country situated along the south Atlantic coast of Africa (Government of the Republic of Namibia - GRN 2012). With its surface area of 824,292 square kilometres, Namibia is the 34<sup>th</sup> largest country in the world. Before obtaining independence in March 1990 – from South Africa - Namibia was previously known as South West Africa. It shares borders with South Africa in the south, Angola and Zambia in the north and Botswana in the east.

The name Namibia is reportedly derived from an old Khoekhoegowab word *Namib* which is also named after Namib Desert – the largest desert in the world which stretches along the whole west coast of the country (GRN 2012). It is generally believed that the Khoisan speaking people, known as San or Bushmen were the first to live in this area. Namibia is a dry country, the annual level of rainfall ranges between 300-400 mm. Nonetheless, the majority (more than 50%) of the population survives mainly on subsistence farming.

According to Namibia Census (2011), Namibia hosts a population of 2,1 million people of which 51 percent are female and 49 percent are male (NPC<sup>6</sup> 2012). Majority of Namibians reside in the rural areas, which is 58 % of the population

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<sup>6</sup> National Planning Commission



(NPC 2012). The northern part of the country is the most populous with over 50 percent of the total population. The country is demarcated in thirteen political and administrative regions as shown in the map on page eleven (11). The thirteen regions are further subdivided into electoral constituencies. I will now give an overview of Ohangwena region, where the study was conducted.

## **5.2 Ohangwena region**

As one of the thirteen political regions, Ohangwena is located in the north of the country. It borders with Angola to the north, Kavango region on the east, Oshikoto region on the south and Omusati to the west and Oshana to the southwest. It is mostly rural and about 90% of its inhabitants live in rural areas. It covers an area of just about 10,703 square kilometres. It has the population of about 245 100 inhabitants, being the second densely populated region in the country (NPC 2012). Its population is composed of more than 40 percent 15-59 age category.

With a literacy rate of 79 percent in the region (NPC 2012), there are four secondary schools and several primary and junior secondary schools. Unemployment rate was estimated to be about 53 percent (2001 Census – NPC 2012) and the main source of income is farming and agriculture. Many unemployed youth engage in non-skilled labour such as selling in shops or bars, selling own goods such as seasonal products (for example fruits and vegetables) and other items. Ohangwena is mostly a subsistence agricultural region with *mahangu* cultivation and herding of cattle as some of the predominant activities prevalent for inhabitants. Oshikwanyama is the commonly spoken language that is also recognised as the home language in Ohangwena region.

Capital city of the region is Eenhana, a recently proclaimed town located about 55 km from Engela. The tarred road connects the settlements and a few villages along the road. Housing is mostly in the form of traditional stick houses with few modern houses in villages than in settlements. Many Namibian politicians are

from Ohangwena region including the current president His Excellency Hifikepunye Pohamba and several other government ministers. During colonial era this region served as a transit for many Namibians who crossed borders into exile to join the SWAPO<sup>7</sup> liberation movement.

Although people of Ohangwena practiced traditional circumcision back in the days, current MC rate is only 1% (NDHS 2006-07). The HIV prevalence rate stands at 20.4% (2008 HIV Sentinel Survey). Apart from Engela district hospital – where I was based during my research - there are other two hospitals of the same standard in Eenhana and Okongo and 29 clinics. I chose to do my study in this region specifically because of the history of circumcision, its population, low rate of circumcision and high rate of HIV/AIDS.

While doing research in Ohangwena, I was based at Engela district hospital. This hospital is found in one of the eleven constituencies in the region. Engela has a population of about 178 855 people, meaning more than 70% of the whole regional population resides in this district. The district hospital has a bed capacity of 230 beds. It is a busy hospital, its catchment population is more burdened by regular Angolan nationals crossing the border in search for health services, and thus its bed occupancy is mostly hundred percent<sup>8</sup>. Engela is one of the places in northern Namibia where missionaries settled. Some old buildings which formed part of the missionary centre are still visible today. Engela is located 8 km away from Helao Nafidi Town (formerly called and still well known as Oshikango), a congested and busy Namibia-Angola border post that became a trade boom town connecting Angola to other foreign traders (Dobler 2008). The next page shows the Namibian administrative map and the map of Ohangwena region. I will thereafter outline chapters contained in this thesis.

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<sup>7</sup> SWAPO stands for South West Africa People's Organisation. It is the ruling political party in Namibia, founded in 19 April 1960. SWAPO has been in power since independence in 1990.

<sup>8</sup> Personal communication with Dr Kashaija, PMO at Engela hospital



## 6. THESIS OUTLINE

This thesis comprises six chapters. Chapter one is the general introduction to the study. It sets out the background to the practice of medical and ritual circumcision. The research problem, objectives and research questions are presented in this chapter as well as an overview of the setting in which the study was conducted.

Chapter two consists of related literature reviewed for the purpose of this study. Firstly, it looks at the relationship between MMC and HIV prevention, with special reference to the clinical trials which found 60% efficacy in reducing HIV acquisition rate among heterosexual men. The chapter then scrutinizes the debates around MMC as a medical practice and its role in reducing HIV risk. Furthermore, some critiques of this practice has also been analysed in order to understand this intervention clearly. Since masculinity is the central analytical concept for this study, studies on masculinity have also been examined for the purpose of understanding men's responses to MMC.

Chapter three outlines methodological approach used throughout the fieldwork process. It raises issues relating to the complexity of accessing research field, ethical challenges, selecting a research topic and how the researcher dealt with such issues. The chapter also discuss the positionality of the researcher being both an 'insider' and 'outsider' to the research field. In this chapter, reflections are also made concerning the gender of the researcher and its possible impact on the process and findings of the research project.

Chapter four focuses on the history of male circumcision as a ritual practice for Ovakwanyama in Ohangwena region. It discusses some of the reasons why MC used to be done and the factors or circumstances that led to the abolishment of the practice in this kingdom (region). The chapter also deals with different versions and meanings of masculinity amongst men in Ohangwena and how they have evolved over the years.

Chapter five generally attends to a range of men's responses to MMC intervention. It focuses on men's understanding of the relationship between MMC and HIV prevention. It also looks at the factors encouraging and discouraging MMC acceptance among men. In addition, the chapter discusses issues pertaining to MMC and the body, gender and sexuality as they emerged from the study.

Chapter six is the conclusion of the thesis. By summing up the main findings, it also gives general impressions of the project and recommendations for future research.

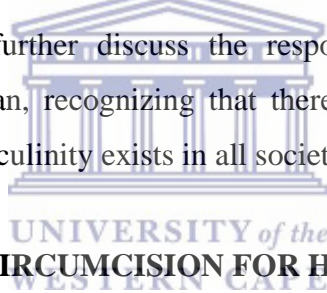


## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **1. INTRODUCTION**

In this chapter, I present a review some of the literatures that are relevant to the subject under study. For the purpose of this study, I firstly look at the relationship between circumcision and HIV prevention with reference to how MMC became one of the latest prevention strategies. I then examine several literatures on how MMC has been accepted in different societies across Southern Africa. In this regard, I also look at some of the debates this intervention has aroused amongst various scholars. The chapter then theorise masculinity as the core analytical concept in this study. I also discuss some studies of masculinities in other contexts. The chapter further discuss the responses to MMC in relation to meanings of being a man, recognizing that there is no universal manhood but different versions of masculinity exists in all societies.



#### **2. MEDICAL MALE CIRCUMCISION FOR HIV PREVENTION**

Between 2002 and 2007, three large-scale randomized controlled clinical trials were conducted in Kenya, Uganda and South Africa to determine MC's safety and efficacy in reducing the risk of heterosexual HIV transmission. The three Randomised Controlled Trials (RCTs) sought to test what has long been suggested by the biological and epidemiological studies, that MC could be a potential intervention for HIV risk reduction (Scott *et al.* 2005). The trial's results showed significant efficacy of 60% (Bailey *et al.* 2007; Gray *et al.* 2007; Auvert *et al.* 2005). This means that men who are circumcised are at lesser risk of acquiring HIV heterosexually than men who are not circumcised. It has been established that the foreskin is rich in HIV T-1 receptor (target) cells and its inner mucosa is highly unkeratinised, making it vulnerable to HIV infection (Donoval *et al.* 2006; McCoombe and Short 2006). This therefore means that the removal of

the foreskin can reduce transmission of HIV and other sexually transmitted infections (STIs).

Successful scaling up and effectiveness of MMC intervention depends largely on how it is accepted in societies, particularly by men whom this program aims to reach out to (Westercamp and Bailey 2007). Several acceptability studies (Wambura *et al.* 2011, Lukobo and Bailey 2007, Westercamp and Bailey 2007, Scott *et al.* 2005, Mattson *et al.* 2005, Kebaabetswe *et al.* 2003, Bailey *et al.* 2002) were conducted in traditionally circumcising and non-circumcising societies to ascertain responses to this medical intervention. The findings were positive with majority of men willing to be circumcised provided the procedure was done safely, with less pain (or no pain at all) and offered for free or at least at an affordable price amongst other reasons(*ibid*). Other factors for which men also showed their willingness to be circumcised include disease prevention and increased sexual pleasure (Lukobo and Bailey 2007, Scott *et al.* 2005, Mattson *et al.* 2005, Bailey *et al.* 2002). In all the studies, it is only a minority of respondents who were not accepting, citing contradiction with religious or cultural beliefs. Other barriers to acceptability of MMC in the studied societies included pain, safety concerns and high costs.

It should be noted that, most studies cited above were conducted before MMC was proved to be 60% protective against HIV infection – with an exemption of Wambura *et al.* (2011). Wambura *et al.* (2011) focused on traditionally circumcising communities where they observed an increasing shift of preference from traditional to medical circumcision – at the time when MMC provision was on-going in Tanzania. In Botswana, Kebaabetswe *et al.* (2003) demonstrated the role that information provision play in the acceptance of MMC. In this study, interviews were conducted before and after an informational session outlining the risks and benefits of MC, hence, improving favourability of circumcision in this research setting. This literature is relevant to my study because in the context of MMC acceptance I am also considering the reasons and factors playing a role in men's acceptance of MMC in Ohangwena.

Following the results from the trials, WHO and UNAIDS jointly announced MMC as an additional HIV prevention strategy to be incorporated in the existing preventative measures (WHO and UNAIDS 2007). They recommended scale up of this intervention in countries hardly hit by the pandemic and those with low circumcision rates. Namibia responded positively and initiated studies to estimate cost and impact of MMC scale up as well as nation's perceptions and attitudes towards MMC for HIV prevention. These surveys were followed by implementation of this intervention in health facilities in 2010. Since then, scaling-up program has been started in most state hospitals. National MC Coordinator and regional coordinators have been appointed to run the programme. The MC Policy was launched by the Minister of Health in March 2010, to inform provision of MMC services nationally. Also, more than 20 health professionals have been trained to train others in rolling out MMC in regions countrywide (Cawood 2009). By the end of 2011, 114 health professionals were trained nationally and 31(out of 45) health facilities were providing MMC<sup>9</sup> nationwide.

Pappas-DeLuca *et al.* (2009) conducted a study in Namibia to determine attitudes, perceptions and understanding of MC for HIV prevention. This study included both men and women in some parts of the country. Their findings revealed a high degree of acceptability with reasons ranging from cultural, to medical (disease prevention – HIV and STIs, hygiene), to social convictions such as sexual pleasure, prerequisite to marriage and others (Pappas-DeLuca *et al.* 2009:240). Perceived disadvantages or barriers to MMC cited by respondents included loss of foreskin as a protective covering, fear of death, pain, disfigurement and perceptions of increased risk for HIV. Another study by Andersson and Cockcroft (2011), a cross-sectional in Namibia, Botswana and Swaziland focused on young people (men and women aged 15-29) and their attitude to HIV prevention and HIV status in relation to MC. Although about 40% reported to be circumcised, study results showed that nearly half of uncircumcised young men planned to be circumcised. The two studies referred to above were all conducted after the

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<sup>9</sup> Personal communication with the MC Nurse at Engela Hospital who is also the MC coordinator for Ohangwena region.



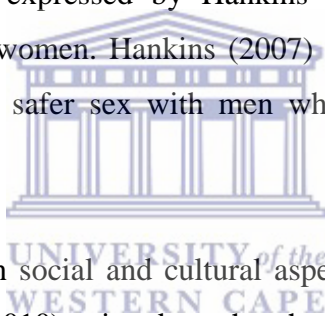
release of WHO/UNAIDS recommendation but before the actual implementation of MC for HIV prevention program in Namibia. My study is therefore unique because it was conducted at the time when MMC is being offered for free in most public hospitals and also because my main targets are men who have undergone MMC. This study therefore considers circumcised men's responses and experiences with the intervention.

Evidently, the subject of sexuality emerged from the above-mentioned acceptability studies particularly those done before RCTs results and provision of MMC in such societies following the results of the three RCTs. Men who believed that circumcision enhances sexual pleasure and performance were more receptive than those who believed otherwise (Westercamp and Bailey 2007, Scott *et al.* 2005). On the other hand, participants in other studies reported that uncircumcised men have greater sensation (uncircumcised penis in its natural state has more nerve endings) and therefore ejaculate early (Lukobo and Bailey 2007, Bailey *et al.* 2002). This could mean that perceptions and understanding of the relationship between circumcision, masculinity and sexual pleasure determines men's level of acceptability. For example, men who perceive being masculine as the ability to perform sexually, may be more receptive to MMC when it is believed to enhance masculine virility. My other interest was to explore such factors - which relate to sexuality and also meanings and constructions of what it means to be a man in my study context.

Most literature I reviewed thus far shows that acceptance of MMC appears to be context-based and vary according to how men construct their masculinity. However, among scholars this prevention technology is a far more complex, problematic and a contested (Dowsett and Couch 2007) intervention as I will show in the next section.

With high levels of acceptance in most communities as reviewed above, some scholars have viewed MMC as not the way to go – as far as HIV prevention is concerned – for various reasons. One of the detractors, Ncayiyana (2011) argued

that the evidence from the trials is insufficient and thus the promise that MC prevents female-to-male HIV infection is illusive. Moreover, Ncayiyana (2011) and Van Howe and Storms (2011) have questioned the premises upon which the intervention is based, arguing that it is a wasteful solution taking resources away from the most effective means. They also stated that it is an act that is likely to increase the number of HIV infections (*ibid*). Further critics have also been brought forward regarding the impact of MMC on women and how they benefit from this men-intended intervention. Stevens (2009) noted that men are reportedly talking about circumcision as a “natural condom”. This is the false sense of protection this scholar referred to elsewhere. Stevens (2008, 2009) further argued that this perception will increase gender-based violence because men might blame women for bringing HIV into the relationship – believing that they are immune. This concern was also expressed by Hankins (2007) while highlighting the implications of MC for women. Hankins (2007) argued that women will face a challenge of negotiating safer sex with men who perceives MMC to be fully protective.



In a conference paper on social and cultural aspects of medical MC services in South Africa, Mfecane (2010) pointed out that the provision of MMC services is a complex issue and it enters deeply into people’s beliefs about manhood, identity, belonging and social status. Therefore it cannot be treated as a mere removal of foreskin. Dowsett and Couch (2007) also argued that the whole question of acceptability is complex, adding that acceptability does not always translate into action. This means that, men can accept the intervention but this does not necessarily mean they will get circumcised. This is because MC just like other related prevention technologies ultimately relies on human behaviour (*ibid*). These authors proposed a shift from medico-behavioural methods into the focus of social and cultural impacts of introducing MMC as a public health intervention. Bonner (2001)’s work seems to be supporting Dowsett and Couch’s (2007) proposal as she emphasized that MC should not simply be seen in a medico-scientific context.

Other studies (Bonner 2001; Hankins 2007) indicated that acceptability of MMC depends on the reasons for which it is performed. Hankins pointed out that socio-cultural reasons for MC far outweigh medical ones in influencing acceptability of the procedure (2007:63). Exploring the issue of gender and sexuality in relation to MMC and HIV transmission, Berer (2007) has questioned as to which category of men will uptake the intervention considering that there are men who are already not using condoms to protect themselves or their partners. Berer (2007) went on to argue that, structural changes in the way in which patriarchal and other social norms of gender and sexuality operate, will continue to be needed, claiming further that what men do with their sexual organs remains key with or without their foreskin.

Aggleton (2007) analysed MMC intervention and viewed it as a contested terrain. He claims that there are different opinions out there regarding circumcision; thus he suggests that MC must be promoted in a culturally appropriate, rights-based and gender sensitive way. He further argues that, circumcision has its roots deep in the structure of society. Even when performed in medical settings, it is a practice which carries with it a whole host of social meanings and some of these meanings link to what it means to be a man. Circumcision is linked to deep-seated beliefs and ideologies about the social order. It has profound social connotations and long lasting physical consequences, thus it is by no means a simple prevention technology (*ibid*).

I value the arguments put forward by Aggleton, because this study explores acceptance of MMC. I presume men's opinions and meanings linked to this intervention do play a role in acceptance of MMC in a non-circumcising community. Moreover, Scheper-Hughes and Lock's (1987) work on anthropology and the body is also relevant at this stage. Their work is pertinent to this research because the body is a significant tool in sexuality and gender studies and its aspects have to be considered. Scheper-Hughes and Lock (1987) argue that, the body is both a physical and cultural artefact, so nothing can change without changing the whole. The physical body does not exist in isolation but in relation

to other bodies as well; that is the individual and the social body (*ibid*). Therefore, as Aggleton (2007) put it, circumcision is not ‘just a snip’. So, what happens to the social body when the foreskin is removed? What happens to meanings of manhood which are linked to and highly value the foreskin? These questions have a special salience for non-circumcising communities because for some, their social identity is highly defined by having a foreskin; for example the Luo of Kenya and Zulus in South Africa (Bailey *et al.* 2002, Scott *et al.* 2005, Mattson *et al.* 2005). In the next section I will outline the theory which frames the context of my study.

### **3. THEORETICAL FRAMEWORK**

#### **3.1 Defining masculinity**

This study will draw on a very complex concept, masculinity, in other words, constructions of manhood. Connell (2005) has defined masculinity as the ‘meanings’ given in any particular society to being a man. Sorrell and Raffaelli (2005) view masculinity as a set of role behaviours or responsibilities that men are encouraged to perform. The ‘set of role behaviours’ is attributed to meanings attached to being a man. Guttman (1997) defined masculinity in four distinct ways: anything that men think and do; anything men think and do to be men; that some men are inherently or by ascription considered more manly than other men; and that masculinity is considered anything that women are not.

These ‘meanings’ imply the plurality of masculinity which exists in various societies. This brings forth the argument by Connell (2005), that there are multiple masculinities. According to him, different forms of masculinity co-exist, but there is one dominating form named ‘hegemonic’ masculinity. Connell did not only recognise the diversity of masculinities but also the relations between different kinds of masculinity – relations of dominance, subordination and marginalisation. The concept hegemonic masculinity therefore refers to an ideal type of masculinity that is powerful and dominant over other masculinities at a given

time. In this case, it should be noted that, hegemony does not mean total control (*ibid*). Connell also cautioned that masculinities should not be taken as fixed categories, hence masculinities do change. Thus Morrell (2001) also agrees that masculinity is not a fixed, essential identity which all men have.

The work of Morrell and Ouzgane (2005) is also significant at this point because they acknowledge that definitions of masculinities are not uniform and monolithic, not generalizable to all men and that masculine behaviours are not natural. These viewpoints are useful because they explain the fluidity of masculinity which I have to be mindful of as I grapple with these notions in this thesis. This concept and the definitions provided will be useful in understanding how men construct masculinities in the context of MMC acceptance.

To understand masculinity in particular, it is important to also use the dominant theoretical framework, social constructionism. The perspectives referred to show that not all these 'meanings' are inherent in men but they can also be constructed. Contemporary work on men has shown that masculinity is a social construction (Connell 2005, Morrell 2001, Lindegger and Quayle 2009). This means knowledge is socially contingent and relative and not universal. According to Lindegger and Quayle (2009), men are part of society, the power of masculinity is deeply embedded in forms of social activity, giving it the appearance of inevitability and ensuring that it is naturally produced and reproduced in social interaction.

Masculinity is shaped, expressed and negotiated differently in different cultures; therefore masculinities are constructed, contested and reconstructed all the time (Connell 2005). Such reconstruction work, according to Morrell and Ouzgane (2005) needs to be informed by analysis of the ways in which men understand and enact their heterosexual desires. In this regard, it is also important to note that constructions of masculinity can be challenged by various factors, such as illness as shown by Mfecane (2010) in his work with men living with HIV. In such instances, men negotiate their way into the dominant masculinity to overcome

what may be viewed as marginal masculinity at that given time. Therefore, understanding how men construct masculinities in a social context is useful in understanding men's behaviour as well as in informing interventions around HIV/AIDS (Barker and Ricardo 2005). Hence for the purpose of this study, masculinity is also considered as a social construction. However, masculinity is not just a construction; it is also a matter of embodiment as I will show below.

### **3.2 Masculinity as an embodied reality**

In discussing masculinity as an embodiment, I find the work of Bourdieu (2001) to be largely useful to my study. He theorised gender as an embodied attribute. This concept of embodiment denotes that masculinity is an embodied experience which does not take place in a vacuum or in isolation but within our societal spaces. This embeddedness means that masculinity forms part of a set of dispositions which individuals have, hence the *habitus* (Bourdieu 1990). Our dispositions are products of our socialisation and they are deeply embedded and inherent in our bodies rather than being external. Bourdieu (1990) coined the concept *habitus* to refer to a system or set of dispositions which tend to generate all the reasonable, common-sense behaviours such as what we consider or see as normal or natural. He further argued that the *habitus* is applied to enact performance, preference and even to reproduce skills and identity depending on the context. Performing the *habitus*, which is an embodiment, can be both a conscious or unconscious act depending on the particular context or condition men - in this case - find themselves in (Bourdieu 1990, 2001). This means, men's perceptions, experiences, desires and decisions emanate from the *habitus*, in other words, they are products of embodiment. Therefore in this study, the *habitus* is applied to understand men's way of living, what is embedded in their meanings of being a man as well as how they respond to MMC intervention. Bourdieu's concept of *habitus* has been useful in framing studies on the body, men and a wide range of many other studies. Below I will look at some which are also relevant to my own work.

In their research with young boys in Cape Town, Gibson and Lindegaard (2007) focused not only on discourses and general structures but also on ways in which people “do” gender in everyday practices. This includes social relations and experiences. Drawing from Bordieu’s (2001) theory of *habitus* – also referred to as ‘hexis’ in their text - they showed how young men embody gender as well as other categories which are often translated into practices of masculinity. These embodied categories and experiences are not on the surface of the body, but deeply grounded in the being and it cannot be manipulated; it is expressed in every single move and cannot be camouflaged (Gibson and Lindegaard 2007). These authors also showed that being a man is also about being perceived as one, thus majority of young men in their study emphasised the necessity of displaying their masculinities at various levels depending on the context – such as being able to do dangerous things. Having discussed masculinity as a lived reality, I now look at various forms of masculinities particularly in an African context.

### 3.3 Masculinities in Sub-Saharan Africa

Barker and Ricardo’s (2005) research with young men in Sub-Saharan Africa has shown that there is no one African version of manhood. They showed that there are numerous “African” masculinities which can be associated with war, violence, farming, cattle-herding etc. Being sexually active, having gone through the rites of passage (circumcised at initiation school), achieving some level of financial independence, employment or income, and starting a family (get married and have children) are also some of the social requirements of achieving manhood in African contexts (*ibid*). For example, in Uganda, a man without children is considered to be a boy. This means that, when those requirements are not met, a man lacks social recognition (Barker and Ricardo 2005).

Walker *et al.* (2004) also acknowledged that there is no single way of being a man in South Africa. Masculinity norms dictate young men’s behaviour especially that which is related to sexual practices. Traditional notions of masculinity are strongly associated with risk-taking behaviour such as increased alcohol



consumption, intravenous drug use, multiple sexual partners and violence (Walker *et al.* 2004). These authors further indicated that the roles that men play in society reflect different experiences of manhood. It is also noted that different communities have varying expectations of their men; for example a religious community may promote the values of sobriety, family responsibility, restraint and spiritual leadership (*ibid*, 24). Walker *et al.* (2004) also argued that, in this context, being a man is also defined in relation to other man, women and children.

There are also plural ways of being a man in Namibia. Becker's (2005) research on masculine identities among the youth in Namibia revealed that sexual prowess, violence and alcohol abuse are central to the discursive construction of their masculinities. Marriage, having a job and being financially independent are some of the factors that the youth in her study used to describe a 'man' in this context. She highlighted the gap that exists between discursive constructions of masculinity and the lived experiences of men. She further noted that masculinity as an object of discourse may not necessarily reflect what is shaped in actual practice. Thus, as young men move between different spaces, their identities shift (Becker 2005, 34). To address this gap, Becker (2005) proposed that masculinity research need to focus on masculinities as social practices to be complemented with research methods that unduly privilege discourse over practice. This approach was applied by Gibson and Lindegaard (2007) in their research with young men as discussed above.

Sorrell and Raffaelli (2005) also explored notions of masculinity and their linkages to HIV/AIDS in Ovamboland, Namibia. Their findings show that to be a real man in Namibia (historically) meant that one should predominantly have many wives, many girlfriends, many children and wealth (many cattle, big *mahangu* field) amongst others. However, contemporary and prevailing indicators of masculinity include being sexually active, owning property (such as a car), being educated and having a job (able to provide for extended family as well). Alcohol consumption and having many girlfriends have also been viewed as symbols of masculinity (*ibid*). Sorrell and Raffaelli (2005) also claim that



activities that lead to HIV transmission are central to who men are. Thus exploring their responses to HIV prevention interventions is important to this study.

The above illustrations also evoke the notion that masculinity is an “accomplishment” (Fenstermaker and West 2002). These provoked questions like: if masculinity is achieved or “accomplished”, to what extent does MC help men to achieve their masculinity? When men are circumcised, does it mean they are now free to embrace certain aspects of masculinity which they feared to take up because of HIV risks such as having many girlfriends? Does MC help men in Ohangwena to be masculine or is it viewed as a manner in which men are emasculated? This study tried to engage with such questions.

#### **4. CONCLUSION**

This thesis explored acceptability of MMC amongst circumcised men. Many scholars have made a link between masculinity and acceptance of MMC, looking at such things as culture, sexuality and meanings of a foreskin. Masculinity has also been theorised in broad terms, showing that various ways of being a man exists in different communities. However, in this thesis, I am showing that the link between masculinity and uptake of MMC is not universal but contextual. In my study, the link does not exist and this is what makes my work different from previous work done in the context of MMC acceptance. My thesis deals mainly with men who have already undergone MMC and has been conducted at the time when these services are being offered for free in most public hospitals in Namibia. Most acceptability studies have not done so. Thus my work is not based on speculations about the likely impact of MMC on masculinity or rather the impact of masculinity on MMC acceptance. The next chapter will present the methodological approaches employed in collecting and managing data for this study. I will also discuss the challenges I encountered throughout the research process.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **1. INTRODUCTION**

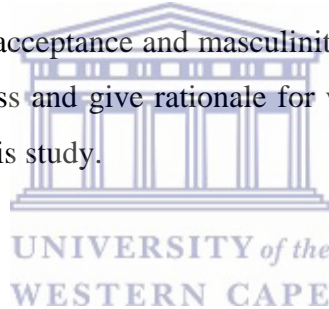
This chapter describes the methodological approach used throughout the fieldwork process. I begin by outlining the research design and research methodology employed in this study. This includes a discussion and rationale for the methods and tools that enabled me to answer my research questions. I will then describe how I accessed and negotiated my entry into the field as well as the challenges encountered with the gatekeepers and the complexity of selecting a research topic. I also discuss how I was received and treated in the field by health workers and community members whom I was in contact with and met during fieldwork. Since I dealt with a sensitive topic, I highlight the ethics observed and also some ethical challenges I experienced. This chapter further discusses my position as a researcher and nurse conducting research at “home” (Kuper 1983) both as an insider and outsider to the research field. Finally I reflect on my position in this study as a young woman researching and “invading” men’s world and the possible impact of such position on the research process.

#### **2. METHODOLOGY**

This study was conducted using a qualitative research methodology with an ethnographic design. Qualitative research was ideal for this study because it involves an interactive process between researcher and participants and also provides in-depth and comprehensive information (Babbie and Mouton 2001). My study is of an explorative nature, thus qualitative methodology enabled a search of in-depth information in attempt to answer research questions. Qualitative researchers study things in their natural settings, attempting to make sense of the meanings people bring to them (Denzin and Lincoln 2011). This ‘interpretive and naturalistic approach’ (*ibid*) is the reason why I spent three months at Engela from January to March 2012, living there and interacting with men, community

members and health workers in their own settings as an ethnographer. Ethnography is a qualitative research design which involves participation in people's lives for an extended period of time, watching what happens, listening to what is said, asking questions and in fact collecting whatever data are available to throw light on the issues that are the focus of the research (Hammersley and Akinson 1995). Ethnographic study requires the researcher to thoroughly immerse himself/herself in the community being studied (Emerson *et al.* 1995). Therefore in order to do a proper ethnography I had to 'live' and remain in close contact with my participants (whom I will rather refer to as "inhabitants" or locals) as noted by Malinowski (2007).

Qualitative research is multimethod in focus (Denzin and Lincoln 2011). Hence the use of multiple research methods in this study aimed to secure an in-depth understanding of MMC acceptance and masculinities in Ohangwena (*ibid*). In the next section I will discuss and give rationale for various methods I have used to gather information for this study.



### **3. METHODS**

#### **3.1 Participants**

Participants were all selected purposefully for the study; for example community elders. I found purposive sampling appropriate in selecting my participants because selection is done on the basis of the nature and purpose of the study (Babbie and Mouton 2001). Purposive sampling largely depends on researcher's judgement in selecting participants (Neuman 2003). Men aged 20 to 35 years were interviewed about their experiences, motivations and knowledge of MC as a medical intervention. Health workers were interviewed about their work and duties in the program as well as their experiences with clients (men). I formally interviewed seven men, two health workers and four community elders (age range 75 to 96 years). Elders were interviewed to ascertain the knowledge about history of MC. Seven men were circumcised for HIV risk reduction, save for one who

said he was circumcised during his childhood. HIV status was not a criterion for inclusion because MMC was available to all men irrespective of their HIV status. I met six male interviewees at the hospital and one at his grandparent's house. All participants were residents of Ohangwena region; some permanently while some are migrant workers. All 13 participants in total were Oshiwambo speakers, but were interviewed in a language of their preference, Oshiwambo or in English.

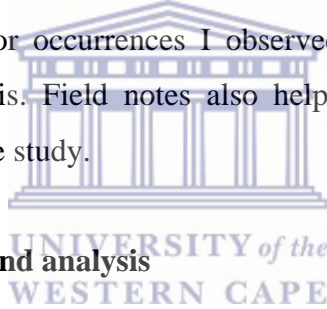
### **3.2 Data collection Methods**

Participant observation, interviews and personal diary (field notes) were the main methods I used to gather data. I also took some photographs. Commonly used by anthropologists, participant observation is liked because of its combination of empathy and detachment which allows an ethnographer to alternate the “inhabitants” or local’s point of view with an objective stance (Robben and Sluka 2007:445). As a participant observer, I spent some time at Casualty section of the hospital where bookings and procedures for MMC are done. I also went to the community whenever there are no procedures scheduled or when I have an appointment with my participants. I was working closely with the MC Nurse, therefore I also spent most times with her – on and off duty. Depending on her work plans, sometimes we would go for information dissemination around the region such as at secondary schools, at meetings with community and spiritual leaders and for radio talks at the local radio station – NBC Oshiwambo service. At all platforms, I was simply a listener and an observer where the MC Nurse always introduced me as “our researcher” (sometimes she will say: “she is doing research on circumcision”). Another part of my participatory role included booking clients for MMC and assisting with pre-operative care of clients scheduled for operation especially with paperwork and parameters<sup>10</sup>. Paperwork included obtaining consent for operation and filling out a pre-operative questionnaire. Since it is required of all men undergoing MMC to go through this process, it was during these interactions that I properly introduced myself to them and inform them about my study and ask them to participate.

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<sup>10</sup> Parameters or vital signs include blood pressure, pulse, temperature and weight.

I also utilised formal and informal interviews to collect data for this study. Formal interviews followed a flexible interview guide with open ended questions. The interview guide covered topics such as: the relationship between circumcision and HIV prevention, responses to MMC, relationship between circumcision and sexuality, historical background of circumcision in Ohangwena and meanings of being a man in Ohangwena. Interviews were unstructured, this enabled participants to express their views without restriction. All formal interviews were audio-recorded with participant's permission and lasted for minimum thirty minutes. Interviews took place at participant's homes. Time and visit to their homes was arranged at their convenience. I conducted interviews in language that participants were comfortable with – English, or in their own vernacular. The use of a journal during fieldwork complemented the methods mentioned above. I recorded mundane activities as well as relevant information that emerged from informal conversations or occurrences I observed and heard in relation to my research on a daily basis. Field notes also helped to facilitate the process of reflexivity throughout the study.



### **3.3 Data management and analysis**

The process of data analysis started with transcription of audio-recorded interviews during fieldwork. Interviews were typed verbatim to ensure that they reflect the participant's original responses to the questions. Interviews conducted in a vernacular were translated into English after transcription. After all the data was organised and transcribed, a thematic analysis approach was used to derive meaning out of it. Information was then coded and grouped into themes or categories. Coding enabled me to review and read the data repeatedly to identify recurring and emergent core themes as well as dominant responses. Reading over the data several times also helped me to obtain a sense of the overall data (Creswell 1998). I constantly referred to field notes to confirm information when necessary.

### 3.4 Limitations

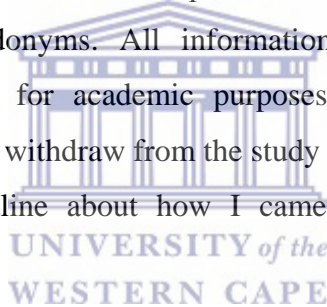
For me the sensitivity of this research topic was the main limitation. It was also not easy to observe MC at first or to openly discuss issues relating to male genitals and sexuality especially with men in general and more particularly with elders. Another limitation has to do with participants as well as the poor turnout of clients for MMC. Although I recruited about 15 men at the hospital, I was only able to get hold of seven (7) men for formal interviews. After agreeing to participate, some men dodged me or indirectly withdrew from the study without telling me because they never picked up their phones or reply to the messages I sent them. Behaviours such as not picking up a call, telling me (over the phone) they have moved out of town, being busy, denying being circumcised, and promising to call back showed indirect withdrawal from the study. I attribute these acts to the sensitivity of the topic as well as my gender as a female researcher. I will reflect on this gender aspect later in this chapter. There were clients booked almost every week but for unknown reasons, most of them did not show up on the scheduled dates. Some of the health workers reasoned that the poor turnout could be related to the weather because it was a rainy season. Considering that majority of Ohangwena residents survive on crop farming, this was a time to cultivate and work on their fields.

This study also aimed at finding out more about the history of traditional circumcision practice in Ohangwena. Most participants knew nothing or very little about this practice. However, I intended to meet with traditional leaders and also visit the Oukwanyama royal house in order to get more information on this aspect or topic of my research. When I contacted the secretary for Oukwanyama Traditional Authority to make an appointment, she told me that traditional leaders were on leave until end of March. Regarding my visit to the royal house, she advised me to write a letter specifying the reasons and intentions for the visit – which I did. Few days later when I inquired about the response to my letter, I learned that visits to the royal house were put on hold until further notice due to a theft of computers and other things on 14 March. This story was also published in

the weekly newspaper, *Confidente* (5 April 2012). No visits were allowed until the day I left Ohangwena region.

### **3.5 Ethical considerations**

The methodology and ethics of my research project were approved by the Senate Research Committee of the University of the Western Cape; Registration no: 11/10/6. I also got an approval letter from MOHSS in Namibia. (See appendix II and III) When recruiting participants, I explained the nature and objectives of the study and that participation is not compulsory. At all times, participants signed an informed consent sheet as indication that they agreed to do a formal recorded interview. Before they signed, I read through the information sheet word by word and gave participants a chance to ask questions if any. Participant's names have been changed to pseudonyms. All information collected has been kept in confidence, to be used for academic purposes only. Participants were also informed of their right to withdraw from the study anytime if they so wish. Below, I will give a brief outline about how I came to do research on men and circumcision.



### **4. RESEARCH TOPIC**

In 2010 when I decided to apply for Masters, my friend Michael Shirungu (who was doing the same program that time) told me I needed to start thinking about a research topic, since I would be required to submit a concept paper about what I intend to focus my research on before my application for admission could be considered. I had two main ideas, one was to work on men's health seeking behaviours and the other idea was related to the youth and HIV. My thoughts were much more focused on the youth and HIV. But this is a broad topic, so I started asking myself, what exactly interests me about HIV? He (Michael) asked



me the same question when I shared my ideas with him; I then explained my interest to work with the youth<sup>11</sup>.

During my nursing profession years, I met a lot of youth in my work environments. Although I nursed them, most of them became friends. They mostly asked for advice and shared their personal information with me because being a young person myself, they were comfortable with me perhaps for having demonstrated an understanding of their situations and problems as their age mate somehow. Generally in health service seeking instances, it is believed that the youth prefer to be attended to by another young person, whereas this is sometimes the opposite in some settings. Mfecane's (2010) study of men living with HIV showed that men found it difficult to open up to young, female health workers especially with regards to sexuality issues or genital problems. These men further considered health facilities as places for women, hence their preference of traditional healers who are mostly adults.

However, my passion to work with the youth also grew when I worked as a youth health program coordinator within the Ministry of Youth in Namibia. Part of my duties was to engage with the youth at different platforms on issues pertaining to their health more especially HIV. Later on, Michael suggested I read about MC as an emerging HIV prevention strategy, I was readily attracted to this topic and started searching for materials on the internet to read more. I learned that Male Circumcision (MC) has just been recommended in 2007 by WHO/UNAIDS to be part of the HIV prevention package. I thought of how interesting it would be as there was no much research done on this topic especially in Namibia. I was already looking forward to work with the youth on this topic, although this is not exactly what my study turned out to be like.

I registered for my Master programme in 2011. During my interactions with fellow colleagues or students, as we started talking about our studies and research

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<sup>11</sup> The National Youth Council Act No. 3 of 2009 defines a youth as any young person aged from 16 to 35 years old (page 4).



topics, I always shared my interest in MC. I remember getting comments like: “that is an interesting topic, or that is a good topic”. On many occasions I also agreed it was interesting, yet I now and then thought it would be challenging as well. I sometimes thought of my topic as too complex and I could probably do better with a simpler topic. At times I also felt incapable with very little research experience in comparison with fellow students who have just completed their Honours program. Thus, I at some point considered changing my topic as well. Nevertheless, I was confident with the process of entering the field, recruiting participants as well as conducting research in a hospital setting, considering my previous work experience as a registered nurse for four years. I believed and assumed that having worked as a nurse is an advantage for me to gain access to the health facilities. My assumptions were however proved otherwise upon commencing fieldwork. I will deal with this part later in this chapter. This was the time I recalled some of the comments and conversations I somehow brushed off without knowing what lied ahead of me as far as research process is concerned:

Lecturer: ... (After reading my research topic aloud) hmm, will men want to talk to you?

Researcher: (confidently) Of course yes, they have to talk to me, I will make them talk.

Lecturer: okay, good luck!!!

Researcher: thank you (with a smile)<sup>12</sup>.

The above conversation happened during research proposal development stage. I had already made up my mind that I will research on MC and men. I did not know what lied ahead of me or what was still to come. Its validity only echoed in my ears later when I was in the field receiving rejections from some of the men I intended to recruit in my study.

What I am implying at this point is that, the whole process of selecting a research topic can be complex and challenging, hence one needs to acknowledge all

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<sup>12</sup> Source: Research notes

possibilities one may encounter which would have not been anticipated. Thus, the complexity surrounding topic selection cannot be overlooked, because the nature of one's topic usually determines the approach and methods to be employed in the research process as emphasised in Davies's (2008) work on reflexive ethnography. I have learned that it is important to pay attention to comments made about one's study. Taking note that there is always a reason why any comment is made. Yet I wish not to discourage a positive attitude towards research process but my point lies with awareness and preparedness of prospective researchers as well as creating room for any methodological hiccups which might have an impact on the research process. However, the process of gaining entry into the field was a complex one; in the next section I discuss this issue and how I negotiated this entry with gatekeepers.

## **5. ENTERING THE FIELD AND NEGOTIATING GATEKEEPERS**

This study involves humans and covers sensitive issues of HIV/AIDS and sexuality. I bear in mind that, this 'sensitivity' potentially affects every stage of the research process as remarked by Lee (1993:1). Therefore I had to follow certain procedures before conducting my research in a careful and ethical manner. The methodology and ethics of my research project had to be approved by the Senate Research Committee of the University of the Western Cape. Furthermore, I also needed to get approval from the Research committee of the Ministry of Health and Social Service (MOHSS) in Namibia. Therefore, from mid-2011, I started communicating via email with one of the officials, Mrs Shaama, at MOHSS research department. She told me how to go about applying for approval and even sent me the forms I needed to complete and submit to the Ministry's head office in Windhoek.

Procedurally, I submitted my application to conduct research within the Ministry of Health by November 2011. Although I did not have all documents required yet, such as the Ethical clearance from the University, I was not discouraged. However, this process took longer than I expected. When the university re-opened

for 2012 academic year, I started writing emails to the faculty officer without getting any response until the time I personally came to inquire about my ethical clearance letter. I was only able to get the ethical clearance letter mid-January when I came back to university for registration. I then submitted the ethical clearance letter to the Ministry of Health in mid-January 2012, since it was the only document outstanding on my application. Without approval from the Ministry and while awaiting response, I decided to travel to Engela.

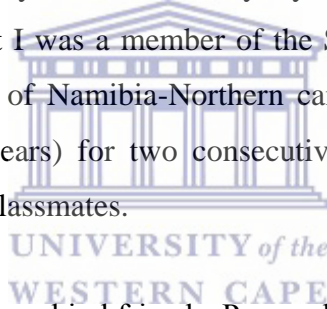
My first day at Engela was just as ordinary. We arrived at Engela District Hospital (before 8am<sup>13</sup>) with my friend who doubles as the MC regional coordinator for Ohangwena and MC Nurse. We travelled from Ondangwa which is more than 50km from Engela. She gave me a brief orientation. She introduced me to the deputy matron (Matron was on leave), the PMO (Principal Medical Officer), other officials in the hospital administration block as well as casualty department staff where she is stationed. One of the officers asked if I have been at the office of the PMO already after introducing myself to him. This is because the PMO is the head of hospital administration, while the Matron heads and manages nursing services. Hence all visitors are supposed to report or go through the PMO's office first. Both the matron and the PMO welcomed me and asked for the approval letters from the MOHSS and the university. I was only able to provide the letter from the university and informed them that am still waiting for response from MOHSS, but I only came to familiarise myself with the research area. I only received the approval letter a week later. By this time, I had already started talking to men (telling them about my study) who have been scheduled for MC that week. I also assisted the MC Nurse in carrying out some of her duties including pre-operative care and circumcision.

I was not familiar with the hospital setup of Engela, although I have briefly been there before in 2006. It was totally a new environment for me. Nevertheless I was delighted to be there, I knew a few faces especially the young nurses because

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<sup>13</sup> 8am to 5pm are the official working hours for all Government of Namibia (GRN) employees.

some were my university classmates whom I had last seen at graduation 2007. As the days progressed, I was in need of accommodation based at Engela because I could not afford to travel from Ondangwa (where the MC nurse was willing to accommodate me) every day since I had to get acquainted with the area and need to go into the community to meet more participants, like the elders and follow-up those I have met at the hospital. Moreover, as already mentioned ethnographic approach to research requires one to thoroughly immerse himself/herself in the community being studied (Emerson *et al.* 1995). A few days later, she took me to the hospital administrator and requested him to provide me with accommodation in the nurse's home. He informed me that hospital only accommodates staffs who serve 24hour shifts or emergency calls. That is the reason why he also resides outside the hospital. As mentioned already, to most of the young staff I was not a stranger. Some knew me by face and even by my name. The reason for this can be attributed to the fact that I was a member of the Student Representative Council (SRC) at the University of Namibia-Northern campus (where we did our basic nursing training for 4 years) for two consecutive years, while some were my juniors and others were classmates.



I was fortunate as one of my kind friends, Pewa who stays in nurse's home agreed to accommodate me as a squatter. It was such a relief. I could not find proper accommodation in Engela except rooms to rent which are not furnished. Another place that has places such as Bed and Breakfast and lodges is Helao Nafidi town also known as Oshikango (at the border post of Namibia and Angola) about 9 km from Engela, which I was uncertain about their safety. Oshikango is well known for its dirtiness, lots of noise and air pollution and high crime rate. Because of its booming business and trade opportunities, the busyness in this place would not have been a conducive environment for me to stay as a student. As time went on, I did not want the administrator to know that am residing in the nurse's home, until one day while we were conversing he asked where I stay and I responded that I stay in Ondangwa, although it was not the case. I did not know how he would have reacted had I told him that I am squatting in nurse's home. As I reflected on this incident later, I wondered why he asked me that question. But this did not go

further as we never conversed about this issue till the time I left Engela. I was later re-assured by my friends that my stay in nurse's home cannot be an issue to the management, since there are also staff members who are accommodating their family members, friends and sometimes even partners. I just described how I entered my field. The next section shows how other health workers received and treated me during fieldwork.

## 6. HEALTH WORKER'S REACTION(S)

Nurses received me well especially in Casualty department. They accepted me as their fellow colleague. On my first day, the nurse in charge of casualty asked if he can add me on their duty roster. I responded positively to his question, although I thought he was possibly joking. When I come late or do not come to work for one or some days, they would ask why I am late, ask where I have been or they would teasingly warn me that they will report me to the matron. Some were keen to know what exactly I am doing. They would also ask questions relating to my studies as well as professional life like where I worked before and where I will work after my studies. This was not the case with many young nurses whom I have known already. Young nurses mostly shared their desire to resign from work to go study as well. One of the male nurses told me about his son who is studying at University of Cape Town (UCT). He also shared his story about being admitted to do medicine at UCT many years ago but his parents did not want him to go to Cape Town; they told him they could not afford his studies, therefore he must go do nursing because student nurses used to be remunerated those days. One of the porters liked greeting me as follows:

*Ongeipi sestera?* (How are you sister<sup>14</sup>?)

Nurses are generally referred to as 'sisters'. Although I never used to put on uniform, this porter (in his greeting) recognised that I am a 'sister' as well. I suppose this is because he has been seeing me talking to clients and assisting the

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<sup>14</sup> 'Sister' is a form of a title generally used in hospital settings to refer to female nurses, and mostly registered nurses.

MC Nurse with some of her duties in casualty. I was also added on the trip authorities of government vehicles each time we travel out with the MC nurse. She also made sure I receive lunch packs, which are normally organised for staff when going for outreach services or any work related trip within the district or region. The next section outlines the location of the study and some of the ethical concerns encountered.

## **7. STUDY SITE AND ETHICAL CHALLENGES**

The Casualty department of any hospital is what can also be referred to as an emergency room. It is the part of a hospital where people who are injured in accidents or suddenly but critically become ill are taken for urgent treatment. Like hospital wards, casualty operates 24 hours a day. One of the vital rooms in casualty is the small or minor operating theatre where minor operations like suturing of cut wound are done – mostly the ones requiring local anaesthesia. This theatre is also called small or minor to differentiate it from the main theatre where major operations such as caesarean section are performed. Circumcision is one of the operations regarded as “minor”. Thus at Engela hospital – and other hospital settings as well, MC is mostly done at casualty department. However, the main theatre is also used depending on the turnout or list of booked men for that day or if there are more than one surgeon or circumciser (MC nurse’s colleagues like medical doctors assists here sometimes). The medical doctor on call is always stationed at casualty. Below I present one of the scenarios where I struggled to maintain my ethical role as a researcher only while working at casualty.

On one of the days, we just finished that day’s procedures. We only had two clients as the other two who were booked did not show up. The MC Nurse was busy doing some record keeping while I looked on. Two policemen entered casualty with a man, handcuffed but they still held his arms each on one side. One of the male nurses received him and ordered him to sit on one of the bed coaches. Policemen removed the handcuffs; he sat quietly and looked calm. While the two cops were giving information about this patient to the nurse attending him, he

started shouting and denying what he heard the policemen telling the nurse. The policemen mentioned that he is a known psychotic patient, with history of alcohol abuse, and he is drunk as he also smelled of alcohol. They found him acting bizarre, aggressive, his speech uncoordinated and incomprehensible. Chaos erupted; this man became aggressive and started to fight the policemen, the male nurse summoned for help. The MC Nurse quickly stood up to go help, I was a bit reluctant. He has to be restrained and get an injection to calm him down. One of the nurses was busy preparing the two common antipsychotic injections mostly given to psychotic patients in such condition; Largactil and Serenace. I was standing closely observing, while a young man entered the department with big cut wound on his forearm which was profusely bleeding. The nurse who was preparing the injections was just getting ready to inject the psychotic patient when she rapidly gave me the two syringes while she go attend to the young man with a cut wound. The male nurse was already calling this nurse to be quick before they get overpowered by this patient. I injected the patient as there was no one else to give the injection. Again, I later ended up helping the nurse to stop the bleeding and suture this young man's cut wound in the small theatre.



Although I never put on uniform, health workers including doctors and even porters knew that I am a nurse because the MC nurse always mentioned my two titles; researcher and nurse every time she introduce me especially to her fellow colleagues. In other sense, and as I will show in the next section, being a nurse made me an insider while being a researcher qualified me to be called an outsider in this context. In her work on writing against culture, Abu-Lughod (1991) argued that, in studying one's own society, the self is always a construction, never a natural or found entity. Thus, in this study my position here as a researcher was not "natural" but rather constructed as shown by Abu-Lughod (1991: 468). Hence I could not maintain that 'self' on an everyday basis. Just like Shirungu (2010) during his fieldwork in Rundu, Namibia, where he was considered as a local person; my position as a researcher was concurrently affected by my status as a nurse. I now discuss my position as a researcher doing fieldwork at "home" as well as my insider and outsider relations while doing research.



## 8. ON DOING ANTHROPOLOGY AT “HOME”

For a long time, anthropology was defined by the exoticism of its research subjects (Peirano 1998). The primitive and isolated communities have been attractive research subjects for anthropologists. Although anthropologists studied societies other than their own, from the 1970s, a gradual paradigm shift saw anthropologists around the world becoming more interested in studying their own societies and conducting anthropology at “home” (Zaman 2008:9). In Southern Africa, this alteration has only taken course from the 1990s. Thus, as Becker *et al.* (2005) related, moving into the 21<sup>st</sup> century the location of anthropologist’s field sites started shifting, the discipline has now moved from an emphasis on the exotic other to gazing upon the “other” at “home” (p 124) or even in their own societies. This may sound easy but, this does not mean anthropologists who study at “home” are not confronted with any difficulties. Several (Barret 1996; Tsuda 1998; Narayan 1993, Shirungu 2010) anthropologists who have reflected on doing fieldwork in their “home” settings have pointed out challenges they faced and problems they encountered, which they did not anticipate such as being received as both insiders and outsiders in their own communities.

Although I decided to pursue my studies in South Africa - away from home, I have never considered conducting research anywhere else apart from my home country Namibia. Not only have I seen other students do the same, but I always thought it would be such a complicated scenario to do research in South Africa because of several reasons. Firstly, I am not familiar with South Africa and its health system - because my focus is on health. Secondly, there is a language barrier which may impact data interpretation and hence the findings. Thus, I preferred to carry out my study at home. Nevertheless, the topic and purpose of study also plays a role in deciding where the research will be conducted such as in this situation. Peirano (1998) argues that, “home” as always, incorporate many meanings. In my research context, “home” refers to my home country, my homeland, amongst people whom we share same or similar cultural values and norms as well as communicating in a language that we all understand. I also



consider the hospital where I did my research as “home”. Although a hospital is a big community on its own with people from all walks of life and different parts of the country, I felt a sense of being at “home”. Because I worked as a registered nurse, I am familiar with the hospital settings, norms, practices and even the medical language. Hence, Barret (1996) argues that, ability to speak local languages, and familiarity with operational setups; particularly in the health care system (Shirungu 2010) are some of the advantages of practicing anthropology at “home”. However, “home” for me was very complex because of geographical location of my research as I will show below.

Namibia is divided into thirteen political regions. Four (Oshikoto, Ohangwena, Oshana and Omusati) out of thirteen regions forms part of a homeland, commonly known as Owamboland, located in the northern part of the country. Oshiwambo is used to collectively refer to different ethnic languages spoken by all people from Owamboland. I am from Oshikoto region and my study was based in Ohangwena region. Although our language dialects<sup>15</sup> differ, we understand each other. However, through language one can easily identify where – or which region one originates from. During my high school and university years I have been exposed to people from other regions. This is how I learned some dialects through my interactions and socialisations with friends and schoolmates. I felt privileged to be able to communicate well with community members in their own language. Most of them could not tell that I am not from Ohangwena region, some only knew when they asked where I am from.

I chose to conduct my study in Ohangwena region and specifically in Engela district because of several reasons. Firstly, the NDHS 2006-07 documents that Ohangwena has the lowest MC prevalence rate (1%) in the country. Secondly, traditional circumcision has been practiced in this region back in the days before it was abandoned around 1881 (Loeb 1962). The National HIV Sentinel Survey

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<sup>15</sup> Ohangwena region is traditionally known as Oukwanyama kingdom. The local dialect in Oukwanyama is called Oshikwanyama. My area of origin is Oshikoto, which is traditionally known as Ondonga, with Oshindonga as the dialect spoken there. Owamboland is divided in seven kingdoms (Nampala and Shigwedha 2006); a detailed discussion will be covered in the next chapter (4).

report (2010) that Engela district has the highest HIV prevalence rate (22.4%) in comparison with other hospitals in the region. Lastly, the MC regional coordinator is based at Engela hospital and for the purpose and success of my study I wanted to work closely with her and observe how she ran the program in this region.

I will share a quote below which reminded me of my “outsiderness” in Ohangwena region. This was part of my conversation with one of the elders I interviewed. As I entered her house and greeted, one of the children came to me and took me to where she was seated and offered me a seat. While approaching, she starred at me. I firstly wondered, but later remembered that am simply a stranger to her. I recognised that her way of looking at me was probably to identify me. This is a common trait or habit among elderly people. After the greetings and my brief introduction, she said:

Mukwaluvala: ... so I guess you are not from here (Engela), where are you from?

Researcher: yes am not from here, am from Onayena, in Ondonga.

Mukwaluvala: aaah, okay.....i see, but why are you not speaking Oshindonga?<sup>16</sup>

My impression of the way this elderly woman was looking at me, was that she was trying to relate me (a stranger) to people she knew. When she realised she could not associate me to people she knew, she asked similarly in a way of confirming my “foreignness” in Ohangwena region. When she asked where I am from, I believe she expected to hear of a village or area in Ohangwena because I was speaking Oshikwanyama fluently. She probably did not expect me to be from such a distant place and yet I was also not speaking the language spoken in Oshikoto region.

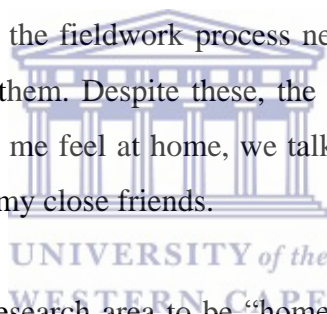
Although I did not face or experience serious challenges while doing fieldwork at a place I considered “home”, where I am as well an outsider, my friend (the MC nurse) made this comment when the hospital administrator informed me am not eligible for accommodation in the hospital:

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<sup>16</sup> Source: Fieldnotes, translated from Oshikwanyama into English.

“My friend, if you were from this region (Ohangwena), that man will not tell you that, he would have given you a room right away”<sup>17</sup>

Although I considered my research area as my “home”, the point raised by the MC Nurse reminded me of my “foreignness” in this region. Meaning if I was from Ohangwena or perhaps related to someone known there, the research process could have turned out differently. This is not an unusual thing in research, I relate to Akuupa’s (2011) work on cultural festivals in Kavango. He described how relations tied in clan affinity can open up opportunities and ease access to field and gather data. When people know “whose child you are”, or whom you are related to; they treat you in a different way as opposed to someone whom they have no connections with or do not know (*ibid*). These kinds of encounters however did not hamper the fieldwork process negatively. I had to find ways to negotiate and deal with them. Despite these, the study had to go on. Moreover, Mukwaluvala later made me feel at home, we talked openly and I found out that she is related to some of my close friends.



Having considered my research area to be “home”, I position myself as both an insider and outsider in this study. As in the abovementioned examples, my role as a nurse, researcher and a person who originates from Oshikoto coming to do research in Ohangwena region depicts my insider and outsider statuses. As an insider anthropologist, I was able to blend in, establish rapport, participate and communicate easily with my research subjects (MacIsaac *et al.* 2009). But as an outsider, I faced several challenges in relation to the ethics, methods and other general provisions such as accommodation. Being a nurse helped a lot in my research especially in the hospital setting. However, the fact that I did not wear uniform differentiated me from other nurses. Hence one of the clients we attended to one day asked me why I did not have my uniform on. This differentiation did not matter much because on days that we do MCs, we dress in theatre clothing or gowns. Furthermore, there were some days when the MC Nurse did not put on her

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<sup>17</sup> Source: Fieldnotes

uniform, so when we are together, I could not be picked out as being a nurse or not. Throughout this research, I maintained my position both as an insider and outsider, therefore I agree with Akuupa (2011) who argues that, insider-ness or outsider-ness can be relative and should be understood contextually. I now reflect on my position as a researcher and how I may have impacted on the research process including the findings.

## **9. REFLEXIVITY**

Anthropology places particular emphasis on reflexivity. Davies (2008: 4) explains that reflexivity means turning back on oneself, a process of self-reference. I am aware of how one's position as a researcher affects one's research process in a negative or positive manner. This pertains to sex, gender, class, religion, age and other aspects or categories that carry social meaning. Bell (1993) emphasised the importance of establishing relationships with participants in ethnographic studies. These relations help the ethnographer build an understanding of people being studied (Davies 2008). However, for a female researcher, it is not always easy. Caplan (1993) noted that being seen as young and single have profound effects on the encounter with the subjects of the study. This relationship of researcher-participant of opposite sex can be uncomfortable especially when they have different objectives.

For example, one of my participants CM 2<sup>18</sup> has not yet given up on 'trying his luck'. He continued calling me after my return to Cape Town. During my research, he always tried to get personal in most of our conversations. When I met him at the hospital and told him about my study, he was looking forward to my visit at his place. During the interview, he was very open to an extent of telling me about his recent break-up with his long time girlfriend. He also promised to help me get more participants through his friends. In our communications, he often invited me to his house or insisted to come see me at the hospital. One day when I stopped by his workplace to find out if he worked on the promise he made, his

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<sup>18</sup> CM 2 refers to circumcised man

response was not positive. Instead he changed the topic and started getting personal such as telling me how he believed I am the ideal woman for him.

In this study, I acknowledge that my inquiries about men's issues (such as sexual organs) may send different messages to participants who may perceive me as an outsider "invading" in men's world. My research subjects obviously did not consider me as one of them because I am a woman researching on men. However, I could not pretend to be a man or whatsoever, I have been myself and I did not put up any character to benefit me or impress my participants in any way. I acknowledge that not all men get comfortable to discuss issues of this nature with a person of the opposite sex, hence their dodgy behaviours I referred to in the section on limitations. For example, I recognised the discomfort most men experienced especially in the operating room when they are told to remove their pants, including underwear. This is one of the incidences that happened one of the days in operating room.

We were three in theatre that day; I was just observing and playing the role of a 'DJ'<sup>19</sup>. The assistant was a woman as well. While the circumciser was suturing, this man gets an erection. When the penis erects, it becomes difficult for the sutures to be properly put in place. This is what the MC Nurse said to the client:

Circumciser: (mentions his name first) *alikhana ihumbata nawa opo tu maneni*<sup>20</sup>  
(please behave yourself so that we can finish, we are almost done)

CM 6: *Ooh, owushi nee kutya omulumenhu oo kehole kukumwa kumwa, ngaashi nee eli mokati koomeme aveshe vatatu, kashipu nande kaa* (Ooh, you know that man does not like to be touched in a manner that is likely to arouse him, and to be surrounded by three women is not an easy thing)

In many occasions, the question of the gender of the circumciser has been posed mostly at public meetings, men calling in the radio program<sup>21</sup> and even by some

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<sup>19</sup> Any type of music is apparently allowed in theatre to soothe the client's mind – while undergoing the operation since it is done under local anaesthesia.

<sup>20</sup> Throughout this thesis, quotes in the vernacular language are italicized while their translations as well as quotes presented in English are written in the normal font.

of the participants I have spoken to. I will discuss this point further in chapter five. I am also aware that my participants might have withheld certain information from me because I am a woman or due to various reasons rather than as they would have if I was a man like them.

## 10. CONCLUSION

This chapter described the methodological approaches to this study. I began by outlining the design of the study. I described and gave rationale for various research methods I utilised throughout the research process. I looked at the challenging stage of selecting a research topic as it is also a determinant of the research methods to be used in the study. Accessing the field was also a challenging encounter; however I described how I negotiated my way into gaining necessary documents before commencing fieldwork. I further analysed and reflected on my position in the field as an insider - outsider in my research area and female researcher studying men. This was rather a complex position which I feel needed thorough preparation. I have also showed that researcher-participant relationships though significant for the purpose and success of ethnographic research, can be uncomfortable especially when objectives tend not to be mutual and therefore impact on the data collection process. The next chapter discusses history of MC as well as the different notions of being a man in Ohangwena.

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<sup>21</sup> The Namibian National Broadcasting Corporation (NBC) radio for Oshiwambo service runs a weekly program that focuses on health related topics or issues. NBC officials invite health workers from different disciplines in health care to share health related information with the nation. I once accompanied the MC Nurse and her two colleagues from different regions when they were invited to talk about MMC for HIV prevention. Since it is a call-in program, listeners get an opportunity to ask questions and health workers provide answers instantly.

## CHAPTER 4

### HISTORY OF CIRCUMCISION AND MEANINGS OF BEING A MAN IN OHANGWENA

#### 1. INTRODUCTION

This chapter is divided into two sections. Firstly, I will present a background history of male circumcision (MC) in Ohangwena region, among Ovakwanyama. Circumcision (also known as *ekengho* or referred to as part of *epitotanda*<sup>22</sup>) used to be a common practice for the people of Ohangwena, performed for various reasons. This practice was abandoned around 1885-1904 although it trivially continued to be practiced in other parts of the kingdom. Christianity and colonial interactions as well as colonial administration had an impact on most traditional practices including circumcision. As mentioned earlier, many of my participants knew nothing about this practice, and those who knew, did not know much as details about these practices were reportedly kept secret. Most details are forgotten because they are rarely spoken about and the generations which lived during those times have died. Therefore, what I will present here is not the comprehensive history but only the information that some of the participants could remember or were able to share during my fieldwork. The second section of this chapter deals with different versions of manhood and being a man in Ohangwena region. I therefore argue that, although circumcision practice formed part of the transition from boyhood to manhood, presently, circumcision status is not a recognised marker of real manhood in Ohangwena. At this point, I must also note that literature on the people of Oukwanyama or history of circumcision in Namibia and specifically in Ohangwena is generally limited. With exemption of anthropologist Loeb, and historians Nampala and Shigwedha, the other work I came across is published in German or Dutch.

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<sup>22</sup> *Ekengho* literally means circumcision which is a practice part of the bigger ceremony or ritual: *Epitotanda* or *okupita etanda* which means initiation or to have access to the *etanda*, “an assemblage of men”. An assemblage of men is an ancient institution held to discuss important “tribal” matters (Loeb 1962:236).



## 2. CIRCUMCISION- A CULTURAL PRACTICE

Circumcision has deep roots in African societies where it is a culturally-charged event. It is performed for various cultural, social and religious reasons. Although the original inhabitants (Khoi-San People) of this area (Africa) were never engaged in ritual circumcision, circumcision has been an important practice among the Bantu-speaking people who migrated from Central African regions to settle in this southern part of Africa (Pappas-DeLuca *et al.* 2009). This is the reason why it is part of rites of passage ceremonies in many countries such as South Africa, Angola, Kenya, Uganda, Malawi, Botswana, Zambia, Zimbabwe, Tanzania and DRC. Namibia is not an exemption: circumcision has been a ritual practice in most parts of the country. American anthropologist Loeb (1962), who wrote about Ovakwanyama and its neighbouring communities, found that all groups of people that migrated south to the country of the Herero and to Ovamboland (northern homeland) practiced circumcision. Among the inhabitants of Ovamboland young boys went through *epitotanda* as part of initiation from boyhood to manhood. People of Ohangwena region (who are Aawambo in general – specifically Ovakwanyama, residing in Ovamboland) used to celebrate and enjoy different kinds of traditional ceremonies and rituals (Nampala and Shigwedha 2006). Hinz and Hangula (2010) indicated that circumcision is one of the important ceremonies that have been practiced since time ‘immemorial’. Its inception in Ohangwena is not clearly known. In an interview with a 96 years old man, Tatekulu H, he referred me to a scripture in the Bible’s Old Testament, which he showed me in his two Bibles, English and Oshikwanyama versions and read:

“And ye shall circumcise the flesh of your foreskin; and it shall be a token of the covenant betwixt me and you”. (Genesis 17:11)

With this scripture, he further explained that circumcision is an old tradition that was practiced by the Jews and even the Lord Jesus Christ was circumcised. This practice dates back to approximately 5000 BC. Although it is not known or there are no records showing when this practice started, (specifically amongst



Ovakwanyama) what Tatekulu H said is indicative of a belief that circumcision is an ancient practice and it did not only start somewhere or initiated by someone. It is an act of following how and what the ancestors also used to live and do.

With regards to the reasons for circumcision, Tatekulu H said<sup>23</sup>:

*“Omunhu ngeenge ina kenghwa otashiti kutya ye okaana natango, okuli moipeta, oipa inai djako. Omunhu opo akule, okuya moukulunhu okuna okukenghwa. Ovanhu ohava ka yelekwa nee opo euye pouyelele.”* (Interview with Tatekulu H, 6 March 2012, Engela)

“If a man is not circumcised, it means he is still a child, he is enclosed (the penis), the foreskin is not removed yet. For him to grow into a man, he has to be circumcised. In other terms, he has to be cleansed (opened up) and remain clean.”

Removal of the foreskin was not only symbolic of growth into manhood as implied by Tatekulu H. The other reason he cited was for prevention of sexually transmitted diseases (STDs) especially syphilis (*endongo*) whose bacteria hide under the foreskin. For Tatekulu K, a 90 years elderly man, the only valuable reasons that he heard about why men used to be circumcised is also for prevention of sexually transmitted diseases such as syphilis and gonorrhoea (*oshinena*), ‘*nokupita etanda*’ (initiation). He further said:

*“Ovanhu vati ohava ka kenghwa vaka konge eenghono domayambeko, va ninge eenghulungu dokupitifa omafundula noshoyo omatanda. Ame inandi shiitavela, eenghono tadi di peni?”*(Interview with Tatekulu K 2 March 2012, Engela)

“Apparently men are circumcised in search for greater powers of blessings, to be able to lead or conduct rituals like circumcision or traditional wedding. I do not believe in such things, great power from where<sup>24</sup>?”

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<sup>23</sup>Narratives quoted in the vernacular means that specific interview was conducted in the vernacular and translated into English.

<sup>24</sup> Tatekulu K clearly explained that as a Christian brought up in a Christian home (his father was a pastor) they strongly believed that these rituals were pagan and that God is the only powerful being thus they were distant from these practices and the information he is providing is what he heard used to be done.

Tatekulu K heard that circumcision enabled men to participate in other rituals and practices of Ovakwanyama. Although he clearly mentioned that he did not believe in the issue of acquiring power because of his Christian beliefs. Rain-making or collecting rain from *Evale*<sup>25</sup> as well as conducting *efundula* (girl's initiation) used to be some of the rituals only performed by circumcised men who possessed this great special power as required.

In response to the question why circumcision used to be a practice amongst Ovakwanyama in the olden days, a health worker said:

At the beginning of this program, we inquired about the history of circumcision in this area, and we were able to get hold of the spokesperson to the royal house who told us that MC used to take place as a rite or passage of men to pass through from childhood into becoming young adult men, and they took it as a rule that is the main reason why they used to circumcise back in the days.” (Interview with MC Nurse 23 February 2012, Engela)

### 3. CIRCUMCISION PROCESS

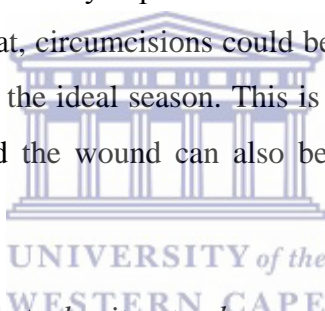
According to Loeb (1962) circumcision ceremonies in Oukwanyama used to take place about every fourth year in a sacred grove near *ouhamba* (royal house – where the King resides) when there is a high wind (*omhepo ihapu*). A high wind is indicative of winter season and it is also a sign given by the spirits in the sacred grove that the proper time for circumcision has come. Moreover, Tatekulu H mentioned that circumcision used to take place at an isolated place in a bush at *Evale*. Boys were circumcised either when they showed signs of puberty or when they were about nine or ten years, before they had nocturnal emissions (Loeb 1962: 236). The conductors of the ceremony as they go around notifying parents of boys who were to go through the rite that year said this to them:

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<sup>25</sup> *Evale* is derived from ‘*ava vale*’ (those who are tall), is a place of a river in Angola. This river could only be crossed by tall people. It has been part of Oukwanyama until the partition of the Namibian and Angola boundaries in 1917 (Nampala and Shigwedha 2006:105).

“Now you are going to be grown up men. Do not be greedy.” (Loeb 1962: 237)

The duration of the ceremony ranged from four to six weeks, and boys remained in the grove during that time or until their wounds have healed. Wounds were treated daily with herbs. Due to the secretive nature of these rites, it is not known what they usually did in the grove for that time period. I also did not come across literature regarding that aspect. Even for Loeb (1962) who studied Ovakwanyama for over a decade found it difficult to obtain detailed information about these rites, he said; most people did not care to talk about any part of the ceremony (p. 236). Circumcisions were normally performed during winter season. Tatekulu H stressed that the reason why it was done in winter season is to accelerate wound healing process, which could even take less than one week. Tatekulu K also added that the duration of the ceremony depended on how long the boy’s wounds took to heal. He also revealed that, circumcisions could be fatal if done in summer, when it is hot, thus winter was the ideal season. This is because when it is hot, healing process is prolonged and the wound can also become swollen and even septic (infected).



Loeb (1962) explained that *okupita etanda* means to have access to the *etanda*, ‘an assemblage of men’. This ancient institution of men discussed important “tribal” matters including kingdom inheritance. My participants did not know what exactly went on in the bush during circumcisions. Loeb also documents that no outsiders were allowed near the camp. No food was received from a woman, only from girls whose breasts were not yet formed. The main emphasis in the instruction given to boys was on the importance of secrecy. Women and children were not told what went on in the camp (*ibid*). He further noted that, circumcised boys were still considered as ‘youth’ until they were thirty years or older at which time they were then prepared for marriage and eligible to own a kraal.

Another participant CM 3 also shared his views about the history of circumcision in Oukwanyama. He said he know that men were circumcised as part of *okupita etanda*. He further related that traditionally, there are things called taboos in

society. These are things which are not spoken about or things which no information or further details are revealed as to why such practices are being done. Therefore, he added, we do not have information today because men were not clearly told why they had to be circumcised. It was a taboo to talk about what happens at Evale - in the bush. This links in with the work of Namibian historians Nampala and Shigwedha (2006) on history and cultural change of *Aawambo* kingdoms. They stated that, in Oshiwambo culture there were lots of things that young people were not allowed to question, but had to follow blindly. Because of that people ended up only following the orders without knowing why, and perhaps those who had such information died without sharing it (*ibid*). This reason was also supported by Talavera (2007) in his study of sexuality in Northern part of Namibia. He pointed out that subjects about or related to sexuality – including manhood were considered to be taboos, thus parents never discussed them with their children. Thus, no detailed information about what exactly used to happen in the sacred grove is known to many.

As already mentioned by Tatekulu K, requirements for the circumciser or '*omupitifi*', the one who officiates or is in charge of the ceremony is that he must be circumcised. Besides being circumcised he must naturally have a "good hand" (*oshipewa* – a given talent) in the way he handles everything. He made comparison with "*okulutula*" (castration of animals). Tatekulu K also said those with *oshipewa* when they cut, wounds do not swell or bleed excessively and they also heal fast. And so that is the criteria used to pick or choose *omupitifi wekengho* in Oukwanyama. In addition, Loeb (1962) revealed that circumcision rites were highly secret and those who officiated wore masked disguises. At the ritual, there was more than one leader to conduct the ceremony. These leaders are directed by *omupitifi*, who is their chief and a medicine man in charge of the ritual (*ibid*: 237).

Among Ovakwanyama, circumcision had never been compulsory but was meant for the boys of the wealthiest and of the chief's family or king's clan (Nampala and Shigwedha 2006). As one of my informant Tatekulu H said: "*Oshilongo*

*ihashi nangalwa komunhu ina kenghwa, ekengho okwali oveta yoshilongo*”, meaning “the kingdom is not ruled by an uncircumcised man, circumcision was one of the rules or laws of the kingdom (land)”. All the kings who reigned in Oukwanyama have been circumcised. Tatekulu H continued to explain that the last king to be circumcised was Haimbili Haufiku. After the death of his maternal uncle Haihambo yaMukwanuli, Haimbili was supposed to take over as the new king of the Oukwanyama kingdom. It was discovered that Haimbili was not circumcised because he has been exiled in his childhood (Loeb 1962). Therefore he could not succeed his uncle. Hamangulu yaNaivala, a nobleman (*elenga*) was asked by Haimbili to rule in his stead. Haimbili was not pleased with him (Hamangulu) because he despised him (Haimbili) for his weakness to refuse the throne, so he secretly went to Evale to be circumcised. That is when he was able to take over the kingdom from Hamangulu. Haimbili then drove Hamangulu out of the kingdom. Tatekulu H could not tell or remember how long Hamangulu reigned as king of Oukwanyama.

During Haimbili’s reign, a great circumcision ceremony was held and every man in the kingdom was forced to be circumcised. This was the last ceremony held because after his death, there was no more circumcision rites in Oukwanyama (Loeb 1962). Those who wished to be circumcised travelled to Angola where these ceremonies are held until today. According to Loeb, King Haimbili died in 1859, after ruling for 40 years. His successor King Mweshipandeka ya Shaningika (Haimbili’s nephew) was never circumcised. When Haimbili came to the throne, he killed his two brothers and drove his sister and her son (Mweshipandeka) out of Oukwanyama to a non-circumcising kingdom (Ondonga) at that time. Upon Mweshipandeka’s return to Oukwanyama after Haimbili’s death, he refused to undergo circumcision. Members of the community also followed his example (Nampala and Shigwedha 2006). These incidences have thus resulted in the end of circumcision among the Oukwanyama kings.

However, there are also other factors which have contributed to the disappearance of this practice. Nampala and Shigwedha (2006) found that circumcision was

abandoned around 1885-1904. But Loeb's (1962) writings suggests that circumcision rites stopped around 1861-1881, during the reign of King Mweshipandeka. Generally, it is acknowledged that looking up to the leaders in many societies is a norm. The refusal of King Mweshipandeka to be circumcised is seen to have given a bad reputation and negative message to community members and a form of disrespect of the ritual by people who are supposed to continue upholding it (Nampala and Shigwedha 2006). The silence or secretive nature of the practice meant that many people in the community probably did not know much about the significance of the ritual. This must have contributed to the ritual losing its meaning as people were only adhering to the rules without questioning. Nampala and Shigwedha (2006) also argued that because circumcision has never been compulsory among Ovakwanyama, it could probably be one of the factors that also led to its disappearance – that lack of enforcement. Furthermore, Evale where circumcisions used to be done was invaded by the Portuguese in 1912. Nampala and Shigwedha (2006) suggested that this invasion could have disrupted the ceremony including others such as that of rain-making. The sacred grove at Evale then fell into disuse. This invasion led to the formation of the current Namibian and Angolan border in 1917 after the death of the last King of Oukwanyama, Mandume yaNdemufayo. Mandume was killed in a battle with an intention to remove him from kingship. The colonial administration replaced the kingship with a system of headmen-in-council (Loeb 1962, Becker 2007). In 2007, Oukwanyama saw the return of kingship in the kingdom with the inauguration of Queen Martha Mwadinomho yaChristian Nelumbu who is currently reigning. It is interesting that in the history of Oukwanyama kingship, she is the first female to rule the kingdom.

In addition, Tatekulu K related the abandonment of circumcision to the arrival of missionaries in Oukwanyama and the consequent spread of Christianity. Missionaries established schools which were not only for education but as tools for evangelism as well (Nampala and Shigwedha 2006:85). German missionaries arrived in Oukwanyama in 1891 during the reign of King Namhadi ya Mweihanyeka. During World War I, the Finnish missionaries later took over from

the German missionaries in 1920. On the impact of Christianity on circumcision, Nampala and Shigwedha stated:

“Missionaries had a negative attitude towards African traditions; they sought not only to convert heathens into Christians but also to convert Africans into Europeans. This caused many of the traditions in the north to be forgotten and abandoned, not so much because of theologically based criticism but rather because of the cultural imperialism of the early European missionaries” (2006:7).

Missionaries clearly viewed Ovakwanyama rituals and ceremonies as pagan and contradictory to the teachings or standards of Christianity. These authors further added that culture was looked at as backward and retarded. However, Tatekulu H pointed out that circumcision has not stopped completely in Oukwanyama. Ovakwanyama residing on the other side of the border (in Angola) still practice circumcision. Nampala and Shigwedha (2006) also revealed that circumcision still takes place among Ovakwanyama of Southern Angola. During my fieldwork, I met a client at the hospital who informed me that before the state hospitals started offering MMC he planned to go to Angola for circumcision with his friends. He later changed his mind because of fear of pain. He said he wanted to be circumcised because of foreskin problems but he heard that it is a very painful procedure. I sensed there was more to this, but the client did not open up more with regard to his intention to get circumcised in Angola. He also could not say more on what happens there apart from *ekengho* because things like that are kept secret, even those who have been there did not share more details with him.

It is clear that there are multiple reasons and factors which contributed and led to the disappearance of ritual circumcision in Oukwanyama – beyond the southern border. A ceremony that was once respected has lost its value and today’s generation know very little or nothing about it. However, when circumcision died out, migrant labour became an alternative rite of passage for young men and boys in Oukwanyama (Nampala and Shigwedha 2006). Presently, without ritual circumcision and migrant labour system, what is the current rite of passage for young men and boys in Oukwanyama? Who is a real man and who is not? The



next section will attempt to answer the abovementioned questions as it deals with different versions of being a man or a “real” man in Ohangwena.

#### 4. BEING A “REAL” MAN IN OHANGWENA

Many African societies practiced MC as a transition from boyhood to manhood. A circumcised man was considered to be a “real” man. History of circumcision in Oukwanyama also shows that an uncircumcised man was not regarded as a real man. However, my research findings indicate that circumcision is currently no longer a recognised marker of real manhood among Ovakwanyama. This can be viewed as a sensible or expected finding considering the fact that circumcision is no more a ritual practice amongst Ovakwanyama. Having said that, question is what are the determinants of real manhood in present day Oukwanyama? To what do men in Oukwanyama associate their manhood since the abolishment of ritual circumcision up to today?

Nampala and Shigwedha revealed that, after the abolishment of circumcision in Oukwanyama, migrant labour provided an alternative rite of passage by which young men who survived the experience could be accepted as “real” men upon their return (2006:92). Mukwaluvala, an elderly woman explains who is a real man:

*“...ngaashi nee nale nokuli, ovalumenhu monale okwali hava talwako,...ndishi monale nale shinya ovalumenhu okwali havayi koushimba, havayi kouhwi tavaka longa, oshikefa ta shuuya opo shomulumenhu owuwete ngoo nokutya omulumenhu aka longele. Ndee ngeenge oshiima evaya ngoo layile koima otali diko ngoo nokashako... ndee omulumenhu elela mefimbo nee ngaashi loomeme noomeekulu, ngeenge omulumenhu adja koushimba wopomukunda apo, aaye nedimba loushimba otali nyika po ngoo. Ngeenge omulumenhu shili elitumba, omukulukadi winya emupa ngoo ofewa, eenda penya ounona okwe va pa nandouleke, ngeenge nokuli omunhu elitumba lela lela, nomukulukadi umwe wopomukunda otemu etele ngoo ekumbafa. Ndo ovanhu otave mu tongo noovo, ooh, ngadi omulumenhu. Oshinima otashiyi ngoo okawi nokawi, ye omulumenhu*



*ngoo shili shaashi ota longo, oha kwafa.*” (Interview with Mukwaluvala 22 February 2012, Engela)

“During our times and those times of our parents, men used to go work far from home, recruited through the contract labour system. So when their contracts come to an end and they return home, the arrival of a real man can be sensed all around the village. But if he is a mere coward he will just return with a simple sac. But a real man will arrive with loads of luggage and cases of all the things he worked hard for while away from home. He would generously give different kinds of gifts (blankets, sweets, soap, sugar etc) here and there especially to the elders in the village. In the process, all that he does and gives becomes the talk of the village and people will start talking like, yes, that one is a real man, and so he is truly identified as a real man because he is helpful.”

Hishongwa (1992) wrote about the contract labour system in Namibia and revealed that, contract workers were recruited from all parts of Ovamboland, but areas such as Oukwanyama provided most of the labour force. This means that most young men from Oukwanyama worked on contract labour in the mines, factories, on railways, commercial farms and also as domestic servants (*ibid*). However, with increased clashes between Christianity and Owambo culture the missionaries at that time opposed this practice as well, claiming that it would lead to divorce because the contract system used to last from 12-24 months, and this was a long period for a man to stay away from his family (Nampala and Shigwedha 2006). Another reason is that contract labour had a tendency of becoming a continuous practice because of men’s need to work and provide for their families. Men would go on their first contract, when it ends they return home and stay for a while before going back to take up another contract.

Tatekulu K also told me of his years as a contract worker. He worked in many places, almost in all corners of Namibia. To him, contract labour was a requirement for a growing up men. When a man grows up, parents remind him of his obligations, which is to work, provide and live an independent life. Through contract labour men were able to earn a living, support their families and be able to marry and provide for his wife and children with the little wages they earned.

He added that, if any young man has not gone to work out of Ovamboland or *koushimba*, he was regarded as *evaya* (coward).

Sorrell and Raffaelli (2005) exploratory study of masculinity in Namibia found that their respondents acknowledged the past (traditional) and present (contemporary) ideals of masculinity in Ovamboland. Having talked about the past, Mukwaluvala explained what constitutes contemporary masculinity at the same time also showing a trajectory of how meanings of a ‘real man’ changed over time. She said:

*“Pefimbo lopaiŋe ngee taku tiwa omulumenhu elela, ihaku talwa koinima oyo yanyika omakengho ile koinima yoilyo yomunhu. Omulumenhu elela ongeenge ashike ena eenghono, ile omupenda moilonga yaye ngee talongo, ile ...hadulu okukwafa ovanhu, hakufa ovanhu uufyoona mepata, ...nande opwa fya omunhu, otadulu oku fiilwa ovanhu, ota dulu oku tekula ovanhu.”* (Interview with Mukwaluvala 22 February 2012, Engela)

“Nowadays, meanings of a “real” man do not consider circumcision or anything related to reproductive organs. A “real” man is the one who is strong, brave and hardworking or the one who is helpful, and able to solve or assist in solving family problems. Even in death, he is capable of looking after or taking care of orphans/widows (in his family) or other family members when in need.”

The above description of a “real” man constitutes features that relates to contemporary issues such as family responsibilities. Since the migrant labour system has now been decolonised, this means men no longer need to show their manhood by surviving harsh working conditions of migrant labour. Ideals of being a “real” man are now located in the current circumstances of life. This demonstrates the fluidity, plurality and multiplicity of masculinities – which exists within societies - as documented by various scholars (Connell 2005; Morrell 2001; Morrell and Ouzgane 2005; Mfecane 2008) of gender and related aspects. Courtenay (2000) and Lynch *et al.* (2010) also recognise that masculinities are socially constructed, thus they are not natural attributes or inherent in men. In addition, Sorrell and Raffaelli (2005) views masculinity as a set of role behaviours

that most men are encouraged to perform. The performance nature of being a man is emphasised by Mukwaluvala when she said:

*“Ito dulu kumona omunhu omulumenhu elela shaa ngoo ta dedauka apo ye ehena eshi ha longo po, ye iha eta po sha. Ka shina nee mbudi kutya okwa kenghwa ndee kena eenghono dasha, omunhu ashike eli poima oulumenhu waye owa talwa ashike moilyo yaye.”* (Interview with Mukwaluvala 22 February 2012, Engela)

“You cannot tell that someone is a “real” man if he is not helpful. A helpless man even if he is circumcised remains a coward. He can only be called a man because of his biological organs, it doesn’t matter if he is circumcised or not, if he does not do something or perform anything that will make him to be identified as a “real” man, he remains as such: helpless and useless man at home who does nothing.

This means that for one to be a “real” man, he must be seen performing roles that are considered to be indicative of real manhood. It is clear that some of the roles expected from men are not always of a personal nature but are sometimes prescribed by society, such as working, getting married and having children.

In his explanation, 35 years old CM 3 perceives real manhood as the act of doing good things, which he said are nowadays viewed by many as boring. He added that, young men of today are mostly involved in drinking alcohol at bars, fighting and having a lot of girlfriends. Things that he considers dangerous and evil, but for most young men they view such acts as good for true (real) man to engage in; the evil has replaced the good. He further said:

“...in reality a true man is just the one who is doing good things. You know the good things are seen to be boring but these things of being seen around with many different girls, chilling and apparently enjoying life that is what people say real man do. But in the end, life is complicated. Again, there is this thing of wealth, people who focuses on material things (such as cattle, cars) are mostly used or influenced by the evil spirits, they tend to be careless, loses their dignity and they no more aim on constructive or doing good things in the right way. Now

it seems like when one is referred to as a real man, you should know that things are not well with that person, there are more negative than positive acts or behaviours. Some purposefully do such things because they know in the eyes of other people; he will be a real man. (Interview with CM 3, 21 February 2012, Omafo)

The ideas raised or expressed by CM 3 constitute indicators of contemporary masculinity which he perceives to be harmful due to the negative consequences which may arise from performing such roles or behaving in such manner. However, to other men these features are associated with being a real man. Although they are aware of the dangers related to the lifestyle they chose, fear of being stigmatised or isolated from their peers and to be called names pressurise them to do what they do in order to achieve manliness and conform to dominant constructions of masculinity in their communities.

Describing who a real man is did not seem to be an easy task for some of the participants. “*A man is just a man*”, was what other men could express as they struggled to put words together and come up with a detailed explanation or description of a real man. Another participant, CM 2 pointed out that being a real man is being careful and taking precautions especially with regards to prevention of diseases such as STDs including HIV/AIDS. Here, CM 2 speaks within a health context because he went on to emphasise the importance of knowing one’s HIV status in order to qualify being called a “real” man. To him, a healthy man is a real man.

Another participant CM 4, 27 years old young men shared similar views as CM 2’s:

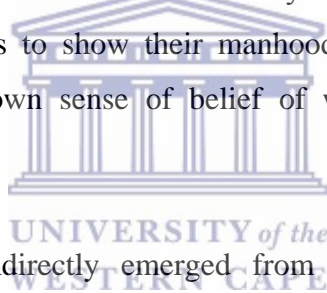
Researcher: So to you, who do you consider as a real man, besides being circumcised or not?

CM 4: To me, I think that one depends on the individual. At this moment, a real man is the one who is circumcised showing that he cares about his health and that

he also wants to prevent infections from getting to his girlfriend. For me, a caring man is a real man. (Interview with CM 4, 27 March 2012, Engela)

In the above illustration, it is clear that meanings of a real man are highly individualised and also contextualised. Both CM 2 and CM 4 construct real manhood from a health perspective. Constructions of masculinity can thus be positioned in any context within which one wishes to express himself as seen above with CM 2 and CM 4.

As for CM 1, a real man is the one who has experienced physiological changes of showing that one is growing up, "*akopola*": such as deepening of voice, facial hair and pimples in the face shows that one is growing from boyhood to manhood. He further explained that material possessions such as cars, cattle, children and wives depends on people's beliefs and how they want to be looked at. Those who do not possess materials to show their manhood are also men physically and naturally and in their own sense of belief of what they consider being real manhood.



Material possessions indirectly emerged from young men's responses. For example, CM 5 said:

"A real man is the one who is independent and work hard to be able to provide for himself. But for me, educated or uneducated, a real man is the one who is not sitting idle doing nothing and waiting for example for a job to come look for him". (Informal conversation with CM 5, 27 March 2012, Engela)

As for CM 6, "a real man is not a coward, it is the one who stands up for himself and go for what is (yours) his".

In this sense, hard work is seen to be consolidating what it means to be a man. When a man has worked hard enough to be independent, then he can afford to own properties and other materials including cars and houses.

## 5. CONCLUSION

This chapter dealt with a history of male circumcision among Ovakwanyama of Ohangwena region. Although it is not detailed, I suggest there is a need for more information on this interesting topic. This will probably not be an easy process considering the secrecy surrounding these rites. Findings show that, circumcision is no more recognised as a marker of real manhood in present day Oukwanyama. Circumcision was mainly practiced as part of initiating boys into manhood. It was a precondition for all Kings, until the time it was abolished. There are several reasons and a series of events which led to the abolishment of circumcision in Oukwanyama. However, since circumcision lost its value as a ceremony in Oukwanyama, there has been no recognised dominant indicator of real manhood. Constructions of masculinity have changed over time. As Nye (2005) argued, the presentation and performance of gender is inherently unstable. Traditional ideals of masculinity are not wholly embraced as contemporary ones are becoming more dominant. Definitions of being a man appear to be individualised and contextualised. Thus we see that versions of being a real man differ in societies, contexts and among individual's practices. Hence I maintain that, masculinity is performed and it is mostly in the doing in which we observe reality, rather than in discourse. The following chapter will present general responses to MMC intervention. I will also look at various factors encouraging or discouraging men to accept and uptake these services.

## **CHAPTER 5**

### **ACCEPTABILITY OF MEDICAL MALE CIRCUMCISION**

#### **1. INTRODUCTION**

The previous chapter dealt with historical background of circumcision in Ohangwena and constructions of masculinity. I concluded that in my research context, circumcision no longer play a role in constructions of masculinity. In this chapter, I discuss men's general responses to Medical Male Circumcision (MMC). I argue that men's constructions of masculinity have no impact on their acceptance of MMC. Instead men are motivated by health benefits in accepting MMC. Their understanding of the relationship between MC and HIV infection also determines their level of acceptance. I also tease out factors discouraging men's uptake of these services. Furthermore, this chapter analyses gender, sexuality and biomedicine perspectives in relation to MMC and argue that the current implementation of this program is not gender sensitive. I also found that MMC acceptance in this society is as well influenced by the emphasis put on the intervention by health workers in educating and promoting MMC at various platforms (for example on radio, at information sessions and community meetings). Men are the direct custodians of this intervention and therefore their responses which determine their level of acceptability needs to be essentially explored.

#### **2. RELATIONSHIP BETWEEN MC AND HIV PREVENTION**

In exploring men's acceptance of MMC, I first assessed their understanding of the relationship between MC and HIV prevention. All participants knew and understood the relationship between MC and HIV prevention. However, their knowledge and understanding varied and also depended on how they became aware of this information, which plays a role in MMC acceptance. All participants knew that MC reduces the risk of acquiring HIV infection during heterosexual



intercourse. Some could clearly cite that risk reduction is by 60%, while others could not remember the exact percentage although they said they have heard about it. Quotes below show how some men responded when asked about their understanding of the relationship between MC and HIV prevention:

“I got this information through radio and television. They say that a circumcised man has got few percentage of contracting HIV ...not only HIV but also some infectious diseases ...apparently if you are not circumcised the foreskin is still soft and it can break easily. I understand that it is really helping us.” (Interview with CM 3, 21 February 2012, Omafo)

“...MC and HIV are actually related ...when you are circumcised, then you have 60% safety from being infected by HIV. But it is not necessarily that it is guaranteed that okay, now when you are circumcised, now you no longer need to maybe use a condom. For me I can say it is just an additional to the previous or existing prevention strategies, so MC is part of prevention. Thus I will say MC alone is not enough...” (Interview with CM 1, 14 February 2012, Eenhana)

“yaa, you know like me myself I am a man, I know it is natural for a man to have a girlfriend, to have sex, and it is not 100% guaranteed that every time you will have sexual intercourse you use condoms. Again there is this STDs including HIV, according to myself, I want to be a healthy man...” (Interview with CM 2 29 February 2012, Omafo)

Although CM 2 sounds vague in his explanation, one can tell that he is informed and he understands that as a sexually active man, MC can serve as a sort of ‘back-up’ for him when he is engaged in unprotected sexual intercourse. While for CM 1 it is an additional measure to the already existing preventative strategies. Apart from being protected from HIV, some men specifically mentioned other sexually transmitted diseases which can also be prevented when one is circumcised. These men also recognize that MC is not 100% protective, hence CM 1 pointed out that there is a need to employ other preventative strategies or methods such as condom use as MC alone is not sufficient for one not to acquire HIV infection. Judging from their responses, these men seem to have also considered that condoms are also not 100% protective, thus their desire to have a sort of ‘double’ protection.



Another participant shared his understanding while at the same time he relates about the risk associated with being uncircumcised:

“I heard if you are not, it’s a bit risky, those stuff can get dirty even if you are having unprotected sex. ...It’s only about safety, ...let me say if you are (circumcised) then... ..it is not so easy to be infected ...and with the spread of diseases like STDs, you are on the safe side. But who knows?” (Interview with MP 1<sup>26</sup>, 7 March 2012, Engela)

MP 1’s response is quite complex and ambiguous. He could not speak openly to me, something I associate with the topic of research and my gender as discussed in chapter three. As much as he regards MC to be about safety and being uncircumcised as risky, he still questions: “who knows?” His question reflects a degree of uncertainty which is likely rooted from the fact that MC only reduces risk by 60% and it’s not completely protective. On the other hand, he probably has personal doubts about the intervention which he perhaps withheld from me. Since I met MP 1 at his grandparent’s home, I am not sure about his circumcision status but rather relied on his (verbal) own assertion that he is in fact circumcised. Genital examination was not part of the study’s methodologies; hence I did not go to an extent of inspecting his genitals to confirm his claim. This act would have contravened the ethics of the study as well as the participant’s right to privacy. Apart from one participant who was not circumcised yet, I was certain about other men because I recruited them at the hospital. Having been present during their operations gave me surety regarding their circumcision status.

I have shown how men understand the relationship between MC and HIV infection. As I will discuss below, men’s understanding of this relationship determined their acceptability of MMC. Their level of acceptability enhanced their likelihood and willingness to be medically circumcised. Therefore, I now look at the factors encouraging men to be circumcised.

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<sup>26</sup> MP refers to male participant

### 3. FACTORS ENCOURAGING MMC UPTAKE

#### 3.1 Reduced risk of HIV infection and other STDs

The primary and most recognized motive for MMC is to reduce men's risk of acquiring HIV infection during heterosexual intercourse. During health education sessions at the hospital given to men before being circumcised, the first and one of the main questions posed by the health workers is; why do they (men) want to be circumcised? Men generally responded that they want to be circumcised so that they can be protected from HIV/AIDS. The same question is also found in the pre-operative questionnaires, where options are provided from which men can choose one or more answers. When completing questionnaires<sup>27</sup> I have observed that before any other reason, reduced risk of acquiring HIV infection was always the number one choice for most men.

Great emphasis is placed on this benefit through educational campaigns, promotional messages on radios, televisions, in newspapers as well as pamphlets and posters found in a number of public institutions. These activities all point to this benefit: reduced risk or protection against HIV infection as a common reason for men seeking MMC services. To complement men's responses, I also asked the MC Nurse about the most common reason why men come for MMC, she said:

“...the one that I mainly come across is, everybody will say, no, I want to be protected against HIV. ...so at least, maybe most of them understand that MC has a certain degree of protection against the HIV and that is one of the main reasons why most of them come. But then at the end of the day we still tell them that despite you being circumcised, you can still get the disease especially if you do not protect yourself and you take part in risky behaviours. But the one most common reason is protection against HIV.”

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<sup>27</sup>I have already explained in chapter two that I recruited men during pre-operative interviews, in which I participated.

Being the leading reason for MMC acceptance and regardless of other benefits MMC has to offer, some participants expressed that there is a component of fear (of HIV) in men. Some participants and clients I spoke to had this to say:

“I don’t think men are going for circumcision to become real men or whatever. Now the information is well clear, the reasons for circumcision are well known... They go because they are afraid of AIDS” (Interview with CM 3, 21 February 2012, Omafo)

Mukwaluvala also commented on MMC acceptance with regards to HIV infection:

*“Ovanhu otava pewa omauyelele unene ngoo moradio, nokongeleka. Ngaashi ounona vomeumbo lange, navo ovalombwelwa ashike kutya eshi tamuka ningwa ngaho, omolwomukifi woAIDS. oAIDS hava lombwelwa, opo yiheva kwate. Pokapuna nee ou ahala okukwatwa koAIDS ndishi, ovanhu aveshe oha ve yi tila. Vo ohava lombwelwa ngoo kutya oAIDS ohayi di momilele.”* (Interview with Mukwaluvala 22 February 2012, Engela)

People are getting information from radio and even at church. Like the children in my house, they were also told that circumcision is for HIV/AIDS prevention. So they are told about AIDS, so that they don’t get infected. There is no one who wants to be infected you know, everyone is scared of AIDS. But they are also told that AIDS spreads through sexual intercourse.

CM 3 stresses out that unlike in the past, like with the practice of ritual circumcision<sup>28</sup>, the reasons for MMC are well known and people understand this practice. Good understanding forms a basis for decision making and thus enables people to make informed decisions. Mukwaluvala shared the similar sentiments. HIV is known to be a deadly disease which has infected many people and affected many others in different ways. Fear for HIV/AIDS is embedded in what people

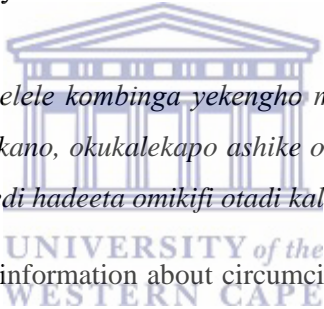
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<sup>28</sup> In the previous chapter (4) CM 3 related to how the reasons for ritual circumcision are not well known and even kept as secret, adding that men were not told the exact reasons or clearly why they were being circumcised.

know especially from their personal exposures and observations around them or their societies, despite being well informed about HIV/AIDS.

### 3.2 Genital Hygiene

Secondary to HIV prevention, men also sought MMC to improve or maintain personal cleanliness specifically genital hygiene. Hygiene of the penis is generally recognised as of great importance because of the unlikelihood of the circumcised penis to collect or hold disease causing agents like bacteria or virus. In their study on perceptions and attitudes towards MMC in Namibia, Pappas-DeLuca *et al.* (2009) found that, the foreskin was viewed as a trap and host for bacteria to hide. Therefore male circumcision is associated with cleanliness. One of the participants explained why he wanted to be circumcised:



*“Eshi nda uda ouyelele kombinga yekengho mo radio, onda tokola opo naame ndi kenghwe. Elalakano, okukalekapo ashike oukoshoki... Ngeenge owa koshoka nena neembakiteli edi hadeeta omikifi otadi kala kokule.”*

“When I heard the information about circumcision, I decided to get circumcised as well. The purpose is just to maintain hygiene. ...the cleaner you are the safer you are and the further you keep bacteria that cause infections (diseases).”  
(Informal conversation with CM 6, Ongha Health Center, 2 February 2012)

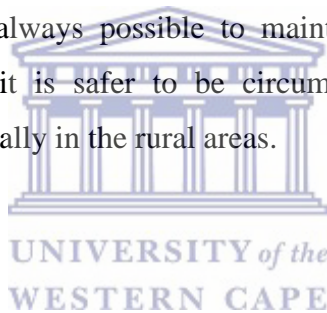
Other participants also shared their views about MMC and genital hygiene:

“For me it’s like something healthy, as I said that it’s not so easy to be infected by so many diseases. To me I think it’s the right thing to do. I think it is better man, cos it’s like you are always clean you see, it’s not like the others who are not”. (Interview with MP 1, 7 March 2012, Engela)

“...being circumcised it’s not only about HIV, it is also about the cleanliness. When you are circumcised, when you are even bathing, the way you clean yourself is easy compared to the person who is not circumcised and we talk also diseases like STIs and other things. So if you are circumcised then you are on a

safer side, when you look at it that way. That's how I look at it myself, personally, I actually appreciate it..." (Interview with CM 1, 14 February 2012, Eenhana)

These two participants both acknowledge the cleanliness associated with being circumcised. They appreciate the practice as well as the benefit of being "clean" hence, they even feel privileged than those who are not circumcised. Genital hygiene is considered to be a pre-requisite for prevention of STIs acquisition and transmission (Pappas-DeLuca *et al.* 2009). Lack of proper hygiene exposes or makes someone prone to infections. In their study, Pappas-DeLuca *et al.* (2009) also found that their participants had a general understanding that a moist and closed environment of the foreskin contributes to the growth of disease causing agents and may result in negative health consequences. Some of my participants admitted that it is not always possible to maintain personal hygiene hundred percent, thus they felt it is safer to be circumcised, considering unexpected shortages of water especially in the rural areas.



### 3.3 Medical conditions

MC is a recognised surgical procedure for correcting medical problems related to blockage and pain associated with urinating especially in young boys (Pappas-DeLuca *et al.* 2009). In such cases, health workers (doctors or nurses) are mostly the one who recommends MMC based on their patient's diagnosis. In this study, I met and talked to some men who came for MMC upon recommendation by the health workers. One of them related:

*"ondakala ndina oupute koulumenhu wange. Onda pangwa oikando ihapu, ndee ohava kala nawa ndee tavaaluka natango. Ovapangi ova lombwelenge kombinga yekengho, andi tokola nee kutya onda hala okukenghwa."*

"I have been having these ulcers and lacerations that come and go, I was treated several times but they kept on coming back. The nurses told me about circumcision, so I decided to get circumcised.

One of the clients also had recurring ulcers and lacerations on the glans penis and the foreskin as well. After being seen by the doctor and treated several times for this condition, the doctor recommended circumcision for him and referred him to the MC Nurse for the surgical procedure. Because of his medical condition, his operation was deferred until he was treated and fully recovered. Besides, the National Policy on MC stipulates that MC should be delayed for clients who are diagnosed with medical conditions (such as recurring STIs) pending complete treatment and recovery.

CM 4, one of the participants explained that, besides being circumcised for health and hygiene benefits, he also had problems with his foreskin:

“My foreskin was too short; it did not cover the whole head (of the penis). I also use to get lacerations sometimes, and when the foreskin stretches (during an erection), it sometimes results in scratches that later becomes small wounds.”  
(Informal conversation with CM 4, 22 March 2012, Engela)

With his understanding, CM 4 is aware of the fact that when someone is circumcised, the head of the penis is always dry, so there won't be chance for bruises and cuts (lacerations). However, in his situation he was not referred by a doctor or nurse, but being a health worker himself and from his experiences he is knowledgeable about these conditions. He clarified that these lacerations are likely to occur as a result of trauma to the penis during sexual intercourse or sometimes from tight underwear.

### **3.4 Sexual pleasure and performance**

Sexual performance is not yet a proven MMC benefit. Among the men I interviewed and those I conversed with informally, none pointed out that the main reason why they undertook MMC is to improve their sexual performance or pleasure. When I asked some men about this perceived benefit, there were mixed reactions - both negative and positive responses. Although some were in the

process of healing (wound), they were looking forward to their new sexual experiences with their partners. For example CM 1 said:

“...from me I will see when I recover, ...and maybe I will also ask my partner if there is a difference between the previous times and this time now that am circumcised.” (Interview with CM 1, 14 February 2012, Eenhana)

With regards to the ‘hearsays’ or perceptions related to circumcision and sexual performance, CM 1 narrated:

“...in our meetings with our field workers we sometimes invite people who have undergone the MC process, and some of those questions (about performance and sexual pleasure) always come up, ...those who have gone through MC already and are now recovered... the answers they are giving are like: some say there is no difference, it’s just the same. ...but there are people who are saying no, there is a difference. But of course there are some women and men who say the performance is actually different, maybe it depends from person to person.” (Interview with CM 1, 14 February 2012, Eenhana)

Other men like CM 3 and MP 1 also shared similar sentiments:

...“yaa, people say it but I really don’t believe it because it is not proven, and it is unbelievable. Yaa, you know people’s perspectives differ. ...but being circumcised and uncircumcised is just the same (sexually), only different perspectives.” (Interview with CM 3, Omafo)

“...when it comes to performing (sexually), it depends. ...coz once you are wearing a rubber (condom) it’s just the same. ...maybe without a rubber, I think that’s where the difference will be.” (Interview with MP 1, Engela)

The above narratives illustrate variations in relation to this belief. On a somehow negative note, one of the participants, CM 4, was not pleased with his new sexual experience. In an informal conversation with him and his friend, they shared how their penises are no more sensitive as they used to be before circumcision. They



both experience longer erections now which can be a good thing sometimes but CM 4 specifically expresses pity for his partner especially when they have sexual intercourse in the morning. He said:

“Sometimes I feel pity for my girlfriend *maan*, especially in the morning; I take time to come...”

Some of my participants spoke about people of Ovaherero and Ovahimba ethnic groups<sup>29</sup> as well as Angolans who prefer or are known to only engage in sexual intercourse with circumcised men. Women belonging to these ethnic groups determine a man’s circumcision status first before accepting a sexual relationship with him. Pappas-DeLuca *et al.* (2009) study which had participants from the two ethnic groups, confirms this notion. I will now look at factors that are viewed as barriers to men’s uptake of MMC services.



#### **4. BARRIERS TO MMC ACCEPTANCE**

##### **4.1 Pain and discomfort** UNIVERSITY of the WESTERN CAPE

In a traditional context, pain is regarded as the main feature of circumcision when it is undertaken as a ritual for passage from boyhood to manhood. Without pain, a boy cannot become a man (Lukobo and Bailey 2007). Thus it is considered to be a necessary component of traditional circumcisions (Bailey *et al.* 2002). However, the MMC procedure is done under local anaesthesia. This involves nerve block at the base of the penis for the man not to feel pain during the procedure. The dosage is calculated depending on the client’s weight. Various acceptability studies conducted in Southern Africa found that, pain is the frequent reason and a leading barrier to MMC acceptance (Lukobo and Bailey 2007; Scott *et al.* 2005; Lagarde *et al.* 2003; Bailey *et al.* 2002).

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<sup>29</sup> Ovaherero and Ovahimba are the only ethnic groups still practicing circumcision as a ritual in their communities.

Relating from personal experience, CM 1 said this about MMC and pain:

“...the way it is being done medically is not such painful. But I know some men are not going because of (fear of) pain.” (Interview with CM 1, 14 February 2012, Eenhana)

After his operation, CM 2 said he was met with questions from his friends as he related below:

“...some of them were even asking me: how is the pain? Then I say, no it is not painful *maan*, but I tell them to go there and feel for themselves and join me.” (Interview with CM 2 29 February 2012, Omafo)

When I further asked what his friends thought of the intervention (MMC), CM 2 said:

“...only few of them are against it but most of them are just thinking that maybe it is more painful. They are concerned about pain.”



It appears that men’s fear of pain is not centred around the surgical operation only. One man I talked to, described his operation as painless, but the painful part he said was during the healing process particularly in the morning hours when he gets an erection. This is what he said about his experience:

CM 7: you know when I got operated I did not feel any pain. But after that, the morning erection is the most painful thing.

Researcher: so, how did you manage that pain?

CM 7: ...you know for us (young man) this thing (erection) comes naturally. So what I used to do is take the painkillers immediately with a lot of water. But later I started timing it, I used to take medication around 6am or so.

With regards to pain, men's responses also varied. Considering that all people have different pain thresholds, I assume it is natural that some perceive the whole intervention as painful while others view it differently.

I observed an interesting scenario one day when two men (who said they were friends) came for MMC. They were welcomed and offered seats while waiting for other men to arrive before starting. After the information session or health talk from health workers, and while men were waiting for their parameters to be taken, one of these two men just walked out of the department without saying anything. After waiting for him to come back, we inquired from his friend, he told us that his friend probably went back home because he was afraid of pain and has been talking about this fear even before they came to the hospital. On another day, one of the clients also told us about his friend who ended up at the hospital gate and decided to return home. The reason given here is also fear (of pain).

Pappas-DeLunca *et al.* (2009) also found that fear of pain; death and disfigurement are some of the barriers to being circumcised. Even the fears expressed above are not only of pain, but may also be fear of "unknown". This is sometimes manifested in client's vital signs such as elevated blood pressure and fast heart rate (pulse) just before the operation. These are signs of anxiety which can be anticipated before experiencing or undergoing an unusual event such as surgery for the first time. Some clients admitted they were afraid after or once the nurse interprets abnormalities in their vital signs. The MC Nurse's role in this regard is to help clients feel at ease and overcome their fears by explaining what they are to expect in the operating room as well as what is expected of them.

Some of the client's fears are derived from what is called "hearsays". It is evident that men share these kinds of information with their acquaintances. However it is not guaranteed that what is shared is truthful information especially with regards to MMC and how it is done at the hospital. Some of these misconceptions inculcate fear in some men and which will have an impact on the decisions they make with regards to being circumcised or not.

MP 2 exemplifies this untruthful transfer of information. He was uncircumcised during my fieldwork. I met him at his parent's house when I went to interview his father. During our conversation, I asked him why he is not circumcised and he said:

*“Ahawe, ame okukengwa ondahala, maar vati ohasheehama nee. Vati omunhu owuna okuteelela eemwedi hamano opo wukale nokaadona.”*

No, me I want to be circumcised, but I heard it's painful. Apparently, one has also to wait for six months before getting intimate with a woman.

Although our conversation grappled around MC topic and other general issues, I managed to correct the misconceptions he heard. He sounded pleased and later asked if I can take his name for booking so that he can also get circumcised. At this point, I think it should be noted that my conversation with MP 2 was not that of an MC promoter. I tried to be as neutral as possible, although I later realized that some men probably thought of me as an MMC advocate or promoter. The information I shared with MP 2 was only to enable him to make an informed decision, rather than leaving him with untruthful information which seemed to have conflicted with his decision to be or not to be circumcised.

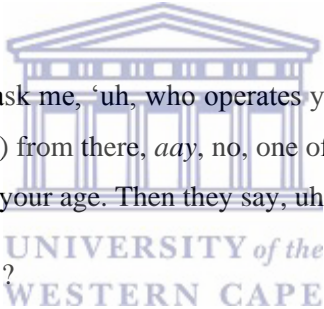
#### **4.2 Gender of circumciser**

The issue of the circumciser's gender was raised by some men I talked to and also at various platforms during public meetings, information sessions as well as by callers on a radio program. In a study by Pappas-DeLuca *et al.* (2009) on attitudes towards MMC in Namibia, one of the participants pointed out that if circumcision is to be done in hospitals, there should only be male nurses (health workers). In another MC acceptability study in KwaZulu-Natal by Scott *et al.* (2005), one of the health workers (STIs nurse) noted that men would not allow themselves to be circumcised by nurses who are generally female. These studies show a resistance - from men's side to be circumcised by female nurses. However, in my study some of my participants felt that being circumcised by a female nurse is not a problem. Most did not express any concern with female nurses performing MMC. I earlier

on discussed the case of CM 6, which is an exemption in this regard because he openly expressed his discomfort among three females while undergoing MMC.

At Engela, the MC Nurse who is also the regional coordinator is female. I have also met other female nurses who are heading this program and performing circumcisions in their respective duty station in Ohangwena and other regions as well. I suspect this situation contributes to the level of MMC acceptance in Ohangwena. According to the information shared with me by the MC Nurse, nationally there are more female nurses in the program than male<sup>30</sup>. Perhaps it is also necessary to consider that the nursing profession is already dominated by the female gender which she said could be the reason for this status quo.

In an interview with CM 2 a few days after his operation, he shared some of his friend's responses towards MMC:



CM 2: ...and they ask me, 'uh, who operates you'? Then I told them, 'one of the ladies'.... (*laughter*) from there, *aay*, no, one of the ladies again, oh maybe which age? Then I say, of your age. Then they say, uh, I will never go there!

Researcher: Serious?

CM 2: Serious. So the gender of the one operating is playing a role to some of the people. But it can only play a role to people who do not understand. Being a nurse is a duty to anybody, why cannot a woman be afraid to go to the hospital and deliver a baby while being assisted or operated by a man who is also of her age even? It is just a misunderstanding and people should just take it as it is.

CM 2's friends were not the only ones concerned about the gender of the one who performs circumcisions. During fieldwork, I also attended information sessions organized by the MC Nurse. I accompanied her and her other colleagues from different hospitals for radio talks. I also attended information session with secondary school boys and a meeting with some community leaders and religious

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<sup>30</sup> The MC nurse also told me how she tried several times to lobby for one of the male nurses from another department to join the MC program but the head of that department refused to let go of his male health worker. At the beginning of the program she had a male colleague who later resigned to go for further studies.

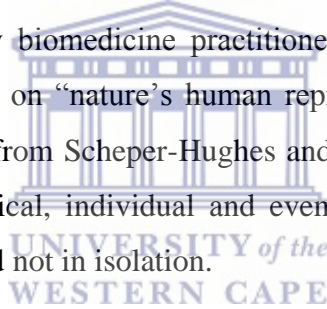
leaders (including pastors) from different faith-based organizations. At all these platforms, the question of gender was brought up. Attendants were interested in knowing who does these circumcisions. Questions like: So, if I come to the hospital who will operate me? Is it you (MC Nurse) or someone else? Can I ask for a male doctor or male nurse to circumcise me, if I want? The gender of the circumciser was clearly what the attendants and callers on a radio wanted to know. This issue appears to be a concern for some if not the majority of men. I believe when men make decisions these are some of the factors they take into consideration, hence interventionists need to critically analyse and consider men's perspectives with regard to this. Aggleton's (2007) caution to promote and implement this intervention in culturally appropriate, rights based and gender sensitive way also need to be seriously considered. The picture below illustrates what I am referring to in this instance. It shows two female nurses performing MMC. My presence there as an observer meant that it was three women attending to one man.



**Picture 1: In this picture, the blue curtain separates the part of body being operated on from the other part of the client's body.**



On the other hand, with regard to the picture above, I also want to discuss another aspect which caught my attention. It is the use of the (blue) curtain as a screen during the procedure. In this case, the curtain serves to separate man's lower body – on which the nurses are working from the torso. It is also there to prevent the client from seeing the 'how' process of MC, but he only has to see the end result. In other instances, I have observed the use of sterile draping paper<sup>31</sup> which is simultaneously used to create a sterile field and mostly cover the client's face. These practices do not only demonstrate what I think is the unpreparedness of the Ministry of health in implementing this program without proper provision of standard equipments at all health facilities; but they also show an anti-human act. I am saying this because, in closing the client's upper body behind the curtain or under the draping papers, it gives an impression that the exposed part (penis) is the only thing or site that matters to those who are operating. This scientific and "naturalist" approach by biomedicine practitioners is what makes them to see themselves as practicing on "nature's human representative" – the human body (Gordon 1988). Instead from Scheper-Hughes and Lock (1987) we learn that the body is a social, biological, individual and even political representative which functions in harmony and not in isolation.



#### **4.3. Fear of Complications associated with Circumcision**

Even with other acceptability studies, men did not only fear pain; they also feared other things such as complications and death amongst others. For the whole period of my fieldwork, no serious complications were reported or observed from circumcised men. From October 2010 when the program started in Engela, the MC Nurse said she had only very few cases of wound infection and no other serious complications. She relates this complication to men not adhering to the post-operative instructions. Some walk long distances or some return to work without taking proper rest. This is the rationale behind follow-ups given to clients because they do not overnight in the hospital for monitoring but they are sent

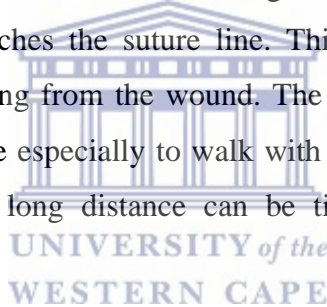
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<sup>31</sup> Draping papers are disposable papers used to create a contaminant free area during a surgical operation



home after operation and advised to return to the hospital if there are any worrying signs such as swelling, bleeding or excessive pain even after taking painkillers.

After circumcision men are advised to rest and not engage in heavy labour. Those with formal jobs are normally given five (5) days sick leave. They are also given strong painkillers to take when necessary. After operation, they are advised to keep the penis in an upright position by use of a plaster to be supported by the underwear. The nurse shows them how to do it when at home and how to place the plaster back after urinating. Men are also advised not to allow the penis to hang downwards in its normal position because its contact with the testicles produces sweat which can impact on the wound healing process. Another important thing they are told is how to manage morning erections because when the penis erects, it stretches the suture line. This line can open or loosen the sutures and cause bleeding from the wound. The MC Nurse explained that men might feel uncomfortable especially to walk with the penis in its newly acquired position. Thus walking long distance can be tiring and risky for the newly operated wound.



I have observed two cases of minor complications whose management I was also involved in. One afternoon after finishing with the only client for that day, we came out of theatre. The client sat on one of the chairs while the MC Nurse was busy writing in his health passport and preparing his take home medication. I noticed a change on the client's facial expressions and asked what was wrong and if he was in pain. He said he was feeling weak and dizzy. I told the MC Nurse and she instructed me to check his blood pressure. The reading showed the blood pressure was very low (hypotension) comparing to the reading before operation. At the same time he also reported that he was feeling nauseous. We let the client lie on the bed in casualty. The MC Nurse diagnosed him with Postural Hypotension<sup>32</sup>. I assisted her to start an intravenous line immediately, and

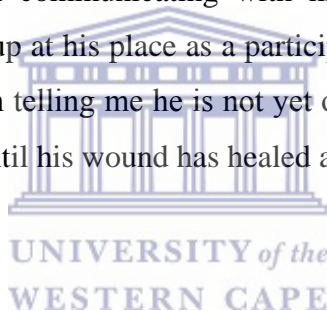
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<sup>32</sup> Postural Hypotension is abnormally low blood pressure, lower than 90/60 mmHg. In this case, blood pressure drops when a person has been lying (mostly in supine) for some

administered Maxalon 10 mg<sup>33</sup> intravenously. We kept monitoring him for few hours until he was feeling better and able to go home.

Another client showed up with a slight swelling and reddish wound when he came for day two follow up. These were signs of wound infection. The plaster was also worn off. The client told us he walks a long distance to the hospital and that he did not get proper rest since the day of operation. This client's wound was managed (cleaned and new dressing applied) and he was put on antibiotics for five days.

These kinds of experiences can be unpleasant for someone who left his home in a healthy state and ends up in a hypotensive state for instance or worse. The client who suffered from postural hypotension was frustrated. He expressed these feelings as I have been communicating with him since his operation. I was supposed to follow him up at his place as a participant, but he kept on postponing our meetings. He kept on telling me he is not yet over the operation's frustrations and he told me to wait until his wound has healed and he was completely fine.



#### **4.4 Other concerns**

Decreased penile sensitivity was also one of the concerns raised by CM 4 and his friend – as already referred to in section 3.4. This did not come out strongly as some of my participants were still to have their post-circumcision sexual intercourse.

Just like the gender of the circumciser, wound healing process and period was one of the things men also wanted to know before deciding to be circumcised. The duration was more of a concern as I assume men want a quick recovery for them to be able to return to their normal behaviour such as work and perhaps sexual activity. Healing duration is quite individualized; it can be delayed and it can be

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time and then stands up too quickly. The body sometimes fails to return the blood pressure to normal fast enough.

<sup>33</sup> Maxalon is an anti-emetic injection given via an intravenous line to prevent or treat nausea and vomiting.

fast especially in young boys – said the MC Nurse. Alcohol, poor nutrition, activities one is involved in, lack of proper rest and lack of oxygen (fresh air) delays the healing process. Adherence to the advices given to the hospital (as mentioned in the section above) is also essential to the healing process. Nevertheless, men have different perceptions and understanding regarding wound healing period. Some of them did not comply with what they were told after their operations. For example CM 4 told me that within five days his wound looked healed and in two weeks he resumed sexual activities although he knew he is supposed to allow the wound to heal for at least six weeks or more.

The outer part of the wound heals faster than the inside. This fact seems to have misled CM 4 as he probably thought the wound was completely healed. Two of my participants had this to say when I asked their opinions about the six weeks healing period:

“aah, to me like for now, am now one week and one day, I don’t even feel like having sex, no am fine.” (CM 2)

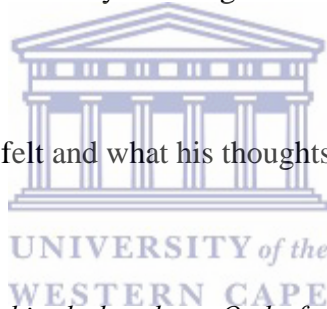
“I think 6 weeks is nothing man, 6 weeks in nothing man.” (MP 1)

These quotes illustrates that six weeks abstinence from sex is not an issue for these men. Even for MP 2 who was informed about six months of abstinence, he looked and sounded relieved when I told him that it is just six weeks. The National Policy on MMC prescribes six weeks abstinence to allow complete wound healing. The document also cautions against sexual activities before six weeks which is viewed as a risky practice. Although the wound heals fast on the outside, the inside takes time thus men are also advised to continue practising safe sex consistently for at least three months after operation. In the next section, I will discuss how men generally respond to and perceive MMC intervention.

## 5. GENERAL PERCEPTIONS AND RESPONSES TO MMC

Participant CM 6 was one of the interesting clients I met. In an informal conversation with him after his operation, he expressed his contentment with the whole practice. Apart from him, there was also another client but he was an Angolan national. He was so excited after his operation that he even offered to buy lunch for me and the MC Nurse in expression of gratitude. According to the MC Nurse, she often does not experience these kinds of expressions from men. Few of them sometimes express such feelings when they come back to the hospital for follow-up visits. I observed that some clients come out of theatre and do not express any feelings unless asked, some complain of pain, or ask for analgesics immediately or about instructions which were not clear to them such as wound care, management of early morning erections and any other health-related information.

So I asked CM 6 how he felt and what his thoughts are regarding this intervention, he gladly said:



*“Ame onda hafa eshi nda kenghwa. Onda fewekwa, ngeno okwali hashi dulika ngeno eshi andi di omu ohandeende ndili ngaashi nda dalwa opo keshe umwe amone nghee nda yela ame onda fewa.”*(Informal conversation with CM 6, 28 February 2012, Ongha Health Center)

“I am so happy that am now circumcised. I am beautified, if it was possible I will walk naked from here for everyone to see how beautiful and clean I look.”

The joy and relief expressed by CM 6 signifies satisfaction with the outcome of the operation. Following the operation, clients are shown the new look their penises have acquired before covering it with dressings. CM 6 could see beauty and cleanliness, the benefits he also desired from the surgery. He feels that he is relieved from the troubles of having to worry about the cleanliness of his penis especially when there is water shortage or when he possibly has to engage in unplanned sexual encounters. CM 6 further explained that on some days, he would wake up and only wash his face then he goes to spend time with friends at

drinking places. In such circumstances, one is likely to have an unplanned sexual encounter. One of them or both might develop signs of STIs later, for which they might blame each other but sometimes it's possibly a bacteria resulting from lack of penal hygiene and he might be the one to be blamed because of his lack of proper hygiene that day. In the next section I present few pictures taken during one of the information sessions I attended during fieldwork. It is through these platforms that health workers promote and advocate for MMC.

## **6. INFORMATION SESSIONS**

The MC Nurse's other responsibility is to disseminate information about the program. Since the inception of MC for HIV prevention in Ohangwena, information sessions have been one of the important tools used to get the message across to community members. Posters and leaflets are also distributed. The various means that the MC Nurse uses includes radio talks on one of the local radio stations mostly with her colleagues from other regions. Visits to secondary schools, where they do not only target boys but also involve girls so that they can understand the importance of MMC to enable them to encourage and support their brothers, friends as well as their partners and children in the future. Community and official meetings are also some of the platforms the MC Nurse use to promote the MC program. Topics covered at these sessions include: basic information about HIV and the status of Namibia and specifically Ohangwena, prevention of STIs including HIV, what is circumcision and its relationship with HIV prevention, benefits and possible complications of MMC, how the procedure (MMC) is done and the healing process. It is at these platforms where I have observed some of the issues I discussed above. For example in one of the meetings with pastors and representatives of different church organisations, the attendants somehow (but not all) expressed their uneasiness to preach or talk about MC to their congregations. They likened MC to promotion of condom use which they somehow resist to talk about. But generally, they were supportive of the practice, recognising that it is for the benefits of the community members who

are members of their congregations. Below are some pictures taken during an information session at a local secondary school.



**Picture 2: A health worker presenting a session to the learners on MMC and STIs**







**Picture 3: Learners paying attention to one of the health workers presentation on MMC**



**Picture 4: Learners had an opportunity to ask questions and give comments. One of the learners asking a question about MMC**



## 7. CONCLUSION

This was the main findings chapter in which I covered several aspects relating to MMC acceptance and men's responses to the intervention. I looked at the factors encouraging and discouraging acceptance of this medical intervention. The chapter also outlined some concerns with regard to MMC as shared by some of the participants. I therefore argued that men are motivated by medical benefits and not their constructions of masculinity in accepting MMC. Generally, it appears that men are willing to be circumcised considering the number of those who come to book for the operation – which is a voluntary act. Gender and sexuality perspectives were also discussed hence my view is that the current implementation of this biomedical intervention is not gender-sensitive. I observed that information sessions are platforms for disseminating information about the program to the community members. During these sessions, men also attain clarity on some of their concerns about MMC. Although the focus and emphasis is on the benefits of the intervention with the aim of encouraging and attracting more men to uptake these services; questions like “who will circumcise me when I come to the hospital?” are strategically answered so as not to encourage men to be circumcised without worrying about the gender of the circumciser. The ministry's preparation for this intervention is another aspect that needs to be seriously addressed especially with regards to resources. The next chapter concludes the thesis and makes recommendations to the MMC program and possible issues that can be researched further.

## CHAPTER 6

### CONCLUSIONS AND RECOMMENDATIONS

This thesis dealt with acceptability of medical male circumcision (MMC). The main focus was on circumcised men whom I met at the hospital as they came for their operations. Most research on acceptability studied general populations and determined level of acceptability based on participant's willingness and desires which do not always translate into action. The study mainly aimed at exploring the role of masculinities in MMC acceptance. It also looked at how men understand, perceive and their general responses to this medical intervention. The study also collected information about traditional circumcision which was a common practice in this region. With this information I also looked at the different meanings of being a man in this setting.

This study was carried out in Ohangwena region, a currently non-circumcising society. Ethnographic design involving qualitative research methods was utilised to gather data for this study. I employed participant observation, formal and informal interviews, conversations and field notes to collect data. Reflecting on my own position as a female researching about men, I acknowledge that my gender and the relations I had with my male participants have possibly influenced my findings in one way or another. The responses I received from men are determined by what they perhaps thought of me based on my identities (female, nurse – MC promoter, researcher, student). I therefore agree with Caplan (1993), who from her research experience noted that being a young and single researcher has profound effects on the encounter with participants.

Data presented in this thesis showed that circumcision was one of the respected rituals in Oukwanyama kingdom and was recognised as a rite of passage from boyhood into manhood until it was abolished around the eighteenth century. Reasons for this abolishment ranged from arrival of missionaries as well as local and colonial administration conflicts. Like many other societies in the world, there is no single way of being a man in Ohangwena. Dominant constructs such as

being strong, independent, having a job and ability to perform family responsibilities are recognised in this society. These constructs do not differ from Becker (2005) and Sorrell and Raffaelli's (2005) findings from different Namibian settings. Evidently circumcision status was not identified as a marker of manhood in this setting. Contemporary meanings of being a man are located in different circumstances of life. Descriptions of real manhood by some of my participants were situated in social and health contexts. This means versions of masculinity are contextualised and also individualised. My study further shows that there is a general paucity of information about circumcision in Namibia and particularly its historical practice in various kingdoms like Oukwanyama. More research therefore needs to be done concerning notions of being a man not only in Ohangwena region but in other societies as well.

The key argument in this thesis is that constructions of masculinity have no impact on men's responses to MMC. In my research context, men were not getting circumcised (medically) to be "real" man or whatsoever. Instead, they are motivated by health benefits. Other factors such as understanding and knowledge of the relationship between MMC and HIV prevention in my views are playing a role in acceptance of this intervention. Thus my findings demonstrate what has been argued by Hankins (2007) and Bonner (2001) that acceptability depends on the reasons for which the intervention is performed. In the discussion on information sessions, I shared my view that in all sessions I attended the emphasis is on the primary benefit of MMC – reduced risk for HIV infection. For this reason, men are getting circumcised for HIV prevention because it is the reason for the implementation of this intervention by the ministry of health. Other motivating factors also include penile hygiene and treatment of medical conditions related to the foreskin. In this work, I also discussed some factors that are viewed as barriers to men's acceptance of MMC. Pain and discomfort, fear of pain and complications, female circumcisers and transfer of untruthful information regarding the procedure somehow discourages men from being circumcised. However, some men expressed contentment with their circumcised penis while

others regret their decision because of their experiences such as complications and lack of penile sensitivity which impacts on their sexual performance and pleasure.

As a participant observer, I have observed how MMC is being done in my research setting. Hence I argued that, the current implementation of MMC is not gender sensitive. Some men were not comfortable and this could be one of the reasons for the poor turnout of the clients despite the increasing number of those who come to book in advance especially at Engela Hospital. This manner of practice can make men feel emasculated and therefore discourage other men to uptake this service. Considering the voluntary nature of MMC services, it need not to be compared to or looked at like any other health service. Moreover, the use of curtains and draping papers in operating rooms in my view is anti-human as it gives an impression that what is being operated on (the penis) is what matters most than the rest of the body. This can contribute to the client's uneasiness throughout the operation. Lack of up-to standard equipments and few male staff in the program shows the unpreparedness of the ministry. This kind of situation is likely to hamper the progress of the program as circumcised men will continue to share their experiences with those who are not yet circumcised.

I acknowledge that women's voices are missing in this study. Perhaps their perceptions and understanding of MMC as partners for example would have complemented men's views in this regard. I therefore recommend further research on MMC acceptability in other contexts with a consideration of women's perspectives about this intervention. The ministry of health need to seriously provide standardised equipments and strategise different ways that can invite men to be circumcised in an environment that does not make them feel emasculated. Factors that determine men's decision to be circumcised cannot be disregarded. The issue of gender in this program also need serious consideration because it also cannot be overlooked. Interventionists need to understand that, willingness (to be circumcised) as speculated by other studies is simply not enough but action is more important to measure acceptability of MMC.

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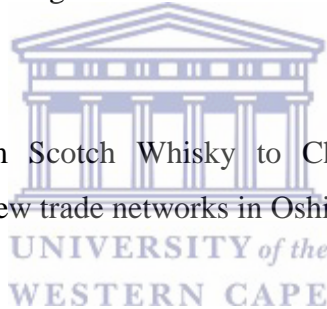
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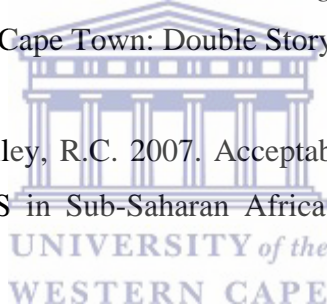
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## APPENDICES

### APPENDIX I: INFORMATION SHEET AND CONSENT FORM



UNIVERSITY of the  
WESTERN CAPE

#### UNIVERSITY OF THE WESTERN CAPE

#### Department of Anthropology & Sociology

#### Information sheet and Consent form

**Title of Research Project: Acceptability of Medical Male Circumcision in Ohangwena region: Namibia.**

#### Introduction

I am Magdalena Ndapewa Nepaya. I am a student at the University of the Western Cape doing Master's Degree in Medical Anthropology. As part of Master's qualification, I am required to conduct a research project. This study is under supervision of Dr Sakhumzi Mfecane (+27 21 959 3346) of the department of Anthropology and Sociology. The research processes for this study have been approved by UWC ethics Committee (Number).

I am kindly requesting you to participate in this study and share your knowledge and understanding related to the topic of this research. The focus of this project is on men and acceptance of medical male circumcision which is being offered at the state hospitals. The study will assess men's understanding of medical MC as well as how they are responding to this new intervention in the fight against the spread of HIV infections. I am interested in knowing more about the history of circumcision in Ohangwena. The study also aims at understanding different meanings of being a man in Ohangwena and how these meanings are constructed and even influenced by this new intervention.

## **Participation**

My target group is men who are 18 years and above, community leaders and some health workers who are working with circumcision at the state hospital. You do not have to be circumcised in order to participate. Participating means that you are asked to make time for me to be able to formally interview you for duration of less than one hour. It is possible that you may be interviewed more than once. I want you to know that participation is voluntary and I am not going to force you to be part of this project. If you agree to participate, please understand that you may stop participating if you choose to do so without being punished or criticised in any way. I am also asking your permission to record the interviews; this will enable me to have accurate information as you have shared it. The tapes will be destroyed later when no longer needed. Please know that you have a choice not to answer some of the questions which will be asked during the interview.

## **Confidentiality**

Please know that all information that will be collected and your identity will be kept confidential. Information will only be shared with the supervisor of this study or in form of published work which may be used for academic purposes only where I am required to present findings from this research. All recordings will be typed in the computer without names attached but you will be given a code or any false name that you choose to be referred to in the written work. Signed consent forms will also be kept confidential and will not be made accessible to anyone else.

## **Risks**

Since this study is about men and you will be required to discuss issues around circumcision and HIV/AIDS. You might feel uncomfortable to talk about these sensitive topics. I am asking you to express yourself in a way that is comfortable for you. Other than that, there are no other risks identified so far in relation to this project.

## **Benefits**

There are no immediate personal benefits from participating in this study. However, your valuable ideas and all the information that will be collected will contribute to understanding of men and their responses to health interventions. This information may also be used to influence health policies and implementation of health programs targeting men.

Please feel free to ask any questions pertaining to this study. You are also welcome to contact me should you have any further questions about this research project:

### **Magdalena Ndapewa Nepaya**

**Cell phone Number (SA) +2778 778 6643**

**Cell phone Number (Nam) +264 81 239 3912**

**Fax: (021) 959-3686**

**Email address: [3105797@uwc.ac.za](mailto:3105797@uwc.ac.za) or [nmaggy@yahoo.com](mailto:nmaggy@yahoo.com)**

**You may also contact my supervisor Dr Sakhumzi Mfecane on the following details:**

**+27 21959 2336 (SA office)**

**+27 834349887 (SA cellphone)**

**E-mail address: [smfecane@uwc.ac.za](mailto:smfecane@uwc.ac.za)**

**Informed consent**

I understand the above information about the nature of this study which has been explained to me in a language I understand.

I know that my participation is voluntary. I am participating in this study at my own free will without being forced. I also understand that I can stop participating anytime without fear or being criticised in any way.

I understand that the information which I will give will be treated as confidential and my name will be anonymous. The information will be used for academic purposes.

_____		_____
Participant's full name		Participant's signature
_____		
Date		

## APPENDIX II: APPROVAL LETTER (UWC)



UNIVERSITY of the  
WESTERN CAPE

### OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

17 January 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:  
Ms M Nepaya (Anthropology/Sociology)

Research Project: Acceptability of medical male circumcision among  
men in Ohangwena Region, Namibia

Registration no: 1110/6

A handwritten signature in black ink, appearing to read 'P. Josias'.

*Ms Patricia Josias  
Research Ethics Committee Officer  
University of the Western Cape*

Private Bag X17, Bellville 7535, South Africa  
Tel: +27 21 959-2948/9  
Fax: +27 21 959 3170  
Website: [www.uwc.ac.za](http://www.uwc.ac.za)

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a place to grow, from hope  
to action through knowledge



**APPENDIX III: PERMISSION LETTER (MINISTRY OF HEALTH)**

9-0/0001



**REPUBLIC OF NAMIBIA**

*Ministry of Health and Social Services*

Private Bag 13198  
Windhoek  
Namibia

Ministerial Building  
Harvey Street  
Windhoek

Tel: (061) 2032510  
Fax: (061) 222558  
E-mail: [shama8@zoho.com](mailto:shama8@zoho.com)  
Date: 08 February 2012

Enquiries: Ms. E.N. Shama

Ref: 17/3/3

**OFFICE OF THE PERMANENT SECRETARY**

Ms. Magdalena N. Nepaya  
P.O. Box 4545  
Windhoek



Dear Ms. Nepaya

Re: Acceptability of Medical Male Circumcision among men in Ohangwena region, 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 completion of your MA (Medical Anthropology);
  - 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. K. KAHURE  
PERMANENT SECRETARY



*"Health for All"*