Medical male circumcision and Xhosa masculinities: Tradition and transformation

by

Lubabalo Sheperd Mdedetyana

A mini-thesis submitted in partial fulfilment of the requirements for the degree of Magister Artium in Medical Anthropology in the Department of Anthropology and Sociology, University of the Western Cape

November 2018

Supervisor: Associate Professor Sakhumzi Mfecane

ABSTRACT

This research study investigates Xhosa men's perceptions of voluntary medical male circumcision (VMMC) in Khayelitsha township (Cape Town). It explored whether the introduction of VMMC as a state HIV-prevention strategy had engendered shifts in constructions of masculinity and negative perceptions of men who had undergone VMMC. Previously traditional male circumcision (*ulwaluko*) was the preferred form of circumcision among amaXhosa and medical male circumcision (MMC) was viewed as alien to Xhosa culture. Xhosa-speaking men who had undergone MMC were stigmatised by peers and viewed as not being 'real men'. VMMC has the potential to shift constructions of masculinity based on circumcision status.

An ethnographic research study was carried out using qualitative research methods, including participant observation, individual interviews and focus group discussions. Data collection occurred over a 6-month period in the Mandela Park community, at Michael Maphongwana Clinic, and at a male initiation school.

The study found that *ulwaluko* remains a definitive marker of masculine Xhosa identity and is still informed by culture and tradition. Despite VMMC, men who undergo *ulwaluko* continue to perceive men who choose MMC as 'the other' and not as 'real men'. The study highlighted that VMMC advocates need to take cognisance of traditional notions of masculinity and address negative perceptions of men in Xhosa-speaking communities who have undergone VMMC.

KEYWORDS

Personhood

Manhood

Ulwaluko

Masculinity

Xhosa men

Khayelitsha

HIV

Voluntary medical male circumcision

Medical male circumcision

Ethnography

DEDICATION

I dedicate this thesis to my wonderful parents, Mongameli Hamilton and Fundiswa Christine Mdedetyana, and to my two beautiful children, Mihlali Timane Misokuhle Mdedetyana and Hlombe Asante Mdedetyana. I also dedicate this thesis to my country, South Africa, as it continues to search for a solution to end the scourge of HIV and AIDS.

ACKNOWLEDGEMENTS

I wish to thank the following people for enabling me to complete this research study and thesis:

My supervisor, Prof. Sakhumzi Mfecane, for his diligent and unwavering intellectual support and encouragement throughout the research study. I would like to thank him for being a great teacher, supervisor and mentor; for encouraging me to pursue postgraduate study, and for making his office space available to me, as well as personal resources such as his laptop, his books and his time. *Ndiyabulela kakhulu Prof*, you have been more than a supervisor to me.

To all the men who participated in this study, thank you so much for your openness, patience and willingness to participate in my research. Thanks for your generosity and kindness in granting me your valuable time. This thesis is possible because of you, and for that I am eternally grateful.

I would also like to express my gratitude to the Western Cape Health Department for granting me access to the clinic. I feel greatly honoured and indebted to you for the privilege.

To the staff at Michael Maphongwana Community Health Clinic, thank you so much for welcoming me into your clinic, and for helping me to find people to participate in the study. *Ndithi nangamso zenenze njalo*.

I thank my parents for their guidance and support. I thank them for instilling in me a passion for education. To my mother for being my 'time-keeper', sacrificing her valuable sleep time to ensure that I stuck to my workplan, and was awake at a particular time for my studies. To my father, for impressing in me the value of books from a young age and for encouraging me to strive for excellence and to believe that excellence is always attainable.

Mkhuseli 'Ta Khusta' Malindi, you are a true big brother to me. Mthembu, Qudeni, I thank you for always being a reliable support structure to me. Without you it would have taken me longer to go to the 'field'. I respect, and appreciate you very much, my big brother and old friend.

To my beautiful and wonderful wife, Siyavuya Ongeziwe Mdedetyana, thank you so much for being my strong pillar of strength and support, my number one cheer leader and best friend. You are everything to me!

To my in-laws – the Ngemntu family – my thanks also go out to them for their support, without which it would have been difficult for me to complete this thesis.

I also acknowledge my sisters for the valuable contribution they made. Portia, Ntombekhaya, Phumla, Vuyelwa, I thank all of you.

I also would like to thank the community of Mandela Park where I grew up: all my neighbours, people who surrounded me in my community while I was growing up, and who played an immense role in shaping the person I became who was able to complete the study and finish writing this thesis.

My colleagues at the Centre for Sexualities, AIDS and Gender (CSA&G), I would like to express thanks to them for reading draft sections of this thesis, especially Prof. Catherine Burns, and Pierre Brouard. Special thanks go to the director of the CSA&G, Mary Crewe, for supporting my professional development, and for allowing me to use some of my office hours to write this thesis. I cannot express my gratitude to her enough.

To all the teachers I have had from primary school to tertiary level, I would like to send my sincere thanks to all of them.

In addition, I would like to thank anyone whose name I have by mistake omitted to mention – you all know who you are – *enkosi ndiyabulela*.

The financial assistance of the National Research Foundation (DAAD-NRF) in conducting this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author and are not necessarily to be attributed to the DAAD-NRF.

DECLARATION

I, Lubabalo Sheperd Mdedetyana, hereby declare that this thesis, *Medical male circumcision and Xhosa masculinities: Tradition and transformation*, is my own original work and it has not been submitted for a degree or examination in any other University nor any other parts of it, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Signed: . . . . Date: November 2018

ACRONYMS

AIDS – Acquired Immunodeficiency Syndrome

HIV – Human Immunodeficiency Virus

MCM – Medically circumcised men

MMC – Medical male circumcision

UNAIDS – Joint United Nations Programme on HIV and AIDS

VMMC – Voluntary medical male circumcision

WHO – World Health Organisation

TABLE OF CONTENTS

CHAPTER 1 THESIS STATEMENT

This study investigates Xhosa men's perceptions of medical male circumcision (MMC) in Khayelitsha township, Cape Town. I specifically explore whether the introduction of MMC for HIV-risk reduction has engendered shifts in ideological constructions of masculinity among a selected group of men residing in a section of Khayelitsha township. In Xhosa-speaking communities circumcision is normally undertaken as a rite of passage from boyhood to manhood (called *ulwaluko*); those who undergo the ritual to completion are generally regarded as 'men', and medically circumcised men are not seen as 'real men'. Given this social reality, my study engaged with ordinary Xhosa-speaking men and sought to understand their views on MMC aimed at reducing the risk of HIV infection. My study found that the introduction of MMC has not engendered shifts in Xhosa men's perceptions of masculinity, since most of my participants insisted that one needed to undergo *ulwaluko* in order to be regarded as a 'real man' (*indoda*). Furthermore stigmatisation and social exclusion of MMC recipients continues. In this regard my thesis argues for culturally appropriate ways of rolling out the MMC programme among amaXhosa that take into account dominant constructions of masculinity, as well as the popular philosophical conceptions of personhood.

Background

The amaXhosa are one of the largest language groups in South Africa. For this language group, circumcision of boys is a component of the integral cultural practice of initiation into manhood known as *ulwaluko* (Doyle, 2005; Vincent, 2008a; Ntombana, 2011). If an adult Xhosa male is referred to as a 'man' (*ndoda*)[1], it is understood that he has undergone the ritual of traditional circumcision. Circumcision status accords Xhosa-speaking males respect, social acceptance and belonging to a collective manhood identity called *esidodeni* (see Mavundla et al., 2009; Mhlahlo, 2009). Ritual circumcision also gives men the right to marry, to inherit property from their parents, and to participate actively in cultural rituals such as ancestral offering of sacrifices (Meissner & Buso, 2007). In contrast an uninitiated male known as *iNkwenkwe* is generally treated as if he were still a child. In the event that such a person marries, his marriage is generally stigmatised by his family and society until he undergoes *ulwaluko* (Venter, 2011).

[1] This concept differs from *ndoda* used by prison gangs (see Steinberg, 2004).

In Xhosa society circumcision is usually performed on adolescents and older males by an *iNgcibi*, a traditional surgeon without Western medical training. He uses a sharp instrument known as *umdlanga* to sever the foreskin and administers no anaesthetic or pain killers during circumcision (Mavundla et al., 2009). After circumcision, the new initiates – called *abakhwetha* – reside in a secluded makeshift lodge that has been built by the surrounding community, and here they spend the entire healing period – approximately 3 to 6 weeks (Kepe 2010; Mavundla et al., 2009). During the healing period, the wound is usually dressed by a traditional attendant – *iKhankatha* – using a traditional wrapping made of leaves known as *isicwe*, although there are sometimes variations on this, especially in contemporary urban contexts where there may be a concession to modern ideas. *Abakhwetha* also usually receive instructions about manhood from *amaKhankatha* and community men who pay them a visit whilst they reside in the temporary lodge.

Traditional circumcision remains the preferred form of circumcision for amaXhosa (Shisana et al.; 2014) and medical male circumcision (MMC) is generally viewed as alien to Xhosa culture. Xhosa-speaking boys and men who opt for MMC are exposed to various forms of discrimination and stigmatisation by Xhosa-speaking men and women in their communities (Meissner & Buso, 2007; Mngqolozana, 2009; Peltzer & Kanta, 2009). Medically circumcised men (MCM) are given numerous derogatory labels by traditionally circumcised men that mark them out as different and as 'other', such as *amadoda asesibhedlele* (hospital men) and *abadlezana* (the literal translation being: those who have just given birth) (Mngqolozana, 2009; Ndletyana, 2000; Tshemese, 2014). Furthermore, they may be ostracised and prohibited from taking part in cultural activities such as offering sacrifices and engaging in community discussions (Meissner & Buso, 2007; Peltzer & Kanta, 2008).

MMC as a South African HIV prevention strategy

The South African government adopted medical male circumcision (MMC) as one of its interventions for combating HIV and AIDS. Since 2010 it has rolled out MMC services to males – 18 years and older – at public health facilities in all nine provinces (GARPR, 2016). The roll-out of MMC was precipitated by positive results in randomised trials for MMC conducted in South Africa, Kenya and Uganda, published in 2007, which produced evidence that MMC provides approximately 60% protection against acquisition of HIV by men through

heterosexual vaginal sex (WHO & UNAIDS, 2007). To date, 3 383 945 males have undergone MMC, although the South African government has failed to meet its 2015 target of circumcising 80% of males (i.e. 4.3 million men) (GARPR, 2016; WHO, 2011).

Since the official roll-out of MMC, a range of social marketing strategies have been used to encourage HIV-negative males to undergo MMC. Brothers For Life, a male gender activist organisation which is a partnership between Johns Hopkins Health and Education South Africa (JHESA), the National Department of Health (NDOH), the South African National AIDS Council (SANAC) and Sonke Gender Justice, has been the leading driver of mass MMC campaigns. The organisation has used television commercials, outdoor media and commuter advertising to promote MMC service provision. A 30-part radio talk show on eleven South African Broadcasting Association (SABC) radio stations to promoting MMC, HIV prevention and healthy lifestyles, a bi-monthly four-page *Daily Sun* feature on HIV prevention (including MMC, condom use and HIV counselling and testing) and related topics, including gender and family planning, form part of the Brothers for Life campaign.

A critique made of these campaigns is that they exclusively target African males, despite the fact that the South African population includes other race groups (Mfecane, 2013). This is reflected in the phrases used in these campaigns, such as '*Yenza kahle*', an Nguni phrase that means 'Do things the right way'.

Problem statement

Given the cultural significance of the Xhosa initiation rituals described above, MMC is a contested intervention in Xhosa society and amongst other language groups that practise traditional male circumcision as a rite of passage from boyhood to manhood. The communities that practice this ritual have deeply entrenched ideas about what constitutes boyhood and manhood, based on circumcision status (Vincent, 2008b). In the past, Xhosa males who had not undergone *ulwaluko* faced pressure from their communities to undergo the ritual through stigmatisation, rejection and marginalisation (Mavundla et al., 2010; Kepe, 2010; Mhlahlo, 2009).

Although government has rolled out VMMC services to males in all nine provinces, there is limited understanding regarding whether or not culturally entrenched ideas about manhood have been affected by the intervention. Although VMMC was initially considered alien to

Xhosa culture, the intervention could have brought about changes in perceptions. Xhosa males may have begun to view VMMC as part of the solution to the problem of HIV, which could lead to VMMC replacing *ulwaluko*, and men who have undergone MMC being perceived as 'real men'. The fact that VMMC is supported by government could play a pivotal role in engendering shifts in social perceptions of VMMC.

Acceptance of VMMC could also shift ideas regarding traditional circumcision as a test of bravery and tolerance of pain. Acceptance of VMMC as a health intervention might alter the belief that male circumcision is a sacred ritual connected to veneration of the ancestors. Men might redefine their masculinity based on an altered conception of 'real manhood' and responsible masculinity propagated by Brothers For Life.

Academic research has not adequately engaged with the effects that VMMC may have had on Xhosa notions of manhood. Scholars have, however, expressed concerns that the scaling up of MMC services in societies that have established traditional circumcision rituals could destabilise prevailing cultural notions of 'boyhood' and 'manhood' linked to not having a foreskin (Dowsett & Couch, 2007; Sawires et al., 2006). Other concerns expressed included whether or not MMC creates social differences between medically circumcised men and uncircumcised men, as has historically been the case worldwide wherever circumcision is practised (Aggleton, 2007; Hellsten, 2004).

Earlier scholarship found that MMC had become a source of conflict between Xhosa-speaking men (Mngqolozana, 2009; Mavundla et al., 2010; Vincent, 2008a; Peltzer & Kanta, 2009), but there is a paucity of current information regarding whether or not this remains the case, now that MMC is backed by government and aims to curb new HIV infections.

Study aims

The approach used in this research study departs significantly from the two distinct streams of research regarding the MMC intervention. First, it differs from a biomedical approach, which has tended to be reductionist in so far as it focused on the health impact of the intervention, and neglected its cultural dimensions (Stevens, 2009; Green et al., 2008; Bollinger et al, 2011; Van Howe & Storms, 2011; Ncayiyana, 2011; Morris et al., 2011; Weiss et al, 2008). Secondly, my thesis differs from studies of the acceptability of MMC in communities where circumcision is not a cultural, social or religious practice. These studies largely provide evidence of a high

degree of acceptability of MMC programmes, and also present MMC as culturally unproblematic (Nepaya, 2012; Kebaabetswe et al., 2003; Scott et al., 2005; Herman-Roloff et al., 2011; Bailey et al, 2002; Mattson et al., 2005).

This research study differs from such studies in two respects: firstly, it takes culture seriously as a significant point of departure for the analysis of MMC, and secondly, it reports the findings of research conducted amongst men who have undergone *ulwaluko* regarding their perceptions of men who have undergone VMMC. Interviewing traditionally circumcised men may help shed some light on the continuing low uptake of MMC services in South Africa (see Shisana et al., 2014).

Thesis outline

Chapter 2 reviews research literature on my topic. Firstly, it examines the practice of male circumcision from a historical perspective: how male circumcision has evolved, its changed meanings, and its uses over the years. The chapter explores *ulwaluko* and changing conceptions of manhood. It also traces the recent development of medical male circumcision as an intervention to combat HIV infection. It summarises arguments for and against the scaling up of VMMC as public health policy in South Africa and in other countries. Finally, the chapter summarises theories of manhood.

Chapter 3 discusses the research methodology to be employed in the study. I discuss plans to access research participants 'in the field', and selection of participants and the difficulties that I experienced in collecting research data. Chapter 4 presents my research findings regarding contemporary meanings of manhood in Khayelitsha in light of the introduction of VMMC as a health intervention programme to prevent HIV.

Chapter 5 deals with perceptions regarding the introduction of VMMC. Chapter 6 provides a conclusion to my study.

CHAPTER 2 LITERATURE REVIEW

In this chapter, I review research literature relevant to my study. I look first at the history of male circumcision: how male circumcision has historically evolved, its changed meanings, and its uses over the years. I explore *ulwaluko* and manhood together with some of the debates about the topic. I then trace the recent rise of male circumcision as an intervention used to combat HIV infection. In this regard, I explore the arguments for and against the scaling-up of VMMC as a public health policy in South Africa and in other countries. Finally, I review research literature on manhood.

Male circumcision

Male circumcision is one of the most ancient and common surgical procedures practiced for religious, cultural, social, aesthetic and medical purposes (Weiss et al., 2008; Hellsten, 2004; Doyle, 2005; Peltzer & Kanta, 2009). Doyle (2005) provides a history of male circumcision as practised by Jews, Muslims, Australian Aborigines, South Sea Islanders, and the Bantu peoples of Africa. He claims that in Egypt circumcision once served as a requirement for admission to the priesthood, and later in other parts of Africa it served as a rite of passage into manhood. Gairdner (1949) states that circumcision was introduced into Roman Europe with Christianity but with the rise of modern surgery in the nineteenth century its status changed from a religious rite to a medical procedure. Aggleton (2007) asserts that from the late 19th century onwards circumcision was viewed in the USA as a cure for a wide range of medical and social problems, from paralysis, joint disease, nervousness and anti-social behaviour to madness. The history of MMC is important as it helps shed light on the historical evolution, meaning and uses of male circumcision.

Ulwaluko and manhood

Ulwaluko is a sacred Xhosa rite of passage to manhood status involving the circumcision of the penis, i.e. cutting of the foreskin by an *ingcibi*, a traditional surgeon without Western medical training. It is a ritual performed on adolescents – or adults – in remote secluded areas, in makeshift huts used as lodges for initiates. The ritual of circumcision tests for bravery, stoicism and forbearance, which are considered the mark of a real man, i.e. *indoda*. In many Xhosa communities, being a man is associated with compliance with all the requirements of

the ritual of *ulwaluko*. Undergoing the ritual confers power on males in Xhosa communities (Meissner & Buso, 2007). Men who have undergone the ritual are accorded a higher social status than their previous status (when they were regarded as 'boys' – *amakhwenkwe* – because they had not yet undergone *ulwaluko*). Such men are respected by younger males who have not yet gone through the ritual. Such respect is normally shown through avoidance of referring to them by their names, but rather addressing them as *ubhuti* (senior or bigger brother), and through younger males being willing to perform tasks delegated to them by older men. Men who have undergone *ulwaluko* also have the privilege of appeasing ancestral spirits during cultural ritual functions, and participating in family meetings and community discussions. In addition, undergoing *ulwaluko* also bequeaths a man with the right to inherit an estate, to take a wife and to establish his own household.

Beyond this, *ulwaluko* is also believed to instil sound morality and good social values recognised by the Xhosa commune (Ntombana, 2011). As part of the initiation process, boys are expected to acquire cultural knowledge, moral codes, and beliefs valued by their communities. The acquisition of these positions them as adults in their communities and permits them to be given leadership responsibilities. During the process of *ulwaluko* boys also acquire a language of manhood known as *isidoda*. This language helps them to legitimise their manhood when with men who have undergone *ulwaluko* (Mngqolozana, 2009; Mavundla et al., 2010). The language also provides them with access to the privileges shared by Xhosa men mentioned above. Importantly, knowledge of the language also positions men who have undergone *ulwaluko* in a higher position than men who have not undergone *ulwaluko*, or who have undergone circumcision at a health facility (Mfecane, 2016; Mavundla et al., 2010; Mngqolozana, 2009). It has also been suggested that some Xhosa women might prefer a man that has been through *ulwaluko*, associating those who have not undertaken it with immaturity and irresponsibility, and with the likelihood of bringing shame with them (Gqola, 2007; Mhlahlo, 2009).

Mavundla et al. (2010) report on a phenomenological study conducted among newly initiated Xhosa men. The purpose of the study was to describe the experience of newly initiated Xhosa men in East London (South Africa). Data for the study was collected through focus group discussions with 14 men. The focus group discussions suggested that uninitiated Xhosa males could face marginalisation, rejection and lack of respect from members of their communities. Most participants expressed a fear of social rejection as a major motivation for their decision to undergo *ulwaluko*. They reported feeling pressurised to undergo *ulwaluko* by the community

at large, by their own families and by peers, as well as by members of the opposite sex. Lack of social acceptance was associated with being uncircumcised or with having failed the manhood test of ritual circumcision. Failing the test occurs when a taboo is violated, such as when hospitalisation is necessary owing to medical complications arising from the circumcision (Mngqolozana, 2009).

Participants cited observations of how uninitiated men are treated, and how they themselves were treated by the community prior to undergoing *ulwaluko,* as major motivations for undergoing the ritual. Prior to undergoing *ulwaluko* one participant reported being beaten up at a shebeen by men sent by a shebeen owner that did not want his shebeen to be patronised by 'boys' (i.e. those who had not undergone *ulwaluko*). Other participants related observing men who were regarded as having failed the test of *ulwaluko* through hospitalisation as being marginalised in traditional ceremonies and community discussions, and as not being respected and not allowed to enter into conversation with men who had undergone *ulwaluko*. Another individual related an experience of how someone in his home who had not been to *ulwaluko* was always blamed whenever something was reported missing. The participant noted that such allegations were made despite the possibility that his older brother who had been to *ulwaluko* might have been the culprit. His older brother was always overlooked because stealing is associated with males who have not undergone *ulwaluko*. Mavundla et al. (2010) note that such treatment of males who have not been to *ulwaluko* might be a means to ensure that the tradition survives.

However, Vincent (2008a) has a different interpretation to the one offered by Mavundla et al. (2010). She argues that the cultural and social meanings of *ulwaluko* have changed over the centuries. She notes that the previous historical purpose of *ulwaluko* as a mechanism for social order marked the point at which sexual responsibility and restraint was introduced into the lifestyle of young men, but that it has eroded with time, and that current perceptions are the ritual gives men an unlimited and unquestionable right of access to sex. Vincent attributes the change partly to the disruptive effects of apartheid, forced removals, the migrant labour system and urbanisation, which fractured the certainty of communal bonds and destroyed predictable hierarchies which once secured a social order in which *ulwaluko* was a mechanism of responsible sexual socialisation.

Kepe (2010) shares Vincent's (2008a) sentiment about the breakdown of the institution of *ulwaluko*. Similarly he argues that urbanisation and education have had an effect on current

practice, in which it is characterised by a crisis of custodianship, deaths and amputations. Kepe argues that traditional leaders and the government are engaged in contestation regarding the custodianship of *ulwaluko*. He contends that traditional leaders use the ritual to assert their power in a context where most power has shifted to the government. He views the government as having been compelled to intervene regarding *ulwaluko* because of its constitutional imperative to protect all South African citizens. Kepe views traditional leaders' deployment of a particular view of the past as part of their effort to reassert power in a social context that differs sharply from the context they describe when they speak about the ritual.

Ramphele (2010) interrogates whether or not *ulwaluko* has a place in contemporary society. In the current social context in which black men experience high rates of unemployment, and are unable to meet social expectations of being heads of households, decision makers and protectors, she wonders whether the ritual has become a sadistic practice that raises unrealistic hope among young Xhosa men who undergo *ulwaluko*. Ramphele argues that the social reality of black men in South Africa has not dramatically improved when compared with the apartheid past, in which black men were marginalised and derogatorily referred to as 'boys'. She argues that the false hope which *ulwaluko* gives Xhosa men might make them more prone to engage in gender-based violence as a means of exerting power denied to them by the socio-economic realities of South Africa.

I acknowledge all of these academic views. However, my critique of their arguments is that they seem to believe that the Xhosa community is incapable of self-reflection and auto-correction. For *ulwaluko* to have survived for so many years Xhosa-speaking people who are committed to *ulwaluko* must have engaged in ongoing self-reflection and cultural renegotiation of these practices. Yet scholars regard the ritual as a rigid practice which cannot accommodate change in society. This is a stark contradiction of the reality of HIV for Xhosa communities, which have adopted use of a different assegai for every individual initiate, or where *ingcibi* sterilise their assegai before using it on another initiate, in order to reduce the risk of transmission of HIV between the same cohort of initiates.

Moreover, I find it implausible that it may be the case that urban based communities who continue to practice *ulwaluko* do so as the result of a strong influence that traditional leaders continue to have over them through a skilful deployment of a particular view of culture as Kepe argues. The presence of people in urban areas alone usually means that they are somewhat free from the authority of traditional leadership that may exercise absolute power over them and

their lives. This point has been the basis of Ntsebeza's (2004) criticism of the post-apartheid era that despite the birth of democracy in 1994 people in rural areas continue to be the subjects of undemocratically elected traditional leaders, as unlike their counterparts in urban areas who are enjoying democratic rights and freedom.

Secondly, I find that Kepe engages *ulwaluko* from a Western perspective of modernity in which a sharp distinction is drawn between tradition and modernity, with the former being viewed as inconsistent with the latter and ultimately giving way to it. In the South African context that Kepe engages modernity and urbanisation have however not necessarily resulted in a decline in popularity of tradition. Several scholars note that there is usually a huge demand made by the South African urbanised youth for African tradition even during instances when parents may disapprove (Wilson & Mafeje, 1963; Suttner, 2007; Mavundla et al., 2009; Vincent, 2008a; Gwata, 2009) Levels of education usually also do not denote any significant differences in attitudes and views about tradition (Gibson & Lindegaard, 2007).

In long established townships of Cape Town, such as Langa, Nyanga and Gugulethu, that I am more familiar with, there is no sign that *ulwaluko* has waned as the result of urbanisation. Countless scores of boys from these areas each year undergo *ulwaluko* even sometimes in the absence of adequate land resource providing the traditional requirement of privacy as initiates next to Nyanga railway station sometimes can be seen.

As early as the 1960's Wilson and Mafeje (1963) give an indication of how *ulwaluko* has been able to adapt in urban conditions in Langa township (Cape Town) with slight improvisations made for it fit the local context. They note as the first change the conducting of *ulwaluko* in December when it is summer as opposed to June as is the norm in the Eastern Cape. They attribute this change to the different weather patterns in the two geographical areas. They submit that winter in Cape Town tends to be a damp season, making it unpalatable for initiates to be sent to camp under such conditions. Secondly, they highlight contextual changes in *ukuyala* admonitions given to boys returning from the initiation schools. They note that though there is a stressed obligation on the young men to look after their parents and younger brothers and sisters, there is no reference to building up the cattle herd as in the countryside, and the adolescent behaviour reprimanded is one that is unique to the environs of the city. These examples illustrate that the ritual is not a static ritual, but one that is flexible and able to adapt in newer conditions, even under conditions of urban life or "modernity".

Lastly, I find Ramphele's suggestions that *ulwaluko* could lead to acts of gender based violence as too subjective for any generalising conclusion to be made. There has not been any empirical evidence that has shown that Xhosa men who have undergone *ulwaluko* are more prone to engage in gender based violence than other men who do not engage in traditional circumcision in South Africa, but who nonetheless also live in vulnerable conditions of poverty and marginalisation.

MMC and HIV

More recently male circumcision has been adopted by various African countries as a means of reducing HIV infection rates. The idea that male circumcision might provide protection against HIV infection is not new; it was first suggested in 1986 (Fink, 1986). The suggestion was supported by ecological descriptions of areas in sub-Saharan Africa with low and high HIV prevalence mapped against rates of male circumcision. This was repeated later across 118 developing countries (Drain et al., 2006).

Randomised controlled trials carried out in South Africa, Uganda and Kenya in 2005 and 2006 revealed that male circumcision reduced transmission of HIV from women to men during heterosexual vaginal sexual intercourse by 60% (Weiss et al., 2008; Green et al., 2008; PlusNews, 2007). The reason for the protective role played by circumcision was that the male foreskin has a high concentration of Langerhans cells that are believed to be an easy entry point for HIV into the male body (Van Howe, 2011; Dowsett & Couch, 2007; Scott et al., 2006). Small tears and lesions which are more likely to occur in the mucosal surface of the inner foreskin of an uncircumcised man and longer survival of pathogens in warm, moist sub-preputial spaces are also blamed for the increased risk of HIV infection in uncircumcised men (see Weiss et al., 2008). In 2007, persuaded by these findings, the World Health Organisation (WHO), together with the Joint United Nations Programme on HIV/AIDS (UNAIDS), recommended that male circumcision should be a component of the standard HIV prevention package (Soul City Institute Health and Development Communication, 2010; PlusNews, 2007; Bateman, 2010).

However, scholars and researchers disagree about the implications of these clinical research findings. On the one hand some hail the trials as a breakthrough in biomedical science which provides a partial solution for reducing the impact of HIV and AIDS, especially in Africa (Morris et al., 2011; Weiss et al., 2008). According to these scholars, male circumcision has the capacity to avert millions of AIDS-related deaths in the coming decades, given its proven

efficacy in trials. Male circumcision is also seen as a way for governments to save by preventing new HIV infection and curbing the number of HIV-positive people requiring treatment. However, MMC services need to be accompanied by messages that male circumcision is not a 'magic bullet' which provides men with complete protection against HIV infection. Men still need to be faithful to one partner or wear a condom every time that they have sex (WHO, 2007).

On the other hand, dissident scholars refute such claims regarding the efficacy of MMC in preventing HIV infection. They are highly critical of the process of clinical research trials, and doubt that in the real world MMC will provide the same benefits as those observed during trials because of dissimilar conditions (Dowsett & Couch, 2007; Green et al., 2008). Moreover, they caution that male circumcision may have unintended negative consequences for recipients. Instead of reducing HIV risk for men, MMC might actually increase HIV risk because the recipients of MMC might perceive themselves as 'wearing a natural condom' (Van Howe & Storms, 2011; Ncayiyana, 2011; Green et al., 2008). Dissenting scholars argue that unnecessary medical male circumcision services in developing countries may overburden already stretched and under-resourced public health care systems (see PlusNews, 2007; Ncayiyana, 2011). In a similar vein, Bollinger et al. (2011) argue that MMC services will draw away limited resources from proven prevention measures such as condom promotion, safe-sex education and anti-retroviral drug distribution.

Bollinger et al. (2011) question the relevance of MMC in protecting women against HIV. They point out that the intervention has no benefit for women. Instead it may increase their risk of contracting HIV, if a couple resume sex before a circumcision wound has completely healed, or when women or their circumcised male partners wrongly believe that circumcision provides complete protection against HIV. Bollinger et al. (2011) argue further that promoting male circumcision as a public health measure is unethical, given the possibility that it could increase the risk of HV infection, and that it could result in complications and negative consequences for MMC recipients.

Green et al. (2008) share the same concerns as Bollinger et al. (2011) regarding the ethics of male circumcision as a means of HIV prevention. They charge that the push for mass circumcision in Africa is unethical as it is based on an incomplete understanding of health issues in the real world. Such real world factors include discrepancies in access to resources, differing sanitary standards, and inadequate counselling offered to males who are recipients of

MMC outside of clinical trials. Moreover, they argue that the policy recommendation of mass circumcision lacks a thorough and objective consideration of costs in relation to hoped-for benefits. They point out that MMC gets the green light despite campaigns to promote safe-sex behaviours having been shown to be highly effective in reducing rates of HIV infection without the surgical risks and complications of circumcision and at a lower cost. They argue that this makes the broad roll-out of MC more unethical.

In driving home the point that male circumcision is not the 'HIV vaccine' that we have been waiting for, Green et al. (2008) develop several arguments that challenge the claim of 60% prevention efficacy for MMC. They argue that all three of the clinical studies mentioned were halted early, there was no long-term follow-up, a large number of participants were lost to follow-up, many HIV infections appeared to be the result of non-sexual transmission, and other confounding factors exist that might have skewed the results.

Stevens (2009) is a supporter of MMC programmes. Her view is that men presenting at public health facilities for MMC provide an opportunity to increase awareness of sexual health through public education with a gender justice focus. She argues that well-tailored MMC could address many of the concerns of scholars who oppose the MMC roll-out. Such fears include that circumcision will expose women to further patriarchal oppression and that men will believe that circumcision creates a 'natural condom' that makes men immune to HIV infection, and as a result, if they become HIV positive, they will blame their infection on their female partners. Instead, she argues that if the MMC intervention is properly managed, it will provide public health officials with an opportunity to raise men's awareness of their sexual health practices, and encourage them to take responsibility for their own health and for that of their sexual partners. Uptake of MMC services, she argues, could be a vehicle to enable men to start talking about issues such as coercive sex and domestic violence.

Stevens (2009) advocates further that MMC needs to be carried out in clinical settings, rather than in settings where traditional circumcision takes place. Her justification includes that in recent years there have been multiple reports of botched traditional circumcision leading to injury of some men's penises and in some cases to partial or complete amputation of the penis. She argues that it is safer for circumcision to be carried out in clinical settings by trained personnel with trusted expertise. Finally, in her view traditional initiation rituals do not assist in addressing patriarchy, but rather put young men in families headed by single mothers in a difficult position as female parents are not allowed to participate in traditional initiation rituals.

Stevens' arguments have some strengths. However, she judges traditional initiation rituals from the position of an outsider. She seems to view the foreskin in societies practising traditional circumcision as being devoid of meaning, i.e. as just a piece of flesh that can be removed anywhere and anyhow. She does not see the foreskin as imbued with cultural meanings regarding what it means to be a man. Aggleton (2007) warns against viewing the foreskin in this reductionist manner. He argues that the foreskin has always had connotations regarding identity even when circumcision is performed in medical settings. Circumcision of the foreskin in Xhosa society has been shown by Mavundla et al. (2009) to be an elaborate religious issue.

Other scholars have described the strong social consequences for those who do not adhere to cultural requirements for circumcision (Ndletyana, 2000; Whissom, 2000; Mngqolozana, 2009). All of these factors point to cultural connotations attached to the foreskin and how it should be removed.

MMC is a highly contentious issue, and its efficacy in HIV prevention is currently unclear. While debates about MMC have been important in raising awareness of biomedical aspects of the intervention, and the benefits and risks involved, they have done little to increase awareness of cultural aspects of circumcision. At best, such debates have ignored these aspects. They have paid no particular attention to the impact that the MMC intervention might potentially have on the cultural norms and lives of individual men who take up the intervention. Their focus has been on the physical aspects of the intervention, i.e. on the foreskin itself.

However, acceptability studies have interrogated cultural aspects of the MMC intervention. These studies, conducted in the Southern African region prior to the implementation of VMMC, explored the influence of culture, religion and other social factors on the uptake of the intervention (Kebaabetswe et al., 2003; Scott et al., 2005; Herman-Roloff et al., 2011; Bailey et al., 2002; Mattson et al., 2005). A notable feature of these studies is that most have been conducted in non-circumcising social settings. Their main concern has been that in non-circumcising societies MMC might be difficult to promote because male circumcision does not form part of initiation rites into manhood (Bailey et al., 2002). These studies showed greater acceptability of MMC programmes in non-circumcising societies than had been expected, with participants pledging to use MMC services (Bailey et al., 2002; Kebaabetswe et al., 2003). Reasons given by research participants for their willingness to be circumcised included perceived enhanced sexual pleasure, hygiene, and protection from STIs and HIV/AIDS (Mattson et al., 2005; Herman-Roloff et al., 2011; Scott et al., 2005). Factors that were

identified as primary barriers to uptake of MMC included fear of pain, cost and issues regarding safety.

Thus the literature on the acceptability of MMC presents it as culturally unproblematic. Furthermore studies claim that some notions of masculinity contribute to men's acceptance of MMC services because some men believe that circumcision will enhance their sexual pleasure. The latter view has been challenged by Nepaya (2012) in her research on the acceptability of MMC among men in the Ohangwena region of Namibia. Nepaya (2012) conducted research amongst men who had undergone circumcision through the national MMC programme in Namibia. She explored the role that masculinity might have played in men's decisions to undergo MMC in the context of a non-circumcising society, and found that the decision to undergo MMC had not been influenced by notions of masculinity but rather by the perceived medical benefits of male circumcision.

I value Nepaya's (2012) findings and the critical engagement with masculinity in her research. However, my study differs from hers and from others already cited in that my study was conducted in a context where traditional circumcision is practised. Moreover, I did not investigate the acceptability of medical circumcision, but rather focused on the perspectives of men who had undergone *ulwaluko* regarding the social acceptability of males who had undergone VMMC. This focus is particularly important, given that circumcision in Xhosa-speaking society is linked to social constructions of manhood.

Theorising manhood

Manhood denotes a collective gender identity that is not an inherent biological attribute but is rather a social construct (Morrell, 1998; Gutmann, 1997). A person may be born as a male (i.e. with a penis), but he becomes a man through his actions and through culturally determined ideas regarding what constitutes manhood. Manhood is not a biological attribute since there is no universal definition of what it means to be a man (Morrell, 1998). Instead, manhood is context bound; it is achieved and performed differently in various social settings. It is not enough to be born with biological male sex organs; manhood almost always involves the taking up of subject positions that demonstrate one's manliness or one's masculinity (Hallway, 1984). These subject positions usually involve high-risk behaviour and sometimes demand that men show evidence of toughness, aggression and stoicism (Gilmore, 1990; Courtney, 2000).

In theorising about masculinity this study specifically adopts the ideas of Connell (1995), an influential scholar in masculinity studies. She coined the concept 'hegemonic masculinity' to refer to the dominant masculinity in society in any particular historical period. This masculinity is a cultural ideal and most men try to live up to its standards. Hegemonic masculinity exists alongside other categories that Connell refers to as 'subordinate', 'complicit', and 'marginal' masculinities (Connell, 1995: 77- 81). Subordinate masculinities are the masculinities of those groups of men who are not living up to the dominant ideas of being a man and that are symbolically expelled from hegemonic masculinity. An example of this in the contemporary context of European/American society is the masculinities of white gay men. According to Connell, these masculinities are expelled from hegemonic masculinity as heterosexuality remains to be a key requirement of hegemonic masculinity. The complicit group of masculinities refers to men who are not entirely engaged in the hegemonic pattern of masculinity, but who nonetheless are benefiting from the "patriarchal dividend" that men derive from the overall subordination of women (Ibid: 79). Marginal masculinity refers to a masculinity that is expelled from the hegemonic masculinity, and that acts as a symbolic authorisation of the hegemonic masculinity. In a white supremacist context, Connell views this masculinity as the masculinities of black men. She views these masculinities in such a context as playing symbolic roles for white gender construction. Connell suggests that these four versions of masculinity compete for legitimacy, and in any given historical period a different version can achieve hegemony.

Connell's (1995) major contribution is the notion that in any given historical period there are a plurality of masculinities which compete with one another. The notion of competing masculinities helps develop the concept of Xhosa manhood as a contested issue. It leads to the realisation that there is no monolithic idea about what it means to be a Xhosa man, but rather a plurality of Xhosa masculinities in a hierarchy and in competition for legitimacy. Mfecane (2016) offers some insight into the hierarchy of Xhosa masculinities, showing that the most revered form of masculinity among the amaXhosa is *indoda*, meaning a traditionally circumcised person. It is the dominant form of masculinity since all Xhosa-speaking males are expected to undergo traditional rites of passage to manhood called *ulwaluko*. Undergoing *ulwaluko* bestows men with respect in society: it gives them the social rights to inherit property, to officiate during rituals and to take part in family discussions. It also gives men the social right to start a family and to assert their independence from their parents.

Inkwenkwe, on the other hand, is a marginalised form of masculinity. It refers to males who are uncircumcised and who have not undergone *ulwaluko*. This form of masculinity is conceived of as embodying childlike qualities. *Amakhwenkwe* (plural for *inkwenkwe*) are generally treated in a paternalistic manner irrespective of their age. An *inkwenkwe* is expected to defer to *indoda*, and to accept delegation of tasks, even if he is older than *indoda*. An *inkwenkwe* is deprived of the social right to inherit property and to have a wife, to share manhood spaces (e.g. *indlu yesibane* (house of the lamp) with *amadoda*, to engage in *imicimbi* (cultural functions), or to preside over rituals (Mayekiso, 2017). An *inkwenkwe* is commonly referred to as a 'dog' (Mavundla et al., 2010), implying that Xhosa society does not see him as a complete man until he has undergone *ulwaluko*.

Similarly, men who have undergone circumcision at a health facility are not seen as 'real men'. They may be given derogatory labels such as *ooNofotyela* (hospital men) or *abadlezana* to mark them out as different and as 'other', i.e. seen as having cheated or forged manhood (Whissom, 2000). Such a version of masculinity can, therefore, be seen as a subordinated masculinity. Men admitted to hospital during *ulwaluko* may also face discrimination and stigmatisation by peers who have completed *ulwaluko*. They are also seen to embody a subordinate form of masculinity.

Connell's theory of hegemonic masculinity has received criticism from various gender theorists (see for example, Connell & Messerschmidt, 2005). Of particular relevance for this thesis are the critiques of Demetriou (2001) and Mfecane (2016). Demetriou praises Connell for his achievement in constructing a theory that encompasses both reproduction of masculine power and change, as well as overcoming the limitations of sex-role theory. However, he criticises Connell's conceptualisation of hegemonic masculinity, arguing that it offers an inadequate explanation of how dominance is maintained in society at different historic moments. For Connell, masculine dominance is maintained by clearly demarcating hegemonic masculinity from subordinate masculinities – these are 'expelled' from the 'circle of legitimacy'. However, Demetriou (2001) differs, saying that hegemonic masculinity does not necessarily expel subordinate masculinities, but instead appropriates some of their elements to strengthen itself. This then results in what he calls a 'hybrid masculinity' or 'hybrid block', uniting diverse practices in order to construct the best possible strategy for the reproduction of patriarchy.

In illustration of this point Demetriou (2001) shows how hegemonic masculinity has maintained its authority despite the challenges of women's movements and feminism, and the

challenges of gay movement, by appropriating some elements of the gay community (subordinated masculinity), so that on the surface hegemonic masculinity appears as if it has yielded to demands for change. Some of these elements include heterosexual men's adoption of mascara and ear rings, and acceptance of middle-class gay men as constituting a consumer culture of popular fashion items. In South Africa this could take the form of men removing their chest hair or attending skin care salons.

Mfecane (2016) has challenged the concept of hegemonic masculinity in understanding Xhosa masculinity. His view is that the concept provides a limited understanding of Xhosa masculinity in its discursive positioning of heterosexual men at the top of a masculine hierarchy and gay men at the bottom. He argues that in Xhosa society, an *indoda* – a traditionally circumcised man – embodies the most honoured form of masculinity, irrespective of his sexual orientation or class. He draws his evidence from the lives of two highly regarded Xhosa-speaking men in the Eastern Cape: the 19th-century intellectual and activist, Tiyo Soga, and the 20th-century writer and scholar, Zakes Mda.

Mfecane (2016) draws on the life of Tiyo Soga (1829–1871), one of the first Xhosa-speaking South Africans to be educated abroad and to be ordained as a minister. Mfecane describes Tiyo Soga as raised by a Scottish Presbyterian missionary, Reverend Thomas Chalmers, after his parents had converted to Christianity. In accordance with Christian values Soga was not circumcised; as a result throughout his life he was considered to be a boy (*inkwenkwe*) by amaXhosa. Mfecane notes that as a married, heterosexual man with six children Soga fits the attributes of the hegemonic masculinity described by Connell. Yet for amaXhosa these 'achievements' did not elevate him to a hegemonic masculine position.

Mfecane also draws on the case-study of the novelist Zakes Mda. Mfecane builds his case citing both Mda's novel, *The Heart of Redness*, and his memoir, *Sometimes there is a Void*. In the novel, Mfecane reflects on the heated debate between key protagonists Camagu and Bhonco, who argue about government development plans for the village of Qolorha. Bhonco, a non-believer (a staunch supporter of development) accuses Camagu of being uncircumcised, after he hears him make a strong case for the believers (those who are opposed to development). Camagu confidently challenges Bhonco to inspect his penis in public, to ascertain whether or not he has a foreskin. Bhonco does not take up the challenge, and the believers applaud Camagu.

Drawing on this text Mfecane (2016) concludes that in Xhosa society cultural and physical rituals on the body are central markers of manhood, and not sexuality per se, as the concept of hegemonic masculinity posits. Despite Camagu being heterosexual, his status as a man is still doubted until he volunteers that his genitals be publicly inspected. Hence Mfecane suggests that gay men in Xhosa society who have undergone *ulwaluko* achieve the same hegemonic masculinity as heterosexual men who have undergone *ulwaluko*. Furthermore, Mfecane draws on Mda's reflections in his memoir, as someone who had undergone medical circumcision while in exile as a young man, of the difficulties of integrating into Xhosa society. Mfecane uses this to show that while Mda fitted Connell's concept of hegemonic masculinity, his medical circumcision positioned him within a marginal masculinity in the Xhosa masculine hierarchy.

Despite such critiques of hegemonic masculinity this thesis still finds powerful insights in Connell, but is mindful of particular cultural and regional particularities.

Conclusion

This chapter has presented a literature review relevant to the study. The chapter has looked at the historical development of male circumcision and its evolving meaning and purpose. The recent development of male circumcision as an intervention to prevent HIV infection was also outlined. In this regard, arguments for and against the scaling-up of VMMC as a public health policy in South Africa and in other countries were explored. Relevant theories about manhood were then described, including how elements of Connell's theory of hegemonic masculinity provide an understanding of the role of *ulwaluko* in Xhosa-speaking communities.

.

CHAPTER 3 METHODOLOGY AND RESEARCH DESIGN

This chapter outlines the area in which sampling took place, and the research design and research methodology deployed in this study. It describes the rationale for the research design and sampling, and outlines challenges encountered with participants and with gatekeepers. Furthermore, it describes how the data was collected and analysed. Finally, the researcher reflects on his positionality in the research as a Xhosa-speaking man conducting research 'at home' (Peirano, 1998; Merriam et al., 2001). Ethical procedures, dilemmas and limitations of the study are finally addressed.

Study area

The study was conducted in Khayelitsha township. Khayelitsha is situated on the Cape Flats, on the outskirts of Cape Town, between False Bay and Somerset West. It is approximately 35 km from Cape Town's central business district (Nleya & Thompson, 2009). The name Khayelitsha has Xhosa linguistic origins, and means a 'new home'. Khayelitsha was established in 1983 in terms of the South African apartheid government's policies of racial segregation, to address overcrowding of established townships such as Langa and Gugulethu, and accommodate growing numbers of migrants and job seekers from the Eastern Cape (Poswa & Levy, 2006). Today Khayelitsha is Cape Town's biggest township and the second largest township in South Africa. It covers an area of 43.51 square kilometres. In 2013 its 11 800 households accommodated 391 749 people (City of Cape Town, 2013).

The majority of Khayelitsha's population is black and most residents speak isiXhosa. The most recent census (2011) describes the racial breakdown of Khayelitsha's population as follows: 90.5% black African, 8.5% coloured and 0.5% white. Khayelitsha's population has an age distribution skewed strongly towards youth: fewer than 7% of Khayelitsha's residents are over the age of 50 years whereas more than 40% of the population is under 19 years of age. The township also has a slight overrepresentation of females, with 52% being girls or women. Hence a larger proportion of households in Khayelitsha are headed by women rather than by men, especially those in the formal residential areas (Seekings, 2013).

There is a range of different types of housing in Khayelitsha. Half of the township's population lives in formal housing made of bricks, sand and cement, while the remainder live in informal settlements with homes constructed of wood, zinc and ceiling board (Seekings, 2013). Formal

housing comprises older houses built by the apartheid government for 'legal' residents in the early years of Khayelitsha, together with dwellings bought using mortgage bond finance or Reconstruction and Development Programme (RDP) houses built under the new democratic dispensation. Informal settlement dwellings, in contrast, are relatively new and are mainly occupied by recent arrivals from the Eastern Cape.

Whilst in recent times there has been an improvement in the quality of life of Khayelitsha's residents, as exemplified by the increase in the number of middle-class households, the majority of residents still live in moderate or severe poverty (Census, 2011; Seekings, 2013; Pinnock, 2016). The 2011 census found that the township is one of the most economically disadvantaged areas of Cape Town. Khayelitsha has a median average annual income of R20 000, compared to the city's median average annual income of R40 000. Widespread poverty in Khayelitsha is linked to the high unemployment rate as a result of high dropout rates in the early years of school education (Seekings, 2013). According to Seekings (2013), more than half of Khayelitsha's young adults have failed to complete secondary school.

Poverty and unemployment are not the only challenges which face the population of Khayelitsha. Crime and inefficient policing are also severe problems (Pinnock, 2016). In Khayelitsha residents report pervasive fear of being on foot in the township as a result of the high incidence of crime, linked to inefficient policing. A commission of enquiry established in 2014 to investigate allegations of police inefficiency in Khayelitsha heard reports that mob justice arose in the township after residents lost faith in the ability of police and the justice system to combat crime. Victims of mob justice are frequently young men 16 years of age or older, who face retribution through being stabbed, stoned, beaten or burnt to death (Pinnock, 2016).

Gang activity contributes significantly to violence in Khayelitsha, particularly the self-identified Vato and Vura gangs. According to Pinnock (2016), the gangs have developed partly as a means for young men to assert their masculinity. Male youth as young as 14 or 15 years may fight to the death using traditional weapons such as sticks, pangas and knives, and derive personal honour from the murder of members of rival gangs. According to Pinnock, many of these young men were born in the Eastern Cape. Their parents are often recent migrants to Cape Town who have severed their ties to rural areas, but have not yet put down roots in the city. These young men use violence to assert themselves in their new communities as a result of the limited range of formal avenues for them to derive social status. Gang members bear

significant responsibility for the high murder rate in Khayelitsha, with an average of one person killed every two days. Increasingly prison incarceration is seen as a rite of passage to seniority in the gang hierarchy (Ibid).

Despite poor housing, poverty, crime and gang activity, Khayelitsha has a remarkably functional health infrastructure, including three provincial clinics, three men's clinics, a children's clinic and a district hospital. The township also has three police stations, a central business district, offices of the Department of Home Affairs and a magistrate's court.

Khayelitsha was identified as a suitable area in which to conduct the research study because the majority of its population speak Xhosa, with male residents engaged in *ulwaluko* either in Khayelitsha or in the Eastern Cape. Secondly, Khayelitsha was chosen because it has an active VMMC programme, which could be easily accessed.

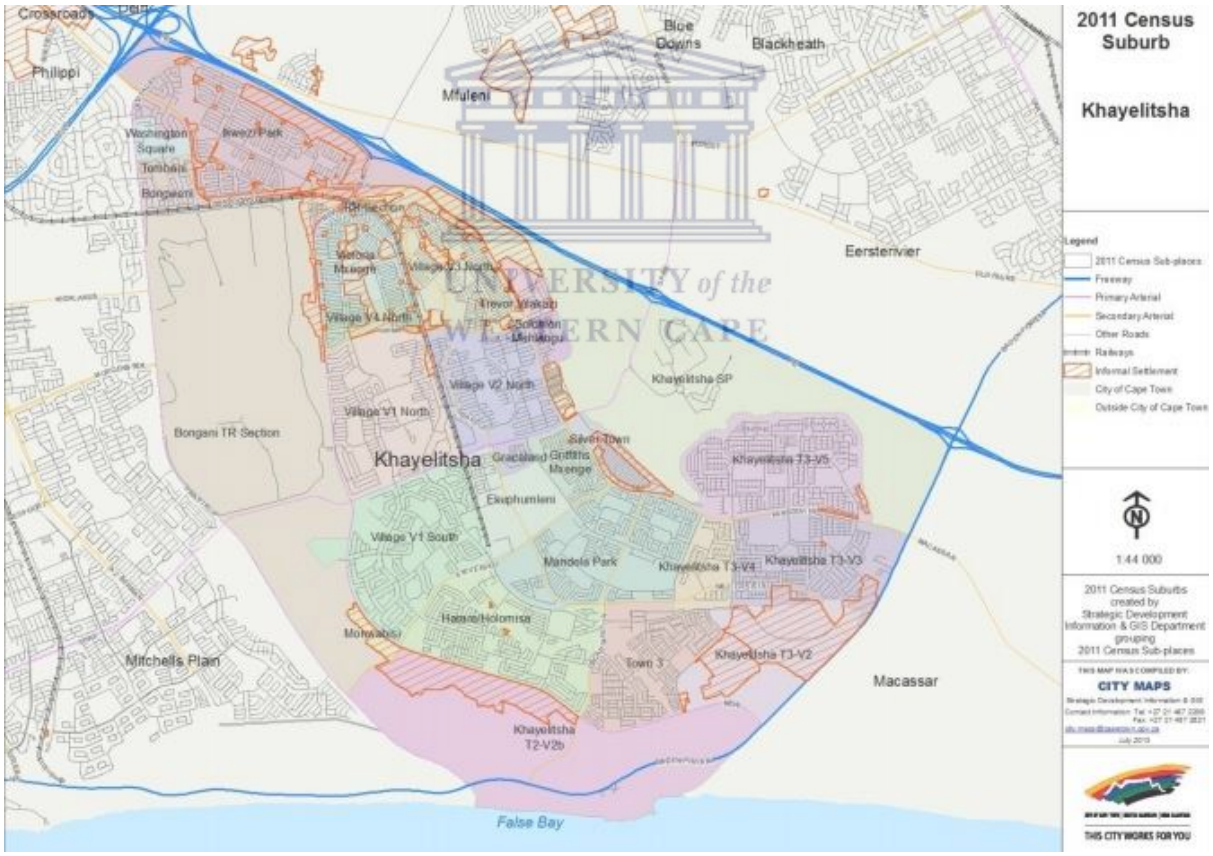

Figure 1 Map of Khayelitsha

Research design

The study adopted a qualitative research methodology with ethnography as a study design. Ethnography has roots in anthropology. It is used to provide a descriptive account of a community or culture from an investigation conducted under naturalistic settings (Hammersley & Atkinson, 2007). An ethnographer is a participant observer that immerses him or herself in the community that he/she is studying. Immersion tends to be over an extended period, involving among other things participation in the daily activities of the community, whilst at the same time making notes of observations of cultural phenomena that is unfolding at the scene (Emmerson et al., 2001).

A qualitative research approach was seen as the most suitable for this study in that it has an exploratory nature and allows the researcher freedom to interact with research participants, and to engage in conversations which yield insight into participants' subjective perceptions (Henning et al., 2004). Qualitative research takes the form of interpretive enquiry, and is most commonly used by ethnographers who seek to study social phenomena in natural settings.

This interpretive approach of qualitative research and naturalistic approach of ethnography motivated me to spend six months in Khayelitsha from May to October 2014 with male community members, health workers and VMMC clients, as well as meeting with traditional attendants and initiates in their own locales. Ensuring an extended stay in the research field, and watching and listening to what was being said while participating and being immersed in the field are important defining principles of ethnography.

Participants

All participants for this study were selected purposively, with convenience sampling and snowball sampling used (see Babbie & Mouton, 2001, for descriptions of each). Convenience sampling and snowball sampling were used to address the challenges of time limitations and taboo accompanying the research topic. Men aged 20 to 65 years were interviewed about their knowledge, motivations, experiences, and understandings of current peer perceptions of men who have undertaken VMMC. Health workers were also informally asked questions about their scope of work in the VMMC programme and uptake of the services in the area. I formally interviewed fourteen men who were members of the community, five men at the local clinic, and eight men from the traditional circumcision initiation school.

Male community members were interviewed to gain insight into the local dynamics of the community regarding who is considered to be a 'real' man. VMMC clients at the clinic and initiates in the traditional circumcision initiation school were interviewed regarding their perceptions of their status once they were re-integrated into their communities. Since they act as care-givers and transmit knowledge to initiates, traditional attendants were also interviewed, regarding their ideas of manhood and also regarding what they see as making a 'real' man. Initiates were also interviewed.

All fourteen male community members who were participants were Xhosa-speaking men who had been traditionally circumcised. They represented a wide age range and differing periods of time since they had undergone initiation (see Mandela, 1994, for importance of date of circumcision as a concept of being a man). Seven of these participants were middle-aged, six were newly initiated men between the ages of 23 and 27 years old, and one was an older man around 65 years of age. Two men had a primary school education, eight of the men had a high school education, while the remaining four had completed tertiary level education, had dropped out of tertiary level studies or were still engaged in studying at tertiary level. Many of the men were either unemployed or were engaged in casual and irregular employment. All participants were residents of the Mandela Park section of Khayelitsha: some from birth, while others had migrated to the area to seek work, to seek an education or to seek both. All participants were interviewed in the language of their preference, either isiXhosa or English. No community members who had been medically circumcised were selected because it was not possible to identify men in the community who were willing to admit having undergone VMMC.

Of five men interviewed at the clinic, two had undergone VMMC at the facility. The remaining three men comprised two who were at the facility to support a relative undergoing the VMMC procedure, and a man who wished to identify potential business opportunities and to learn more about the VMMC services on offer. Four VMMC clients were available for interviews, but owing to problems with communication, only two could be selected for participation. The speech of the two excluded individuals was unintelligible to the researcher.

The two VMMC clients who participated in the study had health issues. One participant was 28 years old and unemployed. He was also HIV positive and epileptic, he suffered episodic memory loss, and he had been diagnosed with low blood pressure. The second participant was a 19-year-old man who was rewriting his school-leaving examinations for a second time. He had been traditionally circumcised, but the circumcision had allegedly been botched and was

only partial, so he was at the clinic to seek treatment for the injury. This participant said that traditional circumcision was responsible for burning sensations and swelling at the tip of his penis. The VMMC clients were recruited at the clinic with the assistance of a male nurse who was responsible for dressing their wounds. Both were interviewed in a quiet private space at the clinic that they were comfortable with.

Five initiates at the traditional circumcision initiation school were recruited, together with three traditional attendants. All eight were recruited and interviewed at the school using their preferred language of isiXhosa, together with the favoured *ukuhlonipha* coded language used at most traditional Xhosa circumcision initiation schools. All of the initiates were from Khayelitsha, while two of the traditional attendants lived in Gugulethu and one in Khayelitsha. Initiates were between 20 and 25 years of age, and all were in their second to fourth weeks at the initiation school. Two had had some form of employment before signing up for initiation school, while the other three were unemployed and financially dependent on their parents. None had passed matric.

The traditional attendants were between 33 and 65 years of age. However, those who participated in the study were between the ages of 33 to 35 years. Two viewed being a traditional attendant as their only occupation, while the remaining attendant saw it as a part-time occupation and he undertook to perform this role to assist his family and friends, or others in need of circumcision.

Data collection methods

Data collection took place through participant observation, making field notes, and interviews conducted which were audio-recorded. Participant observation is an anthropological method which aims to capture an 'insider's view' through prolonged immersion in the natural setting of research participants. As a participant observer, I immersed myself at three sites in Khayelitsha: in Mandela Park, at Michael Maphongwana Community Health Clinic, and at an initiation school. I chose these sites for the convenience and practicality that each offered in helping to answer the research question. Mandela Park is where I was raised, and where I thought that I would have greater success in recruiting Xhosa-speaking males for the study, given the advantage of requesting participation by people I knew.

Michael Maphongwana Community Health Clinic was chosen because of its familiarity (I visited it as a child), and because it has an active VMMC programme. These two factors,

together with its proximity to Mandela Park and to the initiation school, made it an ideal venue in which to conduct the study. Similarly, a particular initiation school was chosen for familiarity because it was where I had undergone traditional circumcision.

Despite my 'insider' position in anthropological terms, prior to recruiting potential participants I first had to obtain access to them. From the beginning, I was confronted with the question of how best to introduce the research topic. I knew that many people would view what I sought to do (writing about *ulwaluko*) as taboo. Even speaking about *ulwaluko* alongside VMMC might suggest disloyalty and threaten my status as an insider of Xhosa culture. My desire to conduct research regarding the impact of VMMC on traditional circumcision could lead others to question my masculinity or doubt my sense of pride in my Xhosa-ness. Given these thoughts, the best place to start appeared to be the community in Mandela Park in which I had grown up, and not the initiation school, where I feared I might receive a highly negative response.

At Mandela Park, a trusted male neighbour was the first person whom I approached. I felt that I could discuss my research topic with him without prejudice. He agreed to participate in the study, and to also help me recruit other participants. However, he agreed with me that I might be at risk of verbal abuse and even face physical assault if I approached the initiation school inappropriately.

In the initial recruitment phase, I approached three male community members. Two participants were interviewed at my home. The third participant was interviewed inside the main family house, which was where he felt more comfortable.

All participants were interviewed using a flexible interview guide with open-ended questions (see Appendices). The interview guide asked about issues such as how men in the township lived, what made someone a man, which types of men were included in, or excluded from certain cultural, social and entertainment spaces in the township, and whether men who had undergone VMMC were seen as 'real' men. Formal interviews were audio-recorded with participants' permission. Each lasted for about 45 minutes and they were conducted in isiXhosa or English.

What made it easy for me to approach the community members was the type of relationship that I had already developed with each individual. Two of the participants were members of my community who had witnessed me undergoing *ulwaluko*. I hoped that this shared experience would lead them to accept my researcher credentials, understand my motives for

conducting research and be willing to answer my questions as frankly as possible. In contrast, the third participant was someone whom I had met recently, but we had quickly become close friends. In a short time-frame I had come to trust him, and to respect him for his ability to listen.

Following successful completion of these three interviews, I visited a childhood friend and an ex-schoolmate from primary school, with whom I had undergone *ulwaluko*. He readily agreed to participate in the study, and offered to introduce me to three friends who had been traditionally circumcised.

On arriving at his home to be presented to his friends, he led me to a darkened room with little ventilation and introduced me to three stern-faced men. I greeted them and introduced myself using my name and surname, the name of my home village in the Eastern Cape, and the name of my clan, as is customary for formal introductions in Xhosa communities. However, none of the men responded by introducing themselves properly to me. Their silence disconcerted me. However, I stuck to my original plan: I introduced the research topic and then proceeded with the focus group discussion. At this stage I saw one of the men slide marijuana onto a plate, to enable another man to roll a joint for them to smoke together. By the time that I turned on the audio recorder and began the discussion the room was already clouded with marijuana smoke. Fortunately for me, the men did not offer to share the marijuana with me.

The focus group discussion lasted about 60 minutes. On completion I thanked the participants and shared a 2-litre bottle of soft-drink with them as an expression of my gratitude to them.

I conducted two further focus group discussions with male community members at my home. Data collection with community members ended after data saturation was reached, i.e. the same themes began to repeat themselves and no new themes emerged.

Fieldwork at the traditional circumcision initiation school began after I attended an *umgidi* ceremony, and I was introduced to a traditional attendant based at the traditional initiation school that I had planned to visit. I received an invitation to meet him at the school on the following Monday.

On the arranged time on the Monday, I met the traditional attendant and he introduced me to a colleague, who appeared to be friendly. The colleague reassured me that I would be able to conduct my research, but that I needed to return in the afternoon of that day and first obtain approval from a traditional circumciser to conduct my research.

In the afternoon I met three traditional attendants and was introduced to the traditional circumciser. The traditional circumciser was initially silent but then proceeded to provide me with a lengthy history of the circumcision of Xhosa-speaking men. Following further delays I was informed that the traditional circumciser had agreed that I could commence with my interviews at the initiation school, on condition that he would not be present during them.

Thereafter I conducted interviews with initiates. I was not always able to conduct interviews without the presence of other initiates owing to the nature of the initiation school. However, this did not much disturb the proceedings of the interviews, as the initiates were in any case people whose views the study had interests on. Instead, this helped me to draw out important synergies and differences between the participants, normally drawn out from focus group discussions. At times, these were teased out from the bodily gestures of the initiates to what they heard said by the interviewee. All the initiates understood that they had to maintain silence when there is an interview underway as they had been briefed at the start of interviews.

The traditional attendants were engaged in a focus group discussion. All interviews and discussions took place either at the initiation school or in makeshift temporary huts located in the bush and where *ulwaluko* was performed. Interviews and discussions were audio-recorded. Data was collected for a month, and data collection was stopped once the data reached saturation point. During this time I observed and participated in the activities of the school.

The language used to conduct the interviews was isiXhosa, together with the specific subcategory of language spoken at initiation schools. Employment of such language enabled me to build rapport and ensure full participation.

After culmination of my research at the initiation school, I conducted fieldwork at Michael Maphongwana Community Health Clinic every Wednesday over a three-month period, the days when VMMC activities were scheduled. I was able to observe clinic activities, including a medical male circumcision, and to interview VMMC clients and health care workers. I met a male nurse who was initially reluctant to be interviewed, as he feared that the information that he shared with me might be broadcast on a local radio station. However, once I gained his confidence, he shared his own experience of traditional Xhosa circumcision, and introduced me to his colleagues. Thereafter the male nurse facilitated my gaining access to VMMC clients. One client, a Zulu-speaking man, permitted me to observe him undergoing VMMC.

Data management and analysis

Interviews were audio-recorded and transcribed, and then translated from isiXhosa into English. Each English transcript was systematically read through several times to identify emerging themes. Once a theme had been identified, a search was conducted of other transcripts for related examples of the same theme. Where necessary I referred to my field notes for confirmation regarding the context in which comments had been made.

Limitations and strengths

One limitation of the study is that I was unable to identify or to interview any community members who had been medically circumcised. This means that the study does not reflect the lived experiences of medically circumcised community members. Participants who were recruited at the clinic did not fulfil my enrolment criteria in this regard.

The Zulu-speaking man who underwent VMMC inhabited a different lived subjectivity to that of Xhosa-speaking men who had experienced medical circumcision.

Hence the findings of the study relate only to Xhosa-speaking men who have undergone *ulwaluko*.

A further limitation is that since this was a qualitative research study, findings cannot be generalised beyond the group of individuals whom I was able to interview individually or through focus group discussions.

A strength of this study is that as a Xhosa-speaking man who has experienced *ulwaluko,* I could more easily establish rapport with participants on this highly sensitive issue. All the participants shared with me confidential details about their experience of the ritual. I was also able to obtain a broad overview of the experiences of different generations of men who had undergone traditional circumcision.

My familiarity with the research location helped me to navigate easily between various research sites. My knowledge of the community's history and politics also helped me to quickly build rapport with participants, as I was not perceived to be an outsider. It also enabled me to contextualise what I heard from participants during interviews and focus group discussions.

Ethical considerations

The research study received ethics approval from the Senate Research Ethics Committee of the University of the Western Cape, and as well as from the Western Cape Department of Health: Division of Health Impact Assessment. Participants were required to give verbal informed consent before participation in the study. Verbal consent was deemed more suitable considering the high levels of sensitivity and secrecy accompanying discussing *ulwaluko* for research purposes. Prior to participation, all participants were informed of the nature and objectives of the study, and informed of their right to withdraw at any stage. At all times, participants gave verbal consent to be interviewed and audio-recorded. This verbal consent was recorded at the audio-recorder of the interviews. Focus group discussions and interviews took place in venues where participants felt comfortable. However, privacy could not always be ensured. Finally, the names and identifying personal characteristics of participants referred to in the following chapter have been disguised in order to ensure confidentiality.

CHAPTER 4 CONTEMPORARY CONCEPTIONS OF BEING A MAN IN KHAYELITSHA

This chapter presents contemporary perceptions of manhood in Khayelitsha by Xhosa-speaking men who had undergone *ulwaluko*, as revealed during the ethnographic research. In terms of the time-frame of the research study, it took place some years after the roll-out by the South African government of VMMC to help prevent HIV.

Participants felt that manhood in Khayelitsha was an identity which was communally acquired, solely through undergoing the full traditional male circumcision initiation ritual of *ulwaluko*. Successful completion of *ulwaluko* was associated with feelings of group solidarity and pride, and with reverence for the ancestors. Non-participation or non-completion of the ritual was seen to bring on the wrath of the ancestors, causing misfortune to the individual and to his descendants for posterity. Medical male circumcision was rejected by participants as a foreign practice that created division in communities, and brought into existence two forms of masculine identity that would be in conflict. These perceptions were underpinned by the belief that *ulwaluko* is a sacred tradition of amaXhosa which all males have to undergo in order to appease the ancestors and to acquire an authentic masculine identity.

Their perception of *ulwaluko* did not appear to have been altered by the introduction of MMC. When I asked one of the participants if he knew that the South African government was using medical male circumcision as a strategy to prevent HIV infection, he said:

> *Yo!* [an expression of shock or disbelief] *No; that thing is new to me. Because circumcision is* isiko *[a sacred spiritual tradition] that was blessed by our forefathers for a person to see himself as a person amongst people. If it is going to be something that prevents an existing disease, no to me that is a new thing* (Ncedisa, 25 year old, initiate, individual interview).

Such understanding of traditional male circumcision as a component of an ancient Xhosa tradition has been noted by other academics writing about *ulwaluko* (Bogopa, 2007; Ntombana, 2011; Mavundla et al., 2009). Several participants also described the relationship between traditional male circumcision and manhood as being part of a tradition:

> *No, like, like, what we get circumcised for is for our ancestors to be pleased, you see? To know that we did that thing which we said we were going to do or that which we promised them, or that which they did, you see? So we brew [traditional beer] when we*

are going to be circumcised, we speak to our forefathers and to our ancestors (Mzonke, 35 years old, traditional attendant, FGD).

The understanding of *ulwaluko* related by the participants confirms Ntozini and Abdullahi's (2016) findings regarding the meaning of *ulwaluko* for Xhosa-speaking men. They argue that its meaning continues to be derived from culture and tradition, even in light of the justification in South Africa of VMMC.

Participants described a man as being someone who has been to *ulwaluko* and completed all stages of the ritual: *umguyo* (a separation phase that involves the bidding of farewell to the boy), *umngeno* (a liminal phase of being *umkhwetha* – in-between and in betwixt – not a boy and not a man), and *umphumo* (the re-integration phase of the boy into society as a man).

We know the steps that we go past to be at this place that we are in now today [manhood], *you see? There is* umojiso *[a ritual ceremony in which an initiate is given the roasted leg of a sheep to eat], to your home-coming* [umphumo], *you perhaps start with* umngeno *[family and community singing all night to bid farewell to boyhood], you see? You make your way in to have your* umojiso *[second phase] and* umgidi *[a celebration of newly acquired manhood status by the community]* (Zolile, 22 years old, community member, FGD).

These stages were viewed as important, but it was not necessary to pass through all of them to be considered a man. For instance, some boys skipped the first stage and went off to initiation school without informing their families or communities. This phenomenon, known as *ukuziba* (to steal one's self off), happened, but was generally discouraged. However, a person who did this would still be regarded as having become a man. The most important aspect for a Xhosa-speaking male was to have gone through and completed initiation school.

For people to say you are a man you are supposed to have gone there in the mountain [metaphor for circumcision initiation school]. It will never be said that you are a man when you didn't go there in the mountain and do the things that are done there. So everyone who is a man has been there in the initiation school (Luyolo, 31 years old, community member, FGD).

Phases involving circumcision, seclusion and deprivation, and the binding and unbinding of the wound until it healed, were described as important for one's transition to manhood. Participants were very clear what satisfying the requirements of each phase meant.

Circumcision needed to be done by an *iNgcibi*, a traditional surgeon who had himself undergone *ulwaluko*. An *iNgcibi* needed to use an assegai – known as *umdlanga* – to sever the foreskins of the boys. Participants maintained that those who had their foreskins removed at a clinic – not following 'Xhosa processes' – had not undergone *ulwaluko*.

> *No, that one is not one of us! No, no, no, sorry man . . . My brother, these things are not the same, they are not the same [circumcision at initiation school and circumcision at the hospital]. We don't even know what is done in the hospital. We don't know what is done. There is that . . . They also use scissors, another thing* [*not* umdlanga]. (Sibusiso, 31 years old, community member, FGD).

> *. . . The way you are circumcised there in the hospital . . . is not the same as that which we have. We on our side have what is known as folding of skin tissue fat [done after circumcision] . . . You see things that are like that? You see? So in the hospital things that are like that maybe are not there* (Luyolo, 31 years old, community member, FGD).

Circumcision by *iNgcibi* was perceived as important for ushering a boy from *ubukhwenkwe* to *ubukhwetha*. It was seen as a way to demonstrate the bravery needed for manhood. In anthropological tradition the phase of *ubukhwetha* can be seen as a liminal stage because of the in-between status of the initiate – not a boy but also not yet a man.

Circumcision is seen as a test of bravery. Sometimes boys go to circumcision intoxicated to avoid feeling pain (Mayekiso, 2017; Vincent, 2008a). I asked participants whether such an incident would disqualify an initiate from being regarded as a man. The view reflected was that this would not be the case as the most important issue was being circumcised, and they would still experience pain when the effects of the alcohol wore off, which would be worse.

> *No, my brother, even me who went there when I was sober. Yes they said* gqu *[circumcised me] and I did not feel anything and time went along. But there is a time now when . . . I stayed the whole Saturday [the day he was circumcised] not doing anything and also not feeling anything that I thought to myself that I was in a wonderful place but Sunday came and it was when things started to turn for the worst. Forget the removal of the foreskin* (Themba, 34 years old, community member, FGD).

> *The most essential thing, my brother, is that one which is wrapping the wound. Traditional circumcision on its own, yes, there are a few pains but they are not significant. They are something that can be tolerated. It's wrapping that is painful.*

> *When you are wrapping or unwrapping, that's where the pain is, because there is pain sometimes even when you are unwrapping. Pains are when you are wrapping, you see? So the most important thing is that wrapping* (Luyolo, 31 years old, community member, FGD).

Based on these views, it seems that traditional circumcision is mainly a symbolic performance. The most important test of manhood is the wrapping and the unwrapping of the wound that follows. The importance of this stage is linked to the pain that characterises it. Mayekiso (2017) has observed pain to be the most important test in the production of men among the Nguni-speaking communities which practise circumcision. Men who do not finish this phase owing to hospitalisation are viewed as failed men (Mngqolozana, 2009. The importance of pain was acknowledged by the participants: without it, there would be confusion regarding what is really being done or achieved.

> *It is part of our culture [pain], you see? So when you put an injection, penicillin and other types of things that when you go there you don't feel any pain. I mean, what is this now? You see* (Luyolo, 31 years old, community member, FGD).

Luyolo made this point in an intense debate regarding the extent to which conventional medicine could be involved in the ritual. Participants were unanimous that their rejection of VMMC did not mean a complete rejection by males of public health care. They acknowledged that today some Xhosa-speaking boys who sought out *ulwaluko* had infections that previous generations would not have had. These illnesses are viewed as contributing to the deaths taking place at initiation schools today. To prevent such deaths, participants deemed it acceptable for boys to first visit a clinic for a check-up and, where necessary, to receive treatment for chronic illness, provided that during the course of treatment boys were not anaesthetised and so could avoided feeling the pain essential during the *ulwaluko* ritual.

> *You can go to the hospital for medical check-ups, you see? To check whether or not your diabetes levels and high blood pressure are standing in good line and other things. But they should not inject you! They should not inject you that tomorrow you are going to go for your traditional circumcision* (Luyolo, 31 years old, community member, FGD).

Vincent (2008b) has cited pain as a fundamental feature of *ulwaluko* and the reason why men who undergo clinic circumcision are ridiculed and are not seen as 'real men' by peers who have undergone *ulwaluko*. Responding to advocates of medical circumcision, she argues that

circumcision using anaesthetic ignores the important role of pain, suffering and risk in the ritual as a way to demonstrate achievement of manhood.

Vincent (2008b) further notes the endurance of physical brutality, seclusion, dietary taboos and testing of initiates as central to the practice of *ulwaluko*. Participants interviewed echoed these sentiments. They viewed these features as defining manhood: the lesson of *ulwaluko* being that being a man means facing hardships stoically.

> *Because here [at the initiation school] you see, it's a process of pains at other times, you see? So I think, you leave here with your brains open knowing that in life you endure . . . There are many pains here, even that time that gets wasted [weeks spent at the initiation school], that passes by. That you can't only stay here for a week, so pain is another thing. Even waking up to not wash is a pain. And waking up, waking up to see shrubs is pain [*ulwaluko *is conducted in the bushes], and waking up to not see the people of your home is a pain, so there are many things that are painful here* (Mzonke, 35 years old, traditional attendant, FGD).

> *Listen. Firstly, you see? That person was not circumcised in a bush, he was circumcised in a hospital, you see. He was eating pap, porridge and soup and in the bush what is eaten is the . . .* Intsedeba *[dried samp]. There in the hospital, you do not eat that, you eat porridge and those soups, they are not the same. They are not going to get along. First thing, there in the hospital you do not traditionally wrap* [awutyami], *you tie a bandage. There in the bush you traditionally wrap* [uyatyama], *you unwrap in the bush* [uyawisa], *there in the hospital you change* [uyatshintsha] . . . *Changing what? You are changing a bandage at the hospital* (Mandla, 31 years old, community member, FGD).

What is striking about both these views is that pain is not seen as just physical in nature, but also as involving psychological and emotional discomfort. Having to adapt to living in the bush and to not bathe involves psychological strain. Not seeing loved ones for a substantial period of time causes emotional distress, just as eating dried samp, rather than porridge or soup, causes physical discomfort. All of these are tests of manhood and opportunities for male initiates to validate that they are real men.

The materials used to help heal the wound also emerged as important factors defining manhood in Mandla's thoughts. *Ityeba*, a belt made from goat skin, is usually used to bind and unbind wounds in initiation schools in Khayelitsha and other Xhosa-speaking communities. *Ityeba* is preferred as it links to tradition, i.e. how Xhosa male ancestors bound their wounds during

ulwaluko. It is also considered more painful to use this than to use a clinic bandage. This perception is based on how *ityeba* is applied. Dressings with *ityeba* are tightened around the penis. *Ityeba* is a tough material, which means using it as a dressing causes pain. The importance of *ityeba* is also linked to the importance of the goat in Xhosa society. A goat is seen as *iyeza* (medication). It is also seen as essential in mediation with the ancestors. Traditional Xhosa-speaking people believe good health is owed to the ancestors.

During an *uMgidi* (homecoming ceremony) I attended while doing my fieldwork, I observed such glorification of pain, and reported reactions to the absence of pain. Young men between 23 and 33 years of age rose to address men in the same age group at *indlu yesibane* (the house of the lamp) (Mnggqolozana, 2009), and employed such a discourse of hardship to assert their manhood, drawing on their experience of traditional circumcision. The bush is reified as the place where real manhood is constructed, as opposed to the clinic or hospital which is viewed as a comfortable space and, therefore, representative of weaker masculinity. To illustrate this, one young man rose and said:

> *Thank goodness for your pain! [Figurative meaning: Greetings, fellow men!] A man is standing. A man that fell from a bed with white sheets inscribed R.S.A. will be busy with talking whilst I am still standing here at this kraal. I stand here as a real man [that has undergone the pain]. I rolled and caught fire. A man that does not understand this thing that I am saying, I will observe by speaking whilst I am still speaking, and we are going to have to ask him to leave this place..*

This statement centralises pain as important and as what brings men together at the house of the lamp. It is further evidence of the role that pain plays in Xhosa-speaking men's performances of gender identity. The statement positions circumcision performed in the bush as superior to that performed in hospital or clinic settings, with use of rhetoric that presents *ulwaluko* as the standard that all men should measure themselves against. This is one way in which *ulwaluko* is performed and normalised as an ideal masculinity without the use of force.

Carrigan, Connell and Lee (1985) argue that excluding force, hegemonic masculinity relies on traditional ideology. The speaker uses ideology when he invokes traditional laws concerning *ulwaluko* and when he expects people to listen to him because he has undergone *ulwaluko*. He also uses ideology to distinguish men who have been to *ulwaluko* from men who have undergone circumcision in a medical or clinic setting. Men who have undergone clinic circumcision are judged not only for having slept in beds with white sheets with the label

R.S.A. (which is perceived as showing weakness), but also for not having followed traditional ideology: when a man who has been to *ulwaluko* speaks, all other men should listen.

Participants said two factors separated boys from men. One is the language of manhood known as *isidoda* that initiates learn at initiation school. The second is the circumcision mark on the traditionally circumcised penis. The language of manhood is known only by men who have undergone *ulwaluko,* as the language is only taught at initiation school, and is supposed to be a closely safeguarded secret communicated only to initiates during healing, to ensure that those who possess the language are men who have endured the pain and hardship of *ulwaluko* (Mayekiso, 2017).

> *Eh, when you get there in the bush [to the initiation school] my brother, you get there and find elderly people of there, you don't stay alone there. There are people who are men who stay with you. For example there are* amakhankatha *[traditional attendants], those are things that you find when you are out there in the mountain* [*at the initiation school]*. Iingcibi *[*traditional surgeons*], you see those things?* Amanqalakatha*, so it's new languages that you learn there. And for example, even there in the bush there is a small language of there. For example certain things get called by certain names, you see? So it's where a person becomes easily identifiable that he is a man or not. A person who had his circumcision at the hospital does not easily come to know the things that are done in initiation schools. A person can go to a hospital right and come back to wear these things that we say are put on by* amakrwala *[newly-initiated men who adopt hat and suits to identify themselves as men coming back from* ulwaluko*] but his peers will know him when they interrogate him about manhood [that he got circumcised at a hospital and not at an initiation school]. There is something that is called* ukudodisa *[interrogation about manhood], you see? When his peers go to him they will find that this person knows nothing* (Luyolo, 31 years old, community member, FGD)!

As is evident in Luyolo's comment, language validates one's manhood to others. The language is based on the full experience of *ulwaluko,* and is used by initiated men to communicate with one another about manhood, preventing those who have not undergone *ulwaluko* from masquerading as men. Scholars have written about *isidoda* language, with all arguing that it is used to prove one's cultural manhood to others, and also to prevent those who have not undergone *ulwaluko* from accessing masculine spaces and privileges (Mngqolozana, 2009; Mfecane, 2016; Ngwane, 2004; Ntozini & Ngqangweni, 2016; Vincent, 2008a).

However, participants observed that there is a difference between men circumcised in *ulwaluko* and in medical settings not only in terms of use of the *isidoda* vocabulary, but also in terms of scarring of their penises. It was said that penises of men who have completed *ulwaluko* are not stitched, but have a dark scar for the incision as they heal naturally through wrapping and unwrapping, whereas the penises of men who have undergone MMC tend to have stitches. Participants viewed a penis that is unstitched as representing real manhood, i.e. a person able to endure the pains of *ulwaluko*. A stitched penis was viewed as a forgery and represented lack of manliness.

> *Another point that I have is that where it also differs [VMMC from* ulwaluko*] is that it takes about two days or one but two days maximum [VMMC] . . . That person is done what he is done there and by tomorrow that person is in his home. Me on the other hand, I am sitting there even though both of us have been cut. Just as he . . . I have a special way of describing what happened to me during* ulwaluko *[making reference to* isidoda]. *I am circumcised with umdlanga* [*ndidlangiwe*: meaning, I have been circumcised with umdlanga] *and that person there is circumcised with a blade there, you see? And after that, what got done to him? He got stitched, you see? I never got stitched, I got myself healed, you see? By traditionally bandaging* [ndityama]. *I was traditionally wrapping* [zandityama]*! He is bathing there every day! He wakes up here in his house, he wakes up here in his house . . . And he bathes whilst I am not bathing so there is nothing, what makes that person to be a man to me, you see* (Zolile, 22 years old, community member, FGD).

Participants mentioned inspection of the penis for evidence of scarring as provision of evidence regarding the type of circumcision which had been carried out. They said this usually occurred as a last resort when an individual had failed to convince other men about his rite of passage to manhood being authentic. Participants were confident that they could differentiate between the penis of a man that had undergone VMMC and the penis of someone who had been through *ulwaluko*.

> *Yes, for us to know that you are a man, can come together to go look at you [your penis]. Yah, it is* isiko *[the* ulwaluko *circumcision mark] so we can see that for real you have gone past this place* [ulwaluko]. *We will see everything. Even on him [a medically circumcised man] we will see because it is, it is not an* isiko *[*ulwaluko *circumcision mark] but a circumcision that has been done a different way. I have never been to the*

hospital and that is why I cannot tell you but there is nothing that I cannot see. You see a donkey. Do you know a donkey? It has a dark mark, it has a dark mark here, that thing that has cut it. That is the umkhango *[zig-zag] of a donkey. You see that thing that every donkey has? That is a mark that is a zig-zag [imprints of stitches]. There is no way that you can never be able to see it. If you can't, it is a zig-zag. If it has turned around [the penis] you can see it. You see what I am talking about?* (Zandisile, 65 years old, community member, individual interview).

Vincent (2008b) has reflected on such inspections, and argued that a man with 'cat claws' – scars from stitches that suggest a medical circumcision – may later even be assaulted by other men for avoiding the pain of *ulwaluko,* yet 'masquerading as a man'. Participants confirmed this perspective by saying that a man who had undergone VMMC but pretended to have been through *ulwaluko* could be assaulted as punishment for the deception.

Because this is something of manhood and manhood does not rub off. You will not attain manhood because I feed you with that nonsense [language of manhood], that I feed you with in terms of what to say when someone says a particular thing, or that I tell you that when you are a man you do things this way and that way. If you did not go there in the mountain you will not know that thing, you will say things that do not connect and you will be beaten, do you see that thing? You will say things that do not mix and you will be beaten. You will be beaten after that (Zolile, 22 years old, community member, FGD).

Most participants viewed a man – *indoda* – as someone who had completed the full process of *ulwaluko* without resorting to medical assistance. This was seen as important for the authenticity of the ritual, and to ensure that the transition from boyhood to manhood was successful. Participants who resorted to medical care were seen as having failed the manhood test of bravery.

Others go there in the bush [initiation school] and fail because of things that happen there only to hear that he is in the hospital. When he comes back he is not a man like those who withstood there and finished their thing there in the bush (Luyolo, 31 years old, community member, FGD).

Firstly, I will mention the issue of hospitals. Yes, in the hospital when they said at home you want to be initiated, you get taken to the bush. You move from the bush to the hospital; that is unacceptable. That is one of them that I can mention. . . It happens

sometimes that an initiate gets stolen [taken secretly by family members] to be sent to the hospital, only to be brought back to here! You see? And to be brought back here again. And when he is sent back to his home to be sent back at night. Yes, those are some of the things that were happening in the olden times of our fathers but in the times that we live in, no, they are unacceptable. They do not go well with Xhosa culture. Should you go to the hospital, remain there in the hospital, and be sent back to your home by your family from there in that side. Because that is not acceptable, it does not go hand in hand with Xhosa people's tradition. We will have to burn your house [makeshift hut][2] (Lwazi, 35 years old, traditional attendant, FGD).

Individuals who failed the test were seen as incomplete and unacceptable to peers and in ritual spaces where manhood was discussed. Individuals were stigmatised, and suffered rejection and for having been circumcised at a clinic or hospital. They were treated with contempt and ridicule as if they embodied an inferior status.

I am trying to say when you are a boy and have never finished your things of manhood [by going to the clinic or hospital], it does not matter wherever you go if you did not finish what you went there to do, you have no worth! You see? You have no worth in the community of men. You see (Zolile, 22 years old, community member, FGD).

Rejection of a medically circumcised man was reflected as normative cultural practice. However, if an initiate had to be hospitalised following performance of traditional circumcision (*ulwaluko*) because of botched surgery by the traditional surgeon, inadequate aftercare or complications arising during the healing process, it was sometimes seen as acceptable for the initiate to receive conventional medical care. Here the decision to seek conventional medical care had to be made by community members; the decision could not be taken by the initiate himself.

There is a young man here, I was still a young man at the time maybe it was only still my third year that I had been initiated. This guy got circumcised with his peers. I should say . . . if you see with this certificate thing that we had spoken about of traditional surgeons. This guy got circumcised good enough, we accompanied him in the morning and when we got there we called his traditional surgeon. This thing that this traditional surgeon did, there is something that is called ukujikijela, *right? One needs to be*

[2] Meaning that he will not be able to come back and finish his process, and is viewed as failed the test of manhood.

circumcised quickly. But what became apparent was that the traditional surgeon was damaging the child and we didn't have any other choice but to beat this traditional surgeon because he is ruining a child. Now because the child was excessively bleeding we felt obligated to take him to the hospital to stop that bleeding. He went even now. He got sutured and came back to finish his thing [initiation] here. We understood his situation because some of us go there knowing nothing, you see? Only wanting to be initiated only to find that there is a man that will ruin you. To ruin you and to ruin your thing. That man, my brother, is still alive today and we know his situation that he went to the hospital out from our own permission. But we are not saying he is a nofotyela *[a derogatory term for a man who is not a real man, but postures as one], you see? I just wanted to clarify based on those conditions* (Themba, 34 years old, community member, FGD).

These views suggest that manhood – *ubudoda* – is negotiable, even if it is usually presented as a fixed construct (Mngqolozana, 2009). The difference between a man who has undergone VMMC and one who has undergone *ulwaluko* is sometimes blurred, and may be redefined by the male collective. Such a flexible definition of manhood was expressed by Zandisile. He thought that a community member could be accepted as a man if his parents informed the community that they had compelled him to undergo VMMC. The parents would have to provide convincing justification for their decision, such as the boy being in frail health.

… maybe he wants us to have his knowledge of him as a man he must come back from there [the health facility]. He has parents, right? He does not go there on his own. I do not think he goes by himself there. Now parents are the main people who are going to confirm that indeed the situation is like this. From our side you see once parents become involved is when we will also not take matters to ourselves when it comes to him. For us to accept him, his parents would have to come up with reasons why he got circumcised there. Yes, he can become circumcised there, we acknowledge him he is a human being but bring your things for us to be able to accept him. Bring the truth (Zandisile, 65 years old, community member, individual interview).

Those who had resorted to medical help prior to completion of *ulwaluko* would not be considered men even if they chose to undertake *ulwaluko* a second time. Permission to seek medical help had to be granted by older and more experienced men.

> *. . . we had an initiate also who got circumcised in 2009 and ran away and again went for* ulwaluko *in June when we were going in 2010 [to the initiation school]. He went again and stayed there [at the initiation school], so of which both of those people I cannot sit with them because I didn't get circumcised twice, I got circumcised only once and stood for my manhood* (Zolile, 22 years old, community member, FGD).

Participants provided various reasons for rejecting initiates who used medical facilities to complete the circumcision process. The first reason given was that medical facilities were not sacred, i.e. they had not been blessed by the ancestors for *ulwaluko*. Xhosa ancestors were uncomfortable about use of medical facilities, and consequently they did not accept *ulwaluko* completed in such a setting.

> *Ay, and another thing our ancestors, our ancestors, our forefathers left us behind telling us about things of Xhosa [culture]. A hospital, from the 80s, to the 60s, yes they were saying certain things will modernise, certain things will change, but they didn't say that we should change and follow from there. They said that we should follow their own way. So when you go to the hospital I feel that you lose your ancestors of your home because it's not something a hospital that is like. . . It's not blessed for you to worship it that ay, I got circumcised at a . . . [hospital]* (Mzonke, 35 years old, traditional attendant, FGD).

A second justification was that medical care was based on Western values and laws, and use would not meet the objective of *ulwaluko*, i.e. to inculcate in the initiates the laws of their people.

> *The difference is that when you leave here [initiation school], when you are here you are worshipping many laws of Xhosa-speaking people. When you walk out from the hospital, you worship laws of white people, coloured people. So I think us here we come to have the laws of people of our tribe. So you on that side, you end up worshipping another tribe's laws. You see? Because they are not going to give you any rules on what you should do after this and that. You see* (Mzonke, 35 years old, traditional attendant, FGD).

The third justification given was that contact with medical facilities would violate the taboo of initiates having no contact with females during the initiation period.

I sometimes hear from people, I sometimes hear from people that, okay, when other people are not well here in the initiation school they run to the hospital, you see? Which means that thing is not right . . . . They will be sleeping on a double bed [initiates sleep on the floor at circumcision initiation schools], you see? So the nurse [woman], will see this thing that she is not supposed to be seeing [the circumcision wound]. You see? To say no this child is injured she should also assist even there [at the penis], which means it is not right [the circumcision wound is considered to be holy] . . . because when you are here in the initiation school sleeping with your blankets, you turn and keep on turning knowing well that there is fire here, knowing that the first thing is fire [element of real danger]. You see? When you are there in the clinic you are not going to turn and meet [fire], you will meet this thing, tiles, you will fall on top of tiles, you see? Which means that thing is not right you see? You also don't have to be always touched by women. And when you are there you are touched by women but when you are here in the initiation school there is no woman here in the initiation school. So women will see things that they are not supposed to see (Siboniso, 22 years old, initiate, individual interview).

Mavundla et al. (2009) reported similar findings regarding *ulwaluko* for health care practitioners. They comment that admission to formal health care is believed to violate many cultural norms.

Beyond the importance of *ulwaluko* as a sacred rite to introduce young males to the ancestors' ways (referred to as 'laws') was the belief in ritual as an important vehicle to preserve the social order. Participants stressed a connection to social order, asserting that without *ulwaluko* there would be a surge in gender-based violence and crime, since boys would not learn responsible adult behaviour, but would be left to their own whims.

The thing that I love the most here is that these boys learn well here to be able to handle their wives. To be able to respect a female. To not be there busy abusing our mothers. To see a boy chasing his mother with a piece of wood demanding to receive bread. They should walk out here knowing how to handle a female (Thamsanqa, 33 years old, traditional attendant, FGD).

Violence would sky-rocket [without ulwaluko*], even crime would sky-rocket. Because you have already heard me even now that we teach here these boys that when they leave here they must leave behind all the bad behaviour that they have been up to when they*

were boys. Now, when you just go to the hospital, who is going to teach you about responsible adult behaviour (Thamsanqa, 33 years old, traditional attendant, FGD).

So I don't know what, even when I hear that he [a medically circumcised man] went to [the hospital], even when I see that television advert [Brothers for Life VMMC campaign] that this boy just went to the hospital I just think to myself what if he goes to the hospital and comes back to do the bad things that he was doing. Because he was not thought to be changed (Mzonke, 35 years old, traditional attendant, FGD).

Pinnock (2016) has described the important role of *ulwaluko* in moulding boys with untameable spirits into socially responsible adults with self-confidence and deterring boys from engaging in violence. Many participants expressed this view. For example:

… there is no man that can have a fight with another man, a man only uses dialogue to resolve conflicts, a man only uses peaceful dialogue. A man resolves a conflict with another man through dialogue, men resolve conflicts through dialogue. There is no fighting. Men engage in respectful dialogue with one another (Zolile, 22 years old, community member, FGD).

Initiates perceived *ulwaluko* as ushering in a new life stage. Undergoing *ulwaluko* meant pursuit of an ethnic masculine cultural identity with privileged access to the cultural knowledge of Xhosa-speaking men, who had acquired it in the same way. Thobela expressed his feelings regarding initiation school and *ulwaluko* as follows:

*No, I feel like, that I will always be similar to other Xhosas who refer to themselves as Xhosas [with great pride]. Because here I am, I can say I have transitioned to another stage. I have transitioned to a stage that I did not know, that of manhood (*Thobela, 22 years old, initiate).

Manhood was construed as ensuring social acceptance from men who had undergone *ulwaluko*, and as well as enabling access to cultural spaces from which they had previously been excluded. Participants anticipated that their change of status would entitle them to the respect of younger males in their communities and those who had not undergone *ulwaluko*.

Okay, I was taken lightly there in esiXhoseni *[at the community] as I was left behind by my peers do you see? I was taken lightly like . . . like. . . yes, they are younger than me but okay they had been to the place, this place [initiation school], so now it makes me to feel . . . like in many things when I am sitting with them, I am always being chased*

away, I am always being chased away. You see? That I should go away. I am sitting with iJuvi[3] *that I am still this thing and that thing you see? So that is that thing which made me to also want to come here you see? So that I can also okay be able to sit with them. Even in the community, they wanted me to finally get circumcised. Wherever I was walking I would be asked by this man: 'Hey, when are you getting circumcised, to be even left behind by your peers?' These are some of the things that were also tormenting me. I am expecting that maybe they will accept me now that I have done this thing that they also did* (Siboniso, 22 years old, initiate, individual interview).

I am happy for being here because I have long thought of coming here but it was circumstances that were preventing me from coming here. So I am happy for being here because all of this thing has gone past [the wound has healed] . . . I have also now passed, I am a man now, I am no longer a boy . . . because there are many places now that I will be able to gain access to that I could not go to before, that of Xhosa, when there are cultural functions (Banele, 21 years, initiate, individual interview).

I can say . . . yes, I am also in a hurry to be ubhuti *[a bigger brother], seniors, my juniors who come behind me, to hear them calling me* bhuti umlomo ugcwale *[big brother all the time]*. Bhuti, bhuti, bhuti, *even other people who are around in the community they will also do the same. So in all, I will also be a man like other men* (Thobela, 22 years old, initiate, individual interview).

These views accord with the findings of a study conducted in East London by Mavundla et al. (2010) to explore the experiences of newly initiated men. They found that the main motivation to undergo *ulwaluko* was fear of rejection by community members. Males who had not undergone *ulwaluko* were marginalised – referred to as 'dogs' – and denied access to social spaces such as shebeens or inclusion in cultural ceremonies. They reported pressure to undergo *ulwaluko* from the community at large, from their families and peers, as well as from the opposite sex.

Rejection by the community was mentioned by Siboniso, Banele and Thobela. Siboniso reports that the community at large marginalised him: peers and community members asked him when he planned to undergo *ulwaluko*, and he was referred to pejoratively as *ijuvi* (a 'dog'). Banele and Thobela reflect that before they undertook *ulwaluko* they were not fully accepted by their

[3] "Juvi" means 'dog', and is used because an uncircumcised man is like a dog, since his foreskin is still intact just like a dog's tail. It suggests too that an uninitiated male is not fully human.

communities, they were denied access to certain spaces and community members did not respect them.

Vincent has written about marginalisation and stigmatisation of Xhosa-speaking boys who have not undergone *ulwaluko*, arguing that these processes reflect a shift in the meaning of *ulwaluko*. She argues that instead of socialising boys and getting them to assume a responsible adult role, *ulwaluko* has become a gateway for sex: males who have completed *ulwaluko* exploit their status to obtain sexual access to female partners of males who have not undergone *ulwaluko.* However, I find myself disagreeing with Vincent on this issue. To me *ulwaluko* seems to be a mechanism to discourage this. Boys who have been through *ulwaluko* are usually encouraged by their traditional attendants, families, friends and neighbours to start to date with the purpose of finding a right partner to settle down with as *indoda yakha ikhaya* (a man reconstructs the family name). Frequent changes of sexual partner with no intention to settle down with any is a behaviour associated with boys, and not with men.

Contrary to Vincent's argument, participants viewed *ulwaluko* as giving them the right to take a wife – privileges denied to them prior to undergoing *ulwaluko*.

> *It's that thing that we want right as people to go to your community, to go appear, to see how the difference is going to be like with the changes that have happened because ultimately we want to achieve what we could not achieve as boys because here we got to learn a lesson that now you are born again, you are now a man, the things that you were doing at the time that you were a boy have been taken away. . . My desire now is to find a job, to do things that I did not do when I was a boy. My objective now is to take a wife because I have been through many things* (Ncedisa, 25 years old, initiate, individual interview).

Ncedisa sees *ulwaluko* as a rite of passage that means that now that he is a man he should have a wife.

Conclusion

This chapter reported on contemporary perceptions of manhood by a sample of Xhosa-speaking men in Khayelitsha who had undergone or who were undergoing *ulwaluko.* The context of the research was that it followed the introduction of VMMC by the South African government to help prevent HIV. The chapter reported on themes that emerged during interviews and focus

group discussions conducted with these individuals. This chapter has shown how *ulwaluko* is highly valued by this group of men. Thematic analysis revealed that the traditionally circumcised Xhosa-speaking men who were interviewed did not appear to have changed their negative perceptions of VMMC. Participants continue to see men who have been traditionally circumcised as superior to males who have not done so, and to males who have undergone VMMC. They see only traditionally circumcised men as permitted to participate in family meetings, to preside at rituals, to inherit property, to engage in discussions about manhood, and to have access to certain social spaces.

CHAPTER 5 "YAH, YOU ARE NOT THE THING THAT I AM, YOU CANNOT SIT, YOU CANNOT SIT, LIKE A WOLF DOESN'T SIT WITH LIONS."

The previous chapter dealt with conceptions of manhood of participants living in Khayelitsha who had been traditionally circumcised. It concluded that *ulwaluko* remained a powerful and definitive marker of masculine identity, and that it was still informed by notions of culture and tradition. This chapter discusses how men who have undergone *ulwaluko* perceive men who have undergone VMMC. I argue that the perceptions of men who have undergone *ulwaluko* towards medically circumcised men have not changed after the introduction of VMMC despite some awareness of VMMC as a government intervention instrument to reduce new HIV infections.

A dominant theme in the transcripts of interviews and focus group discussions was the perception that men who had undergone VMMC were different to men who had undergone *ulwaluko*. Men who underwent VMMC were seen as having failed to follow the tradition of *ulwaluko* prescribed by the ancestors, and as having adopted a Western cultural practice unrelated to *ulwaluko*. Participants viewed VMMC as a practice which was linked to individualism, and not connected to the African belief system of *ubuntu* that many Xhosa-speaking people understand as underlying their culture. *Ulwaluko* is seen as conforming with *ubuntu*.

Ubuntu is an African worldview which is elucidated in the Nguni maxim, *Umntu ngumntu ngabantu* (A person is only a person through others). Hence an individual's humanity derives from his or her interactions with others in the community (Mfecane, 2018; Shutte, 1993). Such interaction is not restricted to the living but can also occur between the living and family members who are deceased and who are known as *izinyanya* (ancestors). Interaction with ancestors occurs through practices such as the offering of beer by pouring it on the ground and the slaughtering of animals for consumption by the ancestors. Such practices align with the values of *ubuntu*, which are understood to include selflessness, respect for human dignity, compassion and empathy for others. A person who exhibits these qualities is said to embody *ubuntu*.

An example of the enactment of *ubuntu* in an African community is the response of the community to a newcomer and stranger. It is likely that the newcomer will be greeted with warmth and interest regarding his or her origins. Information about the individual would be solicited, as well as the identity of the human community into which the newcomer was born

and in which they were probably raised (i.e. the newcomer's clan and their place of origin), and which provides the individual with a sense of connectedness. When a newcomer provides such solicited information to one or more community members, it is common thereafter for the newcomer to then be informed about which individuals in the new community they are most closely related to, and how they are related, which endows the newcomer with a renewed sense of belonging.

In most African communities *ubuntu* is also expressed through all the members of a community sharing each individual's joys, sorrows, losses and triumphs. An example of this occurrence is when the entire community participates in mourning for a community member who has died, regardless of whether or not the deceased was related to other community members. Community members visit the bereaved family to express their sympathy and support. Similarly, if a household has been blessed by the birth of a child, community members will flock to the home to be introduced to the young child, and they will want to celebrate the birth with family members. Both celebrations and funerals are attended by all members of the community, regardless of class, gender or age, and often without formal notification regarding the event or an invitation to attend needing to be sent to everyone.

There has been criticism of *ubuntu*. Louw (2006) views its desire for consensus and communal understanding as too easily derailed and then capable of changing into an oppressive collectivism or communalism if the individual fails to conform to community norms and is then punished by being ostracised. Gathogo (2008) criticises *ubuntu* for supporting tribalism and clan rivalry, which can lead to open conflict if one group perceives its members to be inherently superior to members of another group. He argues furthermore that *ubuntu* fails to accommodate women, as shown by the absence of women in positions of authority, and even worse, in positions of national leadership across Africa. (Ellen Johnson Sirleaf of Liberia is one of very few African women who has been a national leader.) Gathogo suggests that polygamy and domestic violence are problems which *ubuntu* fails to address. In his view, although a person is a person through other persons (as *ubuntu* asserts), this worldview serves boys and men more favourably than it serves girls and women.

Mnyaka and Mothlobi (2005) disagree. They maintain that through *ubuntu* persons are recognised, accepted and valued in their own right regardless of social status, gender or race. They argue that this is true since *ubuntu* is informed by a core belief in the inherent dignity (*isidima)* of all human beings, which makes every person divine and, therefore, deserving of

respect. Moreover, they argue that anything that undermines, hurts or threatens human beings is not accommodated by *ubuntu.* They dispute the idea that *ubuntu* could take the form of communal oppression of an individual. Rather, they argue, ostracism of an individual who does not conform to group norms functions to maintain social order, and is not a disregard of their personhood. They contend that individuality is rejected as it involves dangerous elements which could disrupt the functioning and well-being of the society. Given examples of the failure of *ubuntu* in South Africa, they offer as explanation the impact of colonialism, apartheid, urbanisation and the struggle against apartheid.

Given the precept of *ubuntu*, study participants viewed men who had undergone VMMC as having transgressed community norms, and they suggested that VMMC was an individualistic programme which had no support from the collective. They believed that individuals who underwent VMMC had rejected *ubuntu*.

> *He will be going there [to the clinic] for something that he does not know. That thing [VMMC] has got nothing to do with the Xhosa tradition. You are going there for something that you don't know because the tradition is not only about the removal of the foreskin, it's about this place that you grew up in, that you stay at* (Mzukisi, 25 years old, community member, FGD).

> Just. . . *Go do to yourself that thing you are doing to yourself [VMMC]. You yourself alone are making yourself a human being, right? To outdo who? The majority. So you are running away from the majority. You want to isolate yourself. With whom are you going to speak after that? Go speak with the clinic! All the time you are a man of the clinic. What do you want me to say? Is he not a man of the clinic? Don't you want me to say he is a man of the clinic? And me, I do not allow that. I do not allow it at all. I don't allow it at all* (Zandisile, 65 years old, community member, individual interview).

Menkiti (1984) does not see African thinking characterising personhood as a given, but rather as something that is achieved and defined by and through the community. An individual may have physical and psychological characteristics, but these do not necessarily make him a person. Menkiti (Ibid) argues that African thinking asserts that a human being becomes a person only after a process of 'incorporation'.

This postulation of personhood is consistent with the Xhosa sense of personhood. In Xhosa society, the fact that an individual is alive does not in itself make them a person (Mfecane, 2018). Personhood is acquired through participation in rituals of incorporation over the course

of a lifetime. Amongst amaXhosa, *imbeleko* is the most common ritual of incorporation for children (Ncaca, 2014), by means of which a child is introduced to his or her ancestors and they are asked to provide ancestral protection (Bogopa, 2010). The ritual involves, among others, the slaughter of an animal by a family representative and the child consuming certain sacred parts of the meat (Mfecane, 2018). Community members participate in this family ritual, acting as witnesses of the ritual. Other rites of incorporation which are also public ceremonies mark transitions to adolescence, adulthood, parenthood, manhood or womanhood, old age and joining the ancestors (Mfecane, 2018; Ncaca, 2014).

Given the agreement between Menkiti's view of personhood and the concept held in Xhosa society, personhood is clearly bestowed by the community rather than existing outside it. Two participants felt that a man that had undergone VMMC had moved away from the communal definition of personhood, and sought to make himself a person on his own, contrary to *ubuntu*.

Other participants said that *ulwaluko* was inextricably linked to *ubuntu*, and men who underwent VMMC were not engaged in *ubuntu*. Taking part in *ulwaluko* was seen as a way for boys to demonstrate to their communities their appreciation and respect for communal cultural values and traditions linked to *ubuntu*.

> *A person who got circumcised in a hospital to me now, where is his* umojiso *[a collective cultural ceremony in which an initiate is given roasted meat to eat]? That means that things of* isintu *are not there in all of that thing, there is only the system that is working there, you see* (Zolile, 22 years old, community member, FGD).

> *You cannot live by yourself my Ta, a human being is a human being because of other people, I should just put it that way. You see? When you are excluding yourself from people [by undergoing VMMC] you are isolating yourself and that is why it is said that you should not think of yourself as higher than other people a lot, you see? Even if your social status is high but he is a black person and when you see him there look after him because what? Your things will start to go backwards, they will start to go backwards. I am talking of things like that, my brother* (Cebo, 31 years old, community member, FGD).

During the well-defined stages of *ulwaluko,* families of boys undergoing the process typically perform ancestral ritual sacrifices which involve participation by the whole community (Mayekiso, 2017). An example of such a ritual sacrifice, as a family prepares to send a son for *ulwaluko*. is *umngcamo,* which Ngxamngxa (1971) describes as a ritual animal sacrifice

directed to the ancestors to attract their blessings to the boy. Community members participate during the ritual. Men usually congregate at the family kraal to support the family and to prepare to take the boy to the bush, where he will undergo *ulwaluko*. Women from the community usually support the boy's mother in the domestic sphere, typically within the home: they may sing to offer assurances to the anxious mother that her son is resilient and that he will return safely as a man from *ehlathini* (being in the bush), as so many boys in the community have done previously. In addition, if *imbeleko* was not performed for a boy shortly after birth, then the ceremony is carried out two to three weeks before the boy goes into the bush (Ncaca, 2014).

All these ritual sacrifices and communal practices provide an opportunity to demonstrate *ubuntu*. Participants felt that since VMMC has no similar enactments, men who agree to undergo VMMC do not demonstrate *ubuntu*. Possibly in other communities across South Africa, families of boys who undergo VMMC may observe new rituals, but amongst the Xhosa-speaking men in Khayelitsha who had undergone traditional circumcision, for whom VMMC was still taboo, this appears to be a rare occurrence. Lwazi, who was born in the Eastern Cape and grew up there, said:

> *This VMMC thing to me sounds exactly like the medical male circumcision that has long been happening. I do not see any difference between them. I reject the clinic [VMMC] the same way that I reject the hospital [MMC]. I reject it because in the clinic this tradition is not there that is done here. There is no tradition that is done there as our fathers said that this thing of circumcision is a tradition. There is no tradition that is done [at the hospital]. They are not slaughtering any beast, they are not sacrificing any beast for the ancestors, nothing is being offered as a sacrifice to the ancestors. But the only thing that is done is that you get circumcised and walk out of the door* (Lwazi, 35 years old, traditional attendant, FGD).

> *And you cannot deceive us and say that you are a man. No, no, he is not going to come sit with us when we are doing something to do with cultural functions,* isintu[4]*, because he did not give me* isintu*. He does not have it, he does not know it. So I don't see the point that when I am doing* isintu *that he also comes to do* isintu *which he does not know* (Mbulelo, 24 years old, community member, FGD).

[4] Word means Ubuntu, or practices of Ubuntu.

Traditional attendants who were interviewed also felt that medically circumcised men did not demonstrate *ubuntu*. They argued that by going through VMMC these men effectively snubbed traditional attendants who help boys transition from boyhood to manhood, as well as repudiating the sacred knowledge usually acquired during *ulwaluko*.

> *We will reject them because it can be said that those people are rejecting these things that we were going to teach them* (Mzonke, 35 years old, traditional attendant, FGD).

> *There is no relationship there. There is no relationship there [between us and them]. That one who got circumcised in the hospital, stand very far away from me! There is not a single thing that I will even say to you. Even if we are meeting at a pub, at a shebeen, even if you know me, no matter how it is that you know me, there is nothing that I am going to say to you. I do not even have a 'hi' or a 'hello' to you when you are a Xhosa and have* ulwaluko *as your tradition but have done that thing [VMMC]. Let me say you are a Shona, let us say maybe you are a Zulu, Zulus used to not get circumcised but they are getting circumcised now. As a Xhosa if you get circumcised there in the hospital, there is nothing at all that I will even say with you, when you have not come here to me to do what I did. I hope that I have been heard* (Thamsanqa, 33 years old, traditional attendant, FGD).

Since VMMC is perceived to be a western cultural practice, most participants held the view that men who had undergone VMMC had sold out on their traditions.

> *. . . They are selling our tradition. They are selling it. He sold out his tradition to white people* (Siseko, 20 years old, initiate, individual interview).

Underlying the perception of being a sell-out was the belief that whites were relentless in their efforts to colonise Africa, and to destroy African traditions and the African way of life.

> *Ja, but at the same time my brother, you should understand that the West is still trying to colonise us. The West to be honest is considering us to be barbaric . . . Some of the things that we do, they consider to be barbaric, like things of undergoing traditional circumcision; they take it man as if it's stupidity to them. To be smeared with those things that are white*[5]*, to white people that is something without any sense but at the*

[5] During the process of *ulwaluko* initiates smear their bodies with a white ochre that is known as *ingceke* or *iKota*. This practice is perceived as important for protection against witches and snakes whose habitat is the bush. Ochre makes it hard to differentiate initiates from one another, as they appear identical. In this way it deprives witches of the opportunity to identify initiates whom they want to kill and turn into zombies

> *same time then what I am saying is that they are still trying to destroy it, they are still trying to destroy our culture, my brother, but now they are using other black people. They are still trying to colonise us and as a result in a hundred years' time here in South Africa English will be the language that will be spoken here by black people. I am telling you that after 100 years this country will be like the US. There in the USA there are many people who love it. What do they speak there in the USA, black people? What language do they speak? When they were getting to America, were they speaking English? Okay. So they were destroyed. They were made to not speak their African languages. We are also going to lose them because if you take notice when we speak you hear someone mixing with English. Our languages will die out. Our languages will disappear, including our traditions. . . they are going to die out* (Luyolo, 31 years old, community member, FGD).

As justification, participants made reference to early encounters between Xhosa speakers and Western Christian missionaries, during which the latter tried to persuade the former to abandon their culture, religion and customs for Christianity. According to Mtuze (2003), conflict between Xhosa culture and Western Christian culture occurred mainly during the nineteenth century. Participants characterised this era as marking the beginning of a major western onslaught on Xhosa identity, tradition and culture which was highly destructive of the way of life of Xhosa-speaking people, and which still continues into the present. They viewed proselytisation by missionaries as an attempt to rob black people of their identities.

> *It is foreign, yes [VMMC], and in terms of history we do know what these people came and did here. Their thing was to kill our lifestyle. They wanted their thing to be the one that dominates and to destroy that which is ours. They wanted everything. A black person if you are black must come to an end, traditions to come to an end, and you are Xhosa must end, and that which is theirs must lead. The brandy that is theirs must take the lead. You see? Those things which are ours must come to an end, they were exterminating them* (Themba, 34 years old, community member, FGD).

The brandy that the participant regards as an imposition on Xhosa-speaking people is the alcoholic beverage used during *ulwaluko* rituals as a vehicle for men to socialise, and also to appease the ancestors. Its continued use in Xhosa society is controversial. Those who reject

[Izithunzela]. It is also believed that witches sometimes send snakes to kill particular initiates. Other people believe that the ochre is essential to accelerate recovery as it reduces bodily fluids in the initiate which retard healing.

ongoing consumption view brandy as a vestige of colonialism that needs to be discarded. Those who accept consumption of brandy in Xhosa-speaking settings and encourage its use in traditional ritual consider arguments for banning it small-minded and petty, since they claim that it has already been used in rituals for years, and it has gained acceptance within Xhosa culture.

Themba views the ongoing consumption of brandy as evidence that colonialism retains its grip on Xhosa culture. He argued vehemently that brandy consumption should come to an end, and that amaXhosa should rather revert to consuming *uMqombothi*, a traditional sorghum beer which was brewed and consumed prior to the arrival of the colonists.

> *Yes, my brother let us look at* uMqombothi, *there is* uMqombothi. *We have this thing of putting* uMqombothi *at the back and brandy at the front. You see? Even when you have a dream you dream*[6]*the ancestors are saying to you, 'I am thirsty, brew* ifatyi *[a bucket of sorghum]. ' The ancestors never ask you for a brandy. We should take brandy as sweets [non-essential items and hence not key ingredients in a ritual]. You will never conduct a ritual that you say you had a dream and you are making it for those who are underground [the ancestors] and it is beers and brandies. You see?* Umqombothi *is the main thing. There should be the smell of* iintsipho *[wheat grain]. We should then take brandy as sweets, you see? Because men who are available who are here are used to drinking these things and we are in this time now but not to say that a brandy is what is going to drive the tradition. Brandy should not drive tradition. It's* izinwe *[accoutrements] when you see that your pocket is full and you want to be kind. But in other homes if you do go around you will find that I am crushing medicine*[7] *here. You will see no brandy and you will see no beer but only uMqombothi* (Themba, 34 years old, community member, FGD).

However, other participants in the same focus group disagreed on this issue. They argued that culture is never static, but that it borrows creatively from other cultures in order to revitalise itself and to maintain its relevance. The participant who was most vocal in expounding this perspective had briefly studied anthropology through the University of South Africa (Unisa). Nonetheless, discussions revealed the difficulties that the impact of colonialism still presents for some men in the community. Culture continues to be the site of struggle against dominant

[6] Ancestors communicate with the living through dreams.
[7] Traditional rituals and practices, are viewed as medicine, as a vehicle of good health and blessings. *UMqombothi* is one such traditional practice that is viewed this way.

colonial powers, and a cornerstone of resistance to the forces of globalisation and neoliberalism.

Despite the political change that has taken place in South Africa since 1994, when the country elected its first democratic government, younger participants expressed disillusionment with the transition process. They expressed this viewpoint particularly in relation to the introduction of VMMC. The year 1994 was not seen as having led to meaningful improvements in the material conditions of black people. Therefore, there was a belief that some senior leaders of the African National Congress (ANC), including President Mandela, had betrayed the people by enabling the emergence of 'democracy' rather than the emergence of 'freedom'. Freedom was defined as having access to employment, dignity and equality with white people, but still permitted to retain one's own cultural practices and beliefs. Democracy was viewed as a Western system steeped in immoral Western cultural lifestyles and traditions. Democracy was seen as destructive of local, indigenous customs and practices, and having no connection with realisation of genuine equality, as encapsulated in the participants' definition of freedom. In accord with this belief, they viewed the post-apartheid milieu as an environment where white dominance persisted, and black people were still subjugated and oppressed by the white minority, despite the advent of political freedom.

> *Really with this thing, big brother, I sincerely wish that we were first given a platform to expose, to like express our feelings, about how we feel should that thing happen [whether VMMC should be introduced], just because it is our what? It is our democratic right, you see? And now the way that it is being introduced, you see now it is going to even become relevant to politics because it is what? That way like, you have got rights as a person, you see? If we ever had freedom here in our home [South Africa], these things that are happening now would not be happening, you see? Why am I saying this? We live in a democratic country, not a free country, this is not a free country right? You see? It's a democratic country which means decisions are taken on behalf of us behind our backs. No one has bothered to tell us that they will implement for us VMMC, or to tell us what they think about implementing medical male circumcision, you see? I am just saying. I am making an example because they know that we would never agree, you see? Even this thing that of exposing our things on television, you see* (Zolile, 22 years old, community member, FGD).

No, in the words of democracy of today. My brother, people have got rights, you see? So an individual goes to where he wants to go, no one is going to stop you. A boy can say, 'No, I will go to Michael Maphongwana'. What will you do? You will not stop him. That person has his own rights, you see? So now there are too many rights with these freedoms that are here that there are even things like abuse, you cannot even hit your own child because that is called child abuse, do you see things that are like that (Luyolo, 31 years old, community member, FGD).

You see, I said this thing does eventually come to border on politics just because even on the speech of Chris Hani. He says yes he can see that a black person is attaining somethings in some ways but it does not state at what stage a black person achieves them. The primary or middle stage, or say the middle class, say middle class, upper class and middle class, you see? It does not state where the black person stands in terms of freedom. The oppression we faced during apartheid is still being perpetuated but it is now done in a subtle and sophisticated way, you see? It is being done systematically, and this thing of the introduction of VMMC can oppress other people because there are other people whom this thing makes them to be too emotional and angry because of their emotional sensitivity towards this thing. And a person can even kill a person because of this shit of a thing, that look here I got circumcised isiXhosa, I got circumcised isiSotho, isiHlubi, I am a Pedi, I am this and that. We are not whites. A white, even if he is significantly younger than the person that he wants to address, he addresses him by his name, we on the other hand do not have that thing, we have respect, we have procedures to follow. This means that person who got circumcised in the hospital will not know those procedures, not having been admonished by elderly men. And him not knowing those procedures, there is darkness before his eyes and as there is darkness before his eyes, even the future of children is blank (Zolile, 22 years old, community member, FGD).

When they heard about the national roll-out of VMMC, some participants saw the change in policy as evidence that white supremacy continued despite there being a black majority government in South Africa. White people were seen as having altered their tactics, and now used black people as pawns to serve their own ends by vanquishing them. Hence the participants stressed the importance of preserving African customs and traditions in order to retain vestiges of dignity, given the violence perpetuated on black people and on their culture.

Along the same lines, men who had undergone VMMC were judged as having failed to 'do the right thing', i.e. having failed to keep alive the ritual of *ulwaluko* and having chosen VMMC instead. Preserving the ritual was understood to be the duty of all Xhosa-speaking males.

> *And that thing ruins, it ruins even our tradition. If you are a Xhosa you are a Xhosa because a person is given birth to by a man* perhaps *[someone who has undergone* ulwaluko*] and that father does tradition accordingly and I come to do what you are speaking about of going to the hospital [VMMC]. My children, you understand they will follow me on what I have done. It is clear that my children will go . . . this way that I went through [VMMC]. Which means now it is dying, this Xhosa tradition is dying* (Gcobani, 24 years old, community member, FGD).

> *A tradition is dying because of those* people [men who have undergone VMMC]? *No, no, man* (Mbulelo, 24 years old, community man, FGD)!

> *But I would like to return to that point of politics I was talking about, that this introduction of VMMC could also be involving politics. We cannot run away from the fact that this is a democratic country, you see? And with it being a democratic country that does not indicate that we are free! Yes, according to how they put things we are free. But it is important that we remember that this freedom was imminent had Chris Hani not been killed. Yes we do have freedom of expression as our democratic right, you see? Now my question is, why is that right of ours being violated daily? You see? Why? They should have first come to consult us before implementing this medical circumcision thing, to come to hear our views about it first. 'What do you think about it?' You see? Things that are like that, things that are like that, you see? To only add, you see in that thing [VMMC] what is spoken about is not RDPs there or jobs, it is not jobs that are spoken about there in that thing. With this VMMC it is* isintu[8]*that is being undermined, it is our forefathers' ways of life that are being challenged with that thing, the ancient traditions of how our people lived in ancient times. Before a white person arrived here at this place, how did we use to live? You see that thing? That is the first question that a person will ask. I am just talking about this medical circumcision thing, I will ask myself how did our fathers, how did the forefathers of our forefathers, the first people, those who are black and looked like us. Those of Lesotho like King Moshoeshoe, is it not that they were living in their own ways and we were also living*

[8] The traditional lifestyle of Bantu people connected to their cultural values.

according to our own ways as the Xhosas? We used to live on mountains, right? I am just saying, I am making an example. We used to have our houses on mountains and there was nothing of hospitals and other things, and other things most of the time. You would have traditional medicine crushed for you and be healed, you see? But now with the arrival of the white person . . . with the arrival of the white man many things changed, you see? As a result, we have this medical circumcision that is now here trying to wipe away our traditions! But as I have been saying, a person who wants to go to be circumcised there in that side [clinic] I am not going to judge here, it is his democratic right but he should know only one thing, that there is a boundary between him and me! He has to constantly know that there is a boundary between me and him! It is not going to be removed by him and it is not going to be removed by me, that boundary remains fixed (Zolile, 22 years old, community member, FGD, emphasis is mine).

The manner in which Zolile links the introduction of VMMC to the absence of freedom is unsurprising, given the debilitating impact of colonialism and apartheid on African men's masculinity (Morrell, 2012; Suttner, 2007). During apartheid, irrespective of the age of black men, and whether or not they had undergone *ulwaluko,* whites referred to black men as 'boys', degrading them to a social status below that of white women and white children (Ramphele, 2000). Black men's enactment of their calling to be protectors, providers and decision-makers was undermined by apartheid. Black men could not be protectors because they were either physically absent, or else emotionally, economically and politically absent because of migrant labour, dislocated family structures and political activism. Black men were not able to play the role of the decision-maker or provider because of their absence or the lack of educational or employment opportunities as a result of the policies of apartheid (Ibid).

Hence for most black men freedom came to mean emancipation of their masculinity from the oppression they experienced under the yoke of dominant white masculinity (Clowes, 2003; Xaba, 2001). Suttner (2007) writes that the struggle to be a man meant a struggle for dignity and reclaiming of rights and a struggle to be treated as an adult human being. Given this history, VMMC would naturally engender debate regarding the veracity of the claim that South Africa is a liberated country, when African masculinity and indigenous African cultural practices are still undermined.

I have heard about it man, that the reason why people are pushed to get circumcised in the clinic is to reduce the rate of HIV. To me it seems that it is also reducing our

custom, our culture and our traditions. . . (Mzonke, 35 years old, traditional attendant, FGD).

Importantly, participants did not only perceive men who had undergone VMMC as having sold out on their traditions to white people, but as also having abandoned their identities and as having experienced identity change. This perception was interestingly captured through use of the idiom *ukuguqula ibhatyi,* an idiomatic expression which had a very particular resonance during the apartheid period (see Ratele & Shefer, 2003). *Ukuguqula ibhatyi* is a term in isiXhosa that literally means overturning a jacket, or putting it on with the jacket turned inside out. A jacket as an entity belongs to an individual, but in Xhosa society it is also an entity that carries the symbolic meaning of masculine identity and dignity[9]. In Xhosa society, it is customary for a man to wear a jacket when he attends a formal ceremony such as a cultural function or a funeral. The jacket is usually worn as a sign of respect, and to convey dignity and maturity. During apartheid the idiom *ukuguqula ibhatyi* took on a derogatory meaning because it was associated with certain individuals who applied to the authorities to change their race classification in order to acquire membership of a race group with a higher social status and more material privileges than the racial category they had been assigned to at birth (Ratele & Shefer 2003).

During the apartheid periods a person's race correlated with access to socio-economic and political power. Classification as white meant that the individual was regarded as superior to people who were classified black or coloured. Classification as coloured meant that the individual was perceived officially as superior to people classified as black, but inferior to people classified as white. Criteria for race classification were defined under the Population Registration Act of 1950. Individuals who had the physical features associated with members of another race group (usually a race group with a higher social status) could apply to have their race classification altered, and if their application was granted, they were entitled to access a radically different world, usually one characterised by economic advantage and enhanced social protection (Erasmus & Ellison, 2008). Race classification could only be altered through a formal application process made to an official of the Department of the Interior, who would then decide, based on random criteria such as the curliness of a person's hair, whether or not their application should be approved. If the application was given the green light, race reclassification meant change to one's name, often leaving one's mother tongue behind and

[9] Only a man who has been to *ulwaluko* is permitted to put on a jacket according to our culture.

speaking a different language, denying one's cultural heritage (for example, no longer eating mielie pap), drawing the curtain on one's early life history, and ending all contact with one's family of origin and one's previous social network, in order to 'pass' as a member of the new race group, usually a group with more opportunities. For example in the Western Cape, which was defined as a coloured labour preference area, reclassification from black to coloured enhanced an individual's economic opportunities, as did reclassification from coloured to white (Johnson, 1998).

Most African people associated race reclassification with lack of pride in one's identity, capitulation to the 'enemy' (i.e. the apartheid system), loss of one's heritage, and confusing all future descendants regarding one's true family ancestry.

It was, therefore, interesting that my participants invoked this idiom to describe men who had undergone VMMC, suggested that they were perceived as not only having sold out, but also as having fundamentally surrendered or lost their authentic identities.

> *That is what they say in isiXhosa culture that a man will resolve things for us you see [reason for following the Xhosa tradition]? Yes, a man listens; he knows that when people are speaking he should not be speaking whilst they are still speaking. He listens and then he rises up. When they speak whilst there are some who are speaking you also rise, it's things like that. Xhosa culture, my brother, has its own valuable aspects that make it important. Xhosa culture is not abandoned for other seemingly better cultures. It is not upside down. That one which was done before is the one that we have to hold onto, but we sometimes do our own things and say that was back then when in actual fact there is nothing that has changed. You see? That is that thing which is referred to as abandoning your identity, to turn it upside down [to change it]. That is what is unacceptable* (Cebo, 31 years old, community member, FGD).
>
> *You are turning around your jacket* (Mbulelo, 24 years old, community member, FGD).
>
> *When you abandon that thing, you are making [your] children to be lost* (Gcobani, 24 years old, community member, FGD).

In accordance with these views, participants perceived men who underwent VMMC as people who chose to adopt a modern lifestyle which was contrary to the traditional lifestyle of Xhosa-speaking people, and which did not reflect the influence of the ancestors. They viewed such individuals who chose VMMC as having deserted their ancestors, and as having decided to

follow the culture of white people which was antagonistic to the culture of amaXhosa. This view was unsurprising, since men who underwent VMMC were seen as having engaged in betrayal in a similar manner to individuals who applied for race reclassification during the apartheid era.

> *Eh, and another thing, our ancestors, our ancestors, our forefathers left us behind telling us about things of Xhosa [culture]. A hospital, from the 80s to the 60s, yes they were saying certain things will modernise, certain things will change, but they did not say that we should change and follow from there. Our ancestors said that we should follow their own way. So when you go to the hospital I feel that you lose your ancestors of your home because it is not something a hospital that is like . . . It is not blessed for you to worship* (Mzonke, 35 years old, traditional attendant, FGD).

> *And another thing that also gets forgotten is that those people who go to the hospital, it is not a must for them to do that thing, it is not a must that a person must go to get circumcised in a hospital. A person that I can say that thing is a must to is a white person. I don't, I am not claiming a race now in that way, you see? I am not holding a race accountable or trying to be racist, you see? I said that, you see a coloured can go there but a coloured sometimes can be fathered by a Xhosa, his father is a Xhosa sometimes, but his mother may be coloured and for him to do what? To go do that medical circumcision there? So, his father will never agree with that thing, you see? He can never approve that thing. However, now that sometimes gets to the extent that the father no longer wants to get along with his son. It is because of what? His father is someone of* isiko, *someone of tradition and he on the other hand leads a modern life, you see? So that is why I am saying that that medical circumcision is something that is brought by the system, like the government, I can say (*Zolile, 22 years old, community member, FGD).

> *Hayi mncm . . . No, something that differentiates here is that we here in* esintwini[10] *we worship the ancestors, we don't walk out here [at the initiation school] worshipping people, so now the difference with you is that you can't walk out [from the clinic] worshipping an ancestor, your ancestor can't be a hospital. Xhosas of old used to be afraid of a hospital right, so here are even medicines, so they used to not go to the hospital easily. So we grew up worshipping the ancestors. On the other hand, they are*

[10] Of the culture of the Bantu people informed by beliefs and practices of Ubuntu.

worshipping in a boyhood way things that are made by a man: 'That no, that tablet is treating me well, that tablet.' We here are worshipping, we walk out here worshipping God and our ancestors because we survived difficulties here, through grace for you to not be stolen here[11]*, to die*[12]*. So those are things those ones* [tablets] *that came with white people, and they tested them on animals, they tested them many times on the earth's animals. So then I think when you are praising those things you are praising Western culture. So we are the Eastern culture, we are the black culture, so we don't forget our ancestors. So here you can also see, there is not even one building, we are in the bush, we have put a plastic, yes it's Western culture but we have made that compromise, there is nothing we can do, it's raining. So we are worshipping ancestors here, whereas they are worshipping the Western system. So they end up worshipping whites. They pride themselves with white people, that they were helped by a certain medication. So we here have survived through the grace of many things. I don't want now to mention the things of civilisation here in a recording. But then I can say even when we take a look at the back we can see that there was circumcision here even way before there was civilisation. So we know how those people survived. So more than we are worshipping today's time we are worshipping them* (Mzonke, 35 years old, traditional attendant, FGD).

Zolile's views resonate with problems caused by race reclassification in the past – including sown division in families – despite the fact that he does not make explicit and direct reference here to the parallels between VMMC and race reclassification in the apartheid past. Race reclassification often divided families, since someone who was reclassified would fear afterwards being associated with his family of origin, which could threaten the security of his newly acquired identity. It is also interesting that Zolile reflects the possibility that Xhosa-ness as an identity could be a unifying and inclusive identity that includes not only those with bodies denoted black but also those denoted coloured, a notion which resonates with the Black Consciousness philosophy that aimed to unite all marginalised identities under one umbrella.

[11] The period of *ulwaluko* is considered to be a dangerous period that exposes the initiate to sorcerers who seek to abduct people and transform them into zombies *[Izithunzela]* in their underworld of witches. It is believed that initiates are especially vulnerable during this time. Initiates are made more vulnerable by the fact that witches prefer to do their 'evil work' in isolated locations where they are not visible. Initiation schools are usually isolated, and located in the bush which witches also utilise as a venue for gathering at night, and in which they can practise their evil rituals.

[12] It is believed that the ancestors help to keep one safe from witches and keep one safe from dying. Initiates are generally encouraged to speak with their ancestors when they feel that things are not going well for them. Initiates also observe particular practices such as *ukuhlonipha* in order to appease their ancestors and ensure their protection.

Ncaca (2014) comes to the same finding in his study of an initiation school in Cape Town. I argue that such Black Consciousness thinking might be an attempt to re-define modernity; one that contests the dominant ideas regarding what it means to be modern or pre-modern, especially in a setting which has a constant state of flux, like the setting in which this research study was conducted. Mzonke's views give credence to this idea – to him undergoing initiation means being in opposition to Western modernist ideas, and being in accord with the 'truth' of one's ancestors.

Having said this, the fact that participants chose to undergo *ulwaluko* and, therefore, to follow their ancestors, led them to perceive themselves as differing from men who had undergone VMMC. In contrast with their perceptions of men who had undergone VMMC, participants who had chosen *ulwaluko* felt that they were known by their ancestors. They had slaughtered animals in tribute to their ancestors and blood had been shed through traditional circumcision that bound them all together.

> *. . . what makes that person to be a man to me . . .? Is he known by his people who are underground? His ancestors do not know him. . . He is not welcomed by his people, that person. There is no blood that was sacrificed at his home, that person. In my home it is sacrificed, for which people to know? Those who are under the ground. 'I am going to this place and even when I have come back there has to be blood again'* (Zolile, 22 years old, community member, FGD).

> *Like, we choose boys over them; a boy is still going to make us to eat meat. That person, that one did not even slaughter for us. You see that thing? So to us in our homes a beast was slaughtered, so even our blood, I am not sure that it blends well, because even our ancestors they were slaughtered for. So if you are coming from the hospital, I do not know if your ancestors do give attention to you or even if your forefathers, your ancestors took that road [VMMC]. I am sure that even if they took that road [VMMC] there was a Xhosa road that they should have taken [*ulwaluko*]. So it does disagree a lot, our religion with a religion of the hospital* (Mzonke, 35 years old, traditional attendant, FGD).

Earlier, I argued that some Xhosa-speaking people believe in the ancestors, viewing them as an active and constant presence in their lives. The views of both Zolile and Mzonke seem to confirm this notion, and to support Ncaca's (2014) characterisation of the *ulwaluko* masculinity as an ancestral masculinity. In Xhosa society, the belief is that in

order for one to be known and accepted by one's ancestors first blood has to be shed, i.e. an animal's blood. Usually such an animal is slaughtered before the male initiate is sent for *ulwaluko*. An animal is slaughtered again on the return home of the initiate. Although the animal might be sacrificed in honour of the ancestors, the meat of the animal is usually consumed by members of the community, and this is where Mzonke's concern comes on: that a man who has undergone VMMC would not prepare meat for the community to consume. However, it is important not to place too much emphasis on the importance of this communal feasting: the slaughtering is conducted mainly to appease the ancestors, who are viewed as exerting a strong influence on their living descendants.

If men were not known by their ancestors, this omission was perceived to be likely to cause future problems . Participants believed that it might bring them misfortune.

> *You see? Even ancestors do not know that person, you see? So that is why I am saying there is much at stake because you could keep on seeing that you are not progressing in things that you do . . . You see that you are not progressing but it is things that you did not do well. You suspect that it's witches that are holding you back and you ultimately go to traditional healers who tell you to be cautious of your neighbour, yet that person who is telling you that is lying because it is only your ancestors who do not know you and you will not be accepted here. This is the house of Ceduma[13] right? You will not be accepted here, you see? When you know that you are a child of Ceduma for example, you are Bhomoyi, I am just using this as an example. You will not be accepted here, you are not accepted here, you are not known by these people, you are not known[14]. You sometimes see yourself involved in an accident and you discover misfortune in whatever you do, and no matter what you do nothing succeeds, it is the medical circumcision. Because that thing, what is it? It is* isiko *[a sacred tradition],*[15] *that thing* [ulwaluko]." (Zolile, 22 years old, community member, FGD).

Zolile's views regarding the influence of the ancestors on an individual reveal the perceived relationship between an individual and his ancestors, and, therefore, his personhood. As stated elsewhere, ancestors are viewed as having control over a person's life, as able to influence life

[13] *Ceduma* is my clan name and traditionally households belong to patrilineal clan ancestors.
[14] Ancestors, like household heads, prefer for arrangements to be carried out in accordance with their wishes. When this does not happen, transgressors may experience their wrath.
[15] *Isiko* belongs to the ancestors, and is practised to appease them. *Isiko* is a law that does not change.

either positively or negatively, depending on the relationship that one has established with them. The absence of an established relationship with the ancestors is perceived as likely to cause difficulties for the individual concerned. It is also seen as important for the individual to know his clan name, so that he is able to perform rituals that are directed to the appropriate ancestors. Researchers have noted the importance for some South African youth of knowing their clan names, since without such knowledge they will not experience an authentic breakthrough in their lives (Nduna & Jewkes, 2011). Mfecane (2018) reminds us of popular television programmes such as *uTatakho* and *Khumbulekhaya* that feature adults searching for their parents (generally their fathers) in an effort to find out their clan names.

He notes that generally these individuals' desires to find their fathers is so that they can arrange performance of rituals which will introduce them to their ancestors, which they believe has the power to transform their lives positively and to resolve longstanding life problems.

In a similar vein, participants believed that men who disobeyed the will of their ancestors by undergoing VMMC rather than *ulwaluko* might lose their minds, i.e. become deranged.

> *Does he* [health minister, Dr Aaron Motsoaledi] *think that you will again have brains when you did not get circumcised based on isiXhosa to encourage someone to go get circumcised in a . . .* [hospital] (Zolile, 22 years old, community member, FGD).

This point of view was not unusual. Other participants whom I interviewed shared this sentiment: that failure to undergo *ulwaluko* or to observe rituals properly might lead to illness.

> *The problem is eh, there were talks that if there was a custom [*isiko*] that you did not do as a person who performs traditions you might even have an illness that doctors are not able to cure. I am a Xhosa and I had already done some traditions[16]. So if there is a tradition that you did not do that thing comes back to haunt you over the years. Sometimes you get ill and when you go to the hospital the doctors don't tell you what is making you to be ill. But there is, it being that tradition which you did not do. Yes, that is one of the things that made me to go get circumcised in the mountain* [initiation school]. *Because it is custom* (Zimisele, 19 years old, traditionally circumcised man and VMMC client, individual interview).

[16] This means that he had already disturbed the ancestors, and that there was a greater chance that the ancestors could have punished him had he erred in not undergoing *ulwaluko*.

Look, eh my own understanding even before coming on the things of HIV and other things. Circumcision to me for the sake that I also got circumcised is because I used to take it, I used to value it as a tradition, as something that I am obliged to do and without me doing it I would not become someone who is good here in life. I used to have that belief. That was before I was circumcised until I was circumcised and perhaps even after some years that I was circumcised. It was something that was still there in me as a belief. . . So basically that is the importance of being circumcised that I can put. I must say so (Mxolisi, 35 years old, community member, individual interview).

Have you ever heard the saying that this man behaves like a boy? It shows that a man after all of that process has his own way that he should behave in. You see? Unlike a, there is a man that we have here, but we are still going to come to know him if he is a man in this Sunday. You did go to the meeting, right? Yah. I am just saying that even the way that the person was behaving you could tell that there is something suspect about him, that he did not undergo ulwaluko*, you see? This means that if you did not do that tradition my brother whether you can live in America you are going to come back to do it, it is not something that just fades away, you see? Because you are going to come back to do this tradition. No matter where you are, no matter where you are. There are many of them that are overseas who have come back to do their family tradition. They come back to do it! This means my brother that this tradition is not just a tradition but it is at the same time a medication, it cures people* (Themba, 34 years old, community member, FGD).

The individual whom Themba referred to was a 55-year-old community member who was rumoured not to have undergone *ulwaluko*. It was reported that suspicion arose out in two contexts. The first incident was at an *umgidi* (community celebration of manhood) in the local community. One man developed a suspicion that this individual had not undergone *ulwaluko*. It was not clear to me what this was based on: whether he saw him urinate, or judged him based on his knowledge of the ritual or based on his behaviour. The second incident was said to have occurred in a *shebeen* in a local community. It was reported that a relative from this individual's home village came to the *shebeen* and berated him, saying that it was disgraceful for him to claim to be a man, when he had not been to *ulwaluko,* and outraged that the community had accepted him on face value as a man, and had even allowed him to host rituals.

What was even more astonishing for the men was that the person who declared that he was still a boy was a relative who knew him in his home village, and the fact that he seemed embarrassed when the man berated him. It was reported that he had begged the accuser to keep his voice down. It was also reported that when he was penalised for transgressing, he brought the men a pig as a gift to atone for his offence. Men viewed this as wrong and as suspicious. A pig in Xhosa society is not an animal that is offered in atonement for a transgression.

A meeting was arranged with the community member to inspect his penis and to permit him to prove that he had undergone *ulwaluko* on a Sunday on an adjacent open field. I was present at this meeting. Because he was an older man, older men went over to inspect his penis. Some declared that he had indeed been to *ulwaluko*, but other men who had not inspected him, and a few of those who did, were unconvinced. They argued that the men who had inspected him were covering up for him when they said that he was a man because he was their friend and they drank together at the *shebeen*. It was also reported that his circumcision scar seemed too recent for a man of his age. He had been away for a period of longer than a month in the Eastern Cape, and it was said that during this period he might have undergone circumcision. Outrage was exacerbated by him having a wife and sons that he had taken through *ulwaluko*. According to Xhosa culture, a male that has not been to *ulwaluko* should not have taken a wife, nor take sons to *ulwaluko* if he has been himself. If he sends his sons to *ulwaluko*, he is excluded from the process.

What this story illustrates is the dominance of *ulwaluko* in the community, and the idea that someone who has not undergone *ulwaluko* is not a full man, despite being 55 years old and having had sons and grandchildren. It is significant that someone who had not undergone *ulwaluko* could still be identified through his actions later in life. As Themba argues, circumcision is seen as a cure in Xhosa society for madness and anti-social behaviour. Those who have not undergone *ulwaluko* are viewed as not having reached a full personhood with the accepted moral virtues of being a man.

Conclusion

This chapter has shown that the perceptions of traditionally circumcised men have not shifted since the introduction of VMMC by the South African government. Men who have undergone VMMC continue to be perceived as different and as 'other'. *Ulwaluko* is defended as a rite of passage to manhood that is also about personhood and *ubuntu*. Men who have undergone

VMMC are devalued in terms of this standard. VMMC is perceived as contrary to *ubuntu* and to notions of personhood.

The main issue at the core of such rejection is cultural constructions of personhood. Personhood in this community is not seen as a quality that is a given, or which one is born with, but rather as a characteristic that is achieved procedurally through incorporation into the community. The community defines one and imbues one with personhood. The individual cannot arrogate personhood for himself. It is in this light that men who have undergone VMMC are rejected. By undergoing VMMC they are perceived as having defined themselves independently and outside the collective definition of personhood, since VMMC is seen as an individualistic programme in conflict with the communal cultural values of *ubuntu*. Being connected to one's community and ancestors is what makes one a person.

Participants made a strong connection between VMMC and the continuation of racial oppression which they felt had been a feature of South African society since the arrival of colonial settlers. Colonial oppression was seen primarily as an attempt to impose western culture on Africans (which represented 'progress'), while African cultures were seen as backward and needing to be left behind. It was interesting that most participants had a strong historical sense of the past and could draw on it to support their rejection of MMC and recipients of MMC. This attests to politicisation of MMC in the area where the study was conducted, which may be true of other parts of South Africa too: it is not seen just as a medical procedure, but rather as a political tool to disenfranchise blacks.

CHAPTER 6 CONCLUSION

This research study investigated whether or not the introduction of voluntary medical male circumcision (VMMC) among amaXhosa had brought about any shifts in definitions of manhood amongst traditionally circumcised men. Manhood for the amaXhosa is an achieved status based on undergoing traditional rites of passage from boyhood to manhood called *ulwaluko,* which entails circumcision by a non-medical person (Ntombana, 2011). Someone who has not undergone *ulwaluko* is not considered to be a man – *indoda*. Rather, he is seen as a boy – *inkwenkwe* – throughout his life and regardless of his achievements (Mfecane, 2016). Men who have been medically circumcised are generally marginalised by those who have undergone traditional circumcision, and are seen as unmanly by them because they have not experienced the pain associated with traditional male circumcision (Mayekiso, 2017). *Ulwaluko* creates a hierarchy of masculinities among amaXhosa: its recipients are seen by traditionally circumcised men as having a higher rank, while medically circumcised men and uncircumcised individuals occupy a lower rank. My study sought to understand whether this structure of masculine hierarchy continues, given promotion of MMC by the government and its implementation as a strategy to help curb HIV transmission in South Africa.

This was the first study of its kind to investigate this issue. Most scholarship on MMC has been dominated by a biomedical perspective focused on the physiological and biological aspects of the intervention, to the exclusion of cultural dimensions. Acceptability studies conducted in non-circumcising communities have examined cultural aspects of the intervention, and most conclude that culture is not a barrier to the uptake of VMMC. This study differs from such acceptability studies in three ways. First, it is not an acceptability study, and secondly, the research was conducted in a non-circumcising community. This thesis presents the findings of a qualitative study of traditionally circumcised men's perceptions of those who have undergone VMMC in a particular community where circumcision is a traditional practice. Thirdly, my findings suggest that VMMC is culturally problematic for traditionally circumcised Xhosa-speaking men.

My core findings are that in the community where the study was carried out, *ulwaluko* continues to be hegemonic with regard to traditionally circumcised Xhosa-speaking men's definitions of manhood: they saw those (like themselves) who had undergone *ulwaluko* to its full conclusion as 'real men' – *amadoda*. They see such men as entitled to enjoy the privileges associated with being a man, such as social respect, attendance of rituals and performing rituals

on behalf of the ancestors. *Ulwaluko* as a hegemonic form of masculinity is resistant to incorporation of any elements from the 'outside'. It represents itself as a 'pure' form of masculinity that avoids 'contamination' by, for example, western medical scientific practice.

Recipients of VMMC are seen by traditionally circumcised men as embodying a marginalised masculinity which is oppressed, stigmatised and lacking a key component of communitarian personhood – *ubuntu* – that *ulwaluko* is believed to confer on Xhosa-speaking men. Not only do the traditionally circumcised see medically circumcised men as having deserted their culture and the old-age traditions of the amaXhosa, but they also accuse them of being political 'sell-outs' by virtue of having adopted a medical procedure associated with colonial domination of Africans by European colonial settlers. This leads traditionally circumcised men to inflict violence and various forms of social exclusion sanctioned by Xhosa culture on men who undergo VMMC. Several forms of stigmatisation and exclusion of MMC recipients have been described in this thesis.

Connell's (1995) theory of hegemonic masculinity remains relevant in my analysis. Specifically this study highlights the fact that the hegemony of *indoda* masculinity is maintained through constant policing of men and boys: men are curious to know where and how each man in the community underwent circumcision and what the outcome was. Rituals – especially those associated with *ulwaluko* – become platforms for public 'display' of manhood; they provide a forum for men to sing praises about themselves and to demand social respect, as described in my narratives of the *umgidi* (homecoming) ceremony. Those who are believed to have failed the test of manhood, or who have chosen a different path are known, noted and subsequently denied the right to participate in communal rituals. When they try to 'pass' as men they are subjected to intrusive mechanisms requiring them to prove that they are real men – *amadoda*.

The right to bodily autonomy is denied in the quest to maintain the hegemony of *indoda*. The body is not seen as an entity belonging only to the individual (Scheper-Hughes & Lock, 1987). Since, as my participants insisted, the body of an *indoda* (a traditionally circumcised penis) is created collectively by the cultural group, it is expected that the individual will avail it for inspection when the need arises – for example, when he cannot verbally recount to the satisfaction of his male audience his journey to manhood. Elsewhere this can be seen as violation of the right to bodily integrity; here the body is seen as a metaphor for culture and that is what is believed to give others the right to intrude on its autonomy.

The strength of this research study is that as a Xhosa man who has undergone *ulwaluko*, I was able to build rapport with participants regarding this sensitive and taboo topic in Xhosa society. All participants, including older men, felt able to discuss with me secret details concerning the ritual, and their perceptions of men who have undergone VMMC.

Moreover, my familiarity with the research location helped me to navigate my way easily around the various research sites. My knowledge of its history, politics, and struggles also helped me to analyse the transcripts in perspective. It also helped me to quickly build rapport with my participants, as they perceived me to belong, rather than as being an outsider to their community. I was familiar with the idioms and 'language' used by traditionally circumcised men to communicate about crucial issues. I could tap into this knowledge, and reassure the men that I interviewed that the research would not publicise confidential and secret matters.

The advantage that I had as an insider was also however at the same time a disadvantage to me. As an insider to Xhosa culture, and as a member of the group I studied, I was at times expected to have answers to some of the questions that I was posing to the participants and also be able to make my own input. At other times, I was forced to continuously account and to justify my choice to conduct research on *ulwaluko* when as an insider I was supposed to know that writing on *ulwaluko* is a taboo. This led to feelings sometimes that my identity as a Xhosa man is being questioned and undermined. I overcame these challenges by proving myself a little bit to the participants that I am a Xhosa man. This took the form of informing them that I was circumcised inside that bush, and by whom, and which year. Informing them that I am there as a researcher and as not an insider also helped me with avoiding providing an input on the discussions. The fact that I told the participants that the research is not about *ulwaluko* per se, but about their perceptions that they have of men who have undergone VMMC also helped with easing tensions.

With reflexivity being something that is taught and encouraged in Anthropology, I went into the field acutely aware and sensitive to some of the biases that I may hold as someone who is an insider of the group I was studying. I was aware of the personal value that *ulwaluko* has for me as someone who has undergone the process, and been brought up in a community that valorizes the ritual. I was also aware of my own feminist and ideological orientation gleaned from anthropology, and from the literature on masculinity in South Africa, I read before going to the field. This awareness helped me to be able to reflect on my positionality in gathering and analyzing the data. It helped me to be able to be neutral, and to be able to keep a distance from

the data, to prevent my own personal feelings from affecting the nature and the quality of data I gathered from the field. This approach also helped me with being objective in analyzing and interpreting the data.

One limitation of this study is that no medically circumcised men in the community were interviewed, and so the study reflects only the perceptions of traditionally circumcised Xhosa-speaking men in a certain section of Khayelitsha. Inclusion of men who had been medically circumcised could have provided a more comprehensive perspective regarding Xhosa men's attitudes to VMMC. As it stands, my study is able to describe the perspective of a proportion of the men in the community – those who had undergone *ulwaluko* – and it will need to leave study and description of the attitudes of Xhosa-speaking men who have undergone VMMC to future researchers.

With regard to VMMC, I argue for advocacy that is sensitive to the concerns reflected by these findings, based on traditionally circumcised participants' perceptions of VMMC, including the perceived dominance of Western culture. VMMC advocacy needs to be sensitive to these concerns, so as to be able to create a dialogue and platform for collaboration to take place. *Ulwaluko* must not be seen as a traditional practice which is fixed and outside of modernity. Advocates of VMMC should view traditional circumcision as a practice that is negotiable like modernist practices are. They should recognise that there are many expressions of modernity. The fact that sometimes an initiate who has been sent to hospital can still be considered a 'real' man suggests limited room for dialogue between custodians of *ulwaluko* and advocates of VMMC.

The space for dialogue needs to be harnessed through respect and equal partnership recognition for it to be able to have sustenance. Partnerships can be forged with traditional leaders who are viewed as custodians of indigenous culture and beliefs. Even as it was with urban-based men that the interviews were conducted with, there was still some level of respect and recognition of traditional leaders as the custodians of Xhosa culture who ought to be respected and consulted on things pertaining to Xhosa culture and tradition [This mainly emerged in the transcripts than in the thesis]. Participants' views in this thesis have also shown that dialogues with the community are also possible where there might be an absence of traditional leaders, i.e. chiefs, headmen and kings. In places such as in Cape Town townships, traditional leaders are typically not directly involved in the ritual. It is usually families themselves that take the initiative and lead in the initiation of their sons in support from their surrounding communities.

This calls for critical awareness of contextual differences even within one cultural group of people in order for partnerships to succeed.

This thesis provided empirical evidence that stigmatisation of medically circumcised men by men who are traditionally circumcised persists, despite the fact that MMC is now a component of the government's national health policy and strategy to reduce new HIV infections. The conclusions drawn in this thesis differ from views of scholars such as Robins (2009) and Taljaard et al. (2010), who suggest that widespread roll-out of VMMC services would not have problematic effects on Xhosa society. Contrary to their views, this thesis argues that the services may have a problematic influence, certainly among the amaXhosa whom I studied. VMMC reinforces existing perceptions among Xhosa-speaking men regarding hierarchical ranking of men based on the type of circumcision.

Reference list

Aggleton, P. 2007. “Just a snip”?: A social history of male circumcision. *Reproductive Health Matters*, *15*(29): 15–21.

Babbie, E. & Mouton, J. 2001. *The Practice of Social Research*. Cape Town: Oxford University Press.

Bailey, R.C., R. Muga., R. Poulussen, & H. Abicht 2002. The acceptability of male circumcision to reduce HIV infections in Nyanza Province, Kenya. *AIDS Care.14*(1): 27-40.

Bateman, C. 2010. Male circumcision roll-out certain – now for ‘the how’. *South African Medical Journal*, *100*(2): 1–3.

Bollinger, D, A. Craig, W. John, T. Georganne, & J.D. Chapin. 2011. The Truth: Male Circumcision Does Not Prevent HIV.

Bogopa, D.L. 2007. Challenges facing the initiation schools: The case of Nelson Mandela Metropole in the Eastern Cape, *Acta Criminologica*, 20(4): 55 – 60.

Bogopa, D. 2010. Health and Ancestors: The Case of South Africa and Beyond, *Indo – Pacific Journal of Phenomenology*, 10(1): 1 -7.

Carrigan, T., R. Connell, & J. Lee. 1985. Toward a new sociology of masculinity. *Theory and Society*, *14*(5): 551–604.

Census. 2011. *City of Cape Town – 2011: Census Suburb Khayelitsha.*

Connell, R W. (1995). *Masculinities*. Cambridge: Polity Press.

Connell, R & J. Messerschmidt. 2005. Hegemonic masculinity: Rethinking the concept. *Gender & Society*, *19*, 829–859.

Courtenay, W. H. 2000. Constructions of masculinity and their influence on men’s well-being: A theory of gender and health. *Social Science & Medicine*, *50*: 1385-1401.

Demetriou, D.Z. 2001. Connell’s concept of hegemonic masculinity: A critique. *Theory and Society*, *30*(3): 337–361.

Dowsett, G. W. & M. Couch. 2007. Male circumcision and HIV prevention: Is there really enough of the right kind of evidence? *Reproductive Health Matters, 15*(29): 33-44.

Doyle, D. 2005. Ritual male circumcision: A brief history. *Journal of the Royal College Physicians, 35*: 279–285.

Drain, P.K., D.T. Helperin, J.P. Hughes, J.D. Klausner & R.C. Bailey. 2006. Male circumcision, religion, and infectious diseases: an ecological analysis of 118 developing countries. *Bio Med Central Infectious Diseases*, *6*(172): 1–10.

Emmerson, R.M., Fretz, R.I, & L.L. Shaw. Participant Observation and Fieldnotes. In Handbook of Ethnography. Edited by Atkinson, P. Coffey, A. Dalamont, S. Lofland, J, & Lofland, A. London: SAGE.

Erasmus, Y & G.T.H. Ellison. 2008. What can we learn about the meaning of race from the classification of population groups during apartheid? *South African Journal of Science*, 450–452.

Fink, A.J. 1986. A possible explanation for heterosexual male infection with AIDS [letter]. *New England Journal of Medicine, 315*: 1167.

Gairdner, D. 1949. The fate of the foreskin: A study of circumcision. *British Medical Journal, 2*(4642):1433-1437.

Gathogo, J. 2008. African philosophy as expressed in the concepts of hospitality and *ubuntu*. *Journal of Theology for Southern Africa, 130*: 39–53.

GARPR. 2016. *Progress Towards Targets Desk Review. 2012–2015*.

Gqola, P. D. 2007. 'A woman cannot marry a boy': rescue, spectacle and transitional Xhosa masculinities In *From Boys to Men: Social Constructions of Masculinity in Contemporary Society*. Edited by Shefer, T. Ratele, K & Strebel, A. Cape Town: UCT Press.

Green, L.W., McAllister, R.G., Peterson, W.K., & Travis, J.W. 2008. Male circumcision is *not* the HIV 'vaccine' we have been waiting for! *Future HIV Therapy*, 193–199.

Guttman, M.C. 1997. Trafficking in men: The anthropology of masculinity. *Annual Review of Anthropology, 26*: 385–409.

Hammersley, M. & Atkinson, P. 2007. *Ethnography: Principles in Practice,* Third Edition, Routledge, London.

Hellsten, S.K. 2004. Rationalising circumcision: from tradition to fashion, from public health to individual freedom – critical notes on cultural persistence of the practice of genital mutilation. *Journal of Medical Ethics*, *30*: 248–253.

Henning, E., W. Rensburg & B. Smit. 2004. *Finding Your Way in Qualitative Research*. Pretoria: Van Schaik Publishers.

Herman-Rolloff, A., N. Otieno., K. Agot., J. Ndinya-Achola. & R.C. Bailey. 2011. Acceptability of medical male circumcision among uncircumcised men in Kenya one year after the launch of the national male circumcision programme. *PLoS ONE 6*(5): 1–6.

Hallway, W. 1989. *Gender and Psychology. Subjectivity and Method in Psychology: Gender, Meaning and Science*. Thousand Oaks, CA: Sage Publications.

Human Sciences Research Council. 2018. *The Fifth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey*, 2017 (SABSSM V).

Johnson, A. 1998. People who got themselves classified coloured in the old days are switching back - to black. *Mail and Guardian*, 20 March 1998. Retrieved 11 October 2018 from https://mg.co.za/article/1998-03-20-changing-colour

Kebaabetswe, P., S. Lockman., S. Mogwe., R. Mandevu., I. Thior., M. Essex, & R.L. Shapiro. 2003. Male circumcision: an acceptable strategy for HIV prevention in Botswana. *Sex Transm Infect*, *79*(3): 214–219.

Kepe, T. 2010. 'Secrets' that kill: Crisis, custodianship and responsibility in ritual male circumcision in the Eastern Cape Province, South Africa. *Social Science and Medicine*, *70*(5): 729–735.

Louw, D.J. 2006. *The African concept of Ubuntu and restorative justice. In Handbook of Restorative Justice*, Edited by D. Sullivan & L, Tifft. London and New York: Routledge.

Mandela, N. 1994. *Long Walk to Freedom*. Boston: Little, Brown.

Mattson, C.L., R.C. Bailey, R. Muga, R. Poulussen, & T. Onyango. 2005. Acceptability of male circumcision and predictors of circumcision preference among men and women in Nyanza Province, Kenya, *AIDS CARE: Psychological and Socio-medical Aspects of AIDS/HIV*, *17*(2): 182–194.

Mavundla, T.R., F.G. Netswera, B. Bottoman, & F. Toth. 2009. Rationalization of indigenous male circumcision as a sacred religious custom: Health beliefs of Xhosa men in South Africa. J. *Transcultural Nursing*, *20*: 395–404.

Mavundla, T.R., F.G. Netswera, F. Toth, B. Bottoman, & S. Tenge. 2010. How boys become dogs: Stigmatization and marginalization of uninitiated Xhosa males in East London, South Africa, *Qualitative Health Research*, *20*(7): 931–941.

Mayekiso, A. 2017. 'Ukuba yindoda kwelixesha' ('To be a man in these times'): Fatherhood, marginality and forms of life among young men in Gugulethu, Cape Town. Master's Thesis submitted to the University of Cape Town.

Meissner, O. & D. Buso. 2007. Traditional mle circumcision in the Eastern Cape – scourge or blessing? *South African Medical Journal*, *97*(5): 371–373.

Menkiti, I.A. 1984. *Person and Community in African Traditional Thought.* In *African Philosophy, An Introduction.* Edited by R.A. Wright. University Press of America.

Merriam, S.B., J. Johnson-Bailey., M. Lee., Y. Kee., G. Ntseane & M. Muhamad. 2001. Power and positionality: negotiating insider/outsider status within and across cultures, *International Journal of Lifelong Education*, *20*(5), 405-416.

Meyer, M. & H. Struthers. 2012. *(Un)covering Men: Rewriting Masculinity and Health in South Africa*. South Africa: Fanele.

Mfecane, S. 2011. To drink or not to drink? Identity dilemmas of men living with HIV. *Agenda, 54*(4): 8–17.

Mfecane, S. 2013. Luring men to join war against AIDS. *The Star* 10 April 2013. Retrieved 11 April 2013 from: http://www.iol.co.za/the-star/luring-men-to-join-war-against-aids-1.1498418

Mfecane, S. 2016. *Ndiyindoda! (I am a man).* Theorising Xhosa masculinity. *Anthropology Southern Africa*, *39*(3); 202–214.

Mfecane, S. 2018. Towards African-centred theories of masculinity. *Social Dynamics*, *44*(2): 291–305.

Mhlahlo, A. 2009. What is manhood? The significance of traditional circumcision in the Xhosa initiation ritual. Thesis presented in partial fulfilment of the requirements for the degree of Master of Philosophy in Community and Development. University of Stellenbosch.

Mngqolozana, T. 2009. *A Man Who is Not a Man*. Scottsville: University of KwaZulu-Natal Press.

Mnyaka, M. & M. Mothlobi. 2005. The African concept of *ubuntu/botho* and its socio-moral significance. Black Theology: *An International Journal*, 215–237.

Morrell, R. 1998. Of boys and men: Masculinity and gender in Southern Africa. *Journal of Southern African Studies*, *4*:605–630.

Morrell, R. 2012. Hegemonic masculinity/masculinities in South Africa: Culture, power, and gender politics. *Men and Masculinities*, *15*(1): 11–30.

Morris, B.J., R.C. Bailey., J.D. Klausner., A. Leibowitz., R.G. Wamai, J.H. Waskett., J. Banerjee., D.T. Halperin., L. Zoloth., H.A. Weiss. & C.A. Hankins. 2012. Review: a critical evaluation of arguments opposing male circumcision for HIV prevention in developed countries. *AIDS Care*, 1–11.

Mtuze, P.T. 2003. *The Essence of Xhosa Spirituality and the Nuisance of Cultural Imperialism: (Hidden Presences in the Spirituality of the amaXhosa of the Eastern Cape and the Impact of Christianity on Them)*. Florida Hills: Vivlia Publishers.

Ncaca, M. 2014. *Yithi Uyindoda!* (Say, you are a man!): An ethnographic study on the construction of religion and masculinities in initiation schools in Cape Town Townships. A Masters thesis submitted to the University of Stellenbosch.

Ncayiyana, D.J. 2011. The illusive promise of circumcision to prevent female-to-male HIV infection – not the way to go for South Africa. *South African Medical Journal*, *101*(11): 775-776.

Ndletyana, M. 2000. To restore the honour formerly associated with the initiation ritual, some things must change. *Daily Dispatch,* 11 July 2000. pp. 16-30.

Nduna, M., and R. Jewkes. 2011. Undisclosed paternal identity in narratives of distress among young people in Eastern Cape, South Africa. *Journal of Child Family Studies*, *20*(2): 303–310.

Nepaya, M.D. 2012. Acceptability of medical male circumcision among men in Engela District of the Ohangwena Region, Namibia. A Master's degree submitted to the University of the Western Cape.

Ngwane, Z. 2004. "'Real men reawaken their fathers' homesteads, the educated leave them in ruins': The politics of domestic reproduction in post-apartheid rural South Africa." In *Producing African Futures*: *Ritual and Reproduction in a Neoliberal Age*, edited by B. Weiss, 167–192. Leiden: Brill.

Ngxamngxa, A.N.N. 1971. The function of circumcision among the Xhosa-speaking tribes in historical perspective. In De Jager, E.J. (ed.) *Man: Anthropological Essays*. Presented to O.F. Raum. Cape Town: Struik.

Nleya, N & L. Thompson. 2009. Survey methodology in violence-prone Khayelitsha, Cape Town, South Africa. *Institute of Bulletin Studies*, *40*(3): 50–57.

Ntombana, L. 2011. Should Xhosa male initiation be abolished? *International Journal of Cultural Studies*, *14*(6): 631–640.

Ntozini, A.N. & A.A. Abdullahi. 2016. Perceptions of traditional male circumcision among university male students at a South African university. *Men and Masculinities*, 1-21.

Ntozini, A & H. Ngqangweni. 2016. Gay Xhosa men's experiences of *ulwaluko* (traditional male initiation). *Culture, Health & Sexuality*, *18*(11): 1309–1318.

Ntsebeza, L. 2004. Rural governance in post – 1994 South Africa: Has the question of citizenship for rural inhabitants been settled 10 years in South Africa's democracy? University of Cape Town, Rondebosch, 1 – 29.

Peirano, M.G.S. 1998. When anthropology is at home: The different contexts of a single discipline. *Annual Review of Anthropology*. *27*:105-128.

Peltzer, K. & X. Kanta. 2009. Medical circumcision and manhood initiation rituals in the Eastern Cape, South Africa: a post–intervention evaluation. *Culture, Health & Sexuality*, *11*(1): 83–97.

Pinnock, D. 2016. *Gang Town*. Cape Town: Tafelberg.

PlusNews. 2007. At the cutting edge – male circumcision and HIV. *Global HIV/AIDS News and Analysis* – www.PlusNews.org

Poswa, N & R. Levy. 2006. Migration study in Monwabisi Park (Endlovini), Khayelitsha.

Ramphele, M. 2000. Teach me how to be a man. In *Violence and Subjectivity*. Edited by Das. V., Kleinman, A., Ramphele, A., & Reynolds, P. Berkeley. University of California Press.

Ratele, K. 2014. Currents against gender transformation of South African men: relocating marginality to the centre of research and theory of masculinity. NORMA: *International Journal for Masculinity Studies*, *9*(1): 30–44.

Sawires, S.R., S.L. Dworkin., A. Flamma., D. Peacock., G. Szekeres, & T.J. Coates. 2007. Male circumcision and HIV/AIDS: challenges and opportunities. *The Lancet*, *369*: 708–713.

Shefer, T., K. Ratele, A. Strebel, N. Shabalala, & R. Buikema (Eds). 2007. *From Boys to Men: Social Constructions of Masculinity in Contemporary Society*. Lansdowne: University of Cape Town Press.

Scheper-Hughes, N. & M.M. Lock. 1987. The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, New Series, *1*(1): 6–41.

Scott, B.E., H.A. Weiss & J.I. Viljoen. 2005. The acceptability of male circumcision as an HIV intervention among a rural Zulu population, KwaZulu Natal, South Africa, *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, *17*(3): 304-313.

Seekings, J. 2013. *Economy, Society and Municipal Services in Khayelitsha: Report for the Commission of Inquiry into Allegations of Police Inefficiency in Khayelitsha and a Breakdown in Relations between the Community and the Police in Khayelitsha.* Centre for Social Science Research, University of Cape Town, Rondebosch, 1–27.

Shisana, O., T. Rehle., L.Simbayi., D. Labadarios., S. Jooste., A. Davids., S. Ramlagan., N. Zungu., D. Labadarios., D. Onoya et al. 2014. *South African National HIV Prevalence, Incidence and Behaviour Survey*, 2012. Cape Town: HSRC Press.

Shutte, A. 1993. *Philosophy for Africa.* Milwaukee: Marquette University Press.

Soul City Institute Health and Development Communication. 2010. HIV prevention: Medical Male Circumcision in South Africa. Target Audience Formative Research for the Development of Soul City Series Eleven.

Steinberg, J. 2005. *The Number: One Man's Search for Identity in the Cape Underworld and Prison Gangs*. Cape Town: Jonathan Ball Publishers.

Stevens, M. 2009. Medical male circumcision: current debate around male circumcision could pave a way to discussion of other issues as well. *Nursing Update*, 40-41.

Suttner, R. 2007. Masculinities in the ANC-led liberation movement. In *From Boys to Men: Social Constructions of Masculinity in Contemporary Society*. Edited by Shefer, T. Ratele, K. & Strebel, A. Cape Town: UCT Press.

Taljaard, D., D Shabangu., A. Mkhwanazi., T. Mashigo., P. Lissouba., & B. Auvert. 2010. Traditional initiation and medical male circumcision collaborating: going to the medical mountain? Progressus, Johannesburg, South Africa & INSERM, Villejuif, France.

Tshemese, M. 2014. Time to question what makes a man. *Sunday Independent.*

Van Howe, R.S. & M.R. Storms. 2011. How the circumcision solution in Africa will increase HIV infections. *Journal of Public Health, 2*(1) e4.

Venter, M.A. 2011. Some views of Xhosa women regarding the initiation of their sons. *Koers*, *76*(3): 559–575.

Vincent, L. 2008a. 'Boys will be boys': Traditional Xhosa male circumcision, HIV and sexual socialisation in contemporary South Africa. *Culture, Health & Sexuality*, *10*(5): 431–446.

Vincent, L. 2008b. Cutting tradition: the political regulation of traditional circumcision rites in South Africa's liberal democratic order. *Journal of Southern African Studies*, 34*(1)*: 77-91.

Weiss, H.A., Halperin, D., Bailey, R.C., Hayes, R.J., Schmid. G., et al. 2008. Male circumcision for HIV prevention: from evidence to action? *AIDS*, *22*: 567–74.

Whisson, M. 2000. Circumcision widely approved despite fatalities. *Daily Dispatch.* East London, South Africa, 22 July 2000, 14-27.

WHO. 2007. *Strategies and Approaches for Male Circumcision Programming: WHO Meeting Report, 5-6 December 2006, Geneva.*

WHO & UNAIDS. 2007. WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention.

WHO. 2011. *Progress in Scale-up of Male Circumcision for HIV Prevention in Eastern And Southern Africa: Focus on Service Delivery.*

Wilson, M & Mafeje, A. 1963. *Langa: A Study of Social Groups in an African Township*. Oxford University Press: Cape Town

APPENDICES

APPENDIX I: INFORMATION SHEET AND CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Department of Anthropology and Sociology

INFORMATION SHEET AND CONSENT FORM

Title of Research Project: Medical male circumcision and Xhosa masculinities: Tradition and transformation

Introduction

I am Lubabalo Sheperd Mdedetyana. I am a student at the University of the Western Cape doing a Master's Degree in Medical Anthropology. As part of Master's programme, I am required to conduct a research project. This study is under the supervision of Dr Sakhumzi Mfecane (+27 21 959 2336/3346) of the University of the Western Cape's Department of Anthropology and Sociology. The research processes for this study has been approved by the UWC Ethics Committee (Number).

I kindly request you to participate in this study and share your knowledge and understanding related to the topic of my research. The focus of this project is on Xhosa speaking society and its perceptions of Xhosa males who undertook medical male circumcision for HIV risk reduction. The study will explore the likely cultural impact that the medical male circumcision services offered by the government have had on Xhosa notions of manhood. I am interested to know if the intervention by the government has brought about any changes in attitudes and perceptions of people towards medically circumcised men.

Participation

My target groups are Xhosa males who are 18 years and above. They are males who are traditionally circumcised as part of a rite of passage to manhood and males medically circumcised for HIV risk reduction purposes. As you are a medically circumcised man I want

to ask you questions of how you are viewed and treated in society. As a traditionally circumcised man I want to ask you questions of how you treat and view medically circumcised men. Before medical circumcision became government policy to reduce the spread of HIV infections men medically circumcised were believed to be negatively viewed and stigmatised in their Xhosa communities by their traditionally circumcised male counterparts. My project is about investigating whether these attitudes and perceptions towards medically circumcised men persist and as a medically circumcised man you are best situated to be able to answer these questions. As a traditionally circumcised man you are also well positioned to respond to my questions on how now after government adopted medical circumcision as a policy traditionally circumcised men view and treat medically circumcised men. If you agree to participate you will have to make time for me to formally interview you for one hour and more. It is possible that you may be interviewed more than once. I want you to know that participation is voluntary and I am not going to force you to be part of this project. If you agree to participate, please understand that you may stop participating if you choose to do so; you will not be punished or criticised in any way. I am also asking your permission to record the interviews; this will enable me to have accurate information as you have shared it. The tapes will be destroyed later when no longer needed. Please know that you have a choice not to answer some of the questions which will be asked during the interview.

Confidentiality

Your personal name and address will only be known by me; your identity will be kept secretive by giving you a false name. The only information that will be public will be the written report which may be used for academic purposes only where I am required to present findings from this research. All recordings that identify you will be kept safe and secretive. Signed consent forms will also be kept secretive and will not be made accessible to anyone else.

Risks

You may feel uncomfortable about certain aspects of my research. Please express yourself only on issues that you are comfortable in. I want to ensure you that your identity will be protected by means of you being given a false name. Any other information that may reveal your identity will also not be included in the research report (thesis). Other than these two, there are no other risks identified so far in relation to this project.

Benefits

There are no immediate personal benefits that will be accrued for participating in this study. However, your valuable insight and all the data that will be collected will contribute to an understanding of the likely impact that the medical male circumcision services offered by the government have had upon Xhosa cultural notions of manhood and perceptions of men in society who undertake the services for risk reduction. This information may also be used to influence health policies and the medical male circumcision programmes targeting men from traditionally circumcising communities.

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

Lubabalo Sheperd Mdedetyana

Cellphone number: +27 793455778

E-mail address: 2962574@myuwc.ac.za or lmdedetyana@yahoo.com

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

Office number: +27 21959 2336/2336

Cell phone number: +27 834349887

E-mail address: smfecane@uwc.ac.za

Informed consent

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

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

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

_____ _____

Participant's full name Participant's signature

_____

Date

APPENDIX II: APPROVAL LETTER (UWC)

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 4111/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

17 October 2018

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape, at its meeting held on 07 March 2014, approved the methodology and ethics of the following research project by Mr LS Mdedetyana (Anthropology and Sociology, Arts Faculty)

Research Project:	Medical male circumcision and Xhosa masculinities: Tradition and transformation
Registration no:	14/2/34

Any amendments, extension or other modifications to the protocol must be submitted to the Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

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

APPENDIX III: PERMISSION LETTER (WESTERN CAPE HEALTH DEPARTMENT)

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
Tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: RP 067RP2014
ENQUIRIES: Ms Charlene Roderick

35 Yusuf Arafat Crescent
Mandela Park
Khayelitsha
7784

For attention: **Lubabalo Shepard Mdedetyana**

Re: Medical Male Circumcision and Xhosa Masculinities: Tradition and Transformstion

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Khayelitsha Men's Clinic	**B Stuurman**	**Contact No. 021 360 4627**
Michael Maphongwana Day Hospital	**B Stuurman**	**Contact No. 021 360 4627**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR J EVANS
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 13/06/14
CC **K GRAMMER** **DIRECTOR: SOUTHERN/WESTERN DISTRICT**

Page 1of 1

APPENDIX IV: INTERVIEW GUIDE (MALE COMMUNITY MEMBERS)

How is the life of a man in the township?

What makes a man here in the township?

What are the places that men here at the township go to for entertainment?

What type of men are allowed in these places?

In cultural functions such as *imigidi*, would you say uncircumcised men are welcome?

How do you view a man that has been medically circumcised?

Would you say a man that has been medically circumcised is acceptable in taverns?

What do you think of government's new programme that males can become circumcised medically at the clinic?

How are people who are medically circumcised treated here in the township?

How would you say men who have undergone this government programme of medical male circumcision are going to be perceived in their communities once they come back from the clinic?

Would you say man medically circumcised can officiate in cultural activities and perform cultural rituals?

What makes it important for boys to circumcise in the bush and not at the clinic?

Do you think over time Xhosa notions of manhood have changed? Please elaborate.

Would you say the presence of diseases in society today has had some impact on traditional circumcision?

How would you say the prevalence of HIV in society has impacted on the meanings of being a Xhosa man?

Given that today we have HIV in our society would you say that traditional circumcision still remains as the only way for one to be a Xhosa man?

Thank you.

APPENDIX V: INTERVIEW GUIDE (INITIATES)

How do you feel about being here at the initiation school?

Is being here something that you personally wanted?

How do you expect life for you when you are back at your community?

Have you ever before heard of the benefits of circumcision?

Did you know that the South African government is using circumcision as a tool to combat HIV?

Did you know that circumcision is done at clinics as part of government's plan to reduce HIV?

How are you going to view people who have gone to have their circumcision done at the clinic following what they saw on television or heard from the government?

Do you have any knowledge of experiences of people in their communities who have undergone medical male circumcision?

Okay, as medical circumcision is now enjoying the support of the government do you see that changing the way that men medically circumcised are treated, when you think that in the past it was something that was not supported by government, was just something that was happening. So now when they are supported by government, do you see the way that they are treated changing?

So when you are observing do you think that they can over time come to be accepted, people circumcised in the clinic?

How does that make you to feel?

Is a person circumcised in a hospital a man?

Why do you say so?

Are there perhaps places where a person circumcised in a hospital is not acceptable in?

Okay. How important is it for you to be able to go to the places that they are not able to go to?

Okay, are you in a hurry to go back to your community?

What's the one thing that you can say you are most in a hurry for when you are a man?

Thank you.

APPENDIX VI: INTERVIEW GUIDE (TRADITIONAL ATTENDANTS)

Please tell me about yourself. Your name, who you are, where you were born and also where you grew up, and so on, just simply tell me about yourself.

Please tell me when you started doing this job of yours of being a traditional attendant.

What made you to do this job?

What is it that you love the most about this job?

What do you dislike about this job?

How do you view the issue of circumcision initiation (*ulwaluko*)?

Have you ever heard of the government campaign for people to go have a medical male circumcision to reduce chances of HIV infection?

How do you see this government campaign now that boys have to go to the clinic to be circumcised in order to be protected?

How is government's encouragement of people to undertake MMC going to impact on traditional circumcision? Is it going to impact on it?

What is the nature of the relationship between someone initiated here in the bush and someone circumcised in the clinic?

Thank you.