University of Botswana

Faculty of Education

Master Degree in Religious Education

The Perceptions of Junior Secondary School Teachers and Students on the infusion of Safe Male Circumcision Education into the Religious Education Syllabus

A research dissertation presented to the Faculty of Education in Partial Fulfilment of the requirement for the Degree of Master of Education

By

Elizabeth Queen Thobega

Supervised by:

Dr. B. Dinama

200501621

June, 2019

DEDICATION

This piece of work is dedicated to my late sister who supported and encouraged me throughout my study. It is also dedicated to my children; Mpho Thobega, Tebogo Thobega and Olorato Precious Thobega who missed the motherly love during the hectic time of my study. I also dedicate this work to my friends and relatives. They made my work a success by giving me courage, moral support and love during the difficult time.

ORIGINAL DECLARATION

I solemnly declare that, this dissertation is my own original work that was guided by my supervisor. I understand that except for the parts of particular notice and appreciation, this piece of work does not include the research results that have been published or written by others. I have acknowledged particularly the individuals and a collective that have made important contributions to my study. I will be responsible for all the legal consequences of this statement.

_____

Author's signature **Date: June, 2019**

ACKNOWLEDGEMENTS

There are many people who made this work a success therefore; naming them all is a bit intimidating. I thank God for all the people in my life, who contributed in various ways in this work, including their prayers, well wishes and thoughtfulness. However, in an elite category that demands mention are, the participants from which the information of this project was derived. I say to them the project would not have been successful if it was not for the data they provided.

I wish to extend my gratitude to Dr S. Mmolai who was my initial supervisor for her positive comments and advice and also my present supervisor Dr B. Dinama. Finally, I acknowledge my late sister Patricia Thobega may her soul rest in peace, for her immense support and encouragement. She motivated me to go on despite other professional and family commitments.

My sincere gratitude also goes to my colleagues at work at Tlogatloga Junior Secondary School for their contribution in this project. To all my participants and colleagues, I say, thank you, keep the good spirit and May God bless you.

ABSTRACT

Safe Male Circumcision (SMC) is one of the contemporary issues in Botswana in the fight against HIV and AIDS. Both government and the private sector continue to fight the HIV and AIDS pandemic. Currently, there are school based curriculum programs in which HIV and AIDS related information is infused. However, despite the existence of a curriculum that incorporates HIV and AIDS information, people still lack knowledge about SMC as one of the tools to fight HIV and AIDS. The purpose of this study was to investigate and establish the perceptions of junior secondary school teachers and students on whether safe male circumcision education could be infused into the Religious Education (RE) syllabus in Botswana junior secondary schools.

The study was adopted a qualitative approach. The study was informed by Social Norms Theory which mainly deals with societal views and attitudes and in this case it is in relation to safe male circumcision. The study sampled 144 students and 18 RE teachers from six junior secondary schools in Gaborone. Data was collected through focus group discussion for students, and semi structured interviews for Religious Education teachers. Data was analysed qualitatively using thematic analysis. The study revealed that the participants supported the infusion of safe male circumcision into Religious Education syllabus. They stated that infusion of safe male circumcision will help the students to have knowledge about the benefits of safe male circumcision and also the strategies that could be used to address the challenges were outlined. They also stated that after learning about safe male circumcision students will make decision on whether to go for circumcision or not.

Basing on the findings, this study recommends that practising teachers should be trained on the infusion of safe male circumcision before it can be implemented. Schools should be adequately resourced with relevant materials such as pupils' and teachers' textbooks and guides.

Table of Contents

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This chapter comprises the background of the study, the statement of the problems and research questions. The chapter also presents the purpose of the study, significance of the study, delimitations and limitations of the study. Operational terms used in the study are also defined. The study was investigating the perceptions of junior secondary school teachers and students on the infusion of safe male circumcision education into the Religious Education syllabus in Botswana and the possible challenges encountered when infusing it.

1.1 Background of the study

Safe male circumcision is defined as the removal of the foreskin of the penis (Jacquil, 2006). Circumcision was a ritual performed to preserve culture and not necessarily to enhance sexual pleasure and hygiene. Male circumcision was not only about the removal of the foreskin, but also about learning values on how to conduct oneself in a community (Setswe, Petzer, Majaja, Matseka and Notshe, 2005). During male circumcision period, boys between the ages of 14 to 18 years taught by the elders on cultural and health issues such as taking care of the genital organs, sex education and alerted about the danger of promiscuity (Schapera, 1984). From an African perspective, men who were not circumcised were regarded as boys for the rest of their lives and were not allowed to socialise with those who went to initiation schools (Schapera, 1984).

The Botswana culture, boys who reached puberty had to go through initiation school. Among traditional Batswana, puberty rituals took place in winter season and boys usually went to initiation school when they were about thirteen to eighteen years old (Mosothwane, 2001). They had to stay in the bush for some time with experienced elderly men who have been initiated and a traditional doctor (Schapera, 1984). The role of traditional doctor was to smear traditional herbs on the wounds sustained during the circumcision and also to give boys

some herbal drink in order to make the wounds heal quickly and to strengthen them further (Schapera, 1984).

Male circumcision is not a new concept in Botswana culture; for example, many ethnic groups such as Bakgatla and Balete at initiate are presently practicing it at initiation schools. The main goal of initiation school education was to prepare the youth for adulthood (Comarroff, 1985; Mosothwane; 2001; Turner, 1969). Furthermore, it equipped the learners with survival skills or skills they needed to lead productive adult life in their society (Schapera, 1984). According to Mosothwane (1999) and Brown (1921), the traditional education curriculum consisted of compliance with the norms of society, sex education, taboos, agriculture activities and self-defence. The topics taught in initiation schools included: "physiology of sex relations, the duty of procreation and other rules of conduct in married life, and the dangers of promiscuous intercourse with ritually unclean women" (Schapera, 1984, p. 106). Safe male circumcision in Botswana was done by a circumciser who was not necessarily skilled in surgery. The person was chosen by the chief and was to perform the operation on the whole regiment of boys (Willoughby, 1909). It is worth noting that the way the procedure was carried out was a health risk because an ordinary knife was sharpened and used by the operator on all the initiates (Meissner & Buso, 2007). Again during the circumcision the circumciser inserted his thumb in the foreskin and a circular cut was made right around. Hence, in some cases, the process would lead to infections and severe bleeding which resulted in the death of some initiates (Willoughby, 1909). This practice was found to be cruel, barbaric and unhygienic and was abolished by the missionaries especially by the Dutch Reformed Church in the early 1900s, but only to be reintroduced by the first president Sir Seretse Khama and Kgosi Linchwe ll of Bakgatla in 1975 for both cultural and religious purposes (Mosothwane, 2001).

Furthermore, Safe male circumcision was adopted in Botswana in 2007 and officially implemented in 2009 as one of the National responses to the HIV and AIDS pandemic

(Johnson, 2015). The country has been seriously affected by the HIV epidemic with approximately 17.1 per cent HIV prevalence among the general population and highest prevalence of 40.2 per cent among the 30-45 years age group (The Government of Botswana, 2007).Many preventive measures have been put in place such as; PMTCT programme, BCIC programme, HIV testing and counselling, blood safety program and STI management and control, but there is still a high rate of HIV transmission in the country. Considering this high HIV prevalence the Ministry of Health found it necessary to look for other strategies to prevent HIV transmission in the country. Therefore, safe male circumcision is seen as an additional strategy in preventing the spread of HIV infection (UNAIDS, 2007).

The introduction of safe male circumcision in countries such as Sub-Saharan Africa including Botswana came after three randomised controlled trials in Rakai in Uganda, Kisumu in Kenya and Orange farm in South Africa which concluded that safe male circumcision reduces the risk of men acquiring HIV through vaginal sex by 50-60 per cent is safe and has potential to give lifelong benefits (Auvert, et al., 2005; Bailey, et al., 2007; Gray, et al., 2007). Again another study, a Model-based study carried by Anderson , Owen and Paltiel (2011) examined the influence of safe male circumcision on heterosexual relationships on transmission of HIV in Southern African and found that circumcision programmes could prevent a substantial number of new infections in Africa targeting 10-20% uncircumcised men each year (Anderson , Owen & Paltiel,2011) Since the introduction of safe male circumcision in Southern African countries national leadership have come forth and supported safe male circumcision. For example, in 2011 former South Africa President Jacob Zuma came up with plans for scale- up of safe male circumcision services. The same support was given by former Zimbabwe president Mr Robert Mugabe and his parliamentarians, iSwathini King Mswati III and Tanzania political leaders (Akinyi, 2014). Botswana government also took steps to expedite safe male circumcision services by increasing the prevalence of male circumcision among negative males aged 0-49years to 80 per cent, addressing issues

pertaining to safe male circumcision capacity building including skills building in clinical management of safe male circumcision services, behaviour change interventions communication, research monitoring ,evaluation and documentation (Johnson, 2015). In addition to that, International Organizations and Western donors like the US centres for Disease Control and Prevention and African President Emergency Fund for AIDS Relief(PEPFAR) including the World Health Organizations (WHO) and UNAIDS has recommended that fourteen countries in Africa including Botswana to implement safe male circumcision so as to reach circumcising 20.3 million African. Since the introduction of safe male circumcision in Southern African countries, international donors have invested over $130 million in safe male circumcision and $42 million was spent annually in resources. Even though donors invested a lot of funds in safe male circumcision, progress in implementing the scale–up of safe male circumcision has been slow. As at December 2013, 5.83 million African men in the designated priority countries had been circumcised. This figure constitutes around 27 per cent of the goal to circumcise 20.3 million African men in 2015, Kenya circumcising 85.3 per cent and Ethiopian 98.4 per cent respectively. South Africa 1.4 million men circumcised, Namibia and Malawi 5 per cent of their goal achieved (WHO, 2007).

In addition, there has also been a poor response to this programme (Government of Botswana, 2009). For instance, not enough men are coming forth to utilize the service, which was launched as part of an HIV prevention package. According to the Government of Botswana, the Botswana government targeted 80% of 0-49 years HIV negative males, which is 480 000 males by 2016, but this was not promising because of the number of males who had so far been circumcised. Statistics showed that by February 2013, only 66,596 males have been circumcised (Government of Botswana, 2015). As of March, 2015, statistics from Botswana Ministry of Health showed that a total of 153 000 males have been circumcised which translates to 39% of the targeted population (Government of Botswana, 2015). The reasons which may explain why the country has not performed safe male circumcision as

expected might be fear of pain, lengthy healing and sexual abstinence period after circumcision, the fear of complications, lack of partner support and not believing that there were at risks of contracting HIV (WHO, 2011).

As a result the Ministry of Health in partnership with the Ministry of Basic Education has agreed to launch mass campaigns nationally, focusing on circumcising school going boys, whereby teams of trained health care providers move from one school to another, educating boys on the importance of SMC (Botswana Government, 2015). It is therefore, important to infusion SMC in the school syllabus since infusion might save the government a lot of campaign money as the learners will be taught at school and make decisions based on what they have learned and also spread the message about safe male circumcision to their peers and other people. Similarly, there has been a slow down of safe male circumcision in African countries, most of the adult men above 25 to 49 years old are said to be reluctant to undertake circumcision yet there is a lot of awareness campaigns going on in these countries (WHO,2007; UNAIDS, 2007; Weiss et al., 2008). The reasons for slow down might be due to poor campaigning, communications, limited resources, religion, culture and traditional beliefs (Botswana Government, 2010). For example, the information that safe male circumcision does not offer full protection against HIV and that circumcised men could still use condoms, has made some African males not to accept safe male circumcision (Kebaabetswe et al., 2003). They are saying if safe male circumcision does not offer 100 per cent protection against HIV there is therefore, no need for them to go for circumcision (Johnson, 2015).

According to Johnson (2015), many men were turned off from medical circumcision because of the supposed pain process, and the perception that circumcision would decrease their sexual pleasure and may even make them sterile (Avert et al., 2005). It is however not been proven by research that safe male circumcision makes males to be sterile (Ayiya, 2011). Some males have been circumcised but still were able to bear children. Furthermore, there are rumours that after circumcision procedures, some medical practitioners would sell the

foreskins to traditional healers who could use them to bring bad luck to men and this has brought fear to them hence made the researcher believed that these are just some of the myths that have made the rollout of the safe male circumcision to slow down (Ayiya, 2011). Again some males stated that safe male circumcision is against their cultures, religions and others claimed safe male circumcision to be the work of primitive societies. Johnson (2015) stated that, societal socio-economic changes and specific impacts of Christianity and western education have brought about changes in the way safe male circumcision was done and the education given to the boys has changed. Hence there is low acceptance of safe male circumcision in African countries.

There is need for the country to scale-up the rate of SMC for the country to reach its ambitious goal. Safe male circumcision could, if well accepted increase the mortality rate which has fallen drastically over years, hence positively affecting the economic growth of the country (WHO, 2O12). This would mean less funds being spent on HIV drugs and on the treatment of such patients. The important people in the countries will live long enough to help in the development of the country. The government, therefore, needs to focus on improving not only availability, quality and safety of the procedure but also its acceptability and this can only be achieved through infusion of safe male circumcision into the Religious Education syllabus, teaching the children while they are still young for them to be able to make future informed decisions about undergoing the procedure medically.

1.2 Statement of the problem

Even though the government of Botswana has come up with interventions to make males aware of safe male circumcision, men are reluctant to go for circumcision (WHO, 2008; UNAIDS, 2008). This is because some of them have negative perceptions towards safe male circumcision. For example, some men believe that the information about the benefits of safe male circumcision was not disseminated in a clear and understandable way. Also some

males associate SMC with pain while others view it as a surgical procedure with inherent risks; hence, there is lack of willingness for most males to go for circumcision (Johnson, 2015).

In Botswana, the problem is furthermore compounded by the fact that safe male circumcision is slowly developing, with increasing numbers of males aged between 15-49 years being circumcised from 11% in 2008 to just over a quarter of males being circumcised in 2013, (Ngwanaamotho, 2015). Safe male circumcision prevention strategies in Botswana are struggling to effectively engage young males, with older men more likely to opt for medical circumcision (Ngwanaamotho, 2015). According to the Ministry of Health in Botswana the government has targeted 80% of 0-49 years HIV negative males, which is 480 000 males by 2016 and only 153 000 male have been circumcised (Botswana Government, 2015). In order to achieve population level impact of voluntary medical circumcision on HIV transmission, the country needs to achieve 80% coverage among negative young male adults (WHO,2007; UNAIDS, 2007). It is therefore necessary to establish factors that cause most adult men to be reluctant to undertake circumcision, yet there are a lot of awareness campaigns going on and at the same time, there are very little economic costs involved on their par event if done by the private practitioner.

1.3 Theoretical Framework

Social Norms Theory has been chosen to serve as the framework for this study since it is fundamental in understanding human behaviour. This theory postulates that people's behaviour is influenced by misperception of how their peers think and act (Waldeck, 2003). This implies that when people see their peers circumcise they also think of doing the same thing so that they too look the same or similar. This theory is relevant to the study because it deals with issues of culture and perceptions that people in a society may have towards safe male circumcision (Waldeck, 2003). Social Norms Theory enriches peoples understanding of how routine circumcision became the prominent practice in the countries that practice

circumcision. Circumcision was believed to confer significant medical benefits, the risk of complication was low and infants were not believed to feel pain (Waldeck, 2003). Today parents consistently describe the desire that a boy resembles his peers as one of the primary motivations for circumcision. The parents are also concerned about the future attitudes of peers and their son's self-concept if he remained uncircumcised.

Norms affect the way individuals understand information so that from the outset the behavioural outcome is weighted in favour of the predominant social norms. Norms cover every aspect of decision making, thereby encouraging an individual to either exaggerate or diminish the significance of other factors in the behavioural calculus (Waldeck, 2003). Parents will also see that their peers continue to circumcise their sons, which provides another basis for discounting the disadvantages of the procedures and exaggerating its potential health benefits. Maccoby (1984) stated that, where physicians provided mothers with verbal counselling, researchers were able to assess parental reactions to information that suggested the disadvantages of circumcision outweighed its benefits. Parents were made uncomfortable by the information, expressed resentment that the physician was challenging their previously established beliefs about circumcision and tried to distance themselves from the physician who conveyed the information (Christensen-Szalanki, 1987).

Moreover, given prevalent gender stereotypes, parents might be able to ignore the pain of circumcision. Here norms of Masculinity are relevant, and these norms might cause parents to discount the pain that is experienced by the male infant. Parents perceive their infants through gender biasness and mothers interact with infant sons and daughters differently. For example, mothers hold their daughters more closely than sons, touch them more frequently, and cuddle them more often. Significantly, mothers are highly sensitive to a girl's pain or discomfort, often mirroring the baby's expression, while they tend to ignore such expression in a boy (Maccoby, 1984).

Perhaps parents are able to discount the pain of circumcision because they have the gender-based perception that their son will take the pain like a man. Indeed in early personality tests intended to distinguish between males and females, subjects were awarded masculinity points for agreeing and femininity points for denying that they could stand as much pain as others can (Maccoby, 1984). While explicit reference to pain has disappeared from contemporary measures of masculinity and femininity, personality measures continue to consider toughness a marker of masculinity. It may be that when parents decide whether to circumcise, they are therefore able to discount the pain and trauma that circumcision causes the infant.

Anyone to see a decrease in circumcision rates faces a collective action problem. At present, circumcision is consistent with the American notion of good parenting (Maccoby, 1984). Suborning and circularly, this association is likely to persist so long as most parents continue to circumcise, because conceptions of good parenting are informed and influenced by what significant numbers of parents choose to do. Moreover, the parents who might be inclined towards non-circumcision and could therefore begin to help challenge the social meaning of circumcision have little incentive to not circumcise, because of the esteem based on reputational consequences within that parents group and because norm colours the assessment of other considerations. Thus, for the norm to change, parents have to act collectively. That is, enough of them have to simultaneously choose no circumcision to make the stigma associated with the foreskin disappear and to colour the decision making process with a norm that favours non-circumcision (Maccoby, 1984).

1.4 Rationale

Students should learn about safe male circumcision in the schools so that they can make informed choices and decisions on whether to be circumcised or not. They may also in future act as ambassadors since they would teach their peers the roles of safe male

circumcision in the fight against HIV and AIDS. Many people have mixed attitudes regarding safe male circumcision; some believe that safe male circumcision increases sexual pleasures while others believe that it improves genital hygiene a protective tool against HIV transmission. There are also those who feel that it is a risky procedure that can lead to one losing life or becoming infertile (Karin, 2014). It is therefore important for policy makers and programme designers to understand the reasons that make men to accept or reject safe male circumcision and why this form of awareness needs to be infused.

1.5 Purpose of the study

The purpose of this study was to determine the perceptions of junior secondary schools teachers and students on the infusion of safe male circumcision education into the Religious Education syllabus.

1.6 Objective of the study

This study sought to:

1. Investigate whether junior secondary school teachers support the infusion of safe male circumcision education in the Religious Education syllabus.
2. Investigate whether junior secondary schools students support the infusion of safe male circumcision education in the Religious Education syllabus.
3. Determine reasons for supporting the infusion of safe male circumcision education in the Religious Education syllabus.
4. Establish the challenges of infusing safe male circumcision in Religious Education syllabus and identifying possible strategies of addressing such challenges.

1.7 Research Questions

This study was guided by the following research questions:

1. What are the perceived benefits of infusing safe male circumcision into the Religious Education syllabus?
2. What are the possible challenges of infusing safe male circumcision into the Religious Education syllabus?
3. What are the possible strategies that could be used in addressing the challenges encountered in infusing safe male circumcision into the Religious Education syllabus?

1.8 Significance of the study

From this research some noble ideas have come from teachers and students that would help policy and decision makers to appreciate the benefits of infusing safe male circumcision education in the fight against HIV and AIDS. Policy makers might be assisted in developing relevant policies that would promote the use of safe male circumcision in the fight against HIV and AIDS upon getting the views of students and teachers.

The findings of this research might also act as an impetus to the policy makers, curriculum developers and educators to consider including safe male circumcision education into the Religious Education syllabus and other disciplines. The research is important to the policy makers, program designers and implementers because results from the study might contribute towards improving safe male circumcision information, education and communication pre and post-procedures counselling about long term benefits and risks including those related to male sexuality.

1.9 Limitations of the Study

During data collection, it was observed that it was not easy to get information from some of the teachers and students because they claimed that they did not know anything about SMC and as a result the information given was inadequate. The research only focused on

teachers of Religious Education and students who are doing Religious Education as an optional subject. The exclusion of teachers who are teaching other subjects may have led to the omission of valuable contribution. Again, the literature reviews based on research are not enough and safe male circumcision has insufficient literature hence this was a limitation to support the research findings. This led to difficulties in trying to relate the topic to Botswana context. There was also time constraint issue; the participants had busy schedules at their work places hence postponements of interview appointments.

1.10 Delimitations of the study

The study was conducted in six schools in the South East Region of Botswana and was to investigate the perceptions of teachers and students on whether SMC should be infused into the Religious Education syllabus in junior secondary schools.

1.11 Definition of terms

Infusion: In the context of this study infusion refers to bringing in new content and skills into existing subject content and the integration of basic facts about SMC in the RE syllabus

Circumcision: The act of cutting off the foreskin at the end of a sex organ of a man.

Perception: The views and meanings a person attaches to a situation, event through interpretation.

Education: The transmission of knowledge skills and values particularly to the younger generation of the society.

Curriculum: A course of study offered in academic institutions such as schools and colleges.

SMC: Safe Male Circumcision, Surgical removal of the foreskin from the male penis (WHO, 2012; UNAIDS; 2012)

Religious Education (RE): Refers to the subject within a school curriculum that teaches about religions.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

The purpose of this literature review is to document the information that exists with the aim to enhance the study at hand, identify objectives and assess the views of researchers on the topic under study. This chapter is a review of literature concerning the infusion of safe male circumcision in the teaching of Religious Education in junior secondary schools in Botswana. The rolling out of SMC as a preventive measure to the scourge of HIV/AIDS in Botswana is still- a work in progress in terms of implementation. In this study, literature is reviewed under the following headings: genesis of safe male circumcision, studies of success and acceptability of safe male circumcision, success of safe male circumcision in Botswana, ethical issues surrounding safe male circumcision, challenges of safe male circumcision, rationale for infusion of SMC in Religious Education in Botswana and infusion of SMC, knowledge and perceptions towards SMC and summary of literature reviewed.

2.1 Genesis of Safe Male Circumcision – Religious and Non-Religious

The process of male genital mutilation has originated in Eastern Africa long ago and there are a lot of theories explaining the origins of genital mutilation such as the one explained by DeMeo (1989) and Hodges (2001). One theory held by the above stated theorists' claims that circumcision began as a way of purifying individuals and society by reducing sexuality and sexual pleasure. Human sexuality was regarded as dirty or impure in

some societies; hence cutting off the pleasure-producing parts was the way to purify someone. This was marked among some communities in East Africa mostly the Kikuyu in central Kenya who practice sex for purely reproduction (Pirie, 1927; Paige, 1978).

DeMeo (1989) declares that; "geographical patterns of global distributions of the male and female genital mutilations among native, non-Western peoples, along with history and archaeology, suggest their genesis in the deserts of Northeast Africa and the near East, with a subsequent diffusion outward into sub-Saharan, Oceania and possibly even into parts of the New World" (p.21). Circumcision is called genital mutilation because it deprives of the fine touch nerve receptors and consequently deprives permanently of the pleasure of natural normal sexual intercourse. It is called the genital mutilations of men as it is an irreparable condition. Bigelow (1992) traces the development of various forms of circumcision within Judaism through the centuries and into modern times. He found out that circumcision can cure childhood diseases and disorders and this recommendation was done by USA Allopathic Medical doctors (Bigelow, 1992).

Safe male circumcision is the removal of the foreskin that covers the end of the penis so that the gland is permanently exposed (UNAIDS 2007). Safe male circumcision has been practiced worldwide for religious, cultural, social and medical reasons (Impact Survey, 2008). The operation is performed by circumcision practitioner using surgical clothing and equipment such as injection, knives and Tara clamp (Jacqui, 2006). This suggests that the foreskin does not have any function and there is no biological difference between a circumcised man and an uncircumcised one. Historically, safe male circumcision was practiced among ancient Semitic people including Egyptians (UNAIDS, 2007). Circumcision has also been practiced for non-religious reasons for many thousands of years in the Sub-Saharan, and in many ethnic groups around the world including Aboriginal, Australasian, the Aztec and Mayas in America (USAIDS, 2012).In terms of religious and cultural reasons in many of these cultures, circumcision is an integral part of a rite of passage to manhood,

although originally it may have been a test of bravery and endurances. Circumcision is further associated with factors such as masculinity, social cohesion with boys of the same age who become circumcised at the same time for self-identity and spiritual purpose (USAIDS, 2012).

Infant circumcision is practised in Judaism and Islam. The Jews practice circumcision at infancy as an agreement between them and God (Lissouba et al, 2013). In Judaism, baby boys are traditionally circumcised eight days after birth and this is done to fulfil the external agreement that God made with Abraham and circumcision for purification purposes and as a confirmation of that relationship (Hankins, 2007). Hankins (2007) in Akinya study, states that, an estimation of 665 million men above 15 years of age in the world is circumcised and the majority are Muslim. Those communities who practiced circumcision believed that circumcision is important because of the following reasons, it puts the penis in readiness for procreation, and it tests the courage and endurance at the start of adulthood and also moderate the male sexual instinct hence making man to act responsible (Hankins, 2007).

Similarly, in Botswana, in the past, all boys who had reached puberty had to go through initiation. Boys were circumcised and circumcision was seen as a vital ritual because it united initiates with their peers, society and their ancestors (Schapera, 1984). It was also considered as a test of strength and endurance. A boy was considered a man if he endures pain and survived circumcision. However, circumcision was abolished by the missionaries because they did not understand it though it is now, after many decades, being reintroduced as part of HIV prevention efforts (Schapera, 1984).

Safe male circumcision came up as a strategy to control the spread of HIV and AIDS in the whole world. Since the beginning of the epidemic, almost 75 million people have been infected with HIV/AIDS (WHO, 2011; UNAIDS, 2011). According to the foundation for AIDS Research, (2015), almost 39 million people have died due to HIV and AIDS. In 2013, about 1.5 million people lost their lives to AIDS. That is about 2.7 per cent of deaths worldwide. By the end of 2012, 35.3 million people around the world were infected with HIV

(WHO, 2011; UNAIDS, 2011). Many attempts by the governments of African countries through their ministries of health and Non-government organisations have been made to control the spread of the disease. In 2007, WHO and UNAIDS recommended that safe male circumcision be introduced alongside other HIV prevention strategies such as; HIV testing and counselling, provision and correct use of male and female condoms, screening and treatment for STIs and provision of Antiretroviral treatment for people living with HIV or referral of HIV positive clients to treatment and care (Akinyi, 2014). According to Akinyi (2014) study, the WHO (2007) and UNAIDS (2007) recommendation on safe male circumcision targeted fourteen countries with high HIV prevalence but with lower levels of male circumcision for implementation namely; Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, iSwathini, Tanzania, Uganda, Zambia, and Zimbabwe. The target was to circumcise 80 per cent of men between 15 to 49 years old by 2015 (WHO, 2007; UNAIDS, 2007; Weiss, et al 2008). The programme was funded by Western donors such as the US President Emergency Plan for AIDS Relief (PEPFAR), and French government among others (Akinyi, 2014).

In 2005, Randomised Controlled Trial study was conducted among 3274 uncircumcised men aged between 18-24 years old in South Africa. The men who were participants of the study were randomly assigned whether to be circumcised or not, and they were followed up after a certain period to determine their possibility of having acquired HIV (WHO, 2010). From the findings of the study, it was concluded that safe male circumcision has the protective effect of 60% against HIV (Auvert, Taljaards, Lagaarde et al, 2005). The findings of the study were highly conclusive such that the trial was stopped in 2005 and 2006 after the interim analyses found a significant protective effect of safe male circumcision (WHO, 2008).

A similar study was carried out over 24 months at Rakai, Uganda on 4 996 uncircumcised HIV-negative men aged between 15-49 years produced as treated efficacy of

55% without behavioural dis-inhibition (Gray et al, 2007). Bailey (2007), in another randomized controlled trial study on SMC among young men in Kisumu in Kenya, reported a risk of 53-60% among circumcised men (Bailey, Moses, Parker et al, 2005). The most compelling evidence about HIV and safe male circumcision comes from Uganda in Rakai district. In a study of 187 discordant couples in which the woman was infected with HIV but the man was not, no circumcised man became infected with HIV over a 30-month trial period. Among the uncircumcised men 29% became infected. Among the 223 discordant couples in which the man was HIV positive but the woman was not, circumcised men were less likely to transmit the virus to women, but this protective effect declined at higher viral loads (Gray et al, 2007). Another study conducted a mathematical model known as antenatal clinic surveillance data was used to calculate the public health impact of large scale male circumcision for HIV preventions (Nagelkerk, Moses, De Vlas et al, 2007). The result showed that a programme with high male circumcision uptake of 80per cent of susceptible HIV negative males over a period of 10years would reduce male HIV prevalence from 30 per cent to 10 per cent and among the female from 40 per cent to 20 per cent females who are getting newly infected with HIV. In case of low male circumcision uptake of 50 per cent the prevalence among females decreased from 40 per cent to about 30 per cent while male HIV prevalence decrease from about 30 per cent to 20 per cent (NagelKerke et al.,2007). The above three large –scale randomised control trials in South Africa, Uganda and Kenya has made African countries accepted safe male circumcision as an HIV prevention method.

According to UNAIDS global report of 2013 several countries started the implementation of safe male circumcision in 2010-2011 (UNAIDS, 2015). Wambura. Mwanga, Changalisa et al (2011) state that the status of safe male circumcision scale up towards the 80 per cent target in African countries were very low, that is, most countries failed to reach the target of 80 per cent. It is therefore important for the government in all the Southern African countries to take into consideration the factors that causes most of men to be

reluctant to undertake circumcision and address them. Even though, there has been a lot of awareness campaigns going on in Botswana and the government is using a lot of money on safe male circumcision but still men are not coming forth to circumcise (Kebaabetswe et al., 2003).

2.2 Studies of success and acceptability of safe male circumcision

2.2.1 Regional Success

Safe male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60 per cent (Auvert et al., 2005; Bailey et al 2007; Gray et al., 2007). This was evidenced by the three randomized controlled trials which showed that circumcision provided by well-trained health professionals in properly equipped setting is safe (WHO, 2007; UNAIDS, 2007). The World Health Organisation, WHO (2007) recommendation emphasized that male circumcision should be considered an effective intervention for HIV prevention in the countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence. Safe male circumcision provides only partial protection and therefore should be one of the HIV prevention package which included the provision of HIV testing and counselling services, treatment for sexually transmitted infections, the promotion of safer sex practices; provision of male and female condoms and promotion of their correct and consistent use(WHO,2007& UNAIDS, 2007). WHO and UNAIDS have developed new guidelines on male circumcision in May 2018 as an additional HIV prevention intervention in setting high HIV prevalence. By the end of 2017, programmes in 15 high African countries in eastern and southern Africa had successfully reached nearly 18 million adolescences boys and men with minimum package of services (WHO,2007; UNAIDS, 2007).

2.2.2 Global Success

Safe male circumcision came into public health towards the end of the 19th century, and was mainly practised by Jews and Muslims as part of their religious values, but was

practiced less by Christians. In the United States of America (USA), Canada and Australia, the practice of circumcision is more of hygienic and therapeutic reasons (Hankins, 2007). Safe male circumcision in Africa, for example, Botswana was perceived as an initiation into manhood (Comaroff, 1985; Mosothwane, 2001; Turner, 1969). Nowadays safe male circumcision is mostly used as a preventive medical intervention against heterosexual HIV infection (USAID, 2010). Furthermore, it is practiced as a medical procedure to treat infections, injury, or anomaly of the foreskin.

Safe male circumcision, which is the removal of the foreskin from the penis, confers some protection against HIV infection in men, apparently reducing the risk by about half or more (Jackson, 2002). The protection effect extends to several sexually transmitted infections, possibly because circumcision leads to a toughening of the skin of the glans of the penis. However, the risk to uncircumcised males is greater because the foreskin contains HIV-target cells, the skin on the glands is thinner, and there may be more risks of minor abrasions during sex. Furthermore, the fluids containing germs may be trapped under the foreskin and harbour pathogens that could include HIV and other STIs (Auvet et al, 2001).

Ngalande et al (2000) states that, acceptability of safe male circumcision is often high in areas where safe male circumcision is traditionally practiced than where is less traditionally practiced. According to Westercamp et al, (2002), safe male circumcision in the non-circumcising population may play a major role in the effectiveness of the safe male circumcision intervention. In addition, the awareness about the relative effectiveness of safe male circumcision as a potential weapon to combat HIV infection is growing in some countries in East and Southern Africa. Safe male circumcision is increasingly being recommended by traditional healers while a number of private clinics that specialize in safe male circumcision, run by people with minimum or no medical training, are sprouting up in Tanzania, western Kenya, Rwanda, Uganda and South Africa (Bailey & Poulussen, 1999).

Many young men and adolescents in east and southern Africa are increasingly opting for circumcision in regions where traditionally they have avoided the practice (Bailey & Poulussen, 1999). About 23% of non-Muslim Ugandans, not belonging to any traditionally circumcising ethnic group, reported that they were circumcised (Bailey & Poulussen, 1999), in order to prevent HIV or other diseases, as well as for hygiene, cultural and religious reasons. The enthusiasm of USAID and other sister organizations to adopt safe male circumcision as a preventive strategy against HIV infection has arisen from the positive outcomes of a number of recent randomized studies carried out in Africa (WHO,2007; UNAIDS, 2007). Gray et al, (2007) in their analysis on safe male circumcision for HIV prevention in young men in Rakai in Uganda concluded that circumcision could be recommended for HIV prevention in men on the following grounds; safe male circumcision reduces man's risk of penile cancer. It reduces risk of sexually transmitted diseases, STDs including cancroids, herpes and syphilis; it eliminates problems such as phimosis, that is, narrow foreskin opening and banalities', infected foreskin; reduces the risk of cervical cancer among female partners of uncircumcised men.

Furthermore, circumcised men are less likely to harbour the human papilloma virus (HPV), which causes cervical cancer, a major killer of women in sub-Saharan Africa (USAID, 2007).In addition, both UNAIDS (2007) and its affiliated bodies as well as SADC (2006) have recognized safe male circumcision as one of the most preventive strategies that need to be implemented in tackling HIV pandemic in areas of Africa that do not normally undergo circumcision. In a review of an article, Weiss (2000), eloquently advances a convincing analysis why safe male circumcision is the key to effective control of HIV infection since all other preventive strategies, including condom usage, testing and counselling, have not succeeded in significantly reducing the rate of infection in Southern and Eastern African countries.

2.3 Successes of Safe Male Circumcision in Botswana

In Botswana, SMC was adopted in 2007 and officially implemented in 2009 as one of the National Response to HIV pandemic (WHO, 2007). Unlike in the past where male circumcision was done in the bush during initiation rites SMC is performed in both private and national hospitals and other appointed health facilities. There are approximately 405 trained personnel for carrying out this operation in Botswana (Impact Survey, 2008). The overall objective of this strategy is to contribute to the reduction of HIV infection rates by scaling up SMC throughout the country to reach safe male circumcision prevalence rate of 80% among 0-49 year's old HIV- negative males by the end of 2012 (Impact Survey, 2008).

Botswana implemented SMC as an additional HIV prevention intervention because the country has a high prevalence of HIV and there is evidence that safe male circumcision reduces the risk of heterosexuality acquired infection in men by approximately 60% (SADC, 2008). According to Botswana AIDS Impact Survey II (2004), the government, is promoting safe male circumcision as a way to combat the spread of HIV and AIDS. This came up after the three randomized controlled trials have shown that male circumcision provided by well-trained health professionals in properly equipped settings is safe. WHO (2007) and UNAIDS (2007) recommendations emphasize that male circumcision should be considered an important intervention for HIV prevention in countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence like Botswana. Safe male circumcision provides only partial protection, and therefore should be only one element of a comprehensive HIV prevention package which includes: the provision of HIV testing and counselling services; treatment for sexually transmitted infections; the promotion of safer sex practices; the provision of male and female condoms and promotion of their correct and consistent use.

Since the inception of SMC in Botswana, there has been a poor response to this programme, men are not coming forth to utilize the service, which was launched as part of an

HIV prevention package (Botswana Government, 2009). The government of Botswana targeted 80% of 0-49 years to be circumcised, which is 480 000 males by 2016, but this was not promising because of the number of males who had so far been circumcised. Statistics showed that by February 2013, only 66,596 males have been circumcised (Botswana Government, 2015). The Ministry of Health in partnership with the Ministry of Basic Education has agreed on mass campaigns nationally, focusing on circumcising school going boys. Teams of trained health care provider move from one school to another, educating boys on the importance of safe male circumcision (Ngwanaamotho, 2015). According to Ngwanaamotho, (2015), the boys are given forms and parents have to fill in those forms if they want their children to be circumcised during school holidays.

To encourage more males to get circumcised, the Ministry of Health is embarking on, 'cut your foreskin, and win a P100', Re-structure Circumcision Campaign. If someone recruits a person for circumcision he or she will be paid P100 per head or P1000 for ten males they bring for circumcision. The same will apply to the nurses that will be conducting the circumcision, each nurse will be paid P1000 for 10 circumcision (Ngwanaamotho, 2015).There is also another safe male campaign theme: "Rola Kepese," Circumcise Now! The campaign is aiming in circumcising about 35000 men in six months. The campaign will continue as long as there is a need for circumcision as a preventative measure against HIV and AIDS and it is funded by the United States of America through the president Emergence Fund for AIDS RELIEF (PEPFAR).There is hope that safe male circumcision campaigns will influence males to accept safe male circumcision. In addition, external organisations like the US Centres of Diseases Control and Prevention and African Comprehensive HIV and AIDS partnership funded by the Bill and Melinda Gates foundation partner with the government of Botswana's Ministry of Health to scale up safe male circumcision and encourage HIV negative men of age between 13-49 to circumcise. Again, pop artists have been contracted as the campaign ambassadors to attract men into the programme (Katisi &Daniel, 2014). Also

the infusion of safe male circumcision into the Religious Education syllabus will make young boys and girls to know about the benefits of safe male circumcision and spread the message about the importance of safe male circumcision to other people. Hence, making other peers aware of the importance of safe male circumcision and make the right decision on whether to circumcise or not. The main advantage of safe male circumcision is that it is a one-off procedure, with no on-going costs or supply issues to worry about (Botswana Government, 2015). Once someone has undergone the procedure he will benefit from the preventive effect, for the rest of his life. Nevertheless, it has been calculated that the rapid roll out of voluntary medical safe male circumcision in high-prevalence African countries like Botswana would save billions of Pulas in the long term by reducing the number of people needing HIV treatment which is very costly (Botswana Government, 2015). Fortunately, opportunities exist and they create a conductive environment for scaling up SMC, which are a strong political will and support for SMC by government and development partners. There is also high acceptance of safe male circumcision in the population and existence of good infrastructure and health systems that could enable scaling up safe male circumcision services. Apparently all hospitals are already performing safe male circumcision albeit at a small scale and there is availability of strong programs for example, Routine HIV Testing, Antenatal care at community level (SADC, 2008).

2.4 Ethical Issues surrounding Safe Male Circumcision

There are some disagreements as to whether there are sufficient evidences, on the basis of current data, to justify wide scale adoption of safe male circumcision as a preventive strategy. However, it is also evident that no existing protective device has been proved to be 100% effective, this include the use of condom (Rennie, 2007). Hence it has been argued that any positive impact on reduction of HIV from female-to-male transmission would contribute to the overall reduction in spread of the pandemic, in the long run (Rennie, 2007).

Some framework has been proposed, based on age of the person to be circumcised, and the long- term and short- term effects assessed. These are: neonatal, preadolescent, and adult circumcisions (Rennie, 2007). The intention is to examine exactly the right age (soon after birth, just before sexual debut, or at some point after sexual debut) to focus if circumcision would be adopted as a preventive strategy. There are arguments for and against each point from medical, public health and ethnic perspectives, which we now discussed.

In neonatal circumcision, the strategy is to circumcise a male child soon after birth as done in most of West African countries and in USA, with its attendant advantages. Studies have shown that protection is greater when circumcision is done at early stage in life because of the thickening of the foreskin of the penis as one grows older. The foreskin in newly born babies is thin and healing is faster, usually done within a week, (Poulussen et al, 1999). In terms of cost, neonatal circumcision could be integrated into existing reproductive health clinics and postnatal care programs for babies. The risk of missing school, if done at adolescent is averted and long hospital admission (Haperin et al, 2006). Consequently, the programme is cheaper to run and is accessible to all male children born in a country. Coverage could therefore be essentially universal. The right of consent is vested in the parents, just like in all other decisions taken on children before they reach the age of reason major reservation for neonatal. Circumcision is that the impact on the HIV pandemic is delayed and would only be felt between 10 and 20 years later. It is, however, provides some level of hope that those children circumcised at birth have the probability of being infected with HIV and other STDs significantly minimized (Cassel,et al., 2006).

In pre-adolescent circumcision, where circumcision is practiced as a rite of passage from boyhood to manhood, it can be assumed that the procedure would be feasible and acceptable, when adopted as a HIV prevention strategy. The adoption would simply involve incorporating a new rationale into an existing practice. A model that integrates HIV-prevention into preadolescent circumcision traditions has been successfully implemented on a

small scale in Kenya (Brown et al., 2004). One major challenge of adopting large –scale preadolescent circumcision would be the need to modify some traditional practices, for example, utilizing the same ritual knife among a number of initiates, which poses HIV transmission risk, to align them with good health practices. Secondly such practice would also be complemented with counselling services that discourage initiates from being involved in sexual activities when the penis is not completely healed or giving up other preventive strategies. On ethical grounds, at preadolescent, a child's consent may be very important, particularly since the surgery is irreversible.

2.5 Challenges of Safe Male Circumcision

Male circumcision has negative effects associated with its procedures. For instance, according to De Vincenzi (1994), complications involved can be pain, infection, in a case where circumcision is performed in a less hygienic setting, might result in mutilation, haemorrhage, impaired healing processes and even death. In addition, proper healing may be inhibited by early initiation of sexual intercourse before the wound is completely healed, thus increasing the risk of contracting HIV, and also reduced penile sensitivity and sexual performance may be experienced by the circumcised male (Bailey et al ., 2007).

Though SMC may seem to offer a powerful advantage over other HIV prevention strategies in that it involves a surgery that does not need an on-going behavioural change in order to work, it nevertheless presents challenges. The male circumcision is an unnecessary operation if it is performed in the absence of essential indications, or as some routine procedures, it may be an unnecessary operation (Smith, 2000). Furthermore, Smith (2000) emphasizes that, some men who were not circumcised in infancy feel that they have been mutilated and deprived of an important structure without their consent and they are just as obsessed about this as those who claim to be circumcised. He also added that if not done under medical attention it can be a risky process with side effects including serious bleeding and damage to the penis itself.

Furthermore, it is said that males require a period of abstinence after circumcision and some people do not wait for that period, and if sex is done when the wound is not yet healed, if one partner is infected she or he is bound to transmit the infection. The other main challenge is that circumcision does not prevent HIV and AIDS. Most males in Botswana view male circumcision in a wrong way (Ayiya, 2011). They believe if one has done circumcision they is no need to use condoms claiming to be 100% safe and they end up spreading HIV and AIDS and other sexually transmitted infections or they get infected. They ignore the fact that circumcision is not a "magic condom" as they label it but only reduces the chances of getting infected (Ayiya, 2011).

The other disadvantage is that male circumcision removes nerves from the penis and this causes significant loss of sexual sensitivity and function. For this reason, many circumcised males are reluctant to use condoms since they say it reduces pleasure during copulation. A program of mass circumcision may reduce condom usage and have an adverse effect on the overall HIV infection incidence. Taylor (1996) concern that male circumcision can cause a lot of pain and fear of safety if not done properly and this can cause the person to continue revisiting the clinic to see whether they are alright or not. Taylor (1996) also said that many non-circumcising groups are familiar with circumcising practices of other groups, and cited the endurance of pain as a key component in the rite of passage. Furthermore, circumcision is widely understood as a surgical procedure with inherent risks and in some of the challenges there is cultural and religious bias (Sawyers, 2007). Sawyer (2007) states that when studying circumcision, cultural biasness must be considered, therefore circumcision practices are largely culturally determined and as a result there are strong beliefs and opinions surrounding its practice. He further stated that predominantly, Christian groups hold varying beliefs and inconsistent practices regarding male circumcision.

Bonner (2001) observed that circumcision as a procedure potentially exposes boys to diseases and infections, and the use of one instrument may be particularly risky. Similarly,

Mark et al, (2012), states that, in a Muslim community in Uganda it was reported that it was customary for groups of three to ten infants to be circumcised using a single razor blade and this could result in infecting each other if one of them has the HIV virus. The resources required to perform this procedure are also costly which is inclusive of trained staff, a very hygienic clinic and sterilised tools. The government also spends a lot on buying this equipment's. Bollinger (2009) states that, "scaling up adult and neonatal circumcision to reach 80% coverage by 2025 would result in averting almost 70,000 new HIV infections, at a total cost of US$47 million" (Bollinger, 2009, p.9). So, the money issued, as seen by the above statement, causes the government to be unable to provide infrastructures, provide enough professionals and equipment uniformly across the country. Setting up circumcision facilities in a smaller health centre closer to rural population is also expensive hence people in rural areas are disadvantaged.

The last but not least challenge is the mentality that some men have about this procedure. That is, a "Mentality" and not a misconception because it is strongly emphasized during circumcision that the procedure is not a substitution for a condom (Sturart, 2007). Most men decided to twist the information to suit their desires. For example, men believe that safe male circumcision provide 100 per cent protection against HIV infection and if done there is no need for someone to use condom. Men may engage more often in unsafe sex if they believe circumcision protects them from acquiring HIV (Sturart, 2007). This suggests that instead of maximising protection, some men may use the fact that they are circumcised to put themselves in higher risks of contracting HIV and AIDS, and they may also put their partners at risk. Furthermore, the requirement for men to test for HIV before circumcision deter many men from circumcising as many are not comfortable going for HIV test. Therefore, some men do not bother to think of circumcision as by nature they are private people who do not like their personal life to be exposed to public.

In Botswana, some men decide to abandon the decision to circumcise after having a surgery cancelled because of shortage of supplies. For instance, in Borolong and Kweneng West sub region some men gave up after waiting in long queue, long waiting list or after being told to return at a later date, (Ontebetse, 2013). Treatment centres in places like Kgalagadi South and Ngami are far to reach and forces clients to travel long distances and this discouraged potential circumcision clients due to shortage of transport and a high possibility of coming back after a failed attempt. Batswana's culture also seems to be affecting the success of safe male circumcision. This is because culturally, safe male circumcision was done by males and the topic was only discussed amongst men but these days it is evident that our health system, which is responsible for doing these circumcisions, is dominated by women. So men feel uncomfortable being touched and scrutinized by women they have no sex relation with. Therefore, they shy away from getting this procedure done. Also the community mobilizes are mostly women, so men find it difficult to ask questions and to voice their doubts and concern. They regard surgeon females who approach circumcision as a matter of fact; disrespectful hence they do not turn up for circumcision (Ontebetse, 2013).

2.6 Rationale for Infusion of SMC in Education

Infusion as defined by Hugger (1989) in the UNESCO and UNCIFE document is "The interaction of the content and skills into existing courses in a manner as to focus on that content …" (Hugger, 1989, p.59). According to Hugger, infusion means bringing in the new content and skills into existing subject content. Infusion in any subject brings more quality learning opportunities and change attitudinal behaviour. It ensures that every subject play a part in addressing emerging issues such as HIV and AIDS (Colaugh & Ketlhoilwe, 2000). Nganunu and Cantrel (1992) cited in Ketlhoilwe (2000) came up with the reasons for infusion and stated that: to overcome the problem of overcrowding the already overcrowded curriculum at all levels of education, to help in reinforcing and complimenting different subject content, to become more economic in terms of the time and hiring of specialized

teachers in SMC. The approaches will ensure that there is no need for a period to be created in the timetable and no need for additional specialized teachers.

The above statement it shows that infusion of SMC in schools would be necessary in order to deal with HIV and AIDS issues. It will help to impart knowledge, develop healthy, attitudes and instil skills for healthy decision making, since the learners depends on the acquisition of such skills. The skills provided will help to develop attitudes and practices necessary in curbing the spread and improving the management of HIV and AIDS in order for Botswana to achieve the goal of no new infections by 2017. Infusion is another way of using the living materials and it is encouraged by the Ministry of Basic Education. With infusion, the teacher incorporates the infused topic into the content of other subjects, ensuring that they blend well with the lesson.

In a study carried out by Khattab (2011) it was revealed that students who were given health education gained more knowledge, positive attitudes and better practices in dealing with HIV and AIDS prevention compared to those who were not given similar health education on the prevention of HIV and AIDS. Infusion of SMC in RE syllabus should be seen in the same light, that it can have a positive impact on the prevention of HIV and AIDS. Also another study on the infusion and integration of HIV and AIDS in the curriculum was conducted by Nasibi (2009) found that," The infusion and integration approaches adopted instead of stand-alone model are inappropriate. Therefore, the whole syllabus be overhauled in terms of objectives, content and suggested activities to reflect the expected behavioural outcome among the learners content on values, attitudes, morals and skills are limited making expected behavioural changes elusive" (Nasibi, 2009 ,p 137).

2.7 Religious Education in Botswana and Infusion of SMC

Religious Education is basically a subject, which teaches about various religions, values and codes of behaviour of the people of different religions. Various religions have ethics, which set the standard of behaviour of the people in a particular religious group. These

ethics help the group members to determine whether their behaviour is right or wrong, good or bad, for example students are taught that the Hindus ethics include self -control, austerity, meaning they should be able to plan life, forbearance and uprightness (Watson, 1993).

Religious Education is about everyday life and has immensely contributed to the prevention of drugs in the schools and community (Nkomazana, 2007). It focuses on social, moral and ethical issues of diverse kinds. It teaches students to engage in the process of developing relationships that are relevant to life (Botswana Government, 1996).

Infusion of Safe Male Circumcision can be done in the teaching of the following themes; Religious Ethics (Botswana Government, 1996) that is, in the teaching of the subtopic morality in different Religions. The students will learn the principles that guide followers of different religions as to what are the right and proper conduct and good ways of living. This will encourage students to make choices that are good for their health and discourage them from immoral behaviour such as adultery, promiscuity and others, and such behaviour can increase the spread of HIV. Again the subtopic on the golden rules, that is, how the golden rules can be put into practice when dealing with issues of relationships, HIV and AIDS. In this theme the students will learn the ways of preventing the spread of HIV and AIDS. Furthermore, the theme on the virtue of purity in different Religion in relation to sexual purity will help the learners to refrain from sex while still young (Botswana Government, 1996).

The sub theme such as Rites of passage especially puberty rituals will help the learners to have knowledge about circumcision and as a result learners will able to choose whether to circumcise or not. Also the sub theme HIV and AIDS, in this topic, the learners are taught the views and attitudes of different religions as well as their roles in helping, counselling and accepting people living with HIV/AIDS, this theme will help the learners to know the strategies for preventing HIV and AIDS especially safe male circumcision (Botswana Government, 1996). It should be noted that infusion of safe male circumcision in Religious Education syllabus will help to increase students understanding of safe male circumcision

because they will learn about the benefits of safe male circumcision and able to make decision on whether to go for circumcision or not. Again it will enable the support for the overall goal of the Curriculum Blueprint for Primary and Secondary Education of an Education System that nurtures, promotes and sustains skills that will enable young Batswana to meaningfully participate in national building" (Botswana Government, 1996). After all, purpose of education is to equip learners with life skills beyond the classroom.

2.8 Knowledge and Perceptions towards SMC

A cross-sectional by medical survey was conducted by Auvert and Lissouba (2011) that assessed an association of adult safe male circumcision and the level of acceptability among South Africa community. The survey employed 1198 men aged from 15-49 from Orange farm to which knowledge about SMC and HIV questions were asked. It was discovered that men had fairly good knowledge about SMC and HIV acquisition. Most respondents knew that circumcised men could still acquire HIV through unsafe sexual practices. An uptake of SMC among uncircumcised men of 58.8% was established.

Knowledge about HIV/AIDS plays a vital role in risk reduction as sufficient knowledge may bring about long-lasting behaviour change. Based on this, a survey conducted in 64 countries showed that only 40% of men in the age group have sufficient and comprehensive HIV knowledge, compared to 38% of women of the same age group (Global Report, 2008). For one to have adequate knowledge on HIV and safe male circumcision there is a need to have knowledge of comprehensive HIV prevention. This would facilitate adoption of positive attitude towards safe male circumcision. A study by Cowan and Mavhu (2011), assessed the prevalence and factors associated with knowledge of and willingness for safe male circumcision in rural Zimbabwe, whereby females constituted 64% of the sample, found a relatively low level of knowledge towards SMC benefits among the respondents, with positive attitudes as well as acceptability of SMC and its health benefits of about 52%.

According to the study conducted in Malawi on knowledge attitudes and benefits of safe male circumcision, young men and women demonstrated good knowledge about HIV and safe male circumcision (Ngalande et al., 2000). Most women also exercised the willingness to take their children and partners for circumcision. Generally, people's attitudes may change with education. Individuals' decision to circumcise is more influenced by culture or health and the key persons involved are parents especially when SMC was done in childhood (Pappas-DeLuca, 2009). Furthermore, Pappas- DeLuca (2009) notes that in Namibia, a qualitative research on circumcision which assessed the attitudes towards safe male circumcision was done and it indicated negative attitudes and perceptions in non-circumcising areas such as Caprivi and Ohangwena region. The findings revealed that older men felt they were too old for circumcision and they did not see any need to uptake while some uncircumcised men in non-circumcision tribes were not willing to be circumcised because they believed that they were satisfied with the way they were. Some perceived circumcision as an old and out-dated practice, while some perceived the removal of the foreskin to be a health risk as the foreskin acts as a protective shield to the penis. These findings involve revealed that women have positive attitudes towards male circumcision especially those who are in support of the health benefits associated with circumcision (Pappas-DeLuca, 2009).

More studies conducted on perceptions towards male circumcision concluded negative perceptions towards circumcision performed after childhood (Wambura, et al 2011). A longitudinal study was conducted in Kenya to check the perceptions of female partners of recently circumcised men in Nyanza Province in Kenya. Such women have been in relationships with the circumcised men before and after their circumcision. It was found out that all females were satisfied with their partners' decisions to uptake circumcision, and high rate (91%) of women reported more sexual satisfaction than before circumcision. However, a relatively high number of women were 84% perceived them as not being at risk of contracting HIV and other STIs anymore.

However, safe male circumcision as a measure of HIV prevention may not be efficient when men believe that they will be fully protected from HIV (Halperin & Bailey, 1999). The concerns are that the possibility of behavioural disinhibiting may expose them to the risks of acquiring HIV. Several studies reported an increased potential behavioural disinhibiting among circumcised men than in uncircumcised men (Bailey & Westercamp, 2006). In addition to perceptions, several studies, according to Scott (2006) cited in Bailey and Westercamp. (2006), have found a high proportion of men and more women who had a belief that circumcised men enjoyed sex more than uncircumcised men. These findings were supported by the findings of the study conducted in South Africa that women were eight times more likely to advocate for circumcision if they believed that circumcised men enjoyed sex more than uncircumcised men, and six times more likely to regard it if they believed that women enjoyed sex more with circumcised men.

2.9 Summary of Literature Reviewed

The review of the related literature revealed that SMC was introduced as an additional HIV prevention intervention because the country has a high prevalence and there is compelling evidence that male circumcision reduces the risk of heterosexuality acquired infection in men by approximately 60%. There are many studies that support the idea of male circumcision program. Although religion and culture may act as deterrents, in that the laws and customs of a culture and or of a religion may be used to curb rampant sexual behaviours, it is also necessary to note that circular education may help people to feel more settled on the importance of safe male circumcision as the information they would be given would be used after extensive researches. SMC programs can be tested in areas that are most affected, for instance Botswana will greatly benefit if the program can be implemented.

SMC cannot stand alone and must be used in conjunction with other known HIV preventative techniques. Education about the procedures, healing time, and HIV in general are important. It is also important that the general public is educated on behaviour and actions

which are considered high risk for HIV transmission. Basing on the discussion, the researcher is of the view that male circumcision should be taught in schools and should be performed on children at younger age so that by the time they become grown they fully understand and able to decide whether to circumcise or not.

CHAPTER 3: RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents a description of the methodology used in the study and this includes the research design, population of the study, sample and sampling procedures, ethical considerations and data analysis procedures, data collection, instruments and research design frame work. This study investigated the perception of both secondary school teachers and students with regard to the infusion of SMC education into the Religious Education syllabus as a tool to combat HIV and AIDS.

3.1 Research Orientation

The research orientation used was qualitative and it was found to be suitable for this study because it involved an interaction with participants so that the phenomena being investigated could be fully understood (Creswell, 2003). The qualitative approach helped in bringing out the attitudes, the opinions and the experiences that explain the behaviour of the population hence obtaining an in-depth understanding (Denzin & Lincoln 2005). In addition, a qualitative methodology was preferred because it employed a range of methods such as interviews, focus group discussion and documents (Belly & Smith 2000). According to Creswell (2013), social scientists investigating data from social life occasionally employ qualitative methods to find answers to why and how and in what way questions

3.2 Research Design

The research design is more than a work. Researcher has developed it to use as a guide or plain for carrying out a research project. The Business Dictionary explains a research design as a detailed outline of how an investigation will take place. Labaree (2013) also explains it as the overall strategy that you choose to integrate the different components of the study in a coherent and logical way, thereby, ensuring that one would effectively address the research problem; it constitutes the blueprint for the collection, measurement and analysis of data. Salkind (2010) asserts that the function of a research design is to ensure that the evidence obtained enables the researcher to answer the initial question as unambiguously as possible. Therefore, a research design includes how data should be collected, what instruments should be employed, how the instruments are used and the intended means for analysing data collected.

This study adopted a case study research design. Kombo and Tromp (2006) stated that, "A case study seeks to describe a unit in details, in context and holistically" (p.72). Hence, in this study, the researcher intended to find out in depth the perception the teachers and students have on whether or not safe male circumcision should be infused into the teaching of Religious Education syllabus in Botswana junior secondary schools, challenges and strategies to overcome those challenges. Employing the design, brings about deeper insights and better understanding (Creswell, 2007) about individuals' perspectives regarding the reasons why males are reluctant to circumcise to prevent HIV and AIDS even though there are a lot of campaigns going on in Botswana. The researcher carried out the study in six junior secondary schools to investigate the views of students and teachers on the infusion of safe male circumcision.

3.3 Population of the Study

The target population in this study was the students in Botswana junior secondary schools who took Religious Education as one of their optional subjects. The six community

junior secondary schools were chosen because they were nearer to the researcher's workplace, and therefore, time and costs were the major determining factors. The population also consisted of RE teachers in junior secondary schools within the Gaborone area. The size of the population was 162 comprising of 18 RE teachers and 144 students. Students were included because they are the most affected by HIV and AIDS and the syllabus as an instructional tool is meant for their consumption.

Students are at the puberty stage of life where changes in the development of the body trigger them to try and experience whatever they feel will bring fun. They therefore need to learn how HIV and AIDS is transmitted and prevented. As such, their views on whether SMC should be infused in the teaching of Religious Education or not was pivotal. By virtue of being the curriculum implementers, the teachers' input was very central to what the researcher set out to achieve, so their conclusion in the research sample was fundamental. That is, Religious Education teachers were chosen because they are the ones who teach the subject therefore they are informed in terms of determining as to whether safe male circumcision should be infused into the teaching of Religious Education syllabus or not.

3.4 Sample and sampling Techniques

The sample of the study consisted of 144 RE students' and 18 RE teachers collectively drawn from 6 junior secondary schools. The 144 students from the 6 selected schools comprised of 24 students from each school. The number of teachers was limited to 3 teachers from each of the participating 6 schools because in general, there is a maximum of 3 Religious Education teachers in any given junior secondary schools in Botswana. Therefore, the choice of the maximum of three participating teachers per school was reasonable in ensuring that each school could manage to provide the same number of teachers in the study. The sample of 18 participants was considered to be representative of the population. To ensure that each student had an equal chance of being selected simple random sampling was

used as this kind of sampling prevents biasness in selecting the participants (Miles & Huberman, 1994). From each school the researcher selected 24 students who are doing Religious Education as their optional subject. Where there were more than 24 students the researcher selected the number she wanted, where there were less the researcher selected them all this made a total sample of 144 respondents of the study representing population.

The teachers were purposely selected because they were well informed in the subject as curriculum implementers. They were in a better position to determine whether to infuse circumcision in the RE syllabus or not. Purpose or judgment sampling according to Mason (1994) is based on "the judgment of a researcher regarding the characteristics of a representative sample". So the researcher used her prior knowledge to choose the participants. The aim of the purposive sampling procedure was to save time and effort and also to obtain a sample of people who have valuable information that could benefit the research.

3.5 Data Collection Instruments

According to Pierce (2009), research instruments or tools are ways of gathering data. It is important to use appropriate data collection instruments since inaccurate instrument produce invalid results. In this study, interview guide was used to gather data from the 18 selected RE teachers, and a focus group discussion was used to collect data from the 144 students. The researcher chose two methods of data collection as focus group discussion and interviews, to investigate the perception of teachers and students on the infusion of SMC in to the Religious Education syllabus.

The first section of the interview schedules was concerned with biographical information. This information was used to compile profiles of teachers and students, making up the FGD .It were also used to help the researcher to determine if any of these variables has any influence on the findings. The biographical data was where the students and the teachers gave their personal details. The second section was having three open- ended questions. The

questions were meant to solicit information on the views of both teachers and students towards the infusion of safe male circumcision in the teaching of Religious Education syllabus.

3.5.1 Focus Group Discussion

Focus group discussion was conducted in six schools and each group consisted of about 6-8 participants who were involved in the study. It was facilitated by two facilitators, that is, the teacher and researcher. During the focus group discussions, the teacher asked questions and the researcher took notes. The teacher as a note-taker was responsible for identifying the key notes of each speaker to facilitate data interpretation. The group discussions lasted for up to one hour and thirty minutes and were held in English language. The key demographic details were recorded for each participant. The focus group discussion was chosen because it can produce a lot of information quickly and it is good for identifying and exploring beliefs, ideas, or opinions in the community (Kombo & Tromp, 2006). The FGD could also help participants to share different ideas, it is a good strategy because participants can learn more through interaction with others and also actively participate in group discussion.

3.5.2 Interviews

The researcher chose to use semi structured interview questions as a tool which enabled her to interact with the participants in a direct "face- to- face" contact and this allowed her to make follow-ups using verbal communication whenever the need arises. There were eighteen Religious Education teachers who were drawn from six schools which participated in the study. Each school had three teachers responding to semi structured interview and recorded by the researcher. The number of teachers was limited to three teachers from each of the participating six schools because mostly in junior secondary schools there are a maximum of three Religious Education teachers. So to make sure that each school

was to manage providing the same number of teachers in the study, maximum of three participating teachers per school was reasonable. The researcher was taking about thirty minutes per interviewee. The answers were noted in a short notes form by the researcher. The major advantage of note taking is that it facilitates data analysis (Neumann, 2000).

The reason the researcher used interview is because with interviews, the researcher was able to get information in depth as interviews allowed for probing and prompting. Information gathered by the researcher during the interview helped her to gain insights of the key issues pertaining to the subject of the study. Interviews were relevant to this research because they create a good platform for participants to openly articulate their ideas and opinions about the issue posed to them. Klenke (2008) points out that interview are not one way information gathered situations. They are guided or dialogical conversations between interviewer and interviewee and are conducted such that both parties view reality as a process. The demographic details were recorded for each participant.

3.6 Trustworthiness of Instruments and Data

Trustworthiness is how qualitative researchers establish whether the data is credible, transferable, confirmable and dependable (Lincoln & Guba, 1985). In this study, the researcher showed that the research findings are accurate by employing multiple data gathering methods (Long & Rigour, 2000). Triangulation was also used by the researcher to avoid biasness, for example, two related sources and data collection methods were used with the aim of reducing inherent bias associated with a single source. Self-description and self-reflexivity was done by the researcher to help in discussing her position within the study and how personal beliefs can influence the research findings. Again prolonged engagement with participants in order to gain trust and establish rapport hence the researcher got in-depth information from the participants (Cresswell, 2006). The researcher presented her research

proposal to other researchers and lectures that questioned the researcher interpretations, provided additional perspectives and explanations to the researcher.

After the formulation of the research questions and the collection of data, the researcher gave them to her colleagues and supervisor who reviewed them and made corrections hence avoiding been bias. In addition, the researcher recorded notes during interviews and focus group discussion to keep her busy and avoid contributing during data collection.

3.7 Reflexivity

Reflexivity is the process of examining both oneself as researcher, and the research relationship. Self-searching involves examining one's "conceptual baggage," that is, one's assumptions and preconceptions, and how these affect research decisions, particularly, the selection and wording of questions. Reflecting on the research relationship involves examining one's relationship to the participant, and how the relationship dynamics affect responses to questions. Reflexivity is the process of becoming self-aware, whereby you make regular efforts to consider your own thoughts and actions in light of different contexts, especially as you observe, interview and read documents. Reflexivity, then, is about the researcher's on-going critique and critical reflection of his or her own biases. Reflexivity is a characteristic of research that can be considered during the whole process of qualitative research and is not limited to a certain stage. It is an extensive activity in which the researcher tries to be aware of his or her ideas, attitudes, and beliefs and make their influence on his/her own research clear for him or herself and sometimes the audience.

Long and Johnson (2000) stated that self-description and reflexivity is very important in qualitative research to acknowledge and reduce bias. Hence the researcher used self-description to discuss her position within the study and also considered how her past training can influence the research findings. During interview and focus group discussion researcher

took notes to avoid been bias in order achieving credibility and conformability. Checking of study findings and conclusions was done by the participants from whom the data were originally obtained.

While carrying out this research it was difficult for the researcher to be detached completely from the data in order to maintain objectivity and avoid bias. Sword (1999) states that, "No research is free of the biases assumptions and personality of the researcher and we cannot separate self from those activities in which we are intimately involved" (p. 277). This is true because the researcher is the one who knows what she wants or what should be included in the research hence it is difficult for the researcher to distance herself from the research to avoid biasness. In this study, the researcher allowed participants to tell their perspectives without requiring any confirmation from the researcher. Also the researcher used open-ended question that did not require her to endorse a particular response. Again the researcher used different questions that were worded differently and asked general questions before moving to sensitive questions. Furthermore, the researcher saw herself as a learner and the participants as having knowledge about the topic researched hence monitoring her subjectivity.

Qualitative research paradigm means that researcher is an important part of the process. The researcher cannot be separated from the topic or people he or she is studying; it is the interaction between the researcher and participants that the knowledge is created (Shenton, 2004).

Subedi (2006) stated that, "Insider- outsider research involves a researcher occupying double positions, meaning that he or she is both a member of the researched group and an outsider relative to the group. Insider-outsider researcher positions are usually seen to cause some form of discomfort for the researcher" (p.546). Hence, there are a number of challenges and limitations as well as possibilities when carrying a study as an RE teacher. RE teacher as an insider had easy access when collecting data in schools and there was a certain level of

trust and dependency existed between the researcher and the participants because the researcher is a teacher and was using students and her colleagues to collect data. The participants were more willing to share their experience with a researcher whom they perceive as sympathetic to their situation. The participants regarded the researcher as someone who is knowledgeable and can able to help and give informative information.

On the other hand being an outsider can cause discomforting especially when revealing negative aspects of one's own cultural group (Hamnett, et al., 2006). For example, safe male circumcision is practiced by some ethnic groups for religious and cultural purposes and there are some sensitive issues that are not to be known by a girl child or boys that were not circumcised hence was difficult to get more information. The involvement of girls in research is considered culturally insensitive. Regarding the students, the researcher had realised that some of the words used were not familiar to the students'. Again the boys during focus group discussion felt uncomfortable and preferred to be given written work.

3.8 Data Collection Procedures

One very important element in conducting a research in any particular setting is to seek for permission from relevant authorities to carry out the research and to gain access to the participants or relevant documents to be used in the study. Anderson (1994) describes gaining access as "seeking permission from relevant authority and making his or her research agenda known to the relevant stakeholders" (Anderson, 1994, p. 66).

A researcher required a research permit before embarking on the study. In this study, the researcher and the supervisor wrote letters to the Senior Education Officer in the Ministry Of Basic Education seeking permission to allow the researcher to carry out her study in selected schools in Gaborone. In the letter, the researcher explained the purpose of the project, the research methods to be adopted, and the expected benefits of the study to the teachers and the students. Then, the Senior Education Office in the Ministry of Basic Education wrote letters to schools requesting them to allow the researcher to conduct her study in their

respective schools. The letters were hand delivered by the researcher. The School Heads contacted the Teachers of Religious Education on the issue. The researcher then visited the schools to discuss all the issues about her research with the heads of the schools, Religious Education teachers and the students. The discussion was on what was contained in the letter that was basically the purpose and the benefit of the study.

The Religious Education teachers were interviewed using semi structured interview. Interviews are a bit flexible because they allow the participants to explain their reasons and could still stretch their reasoning if prompted to do so. The researcher used interview to get as much information in depth as possible so that they have the actual insights of the subject at hand. The direct interaction with the individual on a one to one basis allowed for a face to face conversation between the research and the participants. This allowed the research to gather rich information and had a deeper insight into the phenomenon on the area of study.

In this study, before data was collected, the researcher defined the target population. This involved identifying the participants and their accessibility. Also the researcher stated research design to be used and the sample, this was done to ensure the format in which data will be collected. Kombo & Tromp(2006) stated that , "The key data collection instruments to be used in the study for example questionnaires ,interviews, observation, focus group discussions and experimental treatments should be in order "(p.102).Hence the researcher availed the instruments to be used in this research, checked whether they were in order and ready to be used . Again, the researcher defined the data to be collected, that is, ensuring clear of the sample to be used, for instance, the male and female. After designing data collection instruments, the researcher had to ensure if they are good enough to fetch as much information that she intend to get from the target group regarding the research project .This was done through the exercise of piloting the design instruments. The report entails the methodology that was used to carry out the exercise, objectives of the piloting exercise, the finding and the short comings of the whole exercise.

3.9 Data Analysis

Data from interviews and FGD was analysed qualitatively. The aim of qualitative data analysis was to find patterns among the data (Babbie, 2004). The research interview responses and the FGD notes were analysed thematically by coding and describing the responses of students and teachers with regards to their perceptions on the infusion of SMC in the Religious Education syllabus in JSS in Botswana. Thematic analysis as guided by Kombo and Tromp (2006) was used in this study. Common and main themes that recurred across the data were identified. The main constructs are perceptions of junior secondary schools teachers and students on whether safe male circumcision should be infused in the Religious Education syllabus. Data analysis also focused on the benefits of infusing safe male circumcision in the Religious Education syllabus and also analysis of problems that could be encountered if SMC is infused in Religious Education syllabus and strategies that may be applied in solving the problems.

A thorough review of the transcripts of the recorded materials from the FGD and interview was used to identify themes that re-occurred across all the FGD and interview. In particular, the researcher analysed the data by going through each interview responses and the FGD notes and looked across the spectrum of responses, made summary on that question and made quotes from some of the responses. The same procedure was carried out on the rest of the responses. Therefore, in this study knowledge and attitudes were collected in an indirect way using several questions indirectly related to SMC knowledge and SMC attitudes. After data collection, knowledge and attitudes indices were created. In particular, the responses were analysed under knowledge, attitudes and perceptions themes so as to fully address the research questions. Some of the process followed by the researcher in analysing the data were as follows; Familiarization with the data by going through the interviews and focus group discussions written notes. Transcription of written materials into typed word documents. Identification of important ideas and concepts using codes on the transcribed data typed in.

Report writing, the report was written based on the analysis of data theoretical constructs and a comparison of the following findings with pre-existing theory. Verbatim quotes by participants have also been included in the report.

3.10 Ethical Considerations

Before data collection permission was sought from the Permanent Secretary (PS) of Basic Education and the Office of Research and Development (ORD) at the University of Botswana to conduct a research on infusion of SMC in Religious Education syllabus. The researcher was open and transparent about the purpose and sponsorship of the research. Furthermore, when permission was granted, potential participants who fulfilled the recruitment criteria were informed about the objectives of the study and that participation was voluntary. Free will participation allowed the respondents to voluntarily express their in-depth views without pressure therefore data captured would not be compromised. For instance, a written informed consent was obtained from each potential participant and participants were notified that they were free to withdraw from the study at any time.

McNamara (1994) identifies five ethical concerns to be considered when conducting survey research. These are guidelines which deal with voluntary participation, such as confidentiality. The participants were clarified that the information to be provided was for research purposes and would therefore be strictly anonymous and dealt with confidentially. For example, the focus group panel discussion required recording of the voice of the participants and this was done with prior consent. The analysis and reporting was not influenced by external forces. This is so because in research, confidentiality and anonymity should be guaranteed by ensuring that data obtained would be used in such a way that no one other than the researcher knows the source (LoBiondo-Wood, et al., 2006). This is done by attaching pseudo names to the information obtained and using codes.

3.11 Summary

This chapter outlined the logical steps that were used in the study to obtain the data from participants. For instance, the chapter described the research design that was used and the reasons for preferring such an approach. The study setting, study population, sampling method, instrumentation, data management, data analysis and ethical considerations were all discussed here. The chapter also briefly outlined the methods used to maximise validity and reliability were outlined. The next chapter reports the findings of the students.

CHAPTER 4: DATA ANALYSIS PRESENTATION AND DISCUSSION

4.0 Introduction

This chapter presents the results of the research study. The first section presents the demographic information about the participants. The second part presents the main findings of the study. Data analysis entails organizing what the researcher has read, heard and observed in a particular research setting (Anderson 2003; Bless, 1997). Hence this chapter provides an analysis of the data obtained through students' Focus group discussion. The questions used i n the FGD were open-ended questions.The presentations and discussions were dealt with per research guiding questions. In this study, the researcher sought to find out both the merits and demerits of infusing safe male circumcision into the teaching of Religious Education in the Botswana Junior Secondary School Curriculum. The research findings in this chapter are organized according to the research questions and their related items.

4.1 Demographical Information

This section presents and discusses the results of the study on participants' biographical data. The information on participants includes gender, age, qualification, teaching experiences. The analysis will start with students, before analysing the teachers' biographical information. The demographical information of participants here considered

important to the study on the basis that such variation could influence choices of learners to make decision on whether to circumcise or not.

Table 1: Gender of Students

	Gender	No. of participants	Percentages
	Male	67	46.5%
	Female	77	53.5%
Total		144	100%

Table 1 shows the distribution of the students according to gender. It was important to include gender in the research project because it gives us a guide on which sex is mostly doing Religious Education as an optional subject or participated in the research. The information is also very important because it brings clarity where the researcher might need to use numbers to establish the extent or effect of the problem. This information is also helpful for comparative purpose on the basis of gender to establish the rate of interest and dislike among the participants, which would assist when making recommendations. The findings reflect that 46.5%of the students who participated were males while 53.5% were females. According to the Table above, the students who responded to the Focus Group Discussion were almost balanced as per the gender; there is only a slight difference of 6%. The students are still young and flexible to receive new ideas and effecting change while the older people are more attached to their culture and stick to them hence finding it difficult to accept change.

Table 2: Age of students

Gender	Age	No of participants	Percentage
Males and Females			
	8-10	0	0
	11-15	97	67.4%
	16-17	47	32.6%
Total		144	100%

Table 2 shows the range of students from 11-15 female as 67.4%, while 16-17 males occupy the percentage of 32.6%. This will help in the study since most student are mature enough to be able to give informative responses at a stage of life where they are able to explore and grasp information on SMC and continue to use the same information in future. Also they are at the stage where there are also usually more responsive to new ideas and less rigid to changes.

Table 3: Gender of Teachers

	Gender	No. of participants	Percentage
	Male	5	27.8%
	Female	13	72.2%
Total		18	100%

The Table above shows that 27.8% males and 72.2% female responded to the interview. There is a difference of 44.4% which clearly indicates a large margin between males and females. Religious Education teachers might receive information about safe male circumcision from both electronic and print media, health workers, friends and NGO campaigns on SMC. From the knowledge they acquire throughout one's education would help

them make a contribution in influencing uptake of SMC. They would impart knowledge to the students on safe male circumcision hence able to make informed decisions on uptake or rejecting of SMC.

Table 4: Age of Teachers

TEACHERS	Age	No. of Participants	Percentage
Male and Female	20-25	3	16.7%
	26-30	3	16.7%
	31-35	3	16.7%
	36-40	7	38.8%
	41-45	2	11.1%
Total		18	100%

Table 4 indicates that teachers were from the same range of age, which is from 20-45. Age range from 20-25 had a percentage of 6.7%,26-30 is 16.7%, 31-35 is 16.7%,36-40is 38.8% and 41-45 is 11.1%. The reasons might be the participants are mature enough to be able to give informative responses. The population also consists of the young men and women .This could mean that the young are probably more actively interested in receiving or participating in new ideas in their environment.

Table 5: Teacher's teaching Experience

	Teaching Experience	No. of participants	Percentage
	0-5	0	0
	6-10	4	22.2%
	11-15	3	16.7%
	16-20	10	55.6%
	21-25	1	5.6%
	26-30	0	0
	30 and above	0	0
Total		18	100%

Table 5 reveals that 22.2% of the participants had 6-10 years of experience, 16.7% had 11-15 years, 55.6% had 16-20 years and 5.6% had 21-25 years of experience this indicates that teachers have more than 16 years teaching experience as compared to those with 6-10 years. Teachers teaching experience might mean that they are well conversant with the teaching of Religious Education syllabus and could impart knowledge on SMC to students.

Table 6: Professional Qualification of Teacher

	Professional Qualifications	No. of participants	Percentage
	DSE	3	16.7%
	Bed	15	83.3%
	Masters	0	0
Total		18	100%

The results in Table 6 show that all the teachers are educated, 16.7% of them are diploma holders and 83.3% are degree holders. Professionally, teachers are qualified to teach the subject and this can mean that they can handle the infusion of safe male circumcision in the teaching of Religious Education well and apply various teaching strategies where there is need and this include infusion of emerging issues.

4.2 Section B: Perceptions of Junior Secondary School teachers and students on whether safe male circumcision should be infused in the Religious Education syllabus.

This section presents and discusses the results of the focus group discussion and the interview guide which sought information on the following research questions that guided the study:

1. What are the benefits of infusing safe male circumcision into the Religious Education syllabus?
2. What could be the challenges of infusing safe male circumcision into the Religious Education syllabus?
3. What are the possible strategies that could be used in addressing the challenges encountered in infusing safe male circumcision into the Religious Education syllabus?

The section presents and analyses the findings of the study in relation to both students and teachers' perceptions of the infusion of safe male circumcision in to the Religious Education syllabus. The responses and implications are reflected item by item under the research questions to which they belong.

4.2.1 Research Question 1

What are the benefits of infusing safe male circumcision into the Religious Education syllabus?

This research question had one focus group discussion item for students and one interview item for teachers. The researcher will first present data from focus group discussions for students before the interviews for teachers.

Item: Should SMC be infused into the Religious Education syllabus?

4.2.1.1 Students

The results indicated that the students support the infusion of SMC into the Religious Education syllabus. The students stated that infusion will be an eye opener to the school going males to be alerted on prevention measures for HIV and AIDS. They also pointed out that Infusion of SMC will help students to know and understand the strategies used to prevent HIV and AIDS infection. According to them SMC will help male students to reduce chances of contracting STI's and HIV. They also pointed out that when safe male circumcision is infused, students will know the importance of SMC, they will be able to analyse and decide whether to go for circumcision or not based on the knowledge they acquire in Religious Education. Furthermore, they stated that infusion of SMC will enhance young people's ability to help others to protect themselves against high risks behaviours and this will have a major influence on individual behaviour. It was also pointed out that students may act as agent of change influencing fellow peers to adopt behaviours that reduces their risks of contracting HIV and AIDS. As argued, the students will share information, ideas and knowledge they have acquired about the benefits associated with SMC.

It was further argued by the participants that if SMC is infused students will know about it; this will help in erasing misconceptions myths people have about HIV and AIDS. The participants also pointed out that when SMC is infused, students will get knowledge on behaviour and attitudes towards HIV and AIDS and STI's. Also get a free education on family planning and their attitude towards HIV and AIDS. One of the students in FGD: A stated that:

Mpho: It will be an eye opener to the school going students about the benefits of Safe Male Circumcision, Students will learn that safe male circumcision is important, for the prevention of STI's, HIV, penile hygiene and cervical cancer.

Another student in group B added that:

Tebogo: It help in erasing misconceptions about SMC and myths about HIV and AIDS. The clear misconception is the belief among female that circumcised man would protect them from HIV.

One of the group members during focus group discussion stated that, when you have a partner who is circumcised you will feel safer because the chances of him infecting you with HIV are less because he is at least protected with the circumcision even if it is not 100 per cent. (FGD: C).

These responses indicated that students supported the infusion of SMC into the Religious Education syllabus. The students' general consensus that SMC help male students to reduce chances of contracting STI's is corroborated by the Khattab's (2011) assertion that infusion of SMC in the syllabus can have a positive impact on the prevention of HIV and AIDS. According to Khattab (2011), students who are given health education gain more knowledge, positive attitudes and better practices in dealing with HIV and AIDS prevention compared to those who were not given similar health education on the prevention of HIV and AIDS.

It is however, important to emphasizes that SMC will help students to know that circumcision does not provide complete protection from HIV infection, but only reduces the

chances of getting infected. The point to emphasise here is that safe male circumcision is just like any other prevention methods in place, such as condom use, trust, abstinence, being faithful and behaviour change. These are not compulsory, but add value in the reduction of infection rates.

Furthermore, they stated that infusion of SMC will enhance young people's capacity to help others to protect themselves against high risks behaviour and this will have a major influence on individual behaviour. For instance, one of the female students in FGD: D said,

Lebo: Although I am a female, I have young brothers and uncles that I can help to understand safe male circumcision better with information about SMC and encourage them to perform it.

Another female student in group C argued that:

Rati: I have read in the internet that uncircumcised men can cause cervical cancer if the foreskin has been infected with certain viruses …. Something like that. So I am concerned about SMC as a young girl as well.

Still related to this, according to the study conducted in Malawi on attitudes and benefits of SMC, women demonstrated good knowledge about HIV and most women also showed their willingness to take their children and partners for circumcision (Ngalande, et al 2000). Therefore, it is possible that students may act as agents of change influencing fellow peers to adopt behaviours that reduces their risks of contracting HIV and AIDS, arguably helping the nation to move towards zero per cent HIV and AIDS cases. The nation will also be informed about its HIV and AIDS status. Before procedure is done the individual has to go

for HIV test and also screening of other illness such as diabetes, hypertension, prostate cancer, cardiac diseases and STD's. As a result, the government will get the information on HIV status and other diseases in the country. As observed, Gray, et al (2007), in their analysis on SMC for HIV prevention in young men in Uganda concluded that SMC reduces the risk of cervical cancer among female partners of uncircumcised men since circumcised men are less likely to harbour the human papilloma virus which causes cervical cancer.

Since most students supported infusion of SMC into the Religious Education syllabus, the researcher believes that SMC should be infused into the Religious Education syllabus so as to inform the students about the benefit associated with safe male circumcision. The students should know that once a boy or man has undergone the procedure he will benefit from the preventive effect for the rest of his life. That is, it is a permanent procedure and once the person has performed circumcision he does not have to do it again. Furthermore, the couples are given free education on family planning during the process; hence their attitude will change (Karin, 2014). Again it encourages the couple or partners to seek counselling, education and testing of STIs.

4.2.1.2 Teachers

During the interview with the teachers on the same issue teachers stated that students will find it very interesting to learn safe male circumcision during the teaching of Religious Education syllabus because if students learn new subject they will get motivated and eager to learn since safe male circumcision will motivate them unlike RE content which they already know. Safe male circumcision will help students have relevant knowledge about the procedures of safe male circumcision and the reasons why it is promoted. According to teachers the knowledge that the students will get in Religious Education syllabus will help the boys to make appropriate decisions regarding their own sexual behaviour or take informed decisions on whether to circumcise or not. It was stated by the teachers that students will act as ambassadors in advocating for SMC since they will teach their peers the

role of SMC in the fight against HIV and AIDS. Furthermore, teachers stated that infusion of safe male circumcision will help reduce HIV and AIDS. It was argued by the researcher that SMC has been studied and different studies, for example, randomised controlled trial in South Africa, Uganda and Kenya showed that safe male circumcision reduces the risk of acquiring some type of sexually transmitted infections such as HIV and further complications after these infections such as cancer of the penis.

Below are some of the teachers' responses who stated the benefits of SMC:

Teacher A: Safe male circumcision is for cleanliness purpose and protection against HIV but cleanliness of the penis is more important.

Teacher B: If a boy is circumcised, there are benefits in the future
He is protected from getting many bacteria, of course
He will, though the risk is low.

Teacher C: SMC as part of the syllabus will teach male students that safe male circumcision can help them to know how to wash their private parts properly to prevent them from dirt and diseases which can cause cancer of the penis.

The teachers also indicated that it is advisable for students to be circumcised when they are still young because the procedure would hurt less due to lack of physical sensitivity in babies. A baby soft skin bleeds less and creates improved physical conditions that make the procedure and healing easier. Furthermore, the child will grow up thinking that it is normal to be circumcised. This was supported by the following verbatim code:

Teacher C: A baby can be circumcised because he will not feel pain.

The above verbatim quote is also included in the Social Norm Theory which stated that boys should be circumcised at a young age, ranged from birth because of the supposed lack of physical sensitivity in babies (Hellsten, 2004). Parents would therefore prefer safe male circumcision for their sons, since at those tender ages it would be painless, affordable and has been shown that there are some sort of protection against HIV and STIs (Westercamp & Bailey, 2007). The child would grow up thinking circumcision is normal and would not have to grow with the pressure of consider it later at an older age or be teased for being uncircumcised.

From these results, it is clear that in general, the teachers believe that infusion of SMC will help students have relevant knowledge about it. According to them, the knowledge that the students will get in Religious Education syllabus will help the boys to make appropriate decisions regarding their own sexual behaviour and health or take informed decisions on whether to circumcise or not. The argument that the infusion will help to reduce transmission of STI's and HIV and AIDS is in corroboration with the assertion by Rennie (2007) who argued that the positive impact of SMC on reduction in female-to-male transmission would contribute to the overall reduction in spread of the pandemic, in the long run. In addition, the response from teachers is corroborated by Gray, et al (2007) who argued that SMC reduce the risk of acquiring some type of sexually transmitted infections such as HIV and further complications after these infections such as cancer of the penis as the penile areas remains clean and does not harbour germs.

The above teachers' responses imply that some students are aware of the benefits of infusion of SMC into the Religious Education syllabus. As can be gathered from the above

quotes, if SMC is infused into the Religious Education syllabus it will motivate male students to get circumcised thereby helping the younger generation in reducing the risks in contracting HIV and AIDS. The Botswana Government (1994), "require an education system that enables students to acquire knowledge, skills, attitudes and behaviour, that will give them a full, successful life and continued personal growth, and equipped them to participate effectively in a rapidly changing society"(p. 23). In this regard, the infusion of SMC in Religious Education will help students to meet the demands of the governments Revised National policy on Education. The former President of Botswana Dr Festus Mogae has pleaded with the youth to equip themselves with the facts on HIV and AIDS, so that they remain a free generation, with no new infections, (Tabane, 2015). Infusion of SMC will help the students to acquire knowledge and practice of moral standards and health practices that will prepare them to be responsible citizens.

Furthermore, teachers indicated that infusion of SMC into the Religious Education will make them to use student centred methods that will encourage the students to take part in learning. The teacher might use the teaching methods like peer leaders. In this method, young people listen more attentively and accept messages from respected peers than from a teacher. It provides assistance to the teacher which allows him or her to spend more time on preparation, individual attention to students and classroom management. Also the teacher can use group discussion, which stimulates free exchange of ideas, feelings and attitudes. Other methods that might be used are discussion, questioning, case study and role play. Teaching students about safe male circumcision requires the teacher to use participatory methods to validate the learner experience and give them confidence, knowledge and skills to question themselves and others, and take action with regard to themselves and others.

It was argued by participants that the use of student methods and infusion of SMC will make Religious Education more interesting as it will be touching on Religious issues as well as our modern day issues particularly the prevention of the spread of HIV by means of

circumcising, instead of just religious issues. Young people need to know how to protect themselves from HIV and STD. They need to learn about AIDS and prevention in their early teens, when they become aware of their sexuality. Education about sex, AIDS and safe male circumcision will help them realize the consequences of sexual experimentation and will avoid HIV and STD. For instance, some of the benefits teachers have stated are as follows:

Teacher D: Infusion of safe male circumcision will encourage the use of teaching methods that stimulates more Learning. For example, participation methods can be used to validate the learners experience and give the students confidence, knowledge and skills to question themselves and others and take action with regards to themselves and others.' The method is important in dealing with such sensitive topic as HIV and AIDS, STI's and Safe Male Circumcision.

In general, the teachers indicated that infusion of SMC will make teachers to use student centred methods that will encourage the students to take part in learning. During the interview most of the teachers argued that the inclusion of SMC will make Religious Education more interesting as it will be touching on modern issues, particularly the prevention of the spread of HIV by means of circumcision, instead of just Religious issues.

Again the infusion of Safe male circumcision into the Religious Education syllabus will help to promote to the students' behaviour that prevent the transmission of HIV and STD. The students will learn the behavioural skills that are needed for prevention of HIV and STD, also acquire the development skills, positive attitude and motivation. That is, they will get the information that will help them to decide what behaviour is health. For example, ways HIV

and STD are transmitted and means of protection from HIV and STD. Furthermore, the skills relevant to HIV and AIDS for example, decision making skills to ensure protected sex and practical skills for effective condom use.

The teachers also pointed out that infusing SMC into the Religious Education syllabus will help students to be aware of the reasons why they are circumcised, as argued, this will make the students to sensitize others about the benefits of SMC to their peers and societies, hence making the society fully understanding the importance of safe male circumcision. The teachers mentioned the benefits one can get through circumcision. They stated that, it prevents HIV and other STI's, cervical cancer, penile hygiene and sexual pleasure for woman.

One of the teachers during the interview stated that,

Teacher E: A man's penis glands become hard after circumcision and it allows a man to prolong sexual intercourse and was seen as beneficial for the woman. That is, because the front of the man's penis is removed, it allows man to prolong sexual intercourse.

Furthermore, the teachers stated that knowledge of SMC amongst the students is also valuable in the sense that such SMC knowledge in Religious Education will help the male students to make the right decision on whether to circumcise or not. According to them SMC is for cleanliness of the penis. The students will learn about these and able to decide whether to circumcise or not. They stated that;

Teacher C: A man who has a circumcised penis is clean and does not carry dirt and diseases like someone who is not circumcised. It is this dirt and germs which can cause cervical cancer

because they are hidden inside the foreskin and if the man does not bath, the woman can get the germ when they have sex

The students should learn about the benefit of safe male circumcision like penile hygiene so as to help them accept safe male circumcision. They should know that with the penis when you have not washed it for some time it can have some white stuff inside the foreskin which smells showing that there are some germs and dirt there, but when one is circumcised, you do not even have to worry about washing your penis always because it will always be clean.

Based on the above findings, it can be argued that, infusion of SMC in to the Religious Education syllabus will help to impart knowledge, develop healthy attitudes and instil skills for healthy decision making. Therefore, it could be argued that there is need to infuse SMC in to the Religious Education syllabus to sensitize learners about SMC at a tender age. The skills that students will acquire in Religious Education syllabus will help to develop attitudes and practices necessary in curbing the spread and improving the management of HIV and AIDS in order for Botswana to achieve the goal of no new infection by 2018. Students will be able to preach the importance of SMC to their peers, thus encouraging others to go for circumcision.

4.2.2 Research Question 2

What are the challenges that could be encountered in infusing safe male circumcision into the Religion Education syllabus?

The research question had one focus group discussion item for students and one interview item for teachers.

Item: The challenges that could be encountered in infusing safe male circumcision into the Religious Education syllabus.

4.2.2.1 Students

During focus group discussion students stated that infusion of SMC into the Religious Education syllabus will make them lose interest in learning about the topic of SMC because of the attitude they will develop towards circumcision. According to them, the topic on SMC into the Religious Education syllabus will be boring to the female students who have almost nothing to gain on circumcision. They further stated that, if SMC is infused into the Religious Education syllabus students may lose interest in the subject and end up failing Religious Education. Furthermore, they feel that it may lead to stigmatization; they will be afraid of being stigmatized in public health facilities. It is also the feeling of the students that their privacy will be violated. In other words, SMC is performed at the hospital or clinic by a trained nurse or doctor and students felt that during that process one has to expose his body (private part) to the doctor which is not fair. Still related to this, it was pointed out that female students will learn how it is performed and might tease the male students on the circumcision issue. One of the boys in focus group discussion: A stated the challenges cited as follows:

Kago: We may lose interest in the topic and end up failing the subject.
Also may display negative attitude towards Religious Education
and relax in our studies and end up performing poorly.

Another one felt that safe male circumcision should not be infused in Religious Education syllabus or be made compulsory.

Atang: It should not be compulsory and that the individual
should retain the right to choose whether or not to
be circumcised or not.

Another boy stated that:

Phillimon: I have the right myself on such authority.
I have the right to decide .You cannot tell
me to get circumcision or not.

Again one student in the focus group discussion: B argued that:

Tshepo: When carrying out safe male circumcision, we may feel that our
privacy is violated because during the process we have to
expose our body to the female doctor which may be unfair.

Benny: This may lead to stigmatization, that is, female student will know
how it is performed and tease male students.

According to the students, the infusion might make other students lose interest in Religious Education and as a result fail the subject or develop negative attitude towards the subject. They further stated that safe male circumcision will overburden the Religious Education syllabus. The point emphasized here is that infusion of SMC will add too much content in Religious Education and students will end up getting bored or failing the subject. The following verbatim quotes support the students' arguments:

Tshegofatso: It will add too much content which will not be taught within
the recommended minimum teaching time. Most teachers
will fail to cover or complete the syllabus during the three-

year duration and this will lead to low academic performance
in the subject.

In addition, some students argued that their body is the temple of God and if males cut of their foreskin (prepuce) of the penis during SMC they will be acting against the will of God. In particular, some of the students' responses from the focus group E discussions were as follows:

Kabelo: It is against the will of God. If someone cuts his own foreskin,
he is destroying what God has created. One should not temper
will what God has made. God created a man with a foreskin and
there is a reason for it to be there.

In addition to the above statement one of the boys in focus group
Discussion: Group C stated that:

Phenyo: We are Christians, what if God asks for
His Skin back when you die?

One of the groups stated that, safe male circumcision is a very painful procedure especially the cutting of one's foreskin. The wound from the procedures may take too long to heal or sometimes one may die because of too excessive bleeding. The students stated that they want nothing to do with safe male circumcision neither accept infusion of safe male circumcision in the teaching of Religious Education because of the fear of pain, long healing time and death. One of them added that:

Oratile: Safe male circumcision is a very painful procedure that is accompanied by too much bleeding which could lead to death. Healing process can be difficult if you are not treated properly.

However, the researcher argues that people should promote SMC whether their religion support or reject it. SMC is practiced as a medical procedure to treat infections, injury or anomaly of the foreskin hence the researcher see the need for teachers to sensitize students about it. In addition, the researcher believes that if SMC is infused into the Religious Education syllabus it will help to reduce HIV and AIDS among the young people. In particular, to substantially reduce HIV transmission, males would need to be circumcised before they reach sexual maturity and before they commence sexual relations. In this regard the research is advocating for infusion of SMC so that the students can appreciate the need to circumcise before they reach sexual maturity and before they start sexual relations.

Arguably, the students stated that such infusion will bring confusion in that some students will believe that if one has done safe male circumcision there is no need to use condom. As further argued that they will think that it is 100% safe and they will end up spreading HIV and AIDS and sexually transmitted infections or they will get infected. Below is what one of the student stated in group B:

Phenyo: Some students might think that with safe male circumcision in place, students will think it is 100 per cent safe and they will end up having sex without the use of condom hence spreading HIV and AIDS and other sexually transmitted infections or they will get infected.

4.2.2.2. Teachers

During the interview with the teachers on the challenges of infusion of SMC into the Religious Education syllabus, teachers pointed out that the infusion of SMC into the Religious Education syllabus will mean that teachers who are teaching the subject need to be trained, thereby increasing government education expenditure on education. They indicated the issue of mixed reactions and misunderstanding of this infusion by the society as well as the students themselves which might develop a negative attitude towards the subject. Thus they pointed out that this will result in those students who are taking Religious Education as the optional subject could lose interest or failing. Furthermore, they argued that, Religious Education syllabus has a lot of material to be covered within a stipulated period of time so it is impossible to include SMC in Religious Education syllabus. The following verbatim quotes support the teachers' arguments:

Teacher C: Lack of time since infusion of SMC will need a lot of research and understanding.

Teacher A: Lack of adequate knowledge for teaching SMC. Religious Education syllabus may be congested.

They further indicated that time allocated for teaching Religious education is limited and the syllabus is already congested and therefore, teaching SMC concepts might need a lot of research and understanding and there are no textbooks that would guide them on how to go about with the infusion of SMC. According to them, they would have to use their own knowledge to handle infusion of SMC. This being the case infusion of SMC is not possible in the Religious Education syllabus. Therefore, the researcher believes that if SMC is infused into the Religious Education syllabus, teachers need to be equipped in the subject area so as to make implementation a success. Lack of time and inadequate knowledge of the subject is

capable of making infusion of SMC fail or the teacher may fail to implement infusion of SMC.

They also pointed out that it will increase the curriculum of Religious Education. According to them, SMC should be taught in moral Education and Guidance and Counselling because Guidance and Counselling and Moral Education deal with moulding the behaviour of the students. They argued that since students do not write examinations there is no stipulated period of time to complete the syllabus.

Furthermore, they stated that SMC is against the will of God, if you cut someone's skin you are destroying what God has created, after all the circumcision agreement in the Bible was between Abraham not the people of today. The teachers' arguments were echoed through these statements:

Teacher B: It will increase the curriculum of Religious Education syllabus.

Teacher C: It should be infused in Moral Education and counselling.

Teacher D: It is against the will of God. If someone cuts his fore skin, he is destroying what God has created.

They further stated that infusion of SMC will encourage the students to involve in sex before they reach maturity age and before they start sexual relations. According to them, male student will learn about the value of SMC and then make decision to be circumcised. Thereafter, he may think that he is now a man and ready to have sex. Their argument is that, SMC is not the only alternative that one can use to prevent HIV and AIDS. They pointed out

that there are other strategies like using condoms; therefore, they do not see the need to circumcise or include it in to the teaching of safe male circumcision.

As far as they are concerned circumcised men are still at risk. Some of the argument they raised are as follows:

Teacher A: Will encourage the students to have sex before maturity.

Teacher B: SMC is not an absolute protection against HIV and AIDS.

Teacher C: A condom is only 40 per cent safe, and safe male circumcision is only 60 per cent safe.

On a related issue, they further pointed out that once the person has been circumcised their sexual effectiveness is affected or their Libido is always high so they discourage others to go for circumcision and should not be infused into the Religious Education syllabus. Furthermore, they argued that during SMC, one can lose his life during and after operation. This can happen as a result of not following necessary steps or not doing them accordingly which may lead to loss of blood that will in turn cause death. To support this argument, one of the teachers gave an example of a 78 years old man, who underwent the minor supposedly straightforward surgery back in 2004 at Palapye Primary Hospital. He claimed that the operation went disastrously wrong; instead of cutting off just his foreskin, the doctor removed too much of the skin, from his penis. In an attempt to correct the mistake, the doctor pulled his scrotum tightly to cover the exposed area. Apparently, this resulted in the old man's testicles shifting forward (where they remain today).

The argument is supported by the following quotes:

Teacher E: When safe male circumcision is done the foreskin is removed underneath and there are some nerves which are sensitive which are also removed. Also if circumcision procedures are not done properly the penis might be damage and once that happens there is nothing that can be done to make the man okay, and might even fail to have children in future.

The researcher believed that it was an unfortunate mistake that affected the old man's sexual organs, and therefore male students should not fear to go for circumcision.
In Botswana figures indicate that safe male circumcision rate is high among older males, 22.5 per cent among those aged 20-24, to 39.2 per cent among those aged 55-59 years of age. Local health authorities caution that the low circumcision rates among younger males are contrary to the goals of the SMC programme, as HIV is more prevalent among younger members of the population (Emang, 2008). Arguably, in this case, the infusion of SMC into the Religious Education syllabus will help to promote SMC in the fight against HIV and AIDS. Emang, (2008) stated that males are reluctant to go for circumcision and also there is high rate of cancer of the penis. Therefore, the infusion of SMC will help male to know the benefit of SMC and be able to make the right decision on whether to circumcise or not, thus reducing HIV and AIDS and also cancer of the penis. ‘

4.2.2.3 Research Question 3

What are the strategies that could be used to address the challenges encountered in infusing safe male circumcision into the Religious Education syllabus?

The research question on the strategies of solving the challenges of infusing SMC into the Religious Education syllabus had one focus group discussion item for students and one interview item for teachers.

4.2.3.1 Students

The students suggested some strategies for addressing challenges that might be encountered if safe male circumcision is infused into the Religious Education syllabus. The students stated that SMC is for boys and should be taught to them or to students who are interested to the subject privately. According to the respondents, this will help students not to have negative attitude towards SMC or Religious Education as a subject.

Students also believed that if SMC is infused in the Religious Education syllabus they should only be taught the benefits of SMC to avoid too much content which might lead to students losing interest in the subject. It was also argued that counselling should be provided to students before the topic is infused. This will help prepare students to accept, evaluate and appreciate information on infusing SMC or help students to have tolerance. Their argument is supported by the following quotes:

Bonno: Only male students should be taught about safe male circumcision, because they will benefit from that.

In addition to that, one of the students stated that:

Gaone; Boys should only be taught the benefits.

The students in focus group discussion described how they think information on safe male circumcision should be disseminated. They recommended pamphlets and using community leaders and radios.

During the focus group discussion one of the students stated that;

Tshepang: The government should mobilize people. First give them information in the villages. The people from

the village should be educated and give information
to the community. Sometimes, when people come from
far and want to spread information, it is difficult to listen.

Some suggested the importance of information campaigns on people's willingness to be circumcised. The student stated that;

Kago: I felt that if it is done or advertised through media,
like radio and television more boys will go for
circumcision.

Another suggested that;

Prince: Make it compulsory, and open a lot of places
where it could be done.

Most of the students believed that if the government could train some people from the nation, for example, training the youth people to come into the village to provide the message, people will know about safe male circumcision and able to decide whether to circumcise or not. HIV rate is high, it has spread throughout the nation, let the government proceed with safe male circumcision so that we see how it will be in the future.

4.2.3.2 Teachers

The teachers suggested strategies for addressing challenges that might be encountered if male safe circumcision is infused into the Religious Education. During the interviews, the teachers pointed out that they need in-service workshop on the infusion of SMC before implementing the change in Religious Education. This is true in the sense that if teachers are not equipped enough in the subject to be infused they will have problems when it comes to

teaching the subject, because teachers have inadequate knowledge of the subject and will not know what to cover.

The following are some of the teachers' suggestions:

Teacher A: Workshops should be set up for teachers.

Teacher B: They need to have religious tolerance in school.

Teacher C: Counselling should be done before infusion of SMC.

The teachers further suggested that there must be role models who should be paraded and speak to the students about the infused subject. It was argued that students will be motivated and have interest in learning the new infused subject. The results of this study have already revealed that it was a general suggestion of the teachers that the infusion of SMC into the Religious Education should ensure that students who have already been circumcised can be encouraged to urge other male students to get circumcised or talk to other students about the importance of SMC.

The teachers also indicated that when infusing SMC there is need to use various teaching methods that can stimulates more learners' participation by relating the subjects' content to real life situation. Furthermore, they stated that the subject when infused should bring religious tolerance in order to help all students to feel that they are part and parcel of the infused subject. The researcher argues that the tolerance as argued will make sure that all students will enjoy the subject irrespective of their attitudes towards either the Religious aspect or the circumcision aspect. They further pointed out that when SMC is infused, teachers should make the topics very brief, concise and interesting in order to motivate the students.

Teachers suggested that they should be given in-service training or workshops for teachers on infusion of the Religious Education syllabus, such that those who have knowledge about the subject should become resource persons. This particular suggestion concerning in-service training is supported by the Botswana Government, Revised National Policy on Education (1994 Rec.44 Paragraph 5.10.25) which recommends that teachers must be trained in the methodologies at both pre-service levels to ensure that learning result has taken place. This is very important because teachers who are going to infuse SMC need to be equipped with enough knowledge so that relevant knowledge can be imparted to the students. It is worth noting that a majority of both teachers' and students' respondents felt that the gap on the knowledge of SMC amongst the teachers could be closed through workshops to equip teachers with new content and skills. This is agreement with Ford's (1989) suggestion that teachers should be given in-service training and workshops to address the knowledge and skills gap.

The researcher suggested that instead of infusing safe male circumcision into the Religious Education syllabus, the government should come up with programmes to inform and educate the society about safe male circumcision. She suggested that engagement can be done through the local media, newspapers, magazines, television, social networks, and local cell phone network companies. Furthermore, she stated that the government should involve community leaders, church leaders, school heads and principals, councillors, ministers, social clubs, and celebrities to help with the campaign for the programme to be successful. Unemployed graduates can be recruited, empowered, trained and used on a temporary basis to help with the medical male circumcision campaign in house to house visits, looking at communication skills and approach.

We are living in an era where our loved ones are perishing; millions of people are infected by HIV and AIDS. It is high time Batswana, both male and female come together regarding the importance and need for the safe male circumcision programmes. The public

need to be given the opportunity to understand, analyse and decide on whether to accept safe male circumcision or not based on the knowledge acquired from educational campaigns. Knowledge is power, and as long as it is correct, meaningful and accurate, the information issued to the public on this programme will be successful and yield positive results.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

In this chapter, a summary of the findings of the study is made. Then, based on the findings of the study, concluding remarks are made. Recommendations presented herein are based on the suggestions made by the respondents, particularly the strategies of solving the challenges of infusing male safe circumcision in Religious Education syllabus.

5.1 Summary

In order to find out the views of both the students and teachers on the infusion of safe male circumcision into the Religious Education syllabus in Botswana junior secondary schools, the researcher wanted to find out whether teachers and students understand the importance of SMC if infused in Religious Education syllabus or not. The responses indicate that the students and teachers are aware of the benefits of the infusion of SMC into the teaching of Religious Education syllabus.

They indicated that the infusion of SMC will help students to know and understand the strategies used to prevent HIV and AIDS. As argued, it will help male students to reduce chances of contracting STI's. It was argued that if SMC is infused into the Religious Education syllabus students may act as agents of change influencing fellow peers to adopt behaviours that reduces their risks of contracting HIV and AIDS.

The participants have indicated or shown positive attitudes towards infusion of safe male circumcision into the Religious Education syllabus. They indicated that, infusion of SMC will encourage the use of new teaching methods, which will stimulate more learner participation by relating the subject content to real life situations. It was pointed out that Religious Education deals with emotional, attitudes, acceptable behaviour and will provide students with knowledge that informs self-protection and foster the development of constructive value system. Infusion of SMC will create awareness among the students of the value of safe male circumcision in the fight against HIV and AIDS so that they can make informed choices and decisions whether to be circumcised or not. Furthermore, as argued after learning about the value and importance of Safe Male Circumcision in the fight against HIV and AIDS, students will act as ambassadors since they will teach their peers the role of safe male circumcision in the fight against HIV and AIDS.

The findings of this study also indicated that the curriculum is already jam-packed with other subjects; therefore, it is not possible to fit in another subject that deals with the teaching of SMC. Furthermore, there are no teachers who have been trained in teaching SMC as a subject. It was also argued that there is no time, since teaching SMC concepts may need a lot of research and understanding. Also there are no textbooks that would guide the teachers on how to go about with the infusion of SMC. It was further argued that Teachers will have to use their knowledge to handle infusion of SMC.

The teachers and students are of the view that SMC should be taught to the students who are interested to the subject privately. According to the teachers, this will help students not to have negative attitudes towards SMC or Religious Education as a subject. Teachers pointed out that if SMC is infused in the Religious Education syllabus students should only be taught the benefit of SMC in Religious Education syllabus. Teachers also stated in-service workshop on the implementation, also need resources like books and videos about SMC and give them to the schools before infusion is done.

5.2 Conclusion

This research investigated the perceptions of junior secondary school teachers and students with regard to the infusion of safe male circumcision education into the Religious Education syllabus as a tool to combat HIV and AIDS. It established the reasons from both the students and teachers for supporting the infusion of safe male circumcision into the Religious Education syllabus. It has also been established that both junior secondary school teachers and students are in total support of the infusion of safe male circumcision into the Religious Education syllabus. Both junior secondary school teachers and students stated various advantages of infusing SMC education into the Religious Education syllabus. They also stated the challenges of infusing safe male circumcision into the Religious Education syllabus and identified the strategies of addressing such challenges. The study found that there are more benefits to the infusion of SMC into the Religious Education syllabus and that the challenges are just few and cannot outsmart the benefits of the infusion. Furthermore, the suggested solutions to the challenges that might occur due to the infusion of safe male circumcision into the content of Religious Education syllabus have been shown to be effective

Finally, the study has shown that infusion of SMC into the content of Religious Education syllabus would create awareness among the students of the value of safe male circumcision in the fight against HIV and AIDS so that they can make informed choices and decisions whether to be circumcised or not. Furthermore, after learning about the value and importance of male circumcision in the fight against HIV and AIDS, students would act as ambassadors since they would teach their peers the role of circumcision in the fight against HIV and AIDS.

Safe male circumcision was introduced at the Ministry of Health facilities in 2009. The safe male circumcision targeted 81 per cent male to be circumcised by 2015 (USAIDS, 2012). Among the ethnic groups that traditional performed male circumcision as a ritual the preference was on traditional than hospital circumcision and a concern was on preserving the

cultural practice than issues such as sexual pleasure, hygiene and safety (Westercamp & Bailey,2007). Stine (2008) stated that in African countries where male circumcision is not regularly performed there is a high level of acceptance regarding safe male circumcision as a public intervention to combat the spread of HIV. In Southern African countries, the statistics of uncircumcised men willing to go for safe male circumcised was 65 per cent while approximately 70 per cent of women preferred safe male circumcision for their sons and the same percentage of men would prefer safe male circumcision for themselves or their sons (UNAIDS 2012).

One of the most important reasons why safe male circumcision is accepted by both males and females is its perceived role in preventing HIV transmission from female and male during vaginal sex. Male and female recognise and accept safe male circumcision as a convenient one time intervention which provides men with life- long but partial protection against HIV as well other sexually transmitted diseases including prevention of cervical cancer in women.

Several factors that contributed to poor performance of safe male circumcision are poor infrastructure, inadequate space, and shortage of qualified health personnel. Safe male circumcision even when done by qualified personnel may have risk which can hinder its acceptance among circumcised men (Avert, et al., 2005). Furthermore, loss of penile sensitivity, painful erection and erectile dysfunction, fear of potential damage to penis and fear of impotence are regarded as barriers to accepting safe male circumcision. Males have serious doubts about the protection effect of safe male circumcision and saw no reasons to get circumcision if the procedure only offered partial protection against HIV.

Social networks and social norms are found to be important factors in facilitating acceptance of safe male circumcision among males. Young men urgently need information about the actual impact of safe male circumcision on sexual function. Education that one is

exposed to about safe male circumcision can lead them to make informed decision on whether to go for circumcision or not.

The Social Norms Theory was used as the theoretical framework for this study. Social Norms Theory deals with issues of culture and perceptions that people in a society may have towards safe male circumcision. They are the norms or standards for conduct that distinguish between right and wrong. They help to determine the difference between acceptable and unacceptable behaviour. In this study, safe male circumcision was accepted by those belonging to circumcising cultures as a symbol of cleanliness, a rite of passage into manhood and a way to earn respect. They consider that compliance with this tradition was not only important to men individually, but also for parents of young boys and for sexually active women in their relationships with men (Sawyers, et al 2007).Safe male circumcision is seen as a tool to improve hygiene and protection against STI and HIV. Traditionally, non-practicing communities fear to lose their ethical identity by accepting circumcision.

Safe male circumcision provides men a lifelong partial protection against HIV and other sexually transmitted infections. It does not completely remove the risk of acquiring HIV. Circumcised men must also continue practicing safe sex such as reducing the number of sexual partners and consistently and correct using condoms.

5.3 Recommendations

The following recommendations were made from the findings of the study:

- The Ministry of Basic Education should train Religious Education teachers before infusion of SMC to reduce inefficiency in handling the subject.
- There must be in-service course at Education Centres to help teachers already in the field before infusion is done so that they can be competent to implement the SMC syllabus.

- Participants for in-service training or workshops should be given enough time in order to complete the planned program, and training should be done during school vacations so that teachers are ready to start infusion when school reopens. School Heads should be included in the in-service training since they will be monitoring the infusion of SMC into the Religious Education syllabus.
- Resource materials should be availed well on time, so that teachers can use appropriate methods that encourage learner involvement.
- A similar study should be undertaken by researchers' national wide for fair generalization of results. It should be all Religious Education teachers in primary, junior and senior secondary schools.
- The syllabus, textbooks and teachers guides should be availed. Words and concepts to be used should suit the levels of all learners in each standard. Enough time should be allocated to the subject.

APPENDIX A

A Teacher's Guide Questionnaire

I am a Master's Degree student of the University of Botswana (UB) doing a research project on Infusion of SMC education in the Religious Education syllabus. The purpose of the questionnaire is to collect information on this topic. I would really appreciate if you could answer the questionnaires for me. The information will be treated with total confidentiality.

Section A

Instructions:

(i) Please **do not** write your name(s) on this questionnaire

(ii)Tick the answer of your choices in the spaces provided and gives reasons where applicable.

(iii) Please **answer all** questions as honesty as possible

(iv) Please **answer all** questions in the space provided**.**

Demographic Information

Teaching Subject_____

Post of responsibility_____

Religion_____

4. Sex Female ☐ male ☐

5. Professional Qualifications

Diploma in Secondary Education(DSE) ☐

Bed Bachelor of Education(Bed) ☐

Masters ☐

Others ☐

6. Age

20-25 years ☐ **26-30 years** ☐

36-40 years ☐

31-35 years ☐

41-45years ☐

7. Teaching Experience in Years

0-5 ☐

6-10 ☐

11-15 ☐

16-20 ☐

21-25 ☐

26-30 ☐

Above 30 ☐

SECTION B

Teachers' Interviews

1. Do you think SMC should be infused in education? Give reasons.

2. Do you think SMC should be infused in the teaching of Religious Education syllabus?

Yes/No

Give reasons for your answer.

---

3. List the benefits of infusing SMC in the Religious Education syllabus?

4. State the challenges of infusing SMC in Religious Education?

5. What could be the strategies to address the above mentioned challenges?

APPENDIX B

Students' Questionnaire for the Focus Group Discussion

I am a Master Degree student with the University of Botswana (UB) doing a research project. The purpose of this questionnaire is to collect information on the topic: Infusion of SMC education in the Religious Education syllabus. I would really appreciate if you could answer the questionnaire for us. This information will be treated with high level of confidentiality.

Instructions;

(i)Please **do not** write your name(s) on this questionnaire

(ii) Tick the answer of your choice in spaces provided and give reasons where applicable

(iii) please **answer all** questions as honestly as possible

(iv) Please **answer all** questions in the space provided

SECTION A

1. **Name of school:**_____
2. **Subject:**_____

3. **Sex: How many females and males are there in your Focus Group? Write the number in the boxes below:**

Females ☐ **Males** ☐

4. **Age: what is your age range in your Focus Group discussion, tick appropriately below based on your ages.**

11-15 ☐

16-17 ☐

18-20 ☐

20-30 ☐

5. **Nationality: Mention the country which the group discussion members come from_____**

Section: B

Students Narration

1. Should SMC be infused in Religious Education syllabus? Give reasons for your answer.

2. State all the benefits of infusing SMC into Religious Education syllabus.

3. List down all the challenges of infusing SMC into Religious Education syllabus.

4. What do you think could be the solution to the above challenges you listed above?

REFERENCE

Adekunle, H. (1980). *Sexuality transmitted disease in West Africa.* New York, Oxford: University Press.

Aggleton, P., River, K., & Scott, S. (1999*). The use of female condom: gender relations and sexual negotiations in youth contextual factors affecting risk for HIV/ AIDS: A comparative analysis multi studies in developing countries.* Retrieved from http:// www.Scrip.org/

Aggleton, P. (2007). Just a Snip? A social history of male circumcision. *Reproductive Health Matters*.15 (29) 15-21.doi:10.1016/S0968-8080 (07) 29303-3

Akinyi, O.F. (2014). *Factors influencing uptake of voluntary medical male circumcision by Male adults in Kisumu, Sub-country.* University of Nairobi.

Anderson, K.M., Owen, D. K., & Paltiel, A .D. (2011). *Scaling up circumcision programs in Southern Africa: The potential Impact of Gender disparities and changes in condom use behaviours on heterosexual HIV transmission AIDS and behaviour* (15) 938-948. doi:10/1007/s10461-010-9784-y.

Anderson, D. (2003). *Theoretical perspectives on learning in an informal setting.* Retrieved from https://online library wrley.com/

Asiimwe, C. (2011). *Educational attainment and personal willingness to undergo safe male circumcision (SMC) among youth men in rural Uganda.* Duke University.

Avert .B. (2016). *Sub-Saharan-Africa / Botswana.* Retrieved from /www.avert.org: http : //www.avert.org/professionals/hiv-around-world/sub-saharan-africa/botswana

Avert, B.,Taljaard,D.,Lagarde,E.,SobongwiTambekou,J.,Sitta,R.,Puren,A.(2005*).*Randomised controlled intervention trial of male circumcision for reduced of HIV infection risk. *The ANRS 1265 Trial PLos medicine,* (11): e 298.doi:10.1371/ journal. Med 0020298/s1003

Auvert,B.,Taljaard,D.R.,Rech,D.,Lissouba,P.,Sigh,B.,Bouscaillou,J.,&Lewis,D (2013). *Association of the ANRS-12126 male circumcision project with HIV levels Among men in a South African township: Evaluation of effectiveness using Cross sectional surveys Plos medicine,* 10(9), e 100/509.

Ayiga, A. (2011). *Impact of male circumcision on HIV risk compensation through the Pediment of condom use in Botswana. African Health Sciences,* 550-559.

Babbie, E. (2010). *The Practice of Social Research (12th ed.)...Belmont, CA:* Wadsworth Cengage.

Bailey, R.C. & Poulussen, R. (1999). *Phase 1 and II of the trial intervention integration male hygiene and circumcision with reproductive health in Nyanza Province Kenya.* Chicago: University of IIinois at Chicago School of Public Health.

Bailey, R.C., Moses, S., Parker, C. B., Agot, K., Maclean, I., Kruger, J.N., Ndinya-Nchola, J.O. (2007).*Male circumcision for HIV prevention in young men in Kisumu*

Kenya: A randomised controlled trial. The Lancet, 369,643-656.doi: 101016 / 50140-673(7)60312-2.

Bigelow, J., & Warren, J. (1994*).* The case against circumcision. *British Journal of Sexual Medicine, Vol, (9).*6-8

Bigelow, J. (1995). *The development of Japan. In J. Bigelow (Ed). The Joy of uncircumcised.* Hourglass Book Publishing .Aptos, California 95001 1992, 1995. (ISBN 0-934061-22-X).

Bless L., & Smith. (2000).*Fundamentals of Social Research Methods .An African Perspective.* Retrieved from PubMed: http: // www.ncbi.mlm.nih.gov/pubmed/ 19473549780.

Bonner, K. (2001). *Male circumcision as an HIV control strategy: Not a natural condom.* Retrieved from http//www.ncb.nlm.nihgov.pubmed/11765391.

Boyd, B.R. (1990). *Circumcision: What it does.* Taterhill

Boyd, B.R. (1988). *Circumcision exposed: rethinking a medical and cultural traditions.* Crossing press.

Brown, L.D., & Korten, M. (1989). *The role of voluntary organisations in development Concept.* Paper prepared for the World Bank.

Brown, J.T. (1921). Circumcision rites of the Bechuana tribe. *Journal of the Royal Royal Anthropological Society.51*; 419-27.

Boyer, C.B., Barret, D.C., Peterman, T.A. & Bolan , G. (1997). *Sexuality transmitted diseases HIV Risks in heterosexual adults attending a public STD clinic: evaluation of a Randomized controlled behavioural risk. Reduction intervention trial.* AIDS, 11(3) 359-367.

Botswana Government. (2009).*Safe male circumcision: additional strategy for HIV* Gaborone: Gaborone Printers.

Botswana Government. (1994).*Revised National Policy on Education.* Gaborone: Government Printer.

Botswana Government. (1996). *Three-Year Junior Syllabus Religious Education* .Gaborone: Government Printer.

Botswana AIDS Impact Survey 1. (2003, March, 12). *Popular Report NACA in collaboration with CSO and other development partners.*NACA

Cassel, M. M., Haperin, D.T., Shelton, J. D., & Stanton, J. (2006).Risk compensation: The Achilles' heel of innovation in HIV prevention. *British Medical Journal, 332*: 602-607

Cannel J.S. &Kahn S.S. (1995). *Intervention Strategies for HIV prevention.* United Kingdom: Oxford Press.

Christensen-Szalanki, J.J., Boyce, H., Harrell, L., & et al. (1987).Circumcision and informed Consent: is more informed always better. *Medical care,* 25: 856.

Changalunka, J., Mshana, F., Mosha, J.F., Mwanga, J.R., & Wambura, M. (2011). *Acceptability of medical male circumcision in the traditional circumcising communities in Northern Tanzania.* BMC Public Health 11,373 doi: 10.1186/ 471-2458-11-373

Colaugh, M. J., & Ketlhoilwe, D. (2000). *The conservation news of Botswana*.200:12

Cowan, M., & Mavhu, W. (2011).*Prevalence and factors associated with knowledge of and willingness for male circumcision in rural Zimbabwe* .Retrieved from http:www. ncibi.nlm.nih.gov/

Comaroff, J. (1985).*Body of power spirit and resistance: the culture and history of a South African people Chicago IL* .The University of Chicago Press.

Creswell,J.W. (2003) .*Research design: qualitative and quantitative approaches* .London: Sage.

Cresswell, J.W. (2006).*Qualitative inquiry and research design choosing among fire approaches.* Thousand Oaks: Sage.

Cresswell, J.W. (2007). *Qualitative inquiry and research design.* London: Sage.

Cresswell, J.W. (2013). *Qualitative inquiry and research design.* London: Sage

Cresswell, J.W. (2014).*Research design qualitative, quantitative and mixed methods approaches* (4th ed).Thousand Oaks, CA: Sage.

Darby, R.L. (2003).The masturbation taboo and the rise of routine male circumcision: A Review of the historiography. *Journal of Social History, 369 (3)* 737-757

DeMeo, J. (1996, August, 9). *The geography of genital mutilations.* Paper presented at the Symposiums on Sexual Mutilations, University of Lausanne, Switzerland Published in Sexual Mutilations' Human Tragedy. Plenum Press, New York, 1997

DeMeo, J. (1989). *The Geography of Genital Mutilations. The truth seeker* Retrieved from http://www .noharmm.org/

Denscombe, M.(2007).*The good research guide : for small-scale social research projects.* Maidenheed:Open University press.

Denzin,N (2009).*Qualitative inquiry under fire.* Walnut Creek CA: Left Coast Press.

De Vincenzi, I.,& Mertens, I (1994*). Male Circumcision: A role in HIV prevention. AIDS,* 8, 153-160

Douglas, M., & Nyembezi, A. (2013). *Challenges facing traditional male circumcision in Eastern Cape Town.* South Africa: Human Resources Research Council.

Dube, M.L. (2015, December, 4). *Botswana's fight against HIV/AIDS declining.* Mmegi.

Emang,(2008, April.22). *News and Information about HIV and AIDS.* pp6-9. Gaborone, Botswana.

Friendland, B., Hewett, P.C. Apicell, L., Schenk., Sheeny, M., & Mandy, J. (2011).*Evaluation Of the Informed Consent Process For Male Circumcision Scale –up in Zambia.* MacMillan Publishing Company.

Forsyth, I. J. (1999). *Planning a Course*. London: Routledge.

Gebremedhin,S. (2010). *Assessment of protective effect of male circumcision from HIV Infection and sexually transmitted disease: Evidence from HIV infection and sexually Transmitted disease: Evidence from 18 demographic and health surveys in Saharan African countries.* Retrieved from http: // www.ncbi.nlm.gov/pubmed/ 21243923.

Neumann, W.L. (2000).*Social research methods: qualitative and quantitative approaches.* Boston: Allyn and Bacon.

Gollagher, D.L. (2001). *Circumcision: a history of the world's most controversial surgery.* New York; Basic Books.

Gray, R.H ., Kigozi, G., Serwadda, D., Makumb, F., Watya, S., Nalugoda, F.…Chen, M.Z. (2007). *Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial.* The Lancet, 369-657-666.doi:10:1016/so 140-6736(07) 603131-4.

Halperin, D.T, et al (2005).*Acceptability of adults male circumcision for sexuality transmitted and HIV Prevention in Zimbabwe. Sexually Transmitted Diseases*.238-239

Halpern, D. & Bailey, R diseases. (1999). Male circumcision and HIV infection: 10 years and counting. *The Lancet, Vol, 354*.No.20:1813-15

Hammersley,M., & Atkison,P.(1995).*Ethnography: principles in practice (2nd ed).London:* Routledges.

Hamnett, M.,Porter, D.,Singh, A., & Kumar (Eds).(1984). Ethics, Politics, and international Social sciences research? Whose knowledge? Thinking for women's lives (pp. 138 -163), Ithaca, NY: Cornell University Press

Hankins, C. (2007). *Male Circumcision: implications for women as sexual partners and parents.* www.rhmjournal.org.uk/

Hankins, C., Forsythe, S., & Njeumeli, E. (2011).Voluntary medical male circumcision: An Introduction to cost, impact and challenges of accelerated scaling up. *PLOS medicine 8(11) e100//27.doi.10 1371/Journal.pmed.100127.*

Hellinsten, A. (2004).*Rationalising circumcision: from tradition to fashion from public health To individual.* Retrieved from https:// ajme.bw.com/ content 30/3/

Herrmann. (1913). *The catholic encyclopaedia: An international work of reference on the constitution, doctrine, discipline, and history of the catholic church.* Robert Appleton, 1922

Nkomazana, F. (2005). Gender Analysis of bogwera and bojale initiation among Botswana. *Boleswa Journal of theology, Religion and Philosophy.Vol.1*.No 126-49

Nkomazana, F. (2007). *the relevance of Religious Education in Botswana's School Curriculum.* University of Botswana.

Hodges, F, M. (2001). The ideal prepuce in Ancient Greece and Rome: Male Genital Aesthetics and their Relation to Lipodermos. Circumcision, Foreskin Restoration and the Kynodesme. *Bull Hist Med: 75(3), 375-405*

Hodges, F.M. (1999). Phimosis in antiquity. *World journal of urology. 17 (3):*133-136

Hodges, F.M. (1997). *A short history of the institutionalization of involuntary sexual Mutilations in the United States .In G.C. Denniston &Milos MF (Eds.), Sexual Mutilations: A Human tragedy New York:* Plenum Publishing. (pp.17-140)

Jackson, C. (1997). Behavioural Sciences Theory and principles for practical in health education. *Health Education Research, 12(1),* 143-150

Jackson, H. (2002). *Aids Africa continent in crisis.* Zimbabwe: SAFAIDS.

Jackson, S., & Scrambler, G. (2007). *Perceptions of evidence based medicine Traditional acupuriturists in the UK and resistance to biomedical modes of evaluation sociology of health and illness.* 29(3), 412-429

Jacquil, W. (2006). *Bulletin of the world health organisation, academic search premier.* 84 (7). pp56-7).

Johnson, K. (2015). *To Cut and Run: Donor Approaches to Male Circumcision in African studies quarterly.* Retrieved from http: www. Africa.UF/.edu/ asq/vis514a4pdf.

Johnson, K. (2016, September, 4). Cutting to the chase, donor expediency drives the campaign for safe male circumcision in Botswana. *Journal of Southern African Studies. African studies quarterly.*

Joint United Nations Programme on HIV/ AIDS (2012). *Global report UNAIDS report on AIDS epidemic (2013). Geneva. Switzerland Joint United Nations Programme on HIV/ AIDS (2011). Joint strategic action Framework to accelerate the scale –up of*

voluntary medical male circumcision for HIV prevention in Eastern and Southern Africa: 2012-2016

Joppe, M. (2000). The Research Process, the Quantitative. *Report Journal. 8(4),* 597-607

Jowana, M. (2012). *SMC.* Retrieved from http/www.ibotswana.co.bw/

Karin, H., et al (2014). *Barriers and motivation to VMMC uptake among different age groups of men in Zimbabwe.* Macmillan Publishing Company.

Katisi, M., & Marguerite, D. (2015).*Safe male circumcision in Botswana: tension between traditional practices and biomedical marketing departments of health promotion and development.* University of Bergin:Norway.

Kahn, J.G., Marseille, E., Auvert. B. (2006) Cost -effectiveness of male circumcision for HIV Prevention in South African setting. *Plos Med 3(12), doi: 10:137/ journal pmed. 0030317.*

Kebaabetswe, L. M. (2003). *Male circumcision: an acceptable strategy for HIV prevention in Botswana.* Sex Transm Infect.214-219

Kebaabetswe,P., Lockman,S., Mogwe,S.,Mandevu,R.,Thior,L.,Essex.,& Shapiro. L. (2013). *Male circumcision: An acceptable strategy for HIV prevention in Botswana Sexually Transmitted Infection.*79,214-219.doi:10.1156/S179.3.214

Khattab.M. (2011). *Role of school health education in promoting knowledge, attitudes and practices, among secondary school students towards HIV infection.*Khartoum

Locality –Khartoum State, 2011 .A thesis submitted for the degree of PhD.in public and Environmental Health.

Klenke, K. (2008). *Qualitative research in the study of leadership*. Emerald Group Publishing Limited.

Karen, E., & Paige, S. (1978, May, 23). *The ritual of circumcision.* Human Nature, Retrieved From http:/ www.Noharmm.org/

Krueger, L. (1989).*Orientation to adolescent health related attitudes and adolescence*. 27(108):819-7484.Retrieved from. Online 23 December 2015.

Labaree, D.F. (2013). *Organizing your social sciences research paper.* Research guide Retrieved from: scholar google com:https:// www.scrirp.org.doi 101007/ 978-90-481-9873-3-2

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalist inquiry.* Newbury Park CA: Sage

LoBiondo-Wood, G., & Haber, J. (2006). *Nursing research: Methods and critical appraisal for Evidence-based practice (6th ed.).* St. Louis, MO: Mosby

LoBiodo-Wood, G.,& Haber, J.(2014). *Nursing research, methods and critical appraisal For evidence based practice(8th ed.).*St.Louis,MI:Mosby.

Long, T., & Johnson, M. (2000).*Rigour, reliability and validity in qualitative research.* Clin Effect Nurs.

Maccoby, E, E., Snow, E. E., Jacklin, R., et al. (1984).*Children's dispositions and mother*

Interaction at 12 and 18 months. A short-term longitudinal study, development and regulation of norms. Michigan Law Review, 96-338

Malterud, K. (2000).*Qualitative research: standards, challenges and guideline. Lancent* 358: Pp483-488.Retrived from http:// www.qualres.org/Home Ref 1-3703.html

Mason, J. (1996). *Qualitative researching*. London:Sage

Mark, D.,Middle Koop, K., Black,S., Roux,S.,Fleur,L.,Wood,R.,& Bekker,L.(2012) .Low acceptability of medical male circumcision as an HIV/ AIDS prevention intervention within a South African community that practises traditional circumcision. *South African Medical Journal, 102(6),* 571-573.

Matveev, A. (2002). *The Advantages of Empowering Qualitative and Quantitative Methods in International Research; Practical Implications from the study of the Perception of Intercultural Communication Competence by American and Russian Managers Theory of Communication and Applied Communication*. New York, Collected Research Articles, Bulletin of Russian Communication Association.

Meissner,O.,& Buso,D. L.(2007).Traditional male circumcision in the eastern cape Scourage or blessings? *South Africa Medical Journal, 97,*371-373.

Mhangara. (2010). *Knowledge and acceptance of male circumcision as an HIV prevention procedure among plantation workers and Border Limited, Zimbabwe.* Stellenbosch: University of Stellenbosch

McNamara, J. *(1994). Surveys and experiments in education research.* Michigan: Technic: Publisher.

Miles, M., & Huberman, A. (1994).*Qualitative data analysis: an expanded source book (2nd.ed).*London: Sage

Miles, M. B., Huberman, A.M., Saldana, J (2014).*Qualitative data analysis: A methods re source book (3rd ed).*Thousand Oaks, CA: Sage.

Ministry of Health (2009). *Safe Male circumcision: additional strategy for HIV Prevention: A National Strategy.* Gaborone: Government of Botswana Ministry of Health (2010*). Safe Male Circumcision: additional strategy for HIV Prevention: A National Strategy.* Gaborone: Government of Botswana.

Ministry of Health (2015).*Safe Male Circumcision: Additional Strategy for HIV prevention: A National Strategy.* Gaborone: Government of Botswana.

Mosothwane, M.N. (1999). *An ethnographic study of initiation school among the Bakgatla ba ga Kgafela at Mochudi* (1974-1988). Unpublished Research Essay submitted to the History Department. University of Botswana.

Mosothwane,M.N.(2001).An ethnographic study of initiation schools among the Bakgatla ba ga Kgafela at at Mochudi 1874-1988. *pula Botswana Journal of Africa studies, 1,*144-167.

NACA. (2013*). National AIDS Council report HIV/ AIDS program performance; October to*

December 2012 quarterly report. Gaborone: Government of Botswana.

Nasibi, K. (2009). *A critical appraisal of HIV and AIDS curriculum in secondary schools in Kenya. International Conference on Education Innovative Teacher Education and Classroom Practice in the 21st Century* (pp.139-147).Nairobi: Kenyatta University.

Ngwanaaamotho, N.O. (2015, May 9). *HIV/AIDS Prevalence*. Mmegi.

Ngalande, R., Levy, J., Kapondo, C.P.N., Bailey, R.C. (2006). *Acceptability of male Circumcision for prevention of infection in Malawi.* http:// www springer Link.com/content/837530678mj138u/fulltext.pdf

Nguyen,T.S.T.(2008).*Peer debriefing.The Sage encyclopedia of qualitative research methods.* Retrieved from: http/ Srmo.Sagepub.com/ view/Sage-eneye-qualitative research Methods/ n/3/12. Xml accessed 5 June 2014.

Ontebetse, K. (2013).*Challenges in getting target numbers in male circumcision.* Retrieved From http:/ www. Sunday Standards.info

Pappas-DeLuca, K. (2009).*Centres for diseases control and prevention*.GA/CDC/Division Retrieved from https//www linked.com/

Paige, K, E. (1978).*The ritual of circumcision: human nature*.pp40-48.Retrieved from www.noharmm.org/

Peron, J.E. (2000). *Circumcision: Then and Now, Many Blessings*. iii: 41-42

Pierce L. (2009) .Twelve steps in the nursing research journey. *Journal of Continuing*

Education in Nursing.4, 154-167

Pirie, G. R. (1927).The story of circumcision. *Can Med Assoc Jornal, 17(12),* 1540-2

Poulussen,R., Bailey, R.C., Muga, R., & Abicht, H. (2000). *The acceptability of Male Circumcision to reduce infection in Nyanzi Province*, Kenya, AIDS Care 14(1)27-40(Pub-Med) http//wwwhandfontline.com/dom/do/abs/101080/0954 2022097919.

Preston, E.N. (1970).Whither the foreskin? *A consideration of routine neonatal circumcision JAMA, 213*, 1853-1858.

Price, L et al (2010).*The effects of circumcision on the penis microbiome programme on HIV/AIDS (2013)* .Retrieved from http//www.unaids .org/en/medical/unads.

Raditsebe, R, (2016, September 2). *AIDS cure remains elusive*. Guardian.

Rennie, A.S. (2007).Male circumcision and HIV prevention: Ethical, Medical and Public Health Trade-offs in Low-Income Countries. *Journal of Medical ethics, Vol (87)*357-361.

Rogers, E. (1995). *Diffusion of innovation (4th ed).* New York: Free Press

SADC, (2008). *AIDS epidemic Update 2007*, Gaborone: SADC Health Unit; 2008.

Sawiress, S.R., Dworkin.L., & Coates, T.J. (2007). *Male Circumcision and HIV/AIDS: Challenges and Opportunities.* Retrieved on (2nd May 2012), from http//www Unaidsitesa.org/ sites/ default/files/males circumcision/circumcision and HIV-

Challenges and Opportunitiesarticle.pdf.

Salkind, M. (2010).*Encylopedia of research design*. Retrieved from http:// dx. doi / 10. 4135/ 97814/ 2912

Schapera, I. (1984). *A handbook of Tswana law and custom.* London: Frank Cassel

Schoen, E. J. (2007). circumcision as a lifetime vaccination with many benefits. *Journal of men's health and gender, 4 (3),* 30-61.

Scott, B.E., Weiss, H. A., & Viljoen, J. (2006).Acceptability of male circumcision as a HIV Intervention among a Zulu population, KwaZulu-Natal South Africa. *AIDS care 3;* 304-313.

Scott,D.(1999). The researcher's personal responses as a source of insights in the research process. Nursing Inquiry 4: 130-134.

Setswe, G., Petzer, k., Majaja , M., Matseka, G., & Notshe, Y. (2015). *Perception an acceptance of male circumcision in South Africa.* Retrieved from http:// dx.doi Org/1014437/HARDOA-109

Setlhabi,G. K.(2014). *I took an allegiance to secrecy: complexities for conducting ethnographic research at home.* Africa, 84,314-334,doi.10.1017/ 50001972014000059.

Shenton, A.K. (2004).*Strategies for ensuring trustworthiness in qualitative research project.*

Education Inform.

Struin, G.L. (1999). The prepuce: specialized mucosa of the penis and its loss to circumcision. *Medical Association Journal, 17(12),* 1540-2

Sturant, R.A.S. (2007). Male Circumcision and HIV Prevention: Ethical, Medical, Public Health Trade-offs in Low-Income Countries. *Journal of medical Ethics, Vol, issues* 357-361.

Stine, G.J. (2008). *AIDS update 2008*. New York: Mc Graw-Hill

Subedi,B. (2006).Theorizing a 'halfie' researcher's identity in transnational fieldwork. International Journal of qualitative studies in education: 19(5), 573-593).

Sword, W. (1999). Accounting for presence of self: reflections on doing qualitative research. *Qualitative Health Research 9*: 270-278

Tabane. K. (2015, July 31). *HIV and AIDS.* Voice, Newspaper.

Taylor, J.P., & Lockwood, A.P. (1996, December, 20). *The prepuce Specialized Mucosa of the penis its loss to circumcision.* Retrieved from http//www.urp.org/library Anatomy/taylor.

Turner, V. (1969). *The ritual process structure and anti-structure.* London: Routledge and Keegan Paul.

Kombo, K., & Tromp, D.A. (2006).*Proposal and Thesis Introduction*.ISBN:996608133X DonBosco. Makuyu, Kenya .pp.95-8.

USAIDS. (2007). *Safe, voluntary, Informed male circumcision and comprehensive HIV prevention programming guidance for decision-makers on human rights ethical and legal considerations*. UNAIDS: Geneva

UNAIDS. (2007). *AIDS epidemic update. Geneva:* World Health Organization.

UNAIDS. (2007, February 26). *UNAIDS. Male circumcision: context, criteria and culture* (part1.http://www.unaids.org/en/resources/presscentre/featurestories/ 2007/ February/ 20070226mn1.

UNAIDS. (2010). *Report on the global Aids epidemic.* Geneva.

UNAIDS (2013). *Report on the global AIDS epidemic 2013. Joint United Nations Programme on HIV/ AIDS: Date accessed: 22 December 2013* http//www Aids/contentass/document/epidemiology/2013/unaidsglobal/report 2013.en pdf.

UNAIDS & WHO (2012).*Guidelines for second generation HIV surveillance an up epidemic Data.* accessed 22 *December* int/iris/bitsteam/10665/855/1/97892414pdf.

Waldeck, S.E. (2003*). Cutting through social norms theory: male circumcision in the United States.* Forthcoming.

Wambura,M.,Mwanga,J.R., Mosha, J.F.,Mshana,F.,& Changalucha, J.(2011). Acceptability of medical male circumcision in the traditionally circumcising communities in Northern Tanzania. *BMC Public Health,11,*373 doi:10.1186/1471-2458 11-373.

Watson, B. (1993). *The effective Teaching of Religious Education.* London: Longman

Weiss, K., David, S., Lindsay, B., & Louis, M. (2000). *Medical history and medical practice: Persistent myths about the foreskin in East Africa.* London: Oxford University Press.

Weiss, H.A., Quigley, M., & Hayes, R.J. (2000).Male circumcision and risk of HIV infection South Saharan Africa a systematically review and metal-analysis. *AIDS 2000, 14*(15), 2361-2370.

Weiss, H.A., et al., (2008).Male circumcision for prevention: from evidence to action? *AIDS 22*:567-574 doi: 510:1097/ QAD.1090b1013e3282f1093f1406.

Wiseman, D. C. (1999). *Research Strategies for Education Belmont*.Wadsworth Publishing Company.

Westercamp, M., Agot, K.E., Ndinya-Achola, J., Bailey, R.C. (2011).*Circumcision preference among women and uncircumcised men prior to scale –up of male circumcision for HIV prevention.* Kisumu: Kenya.

Westercamp, N., & Bailey, R. C. (2006*).* Acceptability of male circumcision for prevention of HIV/ AIDS in Sub Saharan Africa*. A review in AIDS Behaviour 2007*.321-55 From http//fhinow/cbd/stru/quidcer. Library/westcamp acceptability ofmc.pdf

Westercamp, N., & Bailey, R.C. (2007). Acceptability of male circumcision for prevention of HIV / AIDS in Sub Saharan Africa. *A Review AIDS and Behaviour 11(3).* 341-355

WHO. (2007). *new data on male circumcision and HIV prevention: Policy and programme Implications.* Geneva.

WHO and UNAIDS.(2008).*Report on the global AIDS epidemic (cited 2009,February).* Available from:http// data unaids.org/pub/jc/5/0 2008 global report pp1 10 en pdf.

WHO. (2009). *Traditional male circumcision among young people: a public health perspective in the context of HIV prevention. Geneva WHO and UNAIDS. (2010). Progress in male circumcision scale –up: country implementation and research update.* Geneva: World Health Organisation.

WHO. (2011). *Progress in scale-up of male circumcision for HIV prevention in eastern and Southern Africa: focus on service delivery; Geneva. Joint United Nations Programme on HIV/ AIDS (2012), Global Report: UNAIDS report on Global AIDS epidemic (2013).* Geneva Switzerland

WHO. (2017). *Global health observatory (GHO) data*. Retrieved from World Health Organisation : http://www.who.int/gho/publications/en/

Willoughby, W.C.N (1909*). Notes on the initiation cérémonies of Becwana*. Botswana National Archives and Records Number-BNB370.