KNOWLEDGE AND ATTITUDES OF OFFENDERS TOWARDS THE PERFORMANCE OF MEDICAL MALE CIRCUMCISION IN PRISONS OF GAUTENG PROVINCE, SOUTH AFRICA

by

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DECLARATION

I declare that KNOWLEDGE AND ATTITUDES OF OFFENDERS TOWARDS THE PERFORMANCE MEDICAL MALE CIRCUMCISION IN PRISONS OF GAUTENG PROVINCE, SOUTH AFRICA is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

....

Full names **Date**

DEDICATION

To the Lord Almighty, for his grace and protection, for giving me the strength and patience to carry on with this project.

To my late father, Madisha Frans Monkwe, who would have been proud to see his last daughter growing academically.

To my beloved mom, thank you for believing in me.

To my two lovely kids Keabetswe (daughter) and Ditheto (son).

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To the most high God, who ordained me through this path before I even knew about and made it possible for me to undertake this journey. “I can do all things through Christ who gives me strength” Philippians 4:13.

My sincere appreciation goes to Dr S. F Matlala and Prof Linda Skaal for seeing through all the stages of this project. Thank you for your time, efforts, guidance, and encouragement, I would have not done this without you.

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ABSTRACT

The study was about the knowledge and attitudes of offenders towards the performance of medical male circumcision in prisons. The aim of the study was to determine and asses the knowledge and attitudes of offenders towards the performance of medical male circumcision in prisons. A quantitative study was conducted by using researcher-administered questionnaires at Leeuwkop Management area, maximum centre. A simple random sampling of two hundred and twenty-three male respondents was selected from all races and only two hundred and three managed to complete the questionnaires correctly. Data was analysed using Statistical package for the social sciences software program. Data was presented using descriptive and inferential statistics. More than half of the respondents were medically circumcised and less than half of the medically circumcised respondents had performed it in prisons. Most respondents were between the ages of 25-35 years and majority of them have shown fair knowledge and negative attitude towards the performance of medical male circumcision in prisons. It was recommended that thorough health education on the benefits of medical male circumcision should be stressed to offenders. For medical male circumcision programme to succeed, offenders should have adequate knowledge on male circumcision and its benefits.

DEFINATION OF CONCEPTS

Attitude

Attitude is the positive or negative views of a person (Glover, 2012). In this study attitude means the offenders' emotional feelings towards medical male circumcision.

Knowledge

Knowledge is the fact of being aware of something with familiarity gained through experience or relation (Denning, 2009). In this study knowledge is the understanding and awareness of offenders towards medical male circumcision.

Medical Male Circumcision

According to Right to Care (2010), medical male circumcision is the total removal of the foreskin that covers the head of the penis. In this study, medical male circumcision is the surgical removal of the offenders' foreskin

Offender

An offender is someone who is arrested for committing an illegal act (Gerald & Kathleen, 2015). In this study, an offender is someone who is committed crime and is serving a sentence at a prison in Gauteng province.

ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Antiretroviral treatment
ARVs:	Anti-Retro virus
DC:	Department of Correctional Services
DOH:	Department of Health
HAART:	Highly Active Anti-Retro Viral treatment
HepBSAg:	Hepatitis B Specific Antigen
HIV:	Human Immunodeficieny Virus
HPV:	Human Papilloma Virus
MMC:	Medical Male Circumcision
MDGs:	Millennium Development Goals
PHC:	Primary Health Care
SPSS:	Statistical Package for Social Siences
STI:	Sexually Transmitted Infection
TB:	Tuberculosis
TV:	Television
UNAIDS:	United Nations Programme on HIV/AIDS
UTI:	Urinary Tract Infection
UTT:	Universal Test and Treat
WHO :	World Health Organization

CHAPTER 1: OVERVIEW OF THE STUDY

1.1. Introduction and background

According to the Department of Health (2013), an estimated 360,000 offenders are admitted in South African correctional centres yearly. These offenders come from the communities with high rate of HIV, STIs and TB. They also come from different cultural and religious beliefs, as far as male circumcision is concerned. In conjunction with the recommendations made by World Health Organisation (WHO) in 2007, the Department of Health also adopted medical male circumcision (MMC) in correctional centre.

The head of the penis shows out from the foreskin in some men during erection. Male babies have the foreskin that is lightly attached to the penis underneath it. This makes it to be readily available during circumcision (Morris, 2013). It is therefore more advantageous to perform circumcision while one is still a baby than to delay it. A study done in the US showed that 86% of the parents encouraged neonatal circumcision (Wang et.al, 2010). In South Africa, males are encouraged to perform medical male circumcision because of its HIV prevention strategy and other health benefits. Medical male circumcisions are in both public and private health facilities and in some prisons around South Africa. In prisons and public health facilities, MMC is performed free of charge. This means that performers are not paying for MMC services.

It is believed that the inner aspect of the foreskin carries dirt and is also highly susceptible to Human Immunodeficiency Virus (HIV) infections. In a way of combating HIV, WHO and United Nations Program on HIV/AIDS (UNAIDS) issued recommendations on medical male circumcision as an additional HIV prevention strategy. These recommendations were done in 2007.

South Africa is one of the three randomized country undertaken as the control trials and it has shown that MMC reduces the risk of sexual transmission of HIV from women to men by approximately 60%. In addition to HIV, circumcision also reduces the risk of sexually transmitted infections (STIs), genital herpes by 28% to 34% and Human Papilloma Virus (HPV) by 32% to 35% (Tobian & Gray, 2011). Even though it is aimed at reducing the risk of HIV and STIs, it does not exclude those who are already infected with HIV.

1.2. Research problem

In South Africa, male circumcision has been practised for more than 20 years as a cultural way of turning boys into manhood (Nkosi, 2011). The researcher is a professional nurse at prison and has observed some offenders refusing to be sutured by a female health professional after medical male circumcision was performed on them. MMC is performed in prisons as a means of reducing the risk of HIV infection but there seem to be offenders who have negative attitude towards it. There are still offenders who refuse MMC due to their religious and cultural practices. The researcher had observed few offenders who said they will never perform MMC in prison because it does not make them 'real men' as compared to the one performed for cultural practices. Some say they do not have respect for people who undergo medical circumcision and regard them as not being men enough. Some males refuse MMC in prison while they show willingness to undergo traditional male circumcision out of prison. This seems like there are offenders who still regard circumcision as exclusive concern for males and they seem to be lacking knowledge on medical male circumcision as an HIV risk reduction benefit

1.3. Research method

Research method discusses how data was collected and analysed, the instrument used and how ethical principles were followed. The full chapter on research method is being discussed in chapter 3.

1.4. Literature review

The purpose of literature review is to offer the researcher facts and background information about the study topic (Welman, Kruger & Mitchel, 2011). The researcher reviews other literatures related to her study. Chapter 2 discusses literature review in full.

1.5. Purpose of the study

The study was aimed at determining and assessing the knowledge and attitudes of offenders towards the performance of MMC in prison.

1.6. Research question

What are the knowledge and attitudes of offenders towards the performance medical male circumcision in prisons?

1.7. Objectives of the study

- To determine the knowledge of offenders towards the performance of MMC in prison.
- To determine the offenders' attitudes regarding MMC in prisons.
- To establish relationship between knowledge and practises and demographic factors.

1.8. Outline of chapters

Outline of chapters discusses what the study entails.

Chapter 1 gives introduction of the study, problem statement, aims and objectives of the study.

Chapter 2 is literature review, which offers the researcher facts and information about the researched topic.

Chapter 3 being research methodology discusses how data was collected and analysed and how the principles of ethics were followed.

In chapter 4, the researcher presents the results obtained during data analysis.

The last chapter which is chapter 5, the researcher discusses results obtained in chapter 4 and comes up with the recommendations thereof.

1.9. Conclusion

This chapter introduces the study and outlines the research problem, purpose of the study and the objective of it thereof. The next chapter, chapter 2 is about the literature related to the study

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In the previous chapter, the researcher gave introduction of the study and outlined its aim and objectives. The researcher also outlined the problem statement and the research questions. This chapter reviews literature relevant to the study.

Literature review is written information that has been published by other sources. Literature refers to relevant sources needed to provide knowledge of the researcher's selected topic (Brink, Van Der Walt & Van Rensburg, 2013). The purpose of literature review is to offer the researcher facts and background information about the study topic (Welman, Kruger & Mitchel, 2011). In this study literature will cover the offenders' knowledge and attitude towards the performance of medical male circumcision in prisons. It also covers the benefit of being medically circumcised.

2.2. Male circumcision for cultural practices.

Male circumcision is the oldest procedure that has been carried out by human beings in the whole world. Some cultural groups also practice female circumcision (Dingindlela, 2014). Cultural groups such as Bapedi, VaTsonga and VhaVenda also practice female circumcision. Like male circumcision, female circumcision is also considered a route from being a 'girl' to becoming a 'woman'. Female genital mutilation (FGM), as is commonly known in other cultures, is the partial removal of the outside part of the female genitalia, for cultural reasons. This is mostly done by traditional circumcisers (WHO, 2016). In South Africa female circumcision is being practiced by other cultural groups. This cultural practice is believed that it curbs female sexual desire and their sexual honour before they get married (Von der Osten-Sucken & Uwer,2007)

In Sepedi culture for example, female initiation school is performed in winter for four weeks. Unlike male circumcision, female circumcision is not held in the mountains but at the host's place. FGM is not only practiced in South Africa, but also by 28-30 countries in Africa and most Islamic countries (Von der Osten et.al, 2007). According to WHO (2016), FGM violates the person right to health, integrity and is inhumane.

Von der Osten-Sucken et.al (2007), believe that is painful and one can bleed to death.

The practice of male circumcision in South Africa has been viewed by some cultural groups as a way of moving from being a boy to being a man. This initiation has been practiced by Tswana, Sepedi, Xhosa, Ndebele and Tsonga cultural groups in South Africa (Mathew, 2012). Traditional male circumcision is one of the oldest practices that date back in 1886. Young boys are taken away from their homes to a temporal place in the mountains where the foreskin of their penises are cut using a sharp blade by a traditional surgeon (Dingindlela, 2014).

At the mountain, the initiates are taught the laws which they should not tell anyone. Females are not allowed near the place where the initiation school is held as whatever they are learning there is kept secret and should not be told to females or 'mašoboro' (those who did not undergo traditional male circumcision). After the completion of their school, which normally takes four weeks, they are then regarded as 'men' and no longer 'boys'. Traditional male circumcision plays a major role in some cultures because once one has undergone it, he is given more respect by females and the society of that community as compared to the one who is not traditionally circumcised.

There are other cultural groups in South Africa that do not practice traditional male circumcision. These cultural groups include Zulu, White and Swati. In the 19th century, the Zulu culture abolished traditional male circumcision under the leadership of King Shaka Zulu. The Zulu King, Goodwill Zwelithini revived the practice of male circumcision within the Zulu culture but was lauded for that decision. His decision to bring MMC to the Zulu culture was based on the prevention benefits against HIV (Matthew, 2013).

The need for young boys to be accepted as men, lead them to becoming victims of botched circumcision. They undergo traditional circumcision before time, and some circumcision are performed by people who are not trained for that. Every year there are reports of young boys who died at the initiation schools. This may be due to either they were too young or the person performing circumcision was not trained.

Some circumcision complicates because the treatment used there is not good for the wounds.

2.3. Benefits of MMC

Male circumcision is the removal of the foreskin. The foreskin is the layer that covers the head of the penis. It is a cultural and religious practices on whether to circumcise or not and even when to circumcise. The amount of the foreskin varies in the amount that droops from the end of the flaccid penis (Morris, 2013). Some prefer to circumcise two weeks after birth while others perform it at adolescence. Circumcision is however also done for medical reasons and hygiene in case of STIs (Sengwayo, 2011).

Before it could even be regarded as one of the HIV prevention method, male circumcision was there generations ago. It was regarded as a method of transforming one from boyhood to manhood. During the ancient years our forefathers were practising it as a cultural practice to declare one as a real man. This was practiced at the mountains and some communities still practice this culture.

It is a cultural secrete where women are prohibited from knowing anything happening there and its members are so secretive about it and cannot divulge anything. Xhosa tradition still practice male circumcision as a way to mark the boy's maturity, this tradition changes a boy from boyhood to manhood (Peltzer & Kanta, 2009). Some of the benefits of MMC are discussed in the below sub-headings.

2.3.1 Medical male circumcision as an HIV prevention.

In 2007, WHO/UNAIDS suggested male circumcision as an essential intervention that should be delivered as an HIV prevention method in communities with high HIV prevalence. Since this suggestion, MMC has be practised in several countries in the Eastern and Southern African countries (Lissouba, Taljaard, Dermaux, Legeai, Lewis & Auvert, 2011). South Africa together with other countries have agreed that by 2015, they submit the Millennium Development Goals (MDGs), as a way of

improving the country. Among those MDGs there is MDG 6 which is combating HIV, malaria and other diseases.

As a way of combating HIV/AIDS the UNAIDS has come up with medical male circumcision as an innovation to reduce the risk of HIV by 60%. The health department encouraged public hospitals to perform medical male circumcision to males free of charge. This is done to those males whose cultural practices do not include circumcision and to those who do not believe in this cultural practice.

In 2010, the department of health in Kwa Zulu-Natal together with its tradition leaders launched a campaign on medical male circumcision as HIV prevention method. This campaign had 878 769 people being counselled for HIV, 710 650 did HIV test and 10 229 men and boys got circumcised in the province (Dhlomo, 2010). The aim of this campaign was to encourage all males to perform MMC in order to reduce the rate of HIV/AIDS in the country.

2.3.2. Value for money

According to World Health Organization, medical male circumcision offers value for money as far as HIV prevention is concerned. It further says that if 80% of males between the ages of 15-49 years are circumcised in countries where HIV is high, it could save them a lot on HIV treatment. In a study done by Patrick Connely, 2016, Highly Active Anti-retro viral Treatment (HAART) costs approximately R1850 per month from Aid for Aids and Aids and Management Support says their treatment costs an average of R26 976 per year.

In the mines, to treat an HIV infected employee, it cost them R1500 per month (Connely,2016). According to Rosen & Long, 2006, one HIV positive patient will cost USD396 – USD 2.761, which is equivalent to R5 508.42 to R38 405.90 on ARV treatment in a year. The new HIV guideline on Universal Test and Treat (UTT) states that by the 1st of September 2016, all HIV infected patients should be put on Antiretroviral treatment irrespective of the CD4 cell count. Patients who were initially put on pre-ART and wellness programme should be initiated on ARTs. This means that HIV treatment should always be available.

The costs mentioned above, only includes HIV treatment and not laboratory costs. Before the treatment is initiated laboratory tests should be done. These tests are collection of baseline blood to see which HIV treatment will best suit the patient. These blood includes creatinine clearance, Hepatitis B Surface Antigen (HepBSAg), CD4 cell counts, Full Blood Count (FBC) and depending on the patient's CD4 count, Cryptococcal blood for meningitis is also collected. This also has to be paid for. We should also consider the patient's transport to PHC facilities for treatment collection and monitoring.

WHO state that if 20 million circumcisions are performed by the year 2025, this could save the world US$16.5 billion which is equivalent to R229 52 in South Africa. This could also reduce the rate of new HIV infections. Not only will it save on treatment, laboratory costs together with patient's transport will also be reduced. It is therefore very important to encourage and emphasize the importance medical male circumcision, not only as an HIV prevention strategy but also as a money saving method. The money that was supposed to be used on HIV treatment and laboratory costs can be used for more important things needed in the country.

2.3.3 Penile hygiene

It is difficult to maintain penile hygiene in uncircumcised men. There are bacteria that multiplies immediately after washing along with the skin secretions. This bacteria, is known as the smegma, which is found under the foreskin. The smegma is mixed with epithial cells, dirt and micro-organisms and these produce a foul smell. The bacteria alone have an offensive smell and many people consider it unclean (Addank, Pace & Bagarsa, 2008). This smell is so unpleasant that other people would consider circumcision the best option. Men who are circumcised reported that they find it easier to keep their penis clean after circumcision.

2.3.4. Benefits of Medical Male Circumcision for women

Women also benefits from partners who are circumcised. There is a reduced risk of cervical cancer in female partners of circumcised men (DOH,2016). This could be because of the reduced risk of HPV in circumcised men. Not only does MMC prevent the risk of HIV and other STIs in women, other women reported that sexual pleasure

has increased after circumcision. A study by Laino, C (2009), revealed that females whose male sexual partners performed MMC, reported an improvement in their sex life. This could be because now the penis looks much cleaner as before circumcision.

2.3.5. Other health benefits

A study by the department of health (2016), found that there is a lower prevalence risk of human papillomavirus (HPV) in men that have performed circumcision than those who did not circumcised. Men who did not circumcised have more chances of suffering from HPV as compared to those who are circumcised. The incidence of prostate and penile cancer is also low in circumcised men compared to uncircumcised men. MMC prevents the development of urinary tract infections (UTIs) and posthitis which is the inflammation of the foreskin.

2.4. Risks of medical male circumcision

MMC is considered a healthy practice in the reduction of HIV and other STIs, even though it has its potential benefits, there are also risks associated with it. Like any other surgical operation, MMC has its risks associated with it. These risks may include pain, bleeding, haematoma, infection at the site of the penis, injury to the penis (DOH,2016). Some men may have adverse reaction due to the anaesthetic used during the operation. It is not compulsory that all men who performed MMC will suffer from these risks. The adverse reaction may differ from individual to individual.

2.5. Knowledge on medical male circumcision.

There is lack of knowledge concerning the medical male circumcision. Some participants still do not know about the medical benefits of male circumcision. Some even said they will not perform it not even suggest it for their children (Taremeredzwa, 2011). There are still people who do not see the necessity of medical circumcision, since they do not know the benefit there of.

Knowledge about HIV/AIDS plays an important role and may lead to long-lasting behaviour change (Nashadi, 2013). The more people become knowledgeable about a certain habit the more likely they are to change their behaviour. Once people know

the importance and benefits of being medically circumcised the more they will come to perform it. Ever since offenders knew about male circumcision, they are performing it and the rate is scaling up.

Male circumcision is being practiced in the entire world and there is little knowledge on the public towards circumcision (Baker,2008). According to Wilcken, Keil & Dick (2010), male circumcision is more focused on cultural and religious beliefs and practices and less on health matters. Most African societies consider circumcision for cultural reasons, particularly as a way of proving manhood. This procedure is performed by traditional healers and most of them have no formal medical training.

2.6. Attitude towards medical male circumcision.

The study conducted by Ali (2013), on MMC, concluded that the more experience the person gains the more likely that person will change his/her attitude. This means the more knowledge and experience people gain, their attitude towards a certain habit will change positively. In this regard it can be concluded that knowledge affect people's attitude. When offenders are being knowledgeable towards the performance of MMC, they will ultimately change their attitude towards it.

2.7. Conclusion

Some people might still have negative attitude towards the performance of MMC, but with increased knowledge their attitude may change. If people know of the medical benefits that come with being medically circumcised, they will develop the eager to perform it and might even encourage others to do us. It thus remains the responsibilities of the health professionals to educate and encourage people to perform MMC, stressing the medical benefits that come with it.

This chapter reviewed what other sources say about medical male circumcision. It outlines both the benefits and risks associated with MMC. The next chapter outlines the methodology, that is how data was collected and analysed and how the principles of ethical issues were followed.

CHAPTER 3: RESEARCH METHODOLOGY

3.1. Introduction

The previous chapter, which is chapter 2 is about reviewing of facts and information from other literatures as far as MMC is concerned. This chapter discusses how the study was conducted. It explains how data was collected and analysed. In this chapter the researcher tells how she followed the principles of ethical issues. The chapter also outlines the significance of the study.

3.2 Research design

The study used a cross-sectional research design to determine the knowledge and attitudes of offenders towards the performance of MMC in prisons. Quantitative research method was used in the study. The study determined and assessed the knowledge and attitude of offenders towards the performance of MMC in prisons. The quantitative research study was selected because it minimises the researcher's bias as compared to qualitative study where the researcher collects data that requires active interaction with the participants (Chimuti, 2013).

3.3 Research site

The study was conducted at Leeuwkop management area, maximum centre. Leeuwkop management area is one of the biggest correctional centres in South Africa, located in north of Johannesburg. Leeuwkop management area has four centres, which are Medium A, Medium B, Medium C and maximum centre. Maximum centre accommodates only the sentenced offenders that are sentenced 15 years to life sentence. Some of these offenders are from other prisons around South Africa, where as others are from magistrate courts in the north of Johannesburg.

3.4. Study population

The population for this study was male offenders in Leeuwkop management area, maximum centre. Maximum centre had approximately 1000 sentenced male offenders (in May 2016).

3.5. Sampling

A sample size of 278 offenders was randomly selected according Morgan & Krecjie table. Maximum centre has four units, and each unit has six cells that accommodate 30 offenders each. Offenders were selected randomly from their cells. A minimum of 46 offenders were randomly selected from each unit. The researcher randomly selects the participants.

3.6. Inclusion criteria

Participants were included in the study based on the following characteristics

- Only offenders in maximum centre.
- Both traditionally and medically circumcised and uncircumcised offenders were included in the study.
- All racial groups were included.

EXCLUSION CRITERIA

- Offenders who are working outside the centre, since there are offenders who voluntarily work in prison as part of rehabilitation process.

3.7. Data collection

A structured researcher-administered questionnaire was used for the study. The questionnaire consisted of three sections, section A, section B and section C. Section A was the socio-demographic data and section B was questions on the knowledge concerning MMC and section C was on attitude towards MMC. The researcher had adopted questionnaire from other researcher (Nashadi,2013). The questionnaires were translated from English to Zulu and Setswana because these are the most spoken languages in Gauteng and majority of the offenders were from Gauteng. Though Leeuwkop prison had multi-racial offenders, the researcher believed that the amaSwati, AmaXhosas, and AmaNdebele speaking offenders do understand isiZulu, while the Sesotho and Sepedi speaking offenders do understand Setswana. Coloureds and Afrikaans speaking participants will use English questionnaire. The questionnaires are attached as appendix 1,2 and 3.

The period of data collection was 3 days, from the 4th to the 6th of April 2016. A random sample of 278 participants was drawn from the centre. The researcher was responsible for the distribution and collection of all questionnaires. The researcher managed to give questionnaires to all units in maximum centre. The participants had to fill the questionnaires and return them back to the researcher same day. Forty-six questionnaires were distributed to each unit.

3.8. Data analysis

Most researchers use statistic as a powerful tool to analyse quantitative data. This tool enables the researcher to reduce, summarise, organise, evaluate and interpret quantitative data (Brink, Van Der Walt & Van Rensburg, 2010). The researcher used chi-square test when analyse data. SPSS (Statistical Package for Social Science) was used to analyse the compiled data with the help of a statistician.

Descriptive and inferential statistical analyses were employed. Data was summarized using graphic presentations for the interpretation of findings. Of the 278 questionnaires distributed, 223 were returned which makes a response rate of 80.21%. Of these 223, 20 were incomplete, remaining with 203 for analysis. Statistics were based on percentages and frequencies.

3.9. Validity and reliability

Validity is the measure of whether the results are in relation with the study (Juveland, 2014). To ensure validity, the researcher used existing questionnaire that have been validated and modify them to suit this study. The aims and objectives were clearly defined. The tool measured what it supposed to measure. Reliability is the consistency of the test to give the same results with different groups (Juveland, 2014). To ensure reliability, pilot study was done using the same questionnaire at Medium A prison in Leeuwkop management area. A maximum of fifteen offenders were used to pilot the study. The results gathered on the pilot study was used to clarify the questions asked and to see if they give consistent results when used on the participants.

3.10. Ethical consideration

Ethical consideration is the values and morals carried-out during interaction with others during data collection and distribution of the results. Some of this includes engagement of the researcher, confidentiality of data, anonymity of participants and the emerging problems (Bryman & Bell,2007). The researcher ensured that any possible identified discomfort for the participants was explained during the process of obtaining informed consent especially with questions that were asked. It was important for the researcher to adhere to ethical principles since the participating participants were vulnerable groups.

3.10.1 Informed consent

Written materials accompanied verbal explanation which were perfectly clear that participants have an absolute right to decide to participate or withdraw at any time, participants were informed that participation in the study is voluntary. The researcher informed prospective participants about the study and secured their voluntary consent. Participants were given consent forms to sign to acknowledge that they agree to participate in this study voluntarily. Copies of informed consent have been attached as appendix 4, 5 and 6 which are in English, Zulu and Tswana respectively.

3.10.2 Ethical clearance and permission

Ethical clearance for research includes intellectual honesty, accuracy, fairness and protection of human (Zayed University, 2010). Permission is the act of giving formal consent (Free dictionary, 2017). The purpose of obtaining ethical approval is to protect both the participants and the researcher. Obtaining ethical approval shows that the researcher has adhered to the accepted standards of a genuine research (UCL,2015). Letter requesting permission from the correctional services research directorate is attached as appendix 7. The researcher obtained ethical clearance from the University of Limpopo Research and ethics committee and the copy has been attached as appendix 8. Permission from the correctional services research directorate was obtained before collecting data. The researcher got approval from the department of correctional services research directorate and the approval letter is attached as appendix 9.

3.10.3 Confidentiality

The researcher ensured privacy, worth and dignity of the participants, by not availing the information to anybody except the researcher and the supervisor. In this regard, the researcher used the codes not names on the questionnaires, and had the notebook with names of the participants for follow up visit should the need arise.

3.11 Bias

To eliminate bias, same questions were asked to all the participants. The questions were close-ended questions. No questionnaire was taken to the cell and returned the following day.

3.12. Significance of the study

For MMC programmes to succeed and be seriously taken and recognised as HIV prevention strategy in Gauteng prisons, it is important that offenders and health care providers have adequate knowledge on HIV and MMC. This will ultimately lead them to having positive attitude. The researcher therefore decided to do a study on knowledge and attitudes of offenders towards the performance of medical male circumcision in prisons of Gauteng province.

3.13. Conclusion

Chapter 3, outlined how the study was conducted. It explained the study site, research design, sampling, population and how data was collected and analised. It also explained how the researcher adhered to the principles of ethics since he/she was dealing with vulnerable groups. The next chapter discusses the results obtained during data analyses.

CHAPTER 4: RESEARCH RESULTS:

4.1 Introduction

The previous chapter discussed how data was collected and it will be analysed. It also discussed how the researcher adhered to the principles of ethical approval. This chapter presents and describes the results of data analysis of the study. The results are presented using figures and tables. The chapter is presented in sections in a bid to address research objectives.

In this chapter, the results are presented in two parts: the first part describes the overall findings of the study in descriptive statistics, while the second part comprises of inferential statistics calculated. A structured questionnaire was answered by 203 participants in relation with their knowledge and attitudes towards the performance of MMC in prisons. The SPSS software program was used to analyse the results.

4.2.1 Section A

Socio-demographic characteristics of respondents

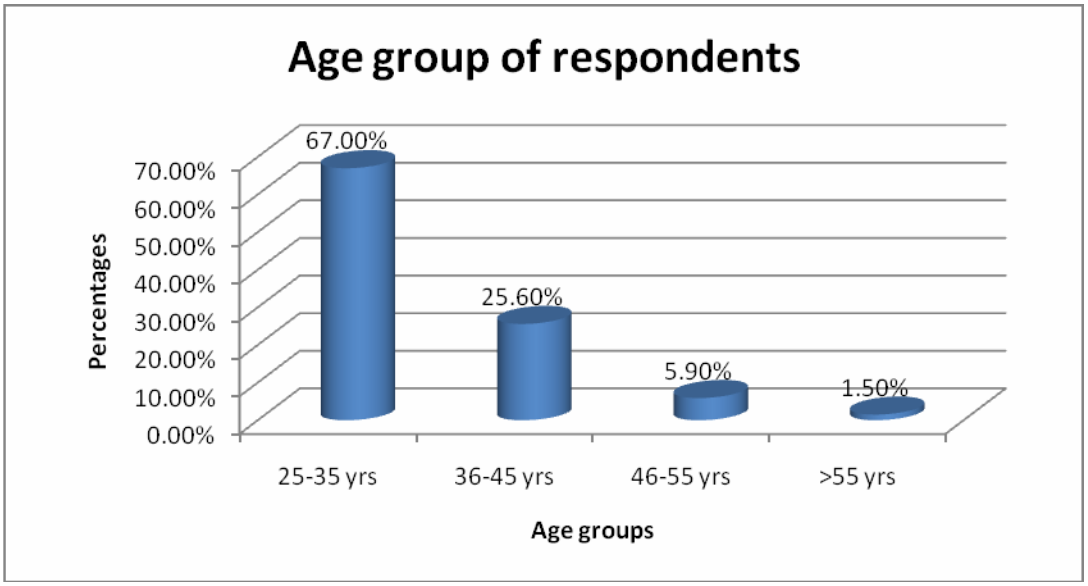

Figure 4.1. Age-groups of Respondents

Figure 4.1 shows that majority of the respondents were between the age of 25-35years (67%) and 25.6% were between the ages of 36-45 years. The least respondents were those above the age of 55 years (1.5%).

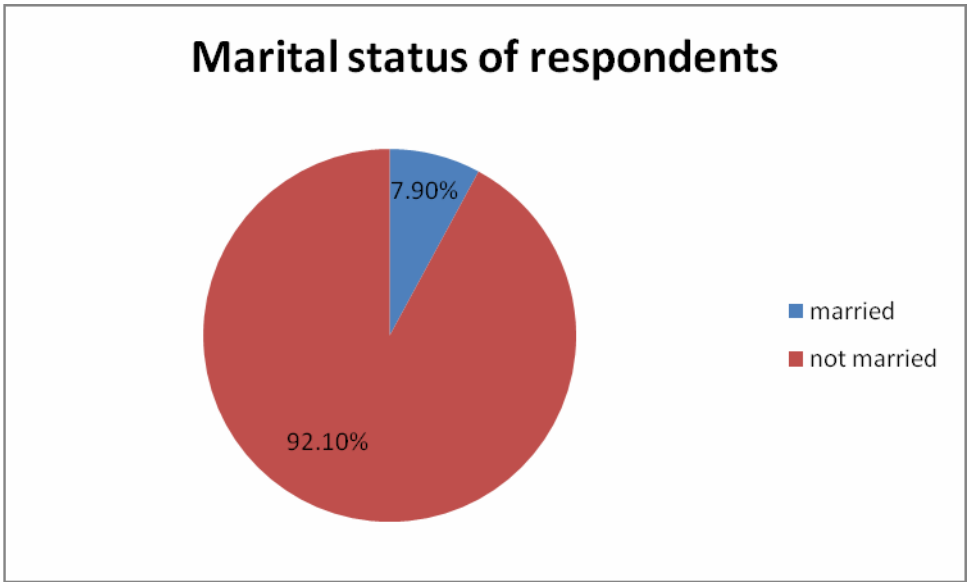

Figure 4.2 Marital status

Figure 4.2 above illustrate that 92.1% of the respondents were not married and only 7.9% were married.

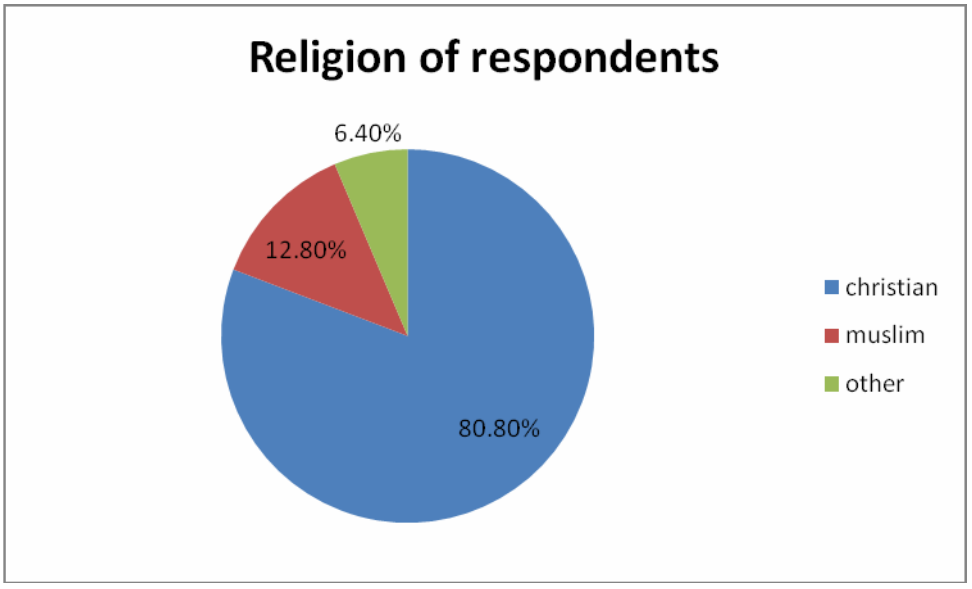

Figure 4.3 Religion of the respondents

Figure 4.3 shows that 80.8% of the respondents were Christians, 12.8% were Muslims and only 6.4% were from other religions.

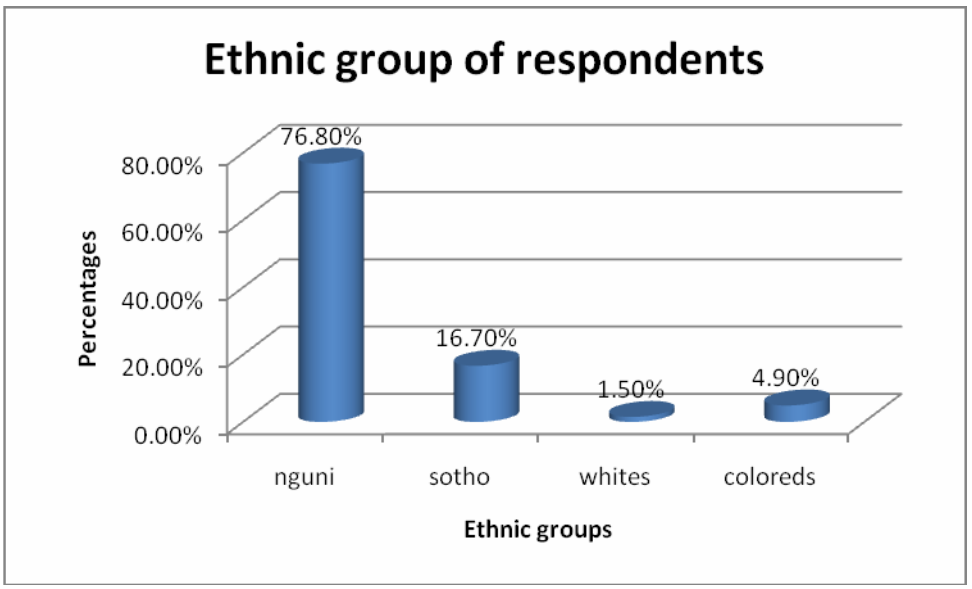

Figure 4.4 Ethnic group of respondents

Figure 4.4 shows that 76.8% of the respondents were Ngunis, 16.7% were Sothos and the least were whites with only 1.5%.

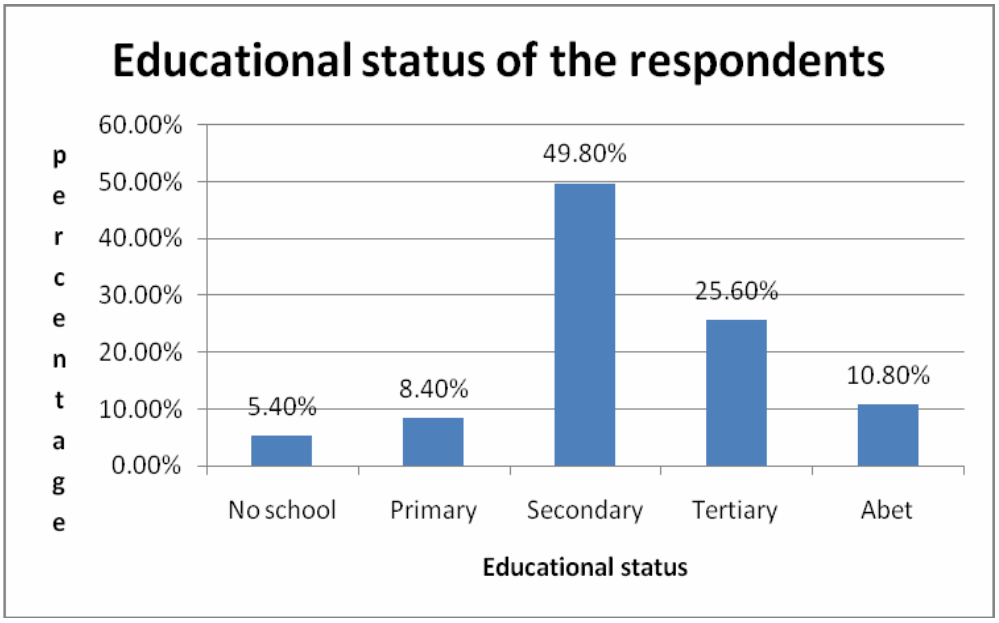

Figure 4.5. Educational status of the respondents.

Figure 4.5, shows that majority of the respondents had secondary school (49.8%), few had no education (5.4%). Respondents who had primary school education were 8.4% and 25.6 % had tertiary education.

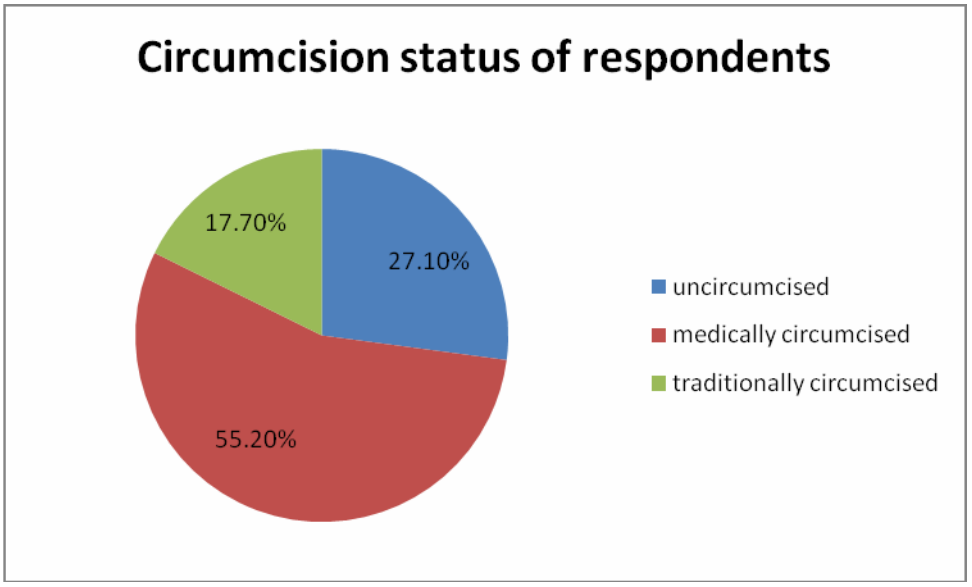

Figure 4.6. Circumcision status of the respondents

Figure 4.6, shows that 55.2% of the respondents reported that they were medically circumcised; 27.1% were not circumcised and only 17.7% were traditionally circumcised.

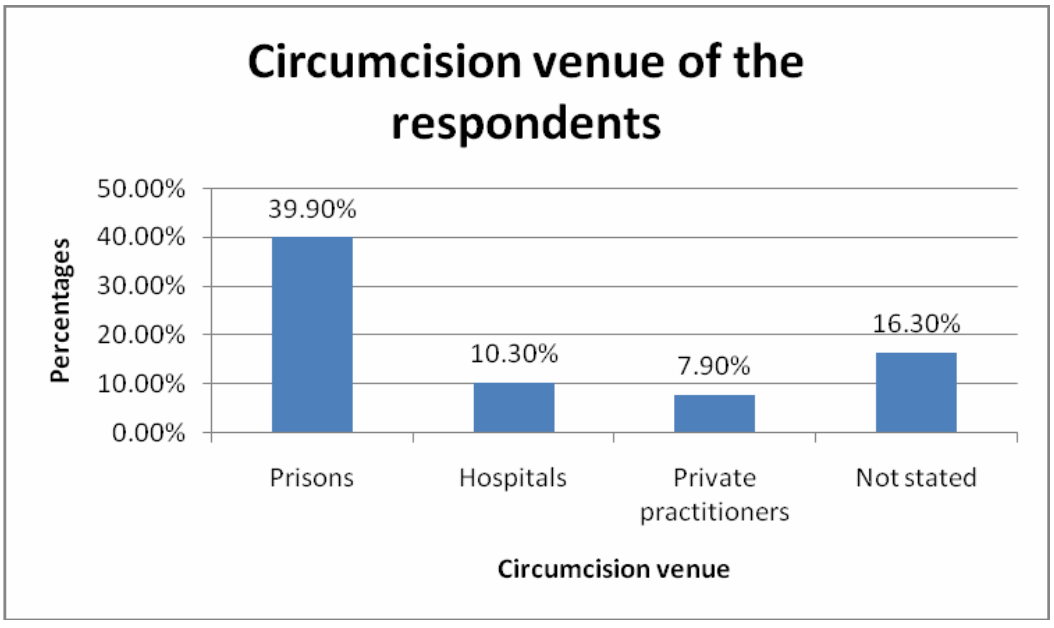

Figure 4.7. Circumcision venue of the respondents.

figure 4.7 above shows that 39.9% of the respondents reported that they performed MMC in prisons. The figure also shows that 10.3% were circumcised in the hospitals and 16.3% did not mention where they were circumcision, since respond to the circumcision venue option.

Table 4.1 Cross-tabulation of marital status by circumcision status.

		CIRCUMCISION STATUS			
		UNCIRCUMCISED	MEDICALLY CIRCUMCISED	TRADITIONALLY CIRCUMCISED	Total
MARITAL2	NOT MARRIED	55(29.6%)	102(54.8%)	29(15.6%)	186
	MARRIED	0	9(56.3)	7(45.7)	16
Total		55	111	36	202

Table 4.1. shows that in 186 respondents that were not married, only 29.6% were uncircumcised, 54.8% were medically circumcised and 15.6% were traditionally circumcised.

4.2. SECTION B.

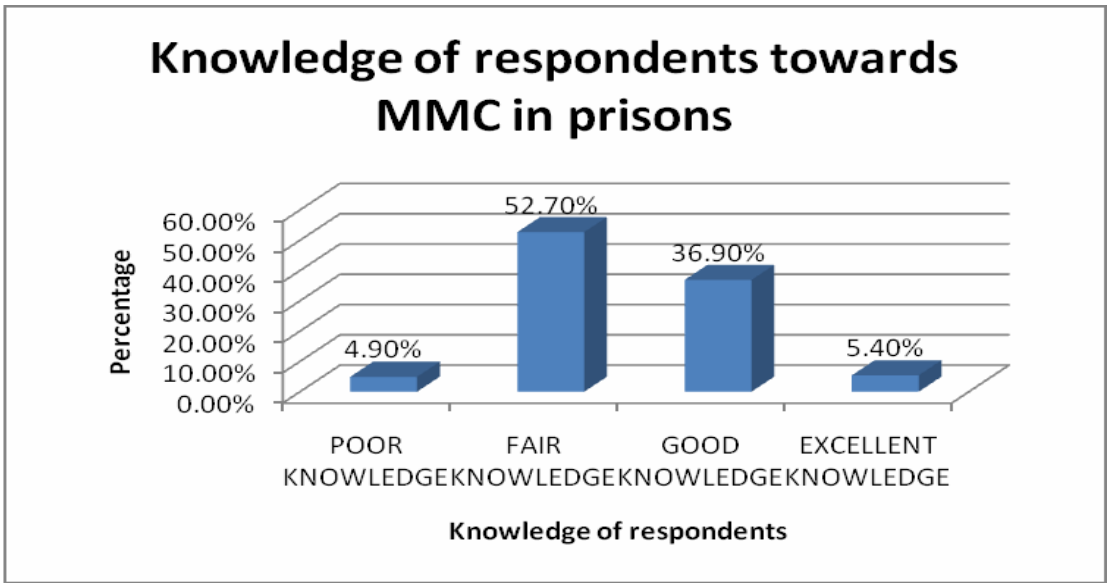

Figure 4.8. Knowledge on medical male circumcision

Figure 4.8 above Shows that more than half (52.7%) of the respondents had fair knowledge on MMC in prisons and 36% of the respondents had good knowledge as

far as MMC in prisons is concerned. Only 4.9% of respondents had poor knowledge about performance of circumcision in prison, whereas, 5.4% had excellent knowledge. The results show that most offenders did not have enough knowledge as far as performance of MMC in prisons is concerned.

4.2.3. SECTION C

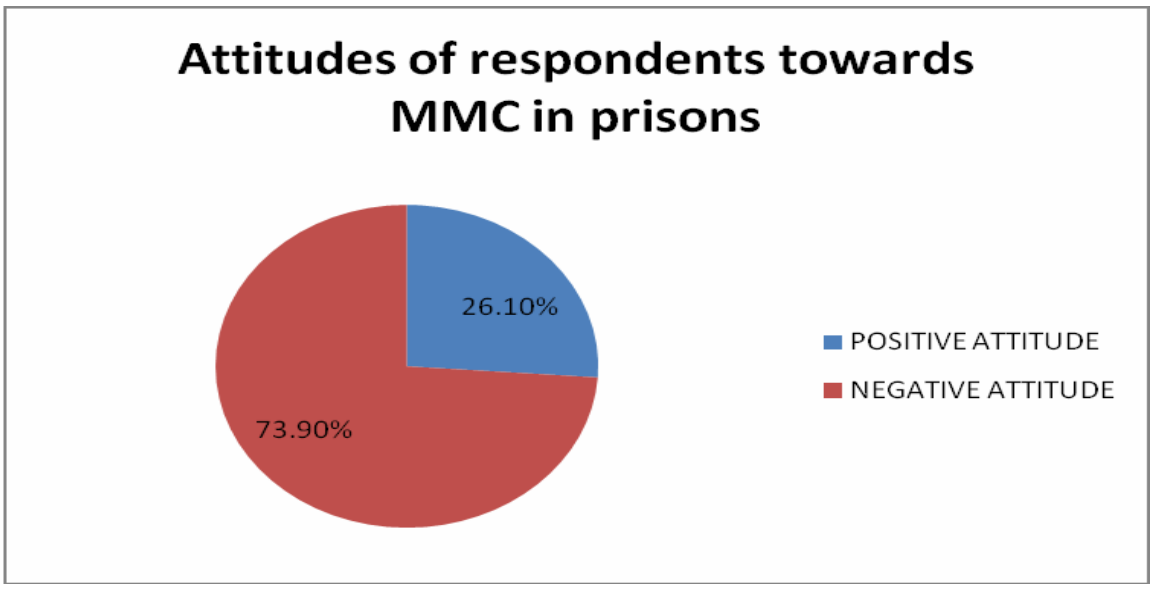

Figure 4.9 Attitude towards medical male circumcision in prisons

The 4.9 above shows the attitudes of offenders towards the performance of MMC in prisons. According to the figure above, 73.9% of respondents had negative attitude towards the performance of MMC in prisons. of the 203 offenders who participated in the study, only 26.1% showed positive attitude towards the performance of MMC in prisons.

4.3. Association between variables

This section explains the association between age, religion, educational status and ethnic group of the offenders in relation to the knowledge and attitudes of offenders towards the performance of MMC in prisons. The aim of this was to determine whether there is an association between the variables.

Table 4.3.1 Association between knowledge, age and level of education of offenders towards the performance of MMC in prisons

		Total	Poor knowledge	Fair knowledge	Good knowledge	Excellent knowledge	P-values
Age groups	≤ 35yrs	136 (100%)	9 (6.7%)	15 (11%)	30 (22.1%)	82 (60.3%)	P=0.378 X^2=3.093
	>35yrs	67 (100%)	4 (6%)	13 (19.4%)	16 (24%)	34 (51%)	
Education	Primary or less	29 (100%)	0 (0%)	1 (3.4%)	6 (20.7%)	22 (75.9%)	P=0.148 X^2=9.487
	Secondary or literacy	122 (100%)	11 (9%)	18 (14.8%)	30 (24.6%)	63 (51.6%)	
	Tertiary	52 (100%)	2 (3.9%)	9 (17.3%)	10 (19.2%)	31 (59.6%)	

Table 4.3.1 shows no association between knowledge and age of offenders towards the performance of MMC in prisons [x^2=3.093, P-value=0.378]. There is also no association between knowledge and offenders' level of education as shown by the above table [X^2=9.487, P-value=0.148].

Table 4.3.2 Association between attitude, age, level of education and religion of offenders towards the performance of MMC in prisons.

		Total	Positive attitude	Negative attitude	P-values
Age groups	≤ 35yrs	136(100%)	78 (57.4%)	58 (42.6%)	P=0.218

	>35yrs	67 (100%)	43 (64.2%)	24 (35.8%)	X^2=0.869
Education	Primary or less	29 (100%)	16 (55.2%)	13 (44.8%)	P=0.455
	Secondary or literacy	122(100%)	77(63.1%)	45 (36.9)	X^2=1.577
	Tertiary	52 (100%)	28 (53.8%)	24 (46.2%)	
Religion	Christianity	164(100%)	100 (61%)	64 (39%)	P= 0.564
	Muslim	26 (100%)	13 (50%)	13 (50%)	X^2=1.144
	Other	13 (100%)	8 (61.5%)	5 (38.4%)	

Table 4.3.2 shows that there is no association between attitude and the offenders' age towards the performance of MMC in prisons [P-value= 0.218, x^2=0.869]. There is no association between attitude and the offenders' level of education towards the performance of MMC in prisons [P-value=0.455, x^2=1.577]. The above table 4.3.2 shows no association between attitude and offenders' religion towards the performance of MMC in prisons [P-value= 0.564, x^2=1.144]

CHAPTER 5: DISCUSSION OF FINDINGS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the results found in chapter 4. The problem statement and objectives of the study are therefore revised and recommendations are made. The findings are from the questionnaire. The researcher also discusses the associations between the variables.

5.2. Discussions of major findings

- Socio-demographic profile of offenders.
- To determine the knowledge of offenders towards the performance of MMC in prison.
- To determine the offenders' attitudes regarding MMC in prisons.
- To establish relationship between knowledge and practises and demographic factors.

5.2.1. Socio-demographic profile of offenders

- **Age of offenders**

Most offenders who participated in the study were between the ages of 25-35 years of age. This age group was the group where most of them became arrested. Generally, men at this age group are likely to be circumcised or ready to be circumcised. This is the age group where males are sexually active, and therefore at high risk of contracting HIV according to Statistics South Africa (Stats SA, 2011). It is therefore important that they be medically circumcised within prison if they are not yet circumcised, in order to minimize being infected with HIV whilst in prison or when they are released from prison. Also, older males are likely to reject the idea of MMC within the prison settings, because of the cultural connotation attached to circumcision. In a study conducted by Chikutsa et Al., (2015), in Bindura Zimbabwe, revealed that men between the ages of 45-54 years were not eager to be medically circumcised. This can be because they lack knowledge on MMC as an HIV prevention strategy as shown by the results in chapter 4.

- **Marital status of offenders**

MARITAL2 * CIRCUMCISION STATUS Cross-tabulation

Count

		CIRCUMCISION STATUS			
		UNCIRCUMCISED	MEDICALLY CIRCUMCISED	TRADITIONALLY CIRCUMCISED	Total
MARITAL2	NOT MARRIED	55	102	29	186
	MARRIED	0	9	7	16
Total		55	111	36	202

The results of this study revealed that the majority of offenders were not married, with only close to a 10th who were married. From the results, all offenders who were married had performed MMC, whilst close to a third of those who were not married were uncircumcised. The majority of single males reported that they were medically circumcised whilst few reported that they were traditionally circumcised. This means that marital status has influence on the performance of MMC. A study conducted by Taremeredzwa (2011), found that some traditional groups consider uncircumcised men as unclean and not fit for marriage, however, Mogere (2015), argued that marital status has no significant impact on MMC status

- **Educational status**

The results of the study revealed that half of the offenders had secondary schooling and only less than a tenth never went to school. From these results, it is expected that the majority of offenders would have good knowledge about benefits of MMC, because of their level of education. In a study by Naidoo, Dawood, Driver, Ndlovu, & Ndlovu (2012), it was found that educational status significantly, influences knowledge on MMC. In contrast Mogere (2014), found that level of education didn't have a significant effect on whether one decision to circumcise or not. A study by Morege (2015), revealed that most people who went up to secondary to tertiary schooling have undergone MMC. Culturally, the passage to manhood is through

informal teachings by men who have already circumcised, irrespective of their level of education, however, the emphasis is mainly on traditional circumcision than on MMC (Wanyama, 2013).

lease just add more info on the both types of circumcision and what influence one to choose one type over another, with emphasis on literature to support.

- **Religion of offenders**

From the current results, majority of the respondents were Christians. According to Mati, Adegoke & Salihu, (2016), there are no religious boundaries that blocks one from performing male circumcision, however, May, (2014) argues that circumcision is performed for religious reasons especially in the Islamic and Judaism. According to Mubekapi (2013), MMC is performed for religious purposes especially by the Muslims and Jews. Egyptians adopted male circumcision in the year 2300BC as a way of obeying God's law (Teremeredzwa, 2011). Different religions practice this culture differently, in some, MMC is performed when the child is very young, others at adolescent stage. In most developing countries and in Islam and Judaism, circumcision is normally performed within few days after birth while circumcision is done in late childhood or adolescent in many African Tribal groups (Teremeredzwa, 2011).

- **Circumcision status of offenders**

The results of this study showed that the majority of the respondents were medically circumcised. The results on circumcision status by marital status revealed that most of the respondents who were not married are medically circumcised (46%). Chimuti (2013), revealed that men between the ages of 15-49 were more likely to circumcise. Only 8% of the married respondents were circumcised both medically and traditionally. A study by Chikutsa et.al (2015) showed that men between the ages of 45-54 did not want to circumcise. This is the age where most men are married.

5.2.2. Knowledge of offenders towards MMC in prisons.

The results of this study further revealed that most of the offenders lack knowledge as far as MMC in prisons is concerned. Most of the respondents did not know who to

approach when they want to circumcise and which day of the week is MMC performed in their prison. A study by Taremeredzwa (2015), in Zimbabwe showed that most respondents said circumcision is not practised in their culture. The study showed that majority of the respondents were Nguni 78.6% (i.e. AmaZulu, AmaXhosa, VaTsonga and AmaNdebele,) and most of them undergo traditional male circumcision other than medical male circumcision hence they have little knowledge on medical male circumcision.

There was no association between offenders' age and knowledge towards MMC in prisons. In a study conducted by Chikutsa et.al, (2015), men between the ages of 45-54 years showed no eager to circumcise. This can be because they lack knowledge on MMC as an HIV prevention strategy. The results of this study showed no significant association between offenders' educational status and knowledge towards the performance of MMC in prisons. This is somewhat surprising since it is believed that education will play a significant role on knowledge towards MMC. Segwayo, (2011), found that the level of knowledge on MMC is high on people who are educated however, Ikwegbue, Ross & Ogbonnaya (2015), found that most respondents with higher level of education had an inverse relationship that MMC prevents HIV infection.

Chimuti (2013) and Ikwegbue et.al (2015) showed poor knowledge of the respondents on MMC as an HIV prevention strategy however, in a study by Segwayo, Christopher, Newell & Imrie argued that most respondents presented with high level of knowledge about MMC as an HIV prevention strategy. They further revealed that young men were aware that MMC is not a replacement for condom use.

5.2.3. Attitude of offenders towards MMC in prisons.

The results showed that majority of the respondents have negative attitude towards the performance of MMC in prison. A study by Naidoo et.al (2012), showed that most of the respondents did not welcome the practice of MMC, revealing that it will lead to risky sexual behavior. They further revealed that more than 50% of the respondents were not willing to circumcise. This may be because other ethnic groups still perform male circumcision for cultural reasons. Sengwayo (2011) believes that

cultural beliefs and practices play an important role on attitudes towards MMC. AmaXhosas, BaSepedi, VaTsonga and VhaVenda still perform male circumcision for cultural purpose. A study by Dingindlela, (2014) revealed that in Xhosa culture traditional male circumcision is still taken seriously therefore it is a challenge for them to fully accept MMC programmes. There is also an event held annually where uncircumcised men are not allowed near that event. Those who are not traditionally circumcised are being ridiculed and harassed and also being labeled as 'leshoboro' meaning that they are not traditionally circumcised (Dingindlela,2014).

Association of variables showed no association between offenders' age and their attitude towards the performance of MMC in prison. A study by Chimuti (2013), found that respondents between the ages of 30-49 years recommended that MMC should be made mandatory to all. A study by Sengwayo (2011), revealed that young men accepted circumcision and were willing to perform it. Older men recommended MMC for younger men because they believe that younger men are highly sexually active and have multiple partners. There was no association between offenders' educational level and their attitude towards MMC in prisons.

5.3 Conclusion.

The aim of the study was to determine and assess the knowledge and attitudes of offenders towards the performance of medical male circumcision in prisons. The following was concluded based on the results found.

More than half (52.7%) of offenders presented with fair knowledge towards the performance of MMC in prisons. Chapter 4 state that 36% of the participated offenders has good knowledge. Some of the offenders do not even know that their prison perform circumcision, whereas those who know do not know which day of the week is MMC performed.

However, not only do they lack enough knowledge on MMC in prisons, offenders also have negative attitudes as far as MMC in prisons is concerned. In all the participated offenders, 73.9% have negative attitude on MMC in prisons and only 26.1 presented with positive attitude. Most participants said they will not allow a female professional to perform MMC on them. Others said allowing female

professionals to perform MMC on them violates their traditional rights. Most of them have negative attitude on MMC yet they still circumcise in prison, this may be due to them being vulnerable groups and are subjected to agree to whatever they are told to do or it may be because of peer pressure encountered in prisons.

5.4 Recommendations

The researcher came up with the following recommendations based on the results obtained.

5.4.1. Recommendation for education

Seeing that most offenders lack knowledge on MMC, they should be thoroughly educated on the importance of being medically circumcised. It is the responsibility of the health care workers to ensure that they disseminate enough information to the offenders concerning the performance MMC in prisons. Offenders should know the benefits and complications of performing medical male circumcision. Offenders should also know which day of the week is MMC performed in their prison and who to consult when they want to perform it. Offenders should know that there is no difference in MMC performed by female and male health care professionals. Health care professionals should clarify all myths associated with medical male circumcision in prisons, especially that say when you are medically circumcised you are not 'man enough' as compared to being traditionally circumcised. Offenders should know that MMC does not only prevent the risk of HIV by 60%, it also prevents the risk of developing cervical cancer in wives or girlfriends of the medically circumcised men.

5.4.2. Recommendation for practice

This review identified numerous factors contributing to lack of knowledge and negative attitudes of offenders towards the performance of MMC in prisons. These factors need careful attention and partnership from both the Department of Health and Department of Correctional Services (DCS) in Gauteng Province. It seems like the DCS is not doing enough in disseminating the message on MMC in prisons. The review suggests that the Gauteng DOH and DCS should put more effort in informing offenders about the benefits of MMC in prisons. This can be achieved through

effective training of health professionals and thorough health education to the offenders.

5.4.3. Recommendation for research

This review revealed several research gaps, there is limited data on MMC in prisons, especially in South Africa. Many studies focused on MMC in the outside world but not in prisons. Cross sectional studies are effective in measuring prevalence and identifying associations but do not reach casualty as much as cohort studies do. There is escalating rate of HIV infection in prisons and this may be due to men sex on men (MSM) which is the fastest transmission of HIV. More research on MMC in prisons in needed, especially if we want to reduce the spread of HIV. This study does not include qualitative study in order to identify the reasons why most offenders had negative towards MMC in prisons. There should more qualitative studies employed to assess factors leading to negative attitudes towards MMC in prisons.

Offenders should know that MMC does not only prevent the risk of HIV by 60%, it also prevents the risk of developing cervical cancer in wives or girlfriends of the medically circumcised men.

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APPENDIX 1

A QUESTIONNAIRE TO DETERMINE THE KNOWLEDGE AND ATTITUDES OF OFFFENDERS TOWARDS THE PERFORMANCE OF MEDICAL MALE CIRCUMCISION IN PRISONS OF GAUTENG PROVINCE, SOUTH AFRICA.

Introduction: This survey is being carried out to assess the knowledge and attitude of offenders towards the performance of MMC in prisons. Please feel free to answer genuinely. The information collected will be treated with utmost confidentiality. Please return the questionnaire to the person who gave it to you.

Instruction: please put a cross (x) in the box corresponding to your answer of choice and fill in the blank spaces.

Part I: Socio-demographic characteristics of the participants

1. Age

25- 35 years	1
36-45 years	2
46-55 years	3
>55 years	4

2. Marital status

Single	1
Married	2
Divorced	3
Widower	4

3. Religion

Christianity	1
Muslim	2
Hindu	3
Other specify	4

.....	

4. Ethnic group

Zulu	
Sepedi	
Tswana	
Coloured	
Swati	
White	
Ndebele	
Southern Sotho	
Venda	
Tsonga	
Xhosa	
Other specify	

5. Highest education obtained:

Never attended school	1
Primary	2
Secondary	3
Tertiary	4
Adult literacy class	5

6. Circumcision status

Uncircumcised	1
Medically circumcised	2
Traditionally circumcised	3

7.If medically circumcised, where?

Prison	1
Hospital	2
Doctor's surgery	3

Part 2: Knowledge on medical male circumcision (Nashadi,2013).

Questions	YES	NO
1. Do you know that prisons do perform MMC?		
2. Do you know which day of the week is MMC performed in your prison?		
3. Do you know who to approach when you want to circumcise in prison?		
4. Were you told about the performance of MMC in prisons?		
5. Based on your knowledge on MMC, can you explain that to other offenders?		
6. Do you think the information on MMC in prisons is well communicated?		
7. Do you think the prison is doing enough in encouraging offenders		

to perform MMC in prison?		
8. Do you know about the benefits of MMC?		
9. Do you know about the complications of MMC?		
10. Does MMC provide 100% protection against HIV?		
11. Does MMC reduce the risk of being infected with HIV?		
12. Is the any need of using condom after performing MMC?		
13. Does MMC reduce the risk of other STIs?		
14. Does MMC improve hygiene?		
15. Does one need to abstain from sex for six weeks after MMC?		

Part3. Attitude towards medical male circumcision

Questions	**YES**	**NO**
1. Do you think is a good idea to perform MMC in prisons?		
2. Do you think is a good idea that female health professionals are performing MMC?		
3. Would you allow a female health professional to perform MMC on you?		
4. Do you think circumcision performed by a female health professional heals faster than the one performed by a male health professional?		
5. Do you think that being circumcised by a female health professional violates your rights?		
6. Do you think people who perform MMC in prison heal faster than those outside?		

7. Would you perform MMC in prison?		
8. Would you recommend other offenders to perform MMC in prison?		
9. Do you think MMC in prison should be compulsory to all offenders who did not circumcise?		
10. Do you think MMC violates the principles of traditional male circumcision?		
11. Do you think performing MMC in prison proves manhood?		
12. Is performing MMC in prison the same as doing it at hospital?		
13. Does performing MMC increase sexual pleasure?		
14. Do you find it easy to perform MMC in prison than outside?		

APPENDIX 2

LETLAKALA-POTSISO LA GO LEKOLA KITSO LE MAIKUTLO A BAGOLEGWA MABAPI LE TIRAGATSO YA TSHEGO YA BONG-TONA BJA MAPHELO KO DIKGOLEGELONG.

Matseno: Dipatlisiso tseno di diragatswa go batlisisa kotso le maikutlo a bagolwegwa ka tiragatso ya tshego ya bong-tona ba maphelo mo dikgolegelong. Gololosega mme o arabe ka boineelo. Kitso e kokoantsweng e tla tshwarwa jaaka khupamarama. Ka kopo kgotlisetsa letlakalapostiso go motho yo a go neileng tsona.

Molawana: Dirisa letshwao (x) mo lebokosong go supa karabo e nepagetseng.

Karolo ya ntlha: Tsa selegae

1. Dingwaga

25- 35 ya dingwaga	1
36-45 ya dingwaga	2
46-55 ya dingwaga	3
>55ya dingwaga	4

2. Kemo ya nyalo

Nosi	1
Nyetsi	2
Thladile	3
Motlhologadi	4

3. Bodumedi

Bokriste	1
Bomuslim	2
Bohindi	3

Nngwe thlalosa ……	4

4. Mofuta wa setso

Zulu	
Sepedi	
Tswana	
Coloured	
Swati	
White	
Ndebele	
Southern sotho	
Venda	
Tsonga	
Xhosa	
Enngwe, tlhalosa	

5. Seemo sa thuto

Ga ke a tsena sekolo	1
Thuto-tlase	2
Thuto e magareng	3
Thuto e kwa godimo	4
Thuto ya bagolo	5

6. Seemo sa lebollo

Ga ka bolla	1
Ke bolotse ka tsa maphelo	2
Ke bolotse ka setso	3

7. Fa ele tsa maphelo, ko kae?

Kgolegelo	1
Bookelo	2
Ko ngakeng ya maphelo	3

Karolo ya bobedi: Kitso ka tshego ya bong-tona ba maphelo

Dipotso	**Ee**	**Nyaa**
1. Aa o itse fa dikgolegelo di diragatsa tshego ya bong-tona?		
2. Aa o itse gore ke letsatsi lefe la tshipi leo tshego ya bong-tona e diragadiwang ka lona mo kgolegelong ya gago?		
3. Aa o itse gore o ka e kgolaganya le mang ga o batla go tsenela tsa tshego ya bong-tona mo kgolegelong?		
4. Aa bolelletswe ka tshego ya bong-tona mo kgolegelong?		
5. Go ya ka kitso ya gago ya tsa tshego ya bong-tona, o ka tlhalosetsa bagolegwa bangwe kay one?		
6. Aa o nagana fa molaetsa wa tshego ya bong-tona mo kgolegelong o gwetlhiwa sentle?		
7. Aa o nagana fa kgolegelo e dira go ka tlala seatla go rotloetsa bagolegwa go diragatsa tshego ya bong-tona mo kgolegelong?		
8. Aa o itse matswela a tshego ya bong-tona ba maphelo?		

9. Aa o itse ditlhakatlhakano tsa tshego ya bong-tona?		
10. Aa tshego ya bong-tona ba maphelo bo thibela leso la HIV kgotlelele?		
11. Aa tshego ya bong-tona ba maphelo bo fokotsa tshwaetsano ya leso la HIV?		
12. Naa go a tlhokagala go dirisa kgotlopo (condom) morago ga tshego ya bong-tona?		
13. Aa tshego ya bong-tona ba maphelo bo fokotsa kotsi ya malwetsi a thobalano?		
14. Aa tshego ya bong-tona ba maphelo bo rotloetsa bophepa?		
15. Aa mongwe o tlhoka go sa ikamane le tsa thobalano ditshipi di le thataro morago ga tshego ya bong-tona ba maphelo?		

Karolo ya boraro (3): Kgwetlo mabapi le tshego ya bong-tona ba maphelo

Dipotso	Ee	Nyaa
1. Aa o nagana gore ke kakanyo e ntle go diragatsa tshego ya bong-tona go kgolegelong?		
2. Aa o nagana gore ke kakanyo e ntle gore bomme ba tsa maphelo ba diragatse tshego ya bong-tona?		
3. Aa o ka dumelela gore motho wa mme wa tsa maphelo a diragatse tshego ya bong-tona go wena?		
4. Aa o nagana gore tshego ya bong-tona e diriwang ke motho wa mme e fola ka bonako go nale e diriwang ke motho wa ntate?		
5. Aa o nagana gore tshego ya bong-tona e diragadiwang ke motho wa mme wa tsa maphelo e nyenyefatsa ditokelo tsa gago?		
6. Aa o nagana gore bao ba dirang tshego ya bong-tona ko		

kgolelegong ba fola ka bonako gona le ba kwa ntle?		
7. Aa o ka tsenela tshego ya bong-tona ba maphelo mo kgolegoleng?		
8. Aa o ka rotloetsa bagolegwa bangwe go dira tshego ya bong-tona mo kgolegelong?		
9. Aa o nagana gore tshego ya bong-tona mo kgolegelong e tshwanetse go nna pateletso go bagolegwa b aba sa segang?		
10. Aa o nagana gore tshego ya bong-tona ba maphelo e nyenyefatsa melao ya setso?		
11. Aa o nagana gore tshego ya bong-tona ba maphelo mo kgolegelong bo bontsha bonna-tota?		
12. Tiragatso ya tshego ya bong-tona ba maphelo mo kgolegelong e tshwana le kwa ntle?		
13. Aa tshego ya bong-tona ba maphelo ke koketso ya tsa thobalano?		
14. Aa o bona go le bonolo go diragatsa tshego ya bong-tona ba maphelo mo kgolegelong gona le kwa ntle?		

APPENDIX 3

IMBUZO EZAMA UKUTHOLA NGOLWAZI NE SIMILO SEZIBOSHWA MAYELANA NOKULUKA NGENDLELA YESEMPILO EMAJELE.

Isaziso: Lolucwaningo lwenzelwa ukuvivinya ulwazi nesimo seziboshwa mayelana nomsebezi we kuluka ngendlela yesempilo emajele. Uyacelwa ukuthi uphendule imibuzo ngekukhululeke nangeqiniso. Ulwazi oluzoqokelelwa lizophathwa ngenkulu inhlonipho lephinde lubeyimfihlo.Uyacelwa okuba uma useqedile uphindisele iphepha lemibuzo kumuntu okunikeze lona.

Umlayezo: uyacelwa ukuthi ufake isiphambano (x) ebokisini eliqondene nempendulo ehambelana nemivo yakho, uphinde ugcwalise izikhala ezishiywe zingabhaliwe.

Isiqephu 1: Isici kwezenhlalo lokubala ubuningi babantu abahlanganyele kucwaningo.

1. Iminyaka

25- 35 yeminyaka	1
36-45 yeminyaka	2
46-55 yeminyaka	3
>55yeminyaka	4

2. Isimo somshado

Angikashadi	1
Ngishadile	2
Ngangishadile	3
Mfelokazi	4

3. Ezenkonzo

Christanity	1
Muslim	2
Hindu	3
Inye, qaza ……	4

4. Ebuhlanga

Zulu	
Sepedi	
Tswana	
Coloured	
Swati	
White	
Ndebele	
Southern sotho	
Venda	
Tsonga	
Xhosa	
Inye, qaza ….....	

5. Izinga lemfundo

Angiyanga esikoleni	1

Emabangeni aphansi	2
Emabangeni aphezulu	3
Emabangeni aphakeme	4
Izimfundo zabadala	5

6. Isimo sokusoka

Angisokanga	1
Ngisokile ngendlela yesimpilo	2
Ngisokile ngendlela yesintu	3

7. Umangesimpilo, kuphi?

Ejele	1
Esibhedlela	2
Ngodokotela yesimpilo	3

Isiqephu 2: Ulwazi ngekuluka ngesimpilo

Imibuzo	**Yebo**	**Cha**
1. Uyanzi yini ukuthi ijele liyayenzisa ukusoka?		
2. Ingabe uyalwazi yini usuku olwenziwa ngalo uhlelo lokusoka ejele lakho?		
3. Ngabe uyazi ukuthi uthintha bani mayelana nokusoka ejele?		
4. Utsheliwe ngendaba ye kusoka ejele?		
5. Ucabanga ukuthi ulwazi lokusoka ejele lutholakala ngokwanele?		
6. Ucabanga ukuthi ijele lenza ngokwanele ekukhuthazeni		

iziboshwa ngendaba yekusoka ejele?		
7. Ngolwazi lwakho mayelana nokusoka, ungachazela ezinye iziboshwa?		
8. Uyazi ngezinkinga zokusoka?		
9. Uyazi ongakuzoza ngokusoka?		
10. Ngabe ukusoka nguvikela ngculaza 100%?		
11. Ngabe ukusoka kunciphisa ingozi yokutheleleka ngeHIV?		
12. Sikhona isidingo sokusebenzisa icondom emva kokusoka?		
13. Ngabe ukusoka kunciphisa ingozi yokutheleleka ngezifo ezithelelana ngokocansi (STIs)?		
14. Ngabe ukusoka kukhulisa inhlanzeko?		
15. Ngabe kulungile ukungalwanzi ucansi amasonto asithupha emva kokusoka?		

Isiqephu 3: Similo sekuluka ngesimpilo

Imbuzo	**Yebo**	Cha
1. Ucabanga ukuthi kunguhlakanipha ukusoka ejele?		
2. Ucabanga ukuthi kofanele/kulungile ukuthi abantu abasemame basebenzisane nokusoka?		
3. Ungamvumela owesimame akusoke?		
4. Ucabanga ukuthi uma usokwe owesimame ukuphola kuyosheshisa ukudlula okwenze umuntu wendoda?		
5. Ucabanga ukuthi ukusokwa ngumuntu wesimame kuhlukumeza amalungelo wakho?		
6. Ucabanga ukuthi abantu abasokwe ejele baphola masinyane		

ukunalaba abangaphandle?		
7. Ungakwenza ukuthi o sokwe ejele?		
8. Ucabanga ukuthi ukusoka ejele kumele kuphoqelelwe kubo bonke abangasokile?		
9. Ungabakhuthaza oboshwe nabo ukuthi basokwe ejele?		
10. Ucabanga ukuthi ukusoka emtholampilo kuhlukumeza imigomo yokusokwa kwabesilisa ngokwesintu?		
11. Ucabanga ukuthi ukusokwa emtholampilo ejele kukwenza ube yindoda?		
12. Ngabe ukusokwa ejele kuyefana nokusokwa esibhedlele?		
13. Ngabe ukusokwa kwenza ulujabulele kakhulu ucansi?		
14. Ngabe kulula ukusoka ejele kunangaphandle?		

APPENDIX 4

University of Limpopo: Consent Form for conducting research

Dear Sir

I am Monkwe Phaphe Declinda and I'm a student at the University of Limpopo studying for a Master's Degree in Public Health (MPH). My research seeks to determine the knowledge and attitude of offenders towards the performance of medical male circumcision in prisons. The research will be conducted at the Leeuwkop Management Area maximum centre, Gauteng Province, South Africa.

I kindly request you to answer and complete a questionnaire which has a list of questions that ask brief information about yourself to help the health care providers understand your level of knowledge and attitude towards the performance Medical Male Circumcision in prisons. The whole questionnaire will take approximately 10 minutes to answer and complete. All the information provided about yourself will be kept strictly confidential. To ensure that you remain anonymous, your name and will not be written down. Should your name reflect on the research without your consent, you have every right to take legal actions against the researcher.

It is completely your choice to participate or not participate in this study. Participation is completely voluntary. You are also at liberty to withdraw from participating at any time. Refusal and withdraw from participation will not be used against you in any way.

NOTE WELL: Participating in the survey has nothing to do with your sentence period.

Should you have any queries about the research study please do not hesitate to contact me at 011 933 7128 or come straight to the hospital section. If you would like to participate in the study, please indicate so by signing the consent form below as this will allow us to proceed with the questionnaire.

Yours Truly

Monkwe P.D

Consent Form

I, Mr/Dr/ Prof.……would like to participate in the research study**: The knowledge and attitude of offenders towards the performance of MMC in prisons.**

Signature: …… Date:…….

APPENDIX 5

University of Limpopo: Tumellano ya go etsa patlisiso.

Motlotlegi

Ke nna Monkwe Phaphe Declinda, ke moithuti kwa Unibesithing ya Limpopo, ke ithutela degree ya godimo ya maphelo a sechaba (Public Health). Ke lakatsa go lekola ka kitso le maikutlo a bagolegwa ka tiragatso ya tshego ya bong-tona mo dikgolegelong. Patlisiso e etla diragatswa mo Leeuwkop Management Area, maximum centre, profensing ya Gauteng, Afrika Borwa.

Ka boikokobetso ke kopa hore o le arabe dipotso tse di amanang le kitso ka ga wena go thusa badiri ba tsa maphelo go tlhalogana kitso le maikutlo a gago ka diragatso ya tshego ya bong-tona ba maphelokodikgolegelong. Dipotso tsotlhe di ka tsaya metsotso e lesome go araba. Tshedimosetso ya gago ke khupamarama. Go nnetefatsa hore o ba hlokaina, leina la gago ga le ilo go kwadiwa fatshe. Fa leina la gago le ka tlhaga mo patlisisong e, o nale tokelo ya go tsaya tshwetso ya semolao kgahlanong le mmatlisisi.

Ke boikgethelo ba gago go tsenela kgotsa go se tsenele patlisiso e. O dumeletswe go ka ikentsha mo patlisisong nako efe kappa efe. Go se kenele kgotsa go folotsa mo patlisisong go ka se diriswe ope kgatlhanong le wena.

Ka thlokomelo: Go kenela patlisiso ga o amane sepe le go tshwarwa gag ago.

Ga o nale dipotso ka patlisiso e, ka kopo golagana le nna ka mogala mo 011 933 7128 kgotsa o tle ko bookelong. Fa o lakatsa go kenela patlisiso e, ka kopo dira jalo ka go tlatsa tumelo e latelang, e etla thusang go tswella pele ka dipotso.

Wa gago

Monkwe P.D

Consent Form

Nna, Mr./Dr./ Prof.……lakatsa go kenela patlisiso e**:** **The knowledge and attitude of offenders towards the performance of MMC in prisons.**

Signature: …… Date:…….

APPENDIX 6

Inyunivesi yese Limpopo: Imvume yokwenza ucwaningo

Sawubona Mnumzane

Igama ngingu Monkwe Phaphe Declinda, ngiwumfundi wase Nyunivesi yase Limpopo ufundela izifundo zezinga eliphakeme Masters of Public Health.Ucwaningo lami lihlose ukuthola ulwazi nesimo sababoshiwe ngomsebenzi wezokusoka kwabesilisa ngendlela yesimpilo emajele. Lolucwaningo luzoyendlelwa eLeeuwkop Management Area, maximum centre, eGauteng province, South Africa.

Ngomusa ngicela uphendule uqedelele lemibuzo enohla elidinga inchazelo yolwazi ngawe ekisizeniezokuphepha nekunakekela ngokuqonda izinga lolwazi lakho nokuqonda umsebenzi wezoluko lwasesilisa ngendlela yesimpilo emajele.Ukuphendula nokuqedelela lemibuzo kuzothatha mizuzu eyeshumi.Ulwazi elizoqokelelwa ngwawe lizogcinwa luyimfihlo ngokuphelele.Ukuqiniseka ukuthi uhlala ungaziwa, igama lakho angeke libhalwe phansi kuleliphepha.Uma kungenzeka igama lakho livele kulolucwaningo ngaphandle kwemvumo yakho, unalo ilungelo lokuthathela umcwaningi amanyathelo omthetho enkantolo.

Ukuhlanganyela kulolucwaningo kuyintando yakho futhi noma ungathandi awuphoqiwe ukuthi uhlanganyele. Ukuhlanganyela kwakho uyavolontiya. Usenkululekweni yokuzikhipha kulocwaningo noma yisiphisikhathi. Ukuzikhipha kucwaningo asoze kwasetshenziswa ekucindezeleni amalungelo akho.

Nakekela: ukuhlanganyela kulolucwaningo akuhlangene nesigwebo sakho.

Uma inemibuzo ngalolucwaningo ngiyacela ukhululeke ungishayela ucingo ku 011 933 7128, noma uze kimi esibhedlela sejele. Uma uthanda ukuhlanganyela

kucwaningo, uyacelwa uthsengise ngokusayina leliphepha lemvume, ukwenza njalo kosivumela ukuthi siqhubeke ngemibuzo.

Owakho weqiniso

Monkwe P.D.

Iphepha lemvume

Mina/Mnu/Dok.....ngiyathanda ukuhlanganyela kulolucwaningo: **Ulwazi nesimo senqondo sababoshiwe ngomsebenzi wokuluka kwasesilisa ngendlela yasesimpilo emajele.**

Sayina ..... Usuku.....

APPENDIX 7

P.O Box 35718
Wonderboom junction
Pretoria
0001
02 June 2015

The Research Directorate
Department of Correctional Services
Private bag X136
Pretoria
0001

Sir/madam
Request for permission to conduct research at your institution.

I, the undersigned a Master's of Public Health student at the University of Limpopo Turfloop Campus, hereby request permission to conduct research study among offenders in Leeuwkop Management Area, maximum centre prison, as requirement for my studies.
The aim of the research is to assess the knowledge and attitude towards the performance of medical male circumcision in prisons. Data will be collected in the form of questionnaires and offenders will be selected from their sections. A copy of the research proposal, clearance certificate and questionnaire are attached.

It will be great to be granted the permission to conduct this study.

Yours faithfully
Phaphe Monkwe
079 444 5514/ 011 933 7128
nmonkwe@gmail.com
phaphe.monkwe@dcs.gov.za

APPENDIX 8

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING:	**02 September 2015**
PROJECT NUMBER:	**TREC/120/2015: PG**
PROJECT:	
Title:	Knowledge and attitudes of offenders towards the performance of medical male circumcision in prisons of Gauteng Province, South Africa
Researcher:	Ms PD Monkwe
Supervisor:	Mr SF Matlala
Co-Supervisor:	Prof L Skaal
Department:	Medical Sciences, Public Health and Health Promotion
School:	Health Science
Degree:	Masters in Public Health

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

APPENDIX 9

correctional services

Department:
Correctional Services
REPUBLIC OF SOUTH AFRICA

Private Bag X136, PRETORIA, 0001 Poyntons Building, C/O WF Nkomo and Sophie De Bruyn Street, PRETORIA
Tel (012) 307 2770, Fax 086 539 2693

Ms PD Monkwe
Wonderboom junction
Pretoria
0001

Dear Ms PD Monkwe

RE: APPLICATION TO CONDUCT RESEARCH IN THE DEPARTMENT OF CORRECTIONAL SERVICES ON: "KNOWLEDGE AND ATTITUDES OF OFFENDERS TOWARDS THE PERFORMANCE OF MEDICAL MALE CIRCUMCISION IN PRISONS OF GAUTENG PROVINCE, SOUTH AFRICA"

It is with pleasure to inform you that your request to conduct research in the Departm t of Correctional Services on the above topic has been approved.

Your attention is drawn to the following:

- The relevant Regional and Area Commissioners where the research will be conducted will be informed of your proposed research project.
  Your internal guide will be **Director Health Care Services, Ms M Mabe Head Office.**
- You are requested to contact her at telephone number (012) 307 2310 before the commencement of your research.
- It is your responsibility to make arrangements for your interviewing times.
- Your identity document and this approval letter should be in your possession when visiting Correctional Centres.
- You are required to use the terminology used in the White Paper on Corrections in South Africa (February 2005) e.g. "Offenders" not "Prisoners" and "Correctional Centres" not "Prisons".
- You are not allowed to use photographic or video equipment during your visits, however the audio recorder is allowed.
- You are required to submit your final report to the Department for approval by the Commissioner of Correctional Services before publication (including presentation at workshops, conferences, seminars, etc) of the report.
- Should you have any enquiries regarding this process, please contact the Directorate Research for assistance at telephone number (012) 307 2770 / (012) 305 8554.

Thank you for your application and interest to conduct research in the Department of Correctional Services.

Yours faithfully

ND SIHLEZANA
DC: POLICY COORDINATION & RESEARCH
DATE: 18/03/2016