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The Bamasaaba People's Response to the Safe Medical Male Circumcision Policy in Uganda

By

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ABSTRACT

The Joint United Nations Programme on HIV (UNAIDS) strongly recommends that developing countries regard medical male circumcision as a biomedical intervention. This recommendation has caused developing countries seeking a radical solution to the prevailing and persistent social problem of HIV to reform their health policies. Most now discourage traditional male circumcision and promote safe medical male circumcision (SMMC) as a strong contributor to reductions in HIV transmission. This has introduced conflicts in traditional African societies such as the Bugisu, where male circumcision is culturally motivated, symbolising a rite of passage from boyhood to manhood. In the Bugisu sub-region, the local Bamasaaba regard their cultural practice of traditional male circumcision (TMC) as prestigious.

This sociological study's broad research aim was to investigate the Bamasaabas' response to the implementation of the Safe Medical Male Circumcision Policy (SMMCP) in Uganda. The specific objectives were to investigate the impact of the SMMCP on the Bamasaabas' cultural practices. Furthermore, the researcher sought to understand both social and political implications of the SMMCP on the Bamasaaba; and how they conceptualise masculinity in response to both TMC and the SMMCP in Uganda. The study adopted the interdisciplinary approach to reviewing the literature. Thus, I reviewed both local and international literature. The study used the gender theory of masculinity with specific reference to Connell (2003), Connell (2005), Connell and Woods (2005), Petersen (2003), Mfecane (2018) and Messerschmidt (2019). They refer to a particular normative form of hegemonic masculinity that prevails in each society and defines what it means to be a man.

I recruited 70 participants from the three selected districts for both in-depth individual interviews and focus groups (FGs). Of the seventy, I chose 40 participants for in-depth interviews and 30 for the discussion groups. I obtained data from cultural and clan leaders, traditional surgeons, medical officers, and 2016 initiates in Bududa, Mbale and Manafwa Districts in the Bugisu sub-region. Processing the audio recorded responses and data analysis involved transcribing, interpreting, coding, categorising and generating findings using the qualitative computer application Atlas Ti.

The results of the study suggest that the Bamasaaba are ambivalent about the implementation of the SMMCP. Both historical and political attempts to abolish TMC have caused resistance, with most holding firmly to TMC as the only means by which the Bamasaaba boys can acquire the status of 'man'. They see some value in the health policy, but only insofar as it has caused positive adaptations to the practice of TMC for purposes of enhanced hygiene and safety. The SMMCP policy conflicts with the cultural practices of *imbalu* (traditional male circumcision) and the way that Bamasaaba men construct hegemonic masculinity in the Bugisu sub-region.

The study found that the health sector's efforts to frame SMMC as both healthy and socially acceptable have primarily failed among the Bamasaaba since it embodies no ability to confer manhood. The Bamasaaba believe that only a traditionally circumcised man becomes *umusaani burwa* (a brave man). Any man who receives SMMC is considered a coward and remains marginalised, discriminated against and stigmatised by traditionally circumcised men. For the Bamasaaba, the blood of a slaughtered animal coupled with pain endurance on the part of the initiates is essential for acquiring manhood and demonstration of masculinity.

At the same time, participants conceded that this understanding is subject to change, as evinced by the participants interviewed who subscribed to a different ideology and rejected TMC as the only means to the acquisition of manhood. For now, these men are in the minority in the Bugisu sub-region.

Keywords

Bamasaaba, Bugisu Sub-Region,
Tradition, Hegemonic masculinity,
Traditional male circumcision,
Safe Medical Male Circumcision, Uganda.

DECLARATION

I, Bernard Omukunyi, declare that ***The Bamasaaba People's Response to the Safe Medical Male Circumcision Policy in Uganda*** is my work. This work has never been submitted for any degree to any examination board at another university. I include a complete reference list of all the sources I have used or quoted.

MARCH 2021

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Bernard Omukunyi Date

DEDICATION

I dedicate this PhD thesis to my Father Late Peter Simiyu, Mother Mary Namono, wife, and all the family members of the Anglican Church of Transfiguration, Bellville, South Africa.

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TABLE OF ACRONYMS

AIC	The AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
AAP	The American Academy of Paediatrics
DoH	Department of Health
DHS	Demographic and Health Survey
EUDP	European Union Development Plan
FGD	focus group Discussion
IDUs	Intravenous Drug Utilizers
HIV	Human Immunodeficiency Virus
MC	Male Circumcision
MCP	Male Circumcision Policies
MMC	Medical Male Circumcision
MDG	Millennium Development Goals
MoH	Ministry of Health
NHC	National Health Council
MMR	Measles, Mumps, and Rubella
NHSPII	The Second Nation Health Strategic Plan
NHSPIII	The Third Nation Health Strategic Plan
NGO	Non-Governmental Organisation
NPH	New Public Health
NSO	National Statistical Office
ODI	The Overseas Development Institute

PEPFAR	President's Emergency Plan for AIDS Relief
RCTs	Randomised Controlled Trials
RHP	Reformed Health Policies
SMMCP	Safe Medical Male Circumcision Policy
SMMC	Safe Medical Male Circumcision
STI	Sexually Transmitted Infection
TASO	The AIDS Support Organisation
TMC	Traditional Male Circumcision
U.N.	United Nations
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNHRC	United Nations Human Rights Commission
USAID	United States Agency for International Development
VMMCP	Voluntary Medical Male Circumcision Policy
WHO	World Health Organisation

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DEFINITIONS OF KEY CONCEPTS

Response: The term 'response' means answer or reply, which may be either in words or in action. 'Response' in the current study implies the Bamasaaba men's reaction to the Safe Medical Male Circumcision Policy.

Manhood/hegemonic masculinity: The terms 'manhood' and 'hegemonic masculinity' refer to qualities commonly associated with men, such as courage, strength and sexual effectiveness. These qualities constitute the characteristics of hegemonic masculinity. Therefore, this study uses the concepts of manhood and hegemonic masculinity interchangeably.

Bamasaaba/Bagisu: The Bamasaaba originate from the Mt. Elgon area and the surrounding areas of Wanale, Wagagai and Namisindwa, all located on the eastern frontier of Uganda, currently known as the Bugisu sub-region. They are united in their strong traditions and culture, including the custom of male circumcision and their language, *Lumaasaaba* or *Lugisu.*

The Bugisu sub-region: The Bugisu is a sub-region in the eastern part of Uganda comprising six districts: Bududa, Bulambuli, Manafwa, Mbale, Namisindwa and Sironko. Culturally, Bungoma, Trans Nzoia, Uasin Gishu, Kakamega and Lugari in Western Kenya are part of the Bugisu sub-region, although they belong to another country. The Bugisu sub-region forms the home of the Bamasaaba who are commonly known as the Bamasaaba or the Bagisu. This study will use the terms Bamasaaba or Bagisu interchangeably.

Traditional male circumcision (TMC): This refers to a non-clinical practice whereby the foreskin of the penis is removed. For this study, traditional male circumcision is considered a culturally motivated action associated with the rite of passage to manhood amongst the Bamasaaba of the Bugisu sub-region. This practice is referred to as *imbalu* by the Bamasaaba and is performed by traditional religious surgeons. It represents a unifying element, a means of contact with the ancestors and a point of pride. The prescriptions of the initiation ritual are handed down from generation to generation.

Safe medical male circumcision (SMMC): This is a medical procedure previously performed on persons with health problems preventing their participation in TMC. In this study, SMMC refers to removing the foreskin in a hospital setting, primarily for HIV transmission prevention.

Uganda: This is a landlocked country in East Africa bordered by Kenya in the east, South Sudan to the north, the Democratic Republic of the Congo to the west, Rwanda to the south-west, and Tanzania to the south. Uganda takes its name from the Buganda Kingdom, which encompasses a large portion of the country's central area, including the capital, Kampala.

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

This study investigates the Bamasaaba people's response to the implementation of the Safe Medical Male Circumcision Policy (SMMCP) in Uganda. In order to pursue this, the concept of male circumcision is explored from a specific context within African traditional and medical perspectives, each of which has its own 'lens' through which the practice is viewed. Although the SMMCP was introduced primarily to stem the flow of HIV transmission, the control of disease is not a focus in this study. Instead, the area of interest is the intersection of two distinct approaches to male circumcision: the traditional or cultural approach, referred to as traditional male circumcision (TMC), and the clinical or medicalised approach, encapsulated in the policy and implementation of Safe Medical Male Circumcision (SMMC). The SMMCP has been widely rolled out amongst communities that practise circumcision in Uganda, stirring up considerable controversy and outright rejection in some quarters.

The study, therefore, investigates the impact of the SMMCP on the rituals and traditional values of the Bamasaaba and explores the extent to which SMMC has affected the philosophical construct of masculinity among selected Bamasaaba men.

Amongst the Bamasaaba, those who undergo the rituals of traditional male circumcision (TMC) are regarded as *basaani burwa* or 'brave men'. In contrast, uncircumcised and medically circumcised men are not seen as real men and are prohibited from playing a role at various traditional events. Given this social reality, it was crucial to analyse Bamasaaba men's meaning ascribed to circumcision – from an ideological rather than a merely functional perspective. To do so, I combine knowledge of indigenous beliefs and practices with the sociological gender theory of masculinity. This attempts to achieve an in-depth understanding of the Bamasaaba's response to contemporary health policies on male circumcision.

This research sets out to question the discourse on circumcision presented through the media in Uganda, which views male circumcision as an entirely medical matter and strips it of all cultural and religious associations central to the Bamasaaba's understanding of the practice.

The study uses qualitative methods to analyse the conflicting etic (outsider) and emic (insider) data, which view male circumcision from both medical and traditional perspectives, respectively. The literature reviewed fails to raise fundamental questions regarding the clash between two socially constructed understandings of the practice – the traditional and the medical. From the traditional perspective, the practice of male circumcision is closely intertwined with Bamasaaba men's construction of masculinity. The selected participants insisted that a male had to undergo TMC or *imbalu* to be regarded as a 'brave man' (*umusaani burwa* – singular; *basaani burwa* – plural).

Stigmatisation and social exclusion are still attached to uncircumcised or medically circumcised men in the Bugisu sub-region. Having investigated the various objections held by the Bamasaaba men toward SMMC, I argue for an appropriate strategy of implementing SMMCP among the Bamasaaba, showing why stakeholders should familiarise themselves with the traditional, cultural understanding of male circumcision before they attempt to implement SMMC. Such a comprehension may enable them to design a more appropriate strategy for effecting hygienic, safe and medically acceptable male circumcision amongst the Bamasaaba – a strategy that would somehow bridge the divide between the two approaches.

A related area of interest in this study is the dominant construct of masculinity amongst the Bamasaaba and how they may have to adapt this construct in view of encroaching Western notions of masculinity with its more 'medicalised' approach to TMC.

1.2 Background of the Study

Male circumcision is the total removal of the foreskin of the penis. In countries across the globe, this practice is undertaken for religious, cultural, social, hygienic and medical reasons (Maibvise and Mavundla, 2013). The practice is widespread as part of traditional culture among some black Caribbean, black African, Indian and Pakistani people in their home countries and countries such as the UK, Austria, the United States of America, the Philippines, Central Asia, Indonesia and the Pacific Islands (Mavundla et al., 2009). In these countries, about 30% of men

are circumcised to fulfil religious and traditional obligations. Of this percentage, "68% are Muslim, and 1% are Jewish" (Weiss et al., 2008: 567).

In Africa, male circumcision is performed in several countries, including Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Uganda, Egypt, Lybia, Tunisia and Zimbabwe; and in some West African countries, such as Ghana and Nigeria (Peltzer, 2012). In these African societies, male circumcision is carried out for cultural reasons and is seen as an initiation ritual and rite of passage from boyhood to manhood. In a traditional setting, male circumcision is primarily performed on boys aged 12 to 18 years. In most African communities, "the practice is conducted in a non-clinical setting by traditional surgeons with no formal medical training" (Wilcken et al., 2010: 907).

Barasa (2015) points out that traditional male circumcision (TMC) contains a vital moral and educational component as a rite of passage. During the ceremony, boys are informed about their responsibilities and duties as adult members of their community. The precise details of what the boys are taught are not well documented, especially in African societies, where the content of the messages conveyed is considered confidential (Peltzer et al., 2008). According to Wanyama (2013), the ritual of TMC often involves demonstrations of bravery and 'manhood' to confirm that the initiates are ready and worthy to become adult members of the community.

However, there are indications that since 2006, the focus of traditional male circumcision has shifted to HIV transmission prevention (Barasa, 2015). As Barasa notes, it appears that the customs and rituals associated with the practice are being diluted as communities and surgeons shift their focus to hygiene for HIV prevention.

The rampant spread of HIV continues to infect young people despite strong messages of sexually responsible behaviour. In the quest to find effective methods to remedy this, various African governments introduced Safe Medical Male Circumcision (SMMC) as an additional strategy (MoH, 2010). According to this UNAIDS (2007) project, trained health professionals perform male circumcisions under hygienic conditions in a hospital. Dickson et al. (2011:2) state that "randomised controlled trials for SMMC were first conducted in Orange Farm in South Africa in 2005".

In 2006, Uganda and Kenya conducted a second and third round of randomised controlled trials. These three randomised controlled trials confirmed that male circumcision performed in a sterile environment by well-trained and equipped medical providers is safe and can reduce the risk of HIV infection by 60%. Brito et al. (2009:1) confirmed that the randomised clinical trials showed that male circumcision has the potential "to reduce HIV infections by 50 to 60% in heterosexual men". Therefore, researchers recommended SMMC for developing countries with a high prevalence of HIV infections, including Uganda.

As a result, the Ugandan AIDS Commission reformulated and introduced the health policy on HIV transmission to include medical male circumcision (Rudrum et al., 2017). The Safe Medical Male Circumcision Policy (SMMCP) thus came into existence in 2010. The SMMCP arrived at a time when Uganda was implementing the national HIV policy, which focused on behavioural change through the 'A-B-C' method. 'A' stands for Abstinence (self-discipline); 'B' for Being faithful (fidelity); and 'C', for Condom use – for HIV prevention (Murphy et al., 2006). Due to this policy's success, Uganda has been applauded for having brought down its rate of HIV infections to 6.5% (Murphy et al. 2006 ; Rudrum et al., 2017). This was achieved through a broad-based information campaign focusing on behavioural change (Rudrum et al., 2017).

Geographically, Uganda is divided into four main regions, with the Eastern region having the highest number of HIV transmission infections. The Bugisu sub-region in which this study is located forms part of the Eastern region. The largest group of people in the Bugisu sub-region are the *Bamasaaba* (singular: *Umumasaaba*), who speak *Lumasaaba,* one of the Lugisu dialects.

Traditional male circumcision (TMC), commonly known as *imbalu,* forms one of the most significant cultural practices of the Bamasaaba. In Bugisu communities, TMC is generally performed outside of formal medical settings by traditional surgeons whose vocation is considered spiritual in nature. The practice is associated with a wealth of spiritual beliefs among all groups who practise it (Kibira, 2017). In Western Uganda, the Bemba and the Bakonzo also practise TMC. Like the Kusu of Western Kenya, these groups practice male circumcision as a significant cultural and religious ritual, not purely medical procedures. Other communities practising traditional male circumcision in this sub-region are the Sabiny, commonly known as the Sebei people.

According to Leddy et al. (2021), the Bamasaaba consist of a community that is highly traditional and culturally consider male circumcision a superstitious practice. In this context, superstition refers to any belief or practice considered supernatural that cannot be scientifically proven. Notably, the Bamasaaba's cultural and spiritual beliefs are essential to their identity, affecting every aspect of their lives (Wanda, 2013). The recent study has suggested the need to adapt the traditional and culturally superstitious practices in the Ugandan context (Leddy et al., 2021).

This study was limited to the Bamasaaba, who form approximately 8.3% of Uganda's national population. They perform *imbalu* for cultural, traditional and religious reasons (UNAIDS and WHO, 2007).

The Bamasaaba communities are organised under one cultural institution known as *Inzu ye Bamasaaba* ('palace of Masaaba'), headed by the ceremonial, cultural ruler called *Umukuuka*. *Umukuuka* is the king of the Bamasaaba. He is assisted by cultural leaders selected from various clans to form his cabinet, which oversees all cultural activities, including *imbalu*. Masaaba is the headquarters of the traditional Bugisu Kingdom, politically known as the Bugisu sub-region. The sub-region comprises six districts: Bududa, Bulambuli, Manafwa, Mbale, Namisindwa and Sironko (Sarvestani and Sienko, 2014).

In this political sub-region or cultural kingdom, the rituals of *imbalu* are officially opened by Umukuuka at the Mutoto Cultural Centre in the Mbale district on the first day of August of every even-numbered year. Studies of male circumcision in Uganda indicate that approximately 90% of men in the Bugisu sub-region have undergone TMC (Wabwire-Mangen et al., 2009). In response to the World Health Organisation (WHO) and United Nations Programme on HIV (UNAIDS) recommendations released in 2006/2007, the Ugandan Ministry of Health (MoH) extended its national HIV policy to incorporate medical male circumcision as one of several preventive strategies. The objective of this extension or reform to the policy was to scale up safe medical male circumcisions to prevent the spread of HIV (MoH, 2010).

Scholars, policy developers and implementers have justified SMMC by noting, firstly, that the traditional practice of male circumcision increased the risks of HIV infections (UNAIDS and

CAPRISA, 2007). Secondly, they have claimed that providers of traditional male circumcision have limited or no formal clinical training and perform TMC in non-clinical settings under unhygienic conditions (AFGH, 2010). Thus, in a bid to discredit TMC, they have claimed that it is ineffective at curbing HIV transmission (Bailey et al., 2007 ; Maughan-Brown et al., 2007). These researchers report that the life-threatening risks and health complications associated with traditional male circumcision are alarming. Other studies confirm their findings: 35% of complications related to TMC were found in Kenya, and 48% in South Africa, some of which record fatalities (Bailey et al. 2007; Herman-Roloff et al. 2011a ; Herman-Roloff et al., 2011b).

In Uganda, complications such as infections, delayed wound healing, bleeding, and excessive removal of the foreskin have been reported (AFGH, 2010). The Bamasaaba and other groups who practise traditional male circumcision believe that delayed wound healing, bleeding, and excessive removal of the foreskin form part of pain endurance that is essential to the ritual, and which thereby qualify a boy to be known as an *umusaani burwa*, or brave man (Wanyama, 2013). As *basaani burwa* (plural), traditionally circumcised men acquire respect, social acceptance and a sense of belonging to a collective (Wanyama, 2013). This collective is primarily shaped by a patriarchal understanding of life and a sense of individual identity firmly rooted in being a real man.

Fulfilling the rituals of traditional male circumcision grants men, the right to marry, inherit property and actively participate in cultural practices such as the ancestral offering of sacrifices (Meissner and Buso, 2007). By contrast, an uncircumcised man is known as *umusiinde* (singular) or *basiinde* (plural). Such a man is generally treated as a boy. If such a person marries, his marriage is usually disrespected by his wife, family and society until he is traditionally circumcised (Wanyenya, 2013). In addition, the *imbalu* ceremony has strong religious connotations for the Bamasaaba. They believe that *imbalu* links men to their ancestral world and that only traditionally circumcised men make it to that world when they die (Khanakwa, 2016).

In the context of this intensely spiritual, cultural and traditional understanding of male circumcision, the quest to prevent HIV transmission comes as an additional consideration for the Bamasaaba men, one of which they are not unaware. According to UNAIDS (2006), the cultural practices associated with TMC foster the transmission of HIV and other STIs. The Bamasaaba are attempting to hold on to their way with minimal modifications to accommodate

hygiene concerns in the face of significant changes sweeping through the country. As a unitary state under one legal system, Uganda is attempting to adhere to global standards in relation to health and other policies.

However, the Ugandan government walks a tightrope as it attempts to balance global and national concerns with various groups' rights, each with its own cultural and religious beliefs and practices. The government is aware that this background cannot be ignored, yet it holds the mandate to ensure its citizens' wellbeing and safety, maintaining proper health and hygiene standards. In the uneasy tension between these two concerns, it is inevitable that health will be prioritised as a national and global standard. This has been shown through the widespread implementation of the SMMCP. Still, the introduction of SMMC has met with some resistance amongst minority groups who hold a traditional understanding of circumcision that goes far beyond its physical or medical aspect.

From observations, it became clear that the government has implemented its SMMCP without probing how the policy is viewed and why it is resisted in many cases. No attempts have been made to consult with minority groups who circumcise or to work out ways of accommodating TMC, with modifications to make the practice hygienically acceptable. For this reason, it was deemed essential to investigate how the Bamasaaba continue to view and implement SMMC. Anecdotal evidence points to the Bamasaaba having conflicting notions and ideas on SMMC.

Many are dismayed that the system imposes medical male circumcision on them, especially in view of the fact that the law states they have the right to practise their traditional beliefs. While the reformed health policy does not ban TMC, it relegates traditional circumcision providers to an inferior and peripheral position (Wambura et al., 2011), overtly seeking to render them unnecessary through its well-funded marketing campaign and complete roll-out of SMMC. Anecdotal reports suggest specific socio-cultural reasons and inadequate knowledge of key SMMC messages may explain the disproportionately low uptake in this region (Nanteza et al., 2020). This is due to the health rules and regulations implemented by the Ministry of Health, which conflict with those people who hold local beliefs, traditions and values of traditional male circumcision (Semwali, 2021).

Conflicting or mixed feelings about TMC is not new to the Bamasaaba, who have, as a group, experienced ambivalence about medical male circumcision practices for generations

(Wanyama, 2013; Wanyenya, 2013). This study focuses specifically on the Bamasaaba's response to the implementation of the SMMCP. In part, it constitutes an attempt to establish whether the latter has resulted in any change in the Bamasaaba's construction of masculinities, besides the modern developments reported by scholars such as Nanteza et al. (2020) and Semwali (2021).

Central to this undertaking is the need to unpack the concepts of traditional male circumcision (TMC) and medical male circumcision (MMC) as presented in the Safe Medical Male Circumcision Policy (SMMCP). The study intends to shed light on a potentially conflicting health discourse delivered by the SMMCP, to establish how the Bamasaaba construct their masculinity through the act of TMC and to uncover the extent to which this construct of masculinity is affected or influenced by SMMC. Male circumcision may consist of a simple cut on the male body but carries significant cultural and spiritual meanings and undertones. Anyone seeking to understand SMMC resistance among the Baamasaba must appreciate that male circumcision holds distinct and overlapping traditional, cultural and religious significances.

1.3 The Rationale for this Study

This study's rationale may be traced to Western political pressure to reinforce the Sustainable Development Goals (SDGs) implementation and the European Consensus on Development in developing countries (Langan, 2018). These agreements express a shared vision and framework amongst the European Union (E.U.) member states for developing countries' development initiatives. The Republic of Uganda continues to be among the least developed countries in the world. Therefore, through its development programmes, the E.U. seeks to help it address critical social challenges such as the spread of HIV, governance matters in a fledgeling democracy and issues of gender discrimination (The Republic of Uganda, 2015).

The European Consensus on Development aligns with the African Union's development policy and the 2030 Agenda for Sustainable Development. The funding that comes with the E.U programmes has dramatically influenced economic growth in developing countries such as Uganda (Szopik-Depczyńska et al., 2018).

As part of their call for good health and radical HIV prevention strategies for developing countries, UNAIDS (2006) and WHO (2007) released health policy statements on the link between male circumcision and HIV prevention. These policy statements have strongly influenced the Ugandan government to reform or redevelop their National HIV Policy due to the strong links drawn between traditional practices and the spread of infections (AFGH, 2010). However, Action for Global Health (AFGH) (2010) claims that both the second Ugandan National Health Policy (NHP II) and the third National Health Strategic Plan (NHSP III) seem to ignore traditional male circumcision practices. Instead, these strategic plans strongly recommend SMMC as a "fit-for-all" procedure, including the Bamasaaba (AFGH, 2010).

These policies include a strong focus on effective, safe medical male circumcision, expressed through the SMMCP. Accompanying the focus on hygienic and safe circumcisions is a recognition of the ethics and humanity of male circumcision procedures, which are promoted as being both safe and pain-free. These public health policies reinforce clinical male circumcision as a biomedical intervention across all social and cultural groups (Lie et al., 2006).

However, Niang and Boiro (2007) have questioned how governments in sub-Saharan Africa, including Uganda, will credibly implement the Safe Medical Male Circumcision Policy (SMMCP) against strongly held beliefs in traditional male circumcision. Kaufman (2003) concurs, stating that convincing traditional communities to accept SMMC may be problematic in view of the many cultural and spiritual values associated with TMC. In light of the clear need to adhere to global and national standards of effective health promotion, this perceived difficulty provided the impetus to investigate the Bamasaaba's views and responses to the implementation of the SMMCP.

The literature reviewed for the study showed that the UN., WHO, UNAIDS and UNHRC all acknowledge that cultural practices in developing countries can present health risks and, in some cases, constitute a violation of human rights (Waiswa et al., 2008). These traditions carry social philosophies, activities and general principles that guide communities on their responses. For this reason, traditional activities such as traditional male circumcision practices are generally maintained and passed down the generations (Arowolo, 2010).

Despite this, the Ugandan Ministry of Health has portrayed and explained male circumcision from a Western perspective. This approach, which many African governments have also

adopted, seeks health principles that largely ignore the practices and beliefs of a minority group (Kalichman et al., 2018). This fact prompted me to understand how the Bamasaaba, whose practice of *imbalu* is so central to their identity and the construction of masculinity, responds to the SMMCP. I hope the findings of this study provide an in-depth understanding of the implications of the implementation of the SMMCP for the culture and identity of the Bamasaaba people.

Empirical investigations have not adequately engaged with how the Bamasaaba's notion of masculinity has been affected by the implementation of the SMMCP (Kibira, 2017; Kironde 2016; Kripke et al. 2016; Mugwanya et al. 2010; Nanteza et al., 2018). Angurini (2017) reported that the implementation of the health policy had caused conflict between practitioners of medicalised and traditional male circumcision, pointing out that local communities are historically attached to the traditional approach. This creates a need in the literature for information that will explain SMMC from the Bamasaabas' perspective.

Certain scholars have conducted studies on how Ugandans respond to Safe Medical Male Circumcision in Central and Western Uganda (Kibira, 2017; Kironde, 2016; Kripke et al., 2016; Mugwanya et al. 2010; Nanteza et al., 2018). Moreover, the research that comes closest to the current study in subject matter investigates the role and importance of traditional male circumcision among various tribes, such as the Bagisu and the Baluya in Kenya (Wanyenya, 2013). The former study only focuses on the use of male circumcision to prevent HIV and AIDS, thus opening the gap to investigate how the Bamasaaba are reacting to its implementation.

1.4 Problem Statement

Given the cultural and traditional significance of the Bamasaaba's initiation rituals conducted during traditional male circumcision (*imbalu*), safe medical male circumcision remains a contested intervention in the Bugisu sub-region. Although the Ugandan government developed and implemented SMMCP in 2010, I found no studies which have examined how the Bamasaaba have responded to the health policies on male circumcision.

Those who profess Christianity and the well-educated among the Bamasaaba tend to adopt SMMC, claiming that it fulfils the cultural requirements. However, conservative traditionalists

aver that SMMCs do not fulfil the essential social and cultural conditions of TMC. Traditionalists perceive the implementation of SMMCP as a political attempt to control people by abolishing traditional practices (Lukobo and Bailey, 2007). The researcher was thus interested in the overall response of the Bamasaaba to SMMC, in light of their deeply held convictions, their precarious sense of cultural identity and their construction of masculinity.

In essence, the problem is that the government, under the influence of global concerns, committed itself to roll out SMMC. The Bamasaaba, like many other traditional groups in Africa, are resisting it. There are; however, pockets of the Bamasaaba community choosing to abandon TMC in favour of SMMC. This dissent leaves unanswered questions about how the Bamasaaba construct masculinities. The TMC ritual has always been a significant expression of the hegemonic masculinity held up as the idea of manhood among the Bamasaaba. Within a group that once prided itself on its strength and unity, such rifts are of particular concern to the traditionalists rather than modernists.

1.5 The Research Objectives and Questions

1.5.1 Objectives

This study's broad aim was to explore and document the Bamasaabas' response to the implementation of the SMMCP. More specifically, the study sought:

1. to analyse the impact of SMMCP on the Bamasaabas' cultural practices
2. to analyse the social and political implications of SMMCP for the Bamasaaba
3. to understand how the Bamasaaba conceptualise masculinity in light of circumcision practices.

1.5.2 The Research Questions

The research questions which direct this investigation are on the list which follows.

1. What is the Bamasaaba's response to the implementation of SMMCP?
2. What is the influence of the SMMCP on the cultural practices of *imbalu*?
3. What are the social and political implications of the SMMCP for the Bamasaaba?
4. How does SMMCP affect the Bamsaaba's construction of masculinity?

1.6 Outline of Remaining Chapters

What follows is an outline of Chapters 2-8 of this thesis.

Chapter 2 presents the relevant theoretical framework and a review of existing studies. The chapter consists of a critical discussion of the theory of masculinities and demonstrates how the Bamasaaba used the concept of traditional male circumcision to construct hegemonic masculinity.

Chapter 3 presents the methodology of the study. It explains the nature of and rationale for qualitative research. It introduces the research site, research design, participant selection and sampling techniques, a profile of participants, the researcher's role in qualitative research, data sources, collection and management, data analysis and interpretation, ethical considerations and the limitations of the study.

Chapters 4 to 7 present and analyse data collected from the research participants, framing it in relation to the research objectives. These chapters systematically examine feedback from focus group discussions (FGD) and individual interviews with cultural leaders, medical officers, traditional surgeons, 2016 initiates, and clan leaders from Bududa, Manafwa and Mbale's districts. Chapter 4 presents data on the Bamasaabas' response to SMMCP; Chapter 5 reflects the cultural impact of SMMCP on their practice of TMC. Chapter 6 offers a systematic analysis of the data concerning the social and political implications of SMMCP on the Bamasaaba.

Chapter 7 dissects the Bamasaaba's construction of masculinity and its influence over their response to the implementation of SMMCP. This chapter invokes Connell's (2003) argument that the notion of masculinity is challenging to separate from the diversity of traditions and cultural practices surrounding male circumcision. The findings devolve from analysed data relating to the Bamasaaba's notions of masculinity and MMC. The contribution of De Vos (2005) is relied on as he notes that a discussion of the findings is a crucial aspect of thesis writing, as it is in this chapter in which a researcher extracts the meaning of data presented, enabling him or her to reach conclusions and to make recommendations.

Chapter 8 presents the conclusion, with a set of recommendations for further study.

1.7 Summary of the Chapter

This chapter presented an introduction and background to the study. It highlighted the tensions relating to the SMMCP in the Bugisu sub-district of Uganda, which the thesis seeks to investigate. It outlined the theoretical framework and methodology and presented the rationale, thesis statement, research objectives and research questions that motivated the study. Thus, the significance of the study was described, with a summary of the remaining chapters and definitions of the key concepts.

The chapter that follows presents the literature review and the theoretical framework of the study.

CHAPTER TWO

2 LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

The purpose of this study was to investigate the Bamasaaba's response to the implementation of the SMMCP and to understand its impact on the cultural and traditional practices of male circumcision amongst the Bamasaaba.

This chapter provides a general overview of male circumcision as it is practised globally. The literature review is a crucial requirement for the principal study and forms part of the emergent research design process (Neuman, 2002). Easterby-Smith et al. (2002) state it is appropriate that scholars familiarise themselves with existing studies before collecting data for their own. They state that in research, the literature review provides direction for constructing data collecting tools. The importance of this is that the use of appropriate tools guards against overloading the data collection stage. Easterby-Smith et al. (2002) observe that a review of the existing scholarship enables a researcher to formulate and articulate a critical analysis of the topic under review and empowers them to make meaning of the data collected, captured, transcribed and presented in later chapters.

In this study, both primary and secondary data sources formed an essential tool for understanding the phenomenon of SMMC and TMC as practised by the Bamasaaba. The literature review made use of sources derived from the Google Scholar search engine search, the UWC Library, the UWC database and newspapers published between 2000 and 2020. In addition, personal recommendations and citations made in other studies led to additional sources of information in accredited international and local journals. These included both recent and older journal articles from the academic domains of Sociology, Anthropology, Psychology, Public Health and Medicine, as well as Strategic Management and Organisational Science. Publications disseminated by local and international organisations such as the WHO and UNAIDS formed a valuable source of data.

2.2 Traditional Male Circumcision (TMC)

In African societies, male circumcision is a mechanism for transmitting three main aspects of crucial cultural information to boys (Mshana et al. 2001; Schenker, 2007; Vincent, 2008; Wotsuna, 2004). Vincent (2008) identifies these aspects as the secret code of the bush, the building of certain character traits and an understanding of the meaning of manhood. Vincent bases his findings on *ulwalukho* (traditional male circumcision) in the South African context, where he claims that the secret code of the bush is used as an instrument for young men to attain the standing of a man, to gain control over their household and to commit to the lifestyle required of a responsible adult. In these social groups, TMC has significant meaning as a mechanism for attaining cultural identity and unification in African culture (Kaufman et al., 2016). Mshana et al. (2001) argue that during this process, Xhosa males assume control and influence and are obligated to undertake family responsibilities as real men. Schenker (2007) adds that the TMC process requires that boys develop the attractive personal qualities of forbearance, courage, fortitude and strength in preparing themselves as men to face life in the future.

Studies by Mavundla et al. (2010), Kepe (2010) and Mhlahlo (2009) among the Xhosa people in South Africa, however, show that Xhosa males who have not undergone *ulwalukho* face social pressure from their communities. As stated earlier, Bugisu communities exert similar pressure on non-conforming males. The Bamasaaba men who are not traditionally circumcised are stigmatised mainly, rejected and marginalised by society. South Africa's government has noted that the practice of *ulwalukho* is frequently practised in unsafe and indeed life-threatening conditions by traditional surgeons who do not adhere to good principles of hygiene and proper care of the young men entrusted to them.

Furthermore, Feni (2012) points out numerous social problems associated with *ulwalukho* in Xhosa communities, including harsh treatment and conditions for initiates attending the initiation schools. However, his newspaper article drew much criticism from political, religious and cultural leaders in South Africa. One of the criticisms was that political figures for their political ends misinterpret the cultural practices of the Xhosa people. Critics of the article also maintained that people who find fault with the practice do not themselves undergo TMC and are not in a position to argue its merits and its dangers.

However, Feni (2012) backs up his claims by documenting the problems that caused the deaths of over 200 initiates in a particular period, mostly occurring in illegal initiation schools where inexperienced traditional surgeons claim to be more skilled than they are. In an earlier study by Van Vuuren and De Jongh (1999), it is pointed out that in Xhosa culture, what makes a man is his ability to endure harsh conditions. Therefore, mistreatment and extreme conditions are claimed to form an essential part of the process by the traditional surgeons and the clan, friends, and cultural leaders.

They claim that the process trains boys in endurance and prepares them for any hardship they may encounter in the future (Nqeketo, 2008). These claims notwithstanding, some politicians and government officials have called for the abolishment of TMC and recommended a medical male circumcision procedure to stem the ongoing deaths associated with every circumcision season amongst the Xhosa people (Feni, 2012).

Similarly, in Uganda, among the Bamasaaba, there are several theories regarding the origin of *imbalu* (traditional male circumcision). Some claim that traditional male circumcision started in Egypt around 4000 B.C. and spread to the Bugisu sub-region as a religious practice (Were, 1982). Another account tells of the first initiates being young men who developed medical conditions of the penis and were operated on as a means to save their lives (Nabafu, 2000). A third explanation is that the Bamasaaba circumcised the first initiate as a punishment for seducing other men's wives. The story goes that after he had been circumcised, he continued with his behaviour and was said to perform better than before. As a result, the other men adopted the practice to be able to compete favourably (Nzita and Mbaga-Niwanga, 1993, cited in Nabafu, 2000).

Yet another account that seems to be popular tells of Masaaba, a man from Mt. Elgon who married Nabarwa, a Masai girl. Nabarwa persuaded Masaaba to go through male circumcision as her kin practised it. He willingly fulfilled the condition for the love he had for her (Wotsuna, 2004). Later on, Mupuuya, a descendant of Masaaba, had children who frequently fell ill, and the cure prescribed by the traditional healer was for all the male children to be circumcised, as their ancestor had been. The maternal uncles of the children, Mupuuya's in-laws from Masailand, circumcised their nephews (Nabafu, 2000; Wotsuna, 2004). From then, the Bamasaaba continued to practise MC as a cultural practice that regulates the social norms in their society.

It is unlikely that any scholar would be able to attest to these tales, as they belong mainly to the realm of legend. It is important to ascertain how these conflicts and contradictions influence the health policy implementation and cultural practices of male circumcision in the Bugisu sub-region.

The following section reviews the global discourse on traditional male circumcision.

2.3 The Global Discourse on Traditional Male Circumcision

This section reviews the literature on male circumcision. In developed countries such as the United States of America and Britain, MC is sometimes viewed as a violation of human rights. The United Nations Human Rights Commission (UNHCR), an international organisation established to protect and assert all people's human rights, presents TMC as a violation of human rights. This perspective is reinforced when Cruz et al. (2003) state that human rights organisations have campaigned for TMC's permanent removal, claiming that it violates male children's rights. However, to those who practise TMC, circumcision forms an essential component of a balanced and orderly life, and it is a symbol of cultural identity. Proponents argue that they have the right to practise the necessary actions associated with their culture. However, the official position of UNHCR remains that TMC is a violation of human rights (Kibira, 2017).

Harcourt (2013) claims that since the United Nations (U.N.) has effectively used its health policy to eradicate female genital mutilation, the policy implementers have decided to extend their reach to male circumcision, viewing it as a violation of the human rights of men. Cruz et al. (2003) support the foregoing claim by arguing that traditionally performed male circumcision is not favoured as a social practice, especially by non-circumcising communities, and this, in turn, means that those who wish to practise it cannot regard it as a 'right'. They question whether the cultural right to practise MC overrides fundamental human rights. Closely linked to the violation of the human rights argument is the historical connotation of TMC with violence. Silverman (2004) identifies a case where men's group identification based on their circumcision status triggered violence and aggression among men who had not undergone TMC.

In support of Silverman's view, Aggleton 2007) refers to the Ottoman and Moorish Empires, India at the time of its partition and the recent genocide in Bosnia, where violence erupted due to men's circumcision status. Aggleton warns that a man's circumcision status can have serious consequences, including violence, torture, and death for those admitted using MC. Given the strong feelings associated with TMC and the spill-over of this practice into the political arena, it is essential to understand the political context in which MC is practised and perceived by traditional communities in African countries. The argument by Aggleton may be the point of departure for developing and implementing a male circumcision policy in multi-cultural and religious settings.

From a sociological perspective, every cultural group's fundamental beliefs, rituals, traditions and customs contribute to its distinctive cultural identity. Venganai (2012) remarks that the world is fascinating because human civilisation is composed of unique cultures and value structures, and these prompt individuals to view life and lifestyles in many different ways. For this reason, cultural practices ought to be understood according to the principles of people's unique cultures, not by the norms of other cultures (Venganai, 2012).

Osabu-Kle (2012) argues that the representation by WHO (2008), WHO (2007) and WHO (2011) of TMC is a human rights violation. It is seen or understood that the World Health Organisation has framed the African method of MC as a barbaric and primitive practice. From this premise, an attempt has been made to introduce health policies that aim at modernising African practices. This could be an indication that international organisations believe they are in a position to advise African countries on their way of life. However, Osabu-Kle (2012) maintains that that honour is reserved for the leaders in each African country.

Shisana and Simbayi (2002) argue that multiple meanings of TMC should be understood in the African context and that the practice should not be generalised. Thus, Osabu-Kle (2012) argues that it is problematic for generalisations to be made about the practice of TMC by organisations such as the WHO and UNAIDS (2007). Yet, despite objections raised by various African authors, it does not seem likely that the WHO and UNAIDS will refrain from making pronouncements on issues they regard primarily from a global and human rights perspective.

Osabu-Kle (2012) states that generalisations concerning health policies such as safe medical male circumcision policy are developed and implemented in all cultural and social settings.

That super-powers and transnational institutions have assumed the responsibility of advising governments of African countries. Scholars such as Darby (2003), Chong and Kvasny (2007) and Gollaher (2001) concur that in considering advice on the management and treatment of HIV transmission, developing countries should carefully consider the ethnopolitical ramifications of any new proposals put to them.

Asiimwe (2011) claims that' missionaries and colonial administrators advised local people to stop MC's traditional and cultural practice in many African communities. She explains that these institutions described their intervention as modernising MC for African people's greater welfare and health. In a similar vein, Maposa (2011) critiques the colonial perspective of Africa that the African lifestyle and the practice of TMC were entirely primitive and barbaric. Maposa argues that this view was propagated to justify Europe's mission to civilise and modernise Africans and exterminate indigenous traditions. But Chitando (2000) reinforces this position by arguing for the modernisation of African practices, a view that nonetheless seems to be supported by African leaders such as President Museveni. For 35 years, this President has been advocating for modernisation at the expense of cultural traditions.

Platon et al. (1993) reported that in Romania, the necessary framework for modernisation was provided. The framework was developed to include the process of organisation and evolution of ancient institutional systems to establish the morality and accepted principles of modern morality, the national state-building process and the evolution of social history (Schifirne, 2011). It is reported that the evolution of social history left organised cultural institutions dysfunctional. Therefore, it is argued that for modernisation to take place, certain cultural traditions and institutions are disadvantaged. For example, adopting medical male circumcision for health could result in adapting or eliminating most cultural and traditional practices of male circumcision to embrace modernisation in Uganda.

According to Chitando's (2000) view, some cultural practices are irrelevant in contemporary society. But a study by Dowsett and Couch (2007) points out that what is irrelevant in one community or society may still be very relevant in another. Silverman (2004) states that people ought to adhere to their cultural standards and abstain from ethnocentrism. Hence it is disappointing that organisations such as UNAIDS and WHO continue to view many African beliefs, customs and cultural practices from an ethnocentric perspective (Silverman, 2004). This perspective is especially apparent with regard to their position on TMC, practised in many

African societies. Although the literature by UNAIDS and WHO does not directly refer to male circumcision, I am of the view that UNAIDS and WHO cannot escape the inference that they are biased against TMC as practised in many African societies.

It has become clear that the WHO and other influential global organisations perceive TMC practices as unhealthy (WHO, 2007). Cruz et al. (2003) argue that in their campaign against TMC as practised in Africa, these organisations hold that certain social and religious practices increase the risk of HIV infections because of the lack of hygiene. These organisations believe that the traditional cultural practices of MC in African societies require modernisation to make them healthy and hygienic (UNAIDS and WHO, 2007). As a result, scholars such as Gwandure (2011) have called for the removal of the traditional practice of MC, claiming that it can lead to permanent scars, erectile dysfunction and damage to the penile glands. Kibira et al. (2013) also argue that *imbalu* of the Bamasaaba does not reduce the risk of HIV infections.

Kibira et al. (2013) state that MC's traditional and cultural form can act as a conduit for HIV transmission, especially when surgical equipment is shared. This observation has resulted in campaigns for MMC uptake to prevent the spread of HIV transmission and other STIs (Lukobo and Bailey, 2007). The government believes that SMMC is the only form of circumcision that can prevent HIV transmission infections. Coates (2005) hails the protective effects of MMC against HIV transmission infections, stating that it is the most significant achievement of African health policies and highly recommended for developing countries, despite its cost to communities' traditions and cultural practices in Africa.

Milos and Macris (1992) and Lagarde et al. (2003) contend that the WHO and UNAIDS recommendations present a dishonest discourse against the cultural practices of African communities. Waskett and Morris (2007) argue that the implementation of the reformed global health policies on MC may have the unintended effect of causing a decline in the rate of condom use globally, since it is apparent that some men, having undergone circumcision, believe themselves to have a 'natural condom'. Lukobo and Bailey (2007) claim that in sub-Saharan Africa, there is a perception that women prefer marriage to circumcised rather than uncircumcised men. Based on the literature by Milos and Macris (1992), Lagarde et al. (2003) and Waskett and Morris (2007), the WHO, together with the UNAIDS, is seen to be in a position to offer misleading information with regards to cultural practices in African communities.

However, the WHO and UNAIDS recommendations seem to carry an element of truth about an appropriate response to HIV transmission through physical contact with specific organisms or sexual intercourse with an infected person. Westercamp and Bailey (2006:8) state: "Circumcision is perceived to influence sexual drive, sexual performance, and sexual pleasure for the man and his partner, which is likely to influence decision making around SMMC". The implication of Westercamp and Bailey's (2006) statement is that some men might undergo MMC mostly to enhance sexual pleasure. However, Meintjies (1998b) notes that in Uganda, Kenya and South Africa, uncircumcised men opt for TMC to avoid stigmatisation and to gain acceptance by their peers. In alignment with this, Winkel (2005) and Mlewa (2013) reveal that some people from communities that do not practise TMC have expressed deep concern about those who may be forced to undergo MMC against their will.

From the above, it seems that the prevailing danger regarding the discourse on TMC is that the greatest critics of the practice seem to be from groups or communities that do not practise circumcision. As such, they tend to hold negative views of TMC. The effect of this is a tendency to resist MMC. For instance, Mhangara (2011) claims that these negative perceptions may lead to medicalised MC dominating TMC and may result in the eventual eradication of TMC. Asiimwe (2011) believes that African people cannot be expected to understand the practice of SMMC outside the context of colonialism, which attempted to destroy the rituals of TMC and African people in general. Bailey et al. (2002), Mavhu et al. (2011), Mhangara (2011), Ngalande et al. (2006) and Scott et al. (2005) all argue that before colonisation began in Africa, TMC was practised far more widely by more ethnic groups than is currently the case.

Wilcken et al. (2010) draw attention to the political games that may be played under the pretext of pronouncing on spiritual or health-related issues. They argue that the failure to remove political undertones from the discussion about the spirituality associated with TMC has led to a misunderstanding of the African concept of TMC. Due to these misunderstandings, the practice is regarded as something inferior and borne of ignorance. This view permeates the thinking of even some Africans, despite its being propagated primarily by non-Africans. This kind of perspective has resulted in developing some policies that determine how people must live their lives. Conducting the current study will establish how Africans, such as the Bamasaaba, respond to the SMMC policies.

Jensen (2001) argues that African traditions are far different in reality from how they are perceived by those who do not practise them. For example, the Bamasaaba believe that to become a traditional surgeon, one must have a spiritual calling from the ancestors. This is something that many who do not share a common African identity would not understand in any depth. It is articulated by Wilcken et al. (2010), who describe TMC as a spiritually motivated practice with social norms attached. TMC is a social activity with cultural significance rather than a mere physical or mechanical activity.

2.4 TMC as Practised by other Cultures

Generally, TMC in Africa is associated with religious beliefs and cultural identity (WHO and UNAIDS, 2007), as is the case amongst the Jewish people and the early Egyptians. Vaidyanathan (2011) points out that unless male children in the Jewish religion are born with medical complications, the procedure of MC is performed eight days after birth. Vaidyanathan's argument shows that traditional male circumcision is not a predominantly African custom but forms part of Judaism. In the Jewish sacred book, the Torah, MC symbolises an agreement made between Abraham and God.

Having inherited specific Jewish law and customs, Christians believe that male circumcision is God's command to all men. The Bible (Holy Bible, Genesis 17:10) expresses this as follows:

> This is my commandment, which you must keep, between you and me and thy seed after thee: each male among you should be circumcised.

Some Christian scholars interpret this commandment as alluding to a spiritual rather than a physical circumcision. Wenham (1994) tacitly agrees that male circumcision is not compulsory in the Christian faith, as it is in Judaism.

By contrast, Gollaher's (2001) argument approaches the traditional African one more closely. He states that through the practice of TMC, important morals and beliefs regarding the family and social relationships are imparted to the adolescent male. He points out that the ceremony associated with TMC can define people and regulate people's way of living.

A qualitative study by Wenham (1994) states that MC is compulsory for all Muslim men to establish social and cultural identity amongst them. Wenham does not explicitly state, however, whether MC practised in the Islamic faith is conducted ceremoniously or as a medical practice. Wenham (1994) notes that the Islamic tradition of MC also stems from the covenant made by God with Abraham, who is regarded as the father of Judaism, Christianity and Islam. According to Ebrey (2013), MC in the Muslim tradition is performed as an outward show of cleanliness among God's people and is associated with the significance of cleanliness amongst Muslim people, who engage in bodily cleansing before prayers.

Leadbeatter (2012) notes that globally Muslim communities do not force TMC on their members. However, to qualify as a member of the Islamic faith, one must go through certain Tahir rituals (circumcision of the flesh). The statement by Leadbeatter indicates that Islamic societies have an opportunity to choose either traditional or medical male circumcision. Wanyama (2012) argues that this is not the case amongst the Bamasaaba who identify as Muslim. The literature suggests that in the Bugisu sub-region, the Bamasaaba practice of TMC is regarded as essential, no matter what one's religious affiliation is.

According to Ebrey (2013), TMC is used to maintain the traditional cultural norms of the Bamasaaba. Some Christian Bamasaaba men practise TMC, but it is not regarded as an obligation according to their faith. In such cases, they may do it purely out of respect for the culture and not for spiritual reasons. Leadbeatter (2013: 37) states:

> Christianity does not usually promote male circumcision as a religious practice; there are churches such as the Orthodox Christians in Ethiopia, who almost universally practice male circumcision. This does not mean that other Christians do not get circumcised or circumcise their children, and it is done for reasons other than a religious obligation.

UNAIDS (2007) has expressed concern that TMC sometimes involves children; in such cases, it recommends that circumcision is performed under hygienic conditions with the permission of the parents. It also suggests the adoption of medical male circumcision as an ideal model for the entire group in cases where TMC is practised – rather than for a few individuals within the group. Gitywa (1976) asserts that TMC, as practised in African societies, has much in common with the Biblical understanding of TMC, as it expresses the norms, values, culture, religious beliefs and identity of the group. Gitywa's statement concurs with Wenham (1994), who also

states that Christians use biblical verses to justify the significance of the rituals performed during TMC ceremonies.

In the religious context of Islam, TMC generally occurs between infancy and the start of puberty. The recommended age is usually before ten. Leadbeatter (2012) argues that some Muslim communities perform MC in medical settings, especially in developed countries. However, he points out that male circumcision is incorporated into traditional African rituals in African Muslim communities. Examples of such cases are the Yao people of Southern Africa and the Bamasaaba of the eastern part of Uganda in East Africa.

2.5 TMC among the Bamasaaba

As indicated, in the Bugisu sub-region, a definite traditional and cultural significance is attached to *imbalu* (TMC). Therefore, it was essential for the researcher to ascertain the Bamasaaba's position on TMC as a social, cultural and religious practice. In the course of reviewing the literature, it became clear that the Bamasaaba regard TMC as a mechanism for transmitting three main aspects of crucial cultural information to young men, which will be discussed in this section.

A study by Nabafu (2002) reveals that some African communities use traditional male circumcision to qualify boys as eligible candidates for marriage. From Nabafu's perspective, some people may misunderstand the cultural underpinning of the ceremony and use MC as a justification for risky sexual behaviour. However, this factor alone would be insufficient to justify the government's move to replace TMC with medical circumcision in the Bugisu sub-region.

If the government were to eradicate TMC among the Bamasaaba, they would be eradicating a significant expression of the culture and rite of passage for young men. Nabafu (2002) refers to initiation as 'all those rites of passage' that the government ought to help the Bamasaaba protect rather than seek to eradicate. The initiation ritual involves moments of crisis, requiring initiates to show self-denial and sacrifice. Benezeri et al. (1997) explain that through accepting suffering, self-denial and sacrifice, young men learn to appreciate the worth of others.

The foregoing scholars attempt to show the social values attached to TMC and the lessons learned from the ceremony by Bamasaaba men. They assert that TMC has always been a gateway for young men to come to terms with their identity, to understand good relationships, to be initiated into the idea of respect for women, and to value equitable access to productive resources – all components of social and cultural values in traditional Bamasaaba society. In contrast to the literature reviewed thus far, Wotsuna (2004) presents TMC as a ritual comprising seven specific phases, in total lasting for an entire year. Wotsuna claims that during the year after circumcision, the initiate gets to experience the life-giving nature of TMC. During this limited period, the young man enjoys a pleasant social environment that enhances his personal development.

Wotsuna (2004) makes an essential contribution to the literature of TMC, taking issue with researchers who see the rituals of TMC as confined to only specific events over a few days. Wotsuna points out that among the Bamasaaba, the events of the ritual itself include the following: there is the Bamasaaba communal dance (*isonja*), then the symbolic search for a woman (*khuwentsa*) and the thrashing of millet (*khukhupaka buuloo*). Other rituals include the brewing of beer (*khukoya),* the convalescence period (*mwikombe),* the hatching ceremony *(khukwiyalula),* and the commissioning dance *(ineemba).* These events mark a transition, the effects of which are especially felt in the year after the event, according to Wotsuna (2004).

When considering these procedures, it is easy to imagine that the lessons learned during the rituals of TMC could last a lifetime, not merely for a few days or even a year. Wangusa (1989) wrote a novel entitled *Upon this Mountain*, in which he creates a vivid impression of *imbalu* as a vital and life-affirming ritual; it is set in the early years of colonialism. His literature is a potent reminder of the essential worth of the circumcision ritual, filled as it is with the songs and folk tales of the Bamasaaba. His work also portrays the clash between traditional culture and the upwelling forces of colonialism and Christianity, experienced so strongly in the early years of the twentieth century, and still reverberating today.

His representation of the conflict is neatly encapsulated in the views of the two protagonists, Wopata and Masaaba, who act as mouthpieces for the two opposing views of *imbalu.*
The author shows the negative consequences of the feud in the sorry state of their sons. Through the characters of Wabwire and Mwambu, the sons of Wopata and Masaaba, Wangusa

(1989) shows that the age-mates (*bubakoki*) of *imbalu* made positive contributions to the social and cultural development of the people in the Bugisu community.

The current study seeks to look beyond loosely held negative attitudes to TMC, often promoted by institutional agents of foreign cultures and expressed through government SMMCP health policies, which may inadvertently strip a people of one of their most essential rituals for promoting respect of self and others.

The literature in this section has demonstrated some contradictions between TMC and SMMC practices. It further indicates that cultural identity embedded in the practice of *imbalu* is limited in scope, and there is scant attention given to the response to SMMC in the Ugandan context. The literature also fails to deal with aspects of the Bamasaaba's reaction to the SMMCP and implications for *imbalu* and construction of hegemonic masculinity.
The current study focused on the response to the implementation of the SMMCP. It established how the aspects mentioned in this section are embedded in the practice of *imbalu* and the rise of SMMC, which is discussed in the next section.

2.6 The Rise of Safe Medical Male Circumcision (SMMC)

Numerous researchers have explored the link between MMC and a lowered risk of HIV infections since the beginning of the pandemic in the 1980s (Rennie et al., 2007). Fink (1986) was one of the early scholars of the pandemic and among the first to suggest the protective effects of MMC against HIV transmission infection. Since then, countless numbers of observational epidemiological research projects have reported the significant association of SMMC with lowered risks of HIV infections (Bailey et al. 2001; Bongaarts et al. 1989). In 1999 and 2000, two meta-analyses of the observational studies reported a significantly reduced risk of HIV transmission among circumcised men and reported high infections of HIV among uncircumcised men.

Van Howe (1999) and Weiss et al. (2000) reported relative risks of 0.52, or 95% CI 0.46-0.68, identified in uncircumcised men. This literature is somewhat misleading because 95% refers to the confidence interval, not the relative risk, as stated by the scholars above. In a subsequent study by Auvert et al. (2005), the infection rate in uncircumcised men was 0.85 per 100 person-years in the intervention group and 2.1 per 100 person-years in the control group. The evidence

from that study corresponded with the relative risk of 0.40 (95% CI; 0.24%-0.65%;$\rho = 0.001$). Gray et al. (2007) conducted a similar survey among 2 784 men aged 18-24 years in Rakai, Uganda, and 4 996 uncircumcised HIV negative men aged 15-49 years in Kisumu, Kenya. These scholars reported that MMC showed a 53% reduction in the rate of HIV transmission in Kenya; and a 51% reduction in Uganda.

It emerged from the literature reviewed that circumcision studies focused mostly on how MMC can be used to prevent HIV transmission. Based on their research results, scholars made urgent calls to prioritise SMMC for the prevention of HIV infections and to introduce new prevention technologies that would enhance the package of effective prevention methods. At present, 'there are global concerns over the high incidence of HIV and AIDS transmission in sub-Saharan Africa, where 22.0 million, or 67% of the total global population, live (UNAIDS, 2008:7). Globally, in 2007, there were 2.7 million new infections, with 1.9 million in sub-Saharan Africa. These global trends of HIV transmission led UNAIDS and WHO (2007) to observe that by the end of 2006, an estimated 39.5 million people were living with HIV, and 4.3 million had become newly infected with the virus that year.

Alderman et al. (2013) report that the WHO and UNAIDS called an international consultation meeting to review the results, discuss the health policy implications, and make recommendations regarding public health issues. In these meetings, the participants concluded and made several recommendations. The research evidence was compelling because three randomised controlled trials showed that MC performed by well-trained medical professionals was safe and reduced the risk of acquiring HIV infection by approximately 60%. The scholars recommended that MMC be recognised as an efficacious intervention and an additional strategy for preventing heterosexually acquired HIV infection in men (Tumwebaze, 2012).

Alderman et al. (2013) claim that scholars drew other conclusions too, noting that MMC did not provide complete protection against HIV infection. Alderman and his colleagues found that circumcised men could still become infected with the virus, and if they were HIV-positive, could still infect their sexual partners. Alderman's observation signalled that MMC could not replace other interventions to prevent heterosexually transmitted HIV. This suggests that the socio-cultural context should inform MC programming and influence how MMC services are rolled out. The prior studies have also raised the need to address the social implications of

MMC as an HIV prevention method, requiring monitoring to minimise potential harmful outcomes.

Accordingly, WHO/UNAIDS (2007) has emphasised appropriate messages and communication about MMC and the consideration of human rights and legal and ethical principles to guide service delivery. The Ugandan government has developed applicable laws, regulations and health policies for the accessibility and safety of MC without discrimination (MoH, 2010). On paper, traditional practitioners were involved in stakeholder consultations to design and deliver SMMC programmes (WHO/UNAIDS., 2007). Yet from the findings in this study, it appears that such consultations were not carried out, and medicalised circumcisions were still seen to stand in stark opposition to TMC.

Soon after the roll-out of SMMC in Uganda, media reports saw Serwadda (2009) arguing that medical male circumcision reduced the infection rate of HIV (The New Vision newspaper, Wednesday, January 28, 2009). The article entitled, 'Research methods determine the results', notes the reduction of HIV by 77% amongst Rakai men who had undergone SMMC. In addition, he observes that the cost of providing SMMC is far less than that of providing antiretroviral treatment to a single man over a lifetime. Serwadda (2009) also notes secondary or further benefits: reduced women's infections due to fewer infected men. He concluded that MMC might offer a critical method for initiating HIV prevention but recommended it be accompanied by voluntary testing and counselling with behavioural approaches such as the 'A-B-C' method (abstinence, faithfulness and condoms).

Although there appeared to be consensus on the benefits of male circumcision between UNAIDS and WHO (2007) on the one hand, and the practitioners of TMC, on the other, Serwadda (2009) points to significant differences. He recognises that TMC among the Bamasaaba includes a spiritual element that demands more of the initiate than simply undergoing a physical procedure. Wotsuma (2004) points out that once initiates have undergone the procedure according to traditional practice, they are expected to serve in the community's cultural and spiritual life and are prohibited from doing so if they had not undergone the SMMC procedure. The spiritual ramifications of the TMC ritual pose a threat to SMMC, which cannot claim to have such a component. Accordingly, it does not meet the traditional and cultural requirements of MC in the Bugisu sub-region.

Serwadda (2009) cites the statistic that the introduction of SMMC reduces HIV transmission by up to 60%. His article may have been instrumental in promoting the shift from TMC to MMC.

Green (2012) observes that the launch of the national campaign for the SMMCP included praise for the Bamasaaba for already practising male circumcision. However, the region's HIV infection rate at 6.9% remains slightly less than the national average of 7.3%, indicating that the SMMC practitioners' endorsements may not have been well-founded (Green, 2012). The figure stated in Green's study seems to blow a whistle that SMMC is more effective at reducing HIV than TMC.

The WHO and UNAIDS have endorsed MMC programmes conducted in 13 countries in East and Southern Africa, which have a high prevalence of HIV infections. Barnes and Parkhurst (2014) observe these organizations report that Kenya achieved a 45.5% rate of medical circumcision for men, the highest figure amongst 13 targeted developing countries. The World Health Organisation pointed out that Kenya had set a high target of 94% of men aged 15 to 45 years, while other African countries had set theirs below 80%. Kigozi et al. (2008) indicate that Uganda fell among the African countries with the lowest SMMC adoption rate for HIV prevention, having achieved less than 1% of their target coverage, especially in the Bugisu sub-region.

Many studies indicate that MMC can reduce men's risk of contracting HIV from their infected female partners by approximately 60% (Mbonye et al., 2016). The question remains whether this intervention has had any significant effect on men having unprotected sexual intercourse with HIV-positive medically circumcised women. The literature advocates no female medical circumcision for women and wholly discounts its effectiveness to reduce the risk of HIV transmission and other sexually transmitted diseases (Mbonye et al., 2016). Hence, female circumcision was abolished in Uganda. (Mujuzi, 2012).

The literature demonstrates clearly that SMMC is used to reduce HIV transmission by removing the foreskin of the penis. Yet, amongst groups where MC is broadly adopted as an HIV prevention strategy, the advantages are likely to emerge only in the long-term. In any event, the various reports and studies still fail to show how the Bamasaaba have handled SMMC in light of the intricate cultural value of TMC.

The section that follows reviews the literature on the cultural discourse surrounding MMC. Due to the current study's scope, I reviewed only the literature pertaining to Sub-Saharan Africa.

2.7 MMC in Sub-Saharan Africa

This section reviews the literature pertaining to views on MMC in some African countries located in sub-Saharan Africa.

Malawi

The executive summary of the Malawi Voluntary Medical Male Circumcision Commutation Strategy (MVMMCCS) 2012-16 indicates that Malawi has integrated Voluntary Medical Male Circumcision (VMMC) into its HIV-prevention interventions. The government of Malawi believes that there has been much progress on service delivery and strategic planning of the VMMC programme in that country. The report states that there is also a need to ensure that the public is aware of VMMC and its benefits (as well as its risks) through a comprehensive communication strategy (Choko et al., 2015).

However, the pilot programme in Lilongwe, Malawi, reported that unsafe surgery, a lengthy recovery period, cultural beliefs, religious beliefs, affordability and age were significant reasons why Malawians generally rejected clinical male circumcision policies (Jung, 2012). Contextualizing this finding, Dickson et al. (2011) and WHO (2013) report significant resistance to national male circumcision policies in sub-Saharan Africa more generally. However, Dickson et al. (2011) point out that the presence of traditional or cultural practices is insufficient on its own to deter the adoption of MMC. Other political organs such as the health department and traditional or cultural institutions are required to actively promote MMC and extol its benefits in this developing country. Jung (2012: 105) states:

> Considering the low perceived acceptability of male circumcision for most Malawian males, except for Muslims and Yaos, the pilot program needed to start with a sensitisation program. This sensitisation program could help to provide villagers with information about the health benefits of male circumcision and a free operation at the hospital.

Furthermore, in their situational analysis of MC in Malawi, Bengo et al. (2010) recorded the Malawian government's disappointment with the local people's response to the male circumcision policy. Ngalande et al. (2006) and Bengo et al. (2010) point out that while it is essential that people realise the health benefits of MMC, the procedure was not free of charge. In their report, Westercamp and Bailey (2006) confirm that the high costs of the MMC deterred the majority of local people. These costs were not only in the form of payment to the surgeons but also the costs of the healing process.

Westercamp and Bailey (2006:348) report that in Malawi, participants in their study raised concerns regarding the implementation of the MMCP; they cited 'lack of access to health care and required time away from work' as impediments. Another objection was a perceived loss of penile sensitivity and reduction in penis size. These perceptions indicate that the local people anticipated perceived disadvantages and did not consider the health benefits of MMC to be compelling. Some participants in Westercamp and Bailey's (2006) study also raised issues such as decreased ability to satisfy women, excessive sexual desire and increased promiscuity. These factors seem not to have been a concern during the implementation of the same health policy in other developing countries.

According to the literature, the policy was implemented in Malawi, but it is still unclear how many local Malawian people, notably from the Yao communities, responded by volunteering for MMC. Parkhurst et al. (2015) report that national data from Malawi suggests the scaling up clinical male circumcision for HIV prevention leaves unpredictable outcomes. Parkhurst et al. (2015: 16) report that

> … 2010 Demographic and Health Survey (DHS) includes statistics of HIV infection from a sample of 6834 men, reporting an HIV prevalence of 10.3% in circumcised men but only 7.9% in non-circumcised men.

Significantly, this kind of data has raised critical questions about the effectiveness of implementing the SMMCP for HIV prevention in African countries. To many, the results of these sorts of investigations are hardly convincing and seem to contradict the much-touted figure of a 60% reduction in HIV infection among medically circumcised men. Such observational findings seem likely to confuse local people in African countries.

Lesotho

In Lesotho, too, the implementation of the global health programme included a medical male circumcision policy as a medical intervention to combat HIV.

As in Malawi, the implementation of the medical intervention received an inadequate response from the local people (WHO, 2012). Barnes and Parkhurst (2014) argue that articles that try to explain the low level of acceptance of medical male circumcision do not adequately address the political nature of decision-making. The political or social aspect is especially relevant in communities with diverse cultural, religious and political beliefs.

Makatjane et al. (2016) state that Lesotho has the second-highest incidence of HIV transmission globally – the figure stands at 23% of the population. Convincing proof from many clinical reviews and randomised clinical trials in Africa have propelled the researchers to recommend VMMC. They show that it decreases the risk of contracting HIV infections in heterosexual men. Thus, these researchers were surprised that the outcomes of the Demographic and Health Survey (DHS) produced contradictory information. They record that the Demographic and Health Survey (DHS) presents the perplexing percentages of a 21% incidence of HIV transmission among circumcised men; and a 16% incidence among uncircumcised men.

Despite the evidence of the protective impact of MMC from environmental reviews and randomised clinical trials, some national policies and programmes in sub-Saharan Africa have neglected to bolster this potential impact with appropriate messaging and campaigns. According to Garenne (2008), information from 13 African DHS studies indicated that no message had subsequently been sent out to reinforce the protective potential of MMCs. DHS procured their information from 18 nations and reported that in ten countries, including Lesotho (Mishra and Assche, 2009), no relationship had emerged between MMC status and reduced HIV transmission rates. Behavioural change was also not in evidence. This situation may be due to the neglect of essential campaign messaging to bolster the idea that MMC could avert HIV infection.

According to UNAIDS, the 44 164 MMC operations conducted in Lesotho would have required upscaling by a factor of seven to have effectively reduced the HIV infection rate in

that country. This scale-up would have helped this developing country to change its position slightly from being at the very bottom of the list of HIV prevalence in Africa (having the highest incidence of infection). Authors such as Bailey et al. (2007), Chimbwete (2007) and Cohen (2005) claim that the people in Lesotho undertook MMCs as a legal obligation while the literature is not clear as to whether SMMC was compulsory for all Malawians.

South Africa

In South Africa, as in most developing countries, investigations into MMC revealed variation in how findings were interpreted. Majaja et al. (2010) believe that the South African state health department recognises that men's attitudes are crucial to the MMC programme's success. Majaja et al. (2010) believe that uncircumcised men in South Africa are responding to the health policy with the perception that this status allows them to have 'safe sex' with multiple partners. Furthermore, Lagarde et al. (2003) observe that others might mistakenly perceive MMC as a means to obtain a 'natural condom'. In their study, they note that in South Africa, some participants were concerned that MMC could promote sexual promiscuity due to the curiosity of the newly circumcised about the effect of the new shape of their penis on the act of sexual intercourse.

On the whole, traditional communities who regard TMC as an essential part of their cultural identity have resisted and hence constrained the success of MMC programmes in Africa. Aggleton (2007) states that the Voluntary Medical Adult Male Circumcision Policy (VMAMC) did more than strain cultural and religious relationships. They point out that the roots of this health policy, based on epidemiological information obtained in Kenya, South Africa and Uganda, were formulated in Geneva and supported by global health organisations such as the WHO. Numerous scholars such as Scott et al. (2005) and Mbito and Malia (2009) believe that at least in South Africa, disagreements over the implementation of the SMMCP may be decreasing along with the fault-lines of identity politics. In South Africa, the government opened discussion on MMC in a combination of influential debates, which allowed for extended arguments both for and against the roll-out. The dominant ideas in these debates concerned the value of TMC to cultural identity, and South Africa's national independence guaranteeing the right to regulate its policies.

Shisana and Simbayi (2002) reveal that the increase in HIV transmission and risky sexual behaviours could contribute to a more positive response to MMCP in South Africa. Scott et al. (2005: 349) also state:

> Men were eight times more likely to accept male circumcision if they believed that circumcised men enjoyed sex more and six times more likely to accept circumcision if they believed women enjoyed sex more with circumcised men.

This study also revealed that older South African men were more likely to be motivated to accept MMC with the perception that MMC would allow them to give women greater sexual pleasure (Scott et al., 2005).

Striking a different note, Tulloch et al. (2011) sought to investigate the medical male circumcision policy's adoption as an HIV prevention health strategy in developing countries such as South Africa. They intended to frame the findings as part of policy and practice. Their investigation reveals certain cultural practices were hindering the development of a national policy on MMC in South Africa. Tulloch et al. (2011) argue that the low uptake of MMC may be traceable to the poor communication strategy that accompanied it, leading to public misunderstanding of the commitment to the scientific principles supporting MMC in the country.

Kenya

In Kenya, Moguche et al. (2011) argue that the VMMC programme encountered substantial resistance in communities and the legislature. However, much of the opposition was overcome, and Herman-Roloff et al. (2011) state that the Kenyan government elicited a positive response to the VMMC programme through its improvement and execution plans. They expected that the rate of HIV infections would be substantially reduced through VMMC scale-up and that those in power would be willing supporters of the policy. The government believed that it was possible to start and extend the VMMC programme in a short time frame. Herman-Roloff et al. (2011) believe that the Kenyan VMMC programme constitutes one of the more successful early MMC interpretations by public health research organisations.

The Kenyan experience of MMC may provide a model that might help other African countries encountering a slower scale-up of their VMMC programmes. Surprisingly, there was no

resistance to the implementation of the Voluntary Medical Male Circumcision Service (VMMCS) from the cultural and traditional leaders in Kenya. The active engagement of traditional and cultural leaders served as the foundation of the successful national roll-out of MMCs in Kenya (Herman-Roloff et al., 2011). Kenya's ability to consider numerous ways in which to deal with and manage execution challenges holds critical lessons for other nations in sub-Saharan Africa.

The experience of Kenya's VMMC programme underscores the importance of having a well-planned, comprehensive methodology for HIV prevention. The success of the Kenyan HIV prevention strategy was partly due to the full-time staff's support in the national government, private health organisations, and community leaders, such as cultural and clan leaders. They were devoted to the implementation of the health programme (Herman-Roloff et al., 2011).

Thus, Kenya's success in the implementation of the reformed health policies on male circumcision stands in stark contrast to the experience of other developing countries, such as Tanzania.

Tanzania

In Tanzania, the Minister of Health, and Director of Human Resources for Health Development in the Ministry of Health and Social Welfare, Dr Gilbert Mlinga, stressed that there was a need for deliberations on the topic (Tanzania Ministry of Health, 2010). Discussions, he declared, could help Tanzania progress in its efforts to introduce medical male circumcision in the country (Tanzania Ministry of Health, 2010). He stated that HIV prevalence in Tanzania was high, even though work on male circumcision had begun in 2006. However, progress had been slow across the country, with only a 5.7% uptake by 2010 (WHO, 2010). The literature did not reveal more recent figures for Tanzania.

In 2010, the Minister stated that implementing any interventions to improve Tanzania's disease burden meant facing significant constraints such as limited human resources, lack of available finances and a shortage of medical male circumcision supplies (Tanzania Ministry of Health, 2010). These constraints affected the roll-out of male circumcision programmes, so Dr Mlinga called for potential partners to identify sustainable funding for these aspects to improve the situation in Tanzania (Tanzania Ministry of Health, 2010).

Nnko et al. (2010) found that despite the Sukuma people's disappointment, the Christian community in Tanzania desisted from promoting TMC in that country on religious grounds (Nnko et al., 2001). Nonetheless, Wambura et al. (2011) noted a significant shift from traditional to medical male circumcision in Tanzania. This shift created an opportunity for the Republic of Tanzania government to introduce Medical Male Circumcision Services (MMCS) to sustain the demand of its population. Moreover, a study by Tarimo et al. (2012) conducted with the Tanzanian police force in Dar es Salaam reveals that knowledge, beliefs, perceptions and attitudes towards TMC determined a positive response to MMC for HIV avoidance ('MC-for-HIV') in that country.

I shall now narrow the focus to review the literature pertaining to Uganda's national response to MMC plans and the regional (Bugisu) response in particular.

2.8 Medical Male Circumcision in Uganda

There is scant literature on how local communities in Uganda have responded to the Safe Medical Male Circumcision Policy (SMMCP) implementation and none on the specific response of the Bamasaaba. They understand TMC as a social, cultural and religious practice. Thus far, no research on their response has been undertaken. This is one reason the current study focuses on how the Bamasaaba of the Bugisu sub-region respond to the reformed health policies on male circumcision. These policies seem to exclude the traditional practice of *imbalu* (TMC).

The government of Uganda is concerned that many local people, especially the Bamasaaba, the Sabini, the Bakonzo and the Bamba, believe that traditionally circumcised men do not contract HIV. Similarly, Mlewa (2013: 66-67), in his study on the acceptability of MMC, states:

> … the consequences of poor access to information is the belief among both men and women that circumcised men are safe from contracting HIV, fuelled by the perception that circumcised men have a 'natural condom'. This is despite public health messages that stress the partial protective effect of the procedure. Such perceptions appear to have the potential of encouraging sexual disinhibition and risk compensation, underpinning the urgency to improve risk perception and reinforce combination prevention among circumcised men …

The WHO and UNAIDS (2007) report a common understanding among African people like the Bamasaaba, who culturally and traditionally practise male circumcision. The Ugandan Ministry of Health requires, as a priority, universal medical male circumcision to prevent the transmission of HIV transmission amongst its population. This type of male circumcision – SMMC – was made universally available across all ethnic groups in Uganda to include those who practise TMC. However, resistance is recorded by Allan and Jacobs (2013: 61), who notes that:

> The Government of Uganda should not interfere with religious or cultural practices that are not imposed on society or citizens outside the religious or cultural group without a person's reasonable assent.

The more educated people in Uganda tend to perceive the rituals performed during TMC ceremonies as a waste of time and detrimental to school education since so many children miss school for days at a time in order to join the festivities. They find support in reports by the WHO (2009), which acknowledge the cultural significance of TMC in African societies but take issue with the preparation time required for TMC ceremonies. The WHO (2009) reports that TMC has educational, social, economic, political, psychological, physical and spiritual implications for the youth. This observation is not delivered in good faith as they insist on implementing the SMMCP for the people collectively.

Furthermore, as stated earlier, even amongst Ugandan politicians, TMC is perceived as a primitive and barbaric practice that enhances the prevalence of coercive and violent sexual relations among the local people (Nalianya, 2014). Ugandan President Yoweri Kaguta Museveni issued a controversial statement noting that the Bamasaaba and Kusu tribes living in Uganda and Western Kenya ought to shun the barbaric practice of undergoing traditional male circumcision and adopt SMMC (Nalianya, 2014). The MoH and Macro (2006) believe that TMC practices are unhygienic and that traditional surgeons are usually illiterate and untrained. For these reasons, the literature alludes to the government's authority to develop and impose health policies such as SMMC in their attempt to modernise and make the practice safe for the people (Vincent, 2008)

In contrast to derogatory opinions, many Ugandans – notably the Bamasaaba – hold highly positive views of TMC, pointing out that to become a traditional surgeon, one must receive a

spiritual calling from the ancestors. This is why Wilcken et al. (2010) refer to TMC as a spiritually motivated practice. According to Vincent (2008), while most African governments pronounce TMC as unhealthy and without value, this does not justify the introduction of medicalised male circumcision for African people. They point out that in many cases, the pronouncement of leaders in this regard is politically motivated. The implementation of the SMMCP may be simply to promote political ambitions such as leaders harbour – of gaining greater control over the Bamasaaba.

The government in Uganda seems to believe that HIV risk factors such as risky sexual behaviour are generally exacerbated by traditional circumcisions as the practice is associated with certain myths. For example, there is a perception among traditionalists that a circumcised man is clean, powerful and resistant to HIV transmission and cannot, therefore, spread HIV (Fountain et al., 2016). Despite holding an opposite view, the Ugandan executive reported that the government would support the local Bamasaaba and the Babukusu of Kenya. The Babukusu, commonly called the Kusu people of Western Kenya, form part of the Bamasaaba of Uganda culturally and historically. They are also governed by the Bugisu cultural body, *Inzu ye Masaaba*.

Statistically, Wakabi (2010:757) report "only 25% of the adult male population in Uganda was circumcised in 2010". The MMC campaign went ahead, as it sought to raise the figure to at least 40% of the male population within five years. Kripke et al. (2016:2) report that Uganda did not meet its target by 2016 and additional efforts were required "to attain 80% SMMC coverage among 15 to 49-year-old males".

Kibira et al. (2017:2) found "African governments had circumcised over 3.2 million males in the 14 WHO-priority countries by 2014" through their ministries of health. This figure brought the cumulative total of circumcised men to 9.1 million men since the first recommendations, Uganda being one of the better performers with 878,109 circumcisions. According to Kibira et al. (2017), the WHO reported 2,114,461 (40%) adult men were circumcised under the SMMC programme between 2010 and 2014 in Uganda.

The literature clarifies that SMMC programmes in Africa effectively introduce the modern practice of medical male circumcision to its people. This has made scholars such as Kibira et al. (2017), Kripke et al. (2016) and Wakabi (2010) give the impression that there has been

widespread adoption of SMMC in Uganda. However, their studies were conducted mainly in the central region of the country, with the results extrapolated to include the whole of Uganda, giving a skewed impression of the facts in the opinion of this researcher. The literature reviewed for this study shows that to date, there have been no updates with regard to the roll-out of MMC, particularly amongst the Bamasaaba. They remain opposed to the practice of modern medicalised circumcision.

Amongst widespread generalisations about SMC as well as an absence of research, almost nothing has been written about the understanding of male circumcision and manhood amongst the people of Bugisu. An illustration of this is that according to the Bamamsaba, SMMC does not qualify boys for manhood as TMC does. The theoretical framework that follows stresses the importance of the status of *basaani burwa* among the Bamasaaba, a position acquired by boys who undergo TMC.

2.9 Theoretical Framework and Application in the Study

Chafetz (2006) describes a theory as an explanation of the general principle of an art or science. The current study required a theoretical framework that would give it a sociological basis or orientation. There are several theories that offer a frame through which to view the traditions and cultures of people in society (Allan, 2005). Still, this study adopted the theory of masculinities to underpin the issues investigated, which centre on the culture and traditions of male circumcision rituals with regard to perceptions of manhood and the Bamasaaba's response to the SMMCP.

Mfecane (2010) states that there is a particular normative aspect of masculinity that constitutes the most honoured way of being a man (Mfecane, 2010). This normative form is known as hegemonic masculinity, a dominant ideology that requires all men to position themselves somewhere within it. The pattern of practice primarily represents a Western society where the dominant form of masculinity, or the cultural ideal of manhood, has always been reflective of mainly white, heterosexual, middle-class males (Connell, 1995). Nevertheless, this study used the gender theory of masculinity to understand the interplay between TMC, traditions, culture, rituals and hegemonic masculinity.

During the interviews, I purposively considered masculinity theory as a backdrop to the responses regarding medical and cultural practices. The theory helped to explain the lifestyle choices the Bamasaaba men demonstrated after having undergone TMC. The theoretical approach also helped to clarify how MMC may be employed to introduce contemporary forms or constructions of masculinities that might enhance its uptake in the future. While holding masculinity theory always before me, I made a point of never assuming anything about the research sites or the participants; instead, I probed their language terms and statements whenever meaning did not seem obvious.

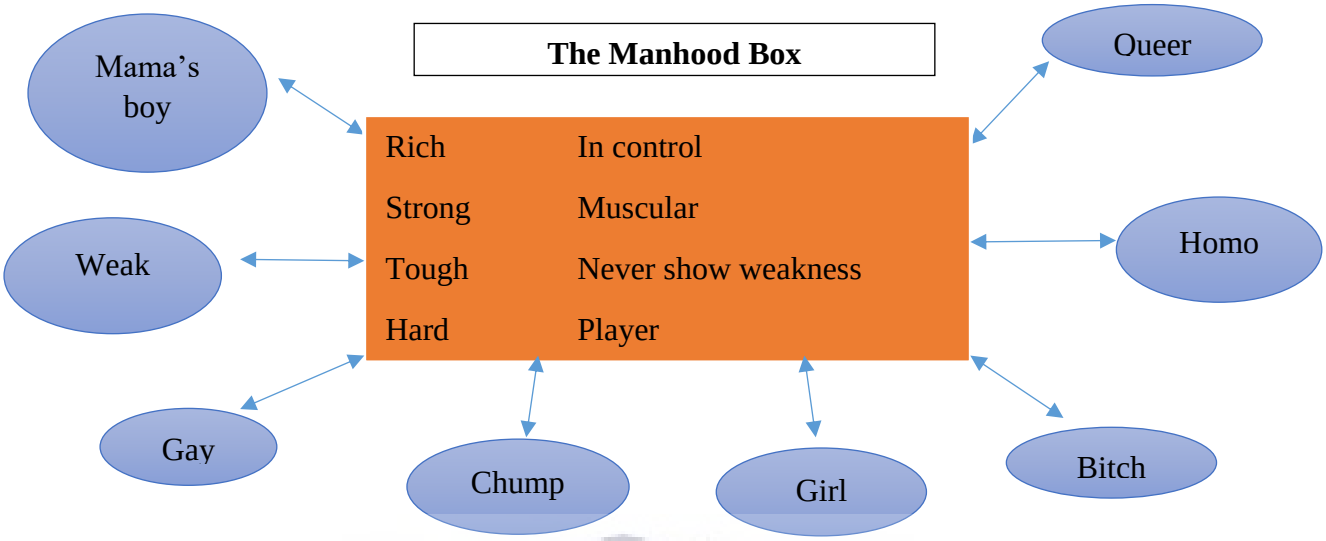
The section that follows begins by theorising and contextualising manhood.

2.9.1 Theorising Manhood

The term manhood refers to a collective gender identity that is not characterised by a set of biological traits but as a social construct (Morrell, 1998). People may be born having male features such as a penis, but they choose to be men through their social actions. In many African communities, men culturally define their manhood through the fulfilment of certain cultural obligations. According to Morrell (1998), manhood is not a biological characteristic because biology does not offer a general definition of what it means to be a man in practice.

Manhood is bound, achieved and performed according to different social contexts. To be born with male biological organs does not automatically qualify one to be a man. According to Naremore (2017), manhood involves taking up a subjective position that should demonstrate one's masculinity. Scholars such as Gilmore (1990) and Koureas (2017) argue that these personal positions may involve high-risk behaviour since they frequently demand that men should show signs of strength, aggression and impassiveness to the society to which they belong. There are several ways in which scholars explain masculinity socially in relation to men and boys. Some scholars such as Kivel (2006) present manhood through the figure of the 'manhood box', as shown in Figure 2.1, which follows.

Figure 2.1: The Manhood Box



Source: (Kivel, 2006:2).

Inside the box is a list of socially valued roles and expectations that constitute conventional masculinity. Simultaneously, the words outside indicate monikers generally given to boys and men who do not conform to or display the qualities shown inside the box. They are not, in a word, 'real men'. The man or manhood box representation seems to explain the categories of masculinities as defined by Connell.

This study explicitly adopts the gender theoretical concept of Connell (1995), whose academic work on masculinity has become influential. Connell coined the term "hegemonic masculinity", referring to qualities associated with the dominant masculinity of a certain period in the history of the West. Western society at that time used the ideals of masculinity to shape cultural models, with a significant number of men attempting to live up to the standard of hegemonic masculinity in contemporary society. Hegemonic masculinity, according to Connell, exists alongside other categories of masculinity such as 'subordinate', 'complicit' and 'marginal' masculinities (Connell 1995:77-81).

According to Connell, subordinate masculinity is the masculinity of certain groups of men who do not seem to be living up to the dominant ideas of being a man. The hegemony of masculinity symbolically eliminates these groups of men from the definition of manhood. This explains the

contemporary Western (European and American) treatment of gay men who do not conform to hegemonic masculinity and are therefore expelled from the group because heterosexuality is a significant expression of hegemonic masculinity (Wyrod, 2008).

Connell (1995) defines complicit masculinity as applying to men who, while not entirely participating in or acknowledging hegemonic masculinity patterns. However, these men directly benefit from the patriarchal dividends of men who feed off women's general subordination in society. Robertson (2007) explains that within the context of complicit masculinity, patriarchal power encourages many men to sustain the appearance of hegemonic masculinity. Robertson argues that complicit masculinity is not always or not often a deliberate decision or process; usually, it is a far less conscious form of daily practice.

Marginal masculinity, by contrast, refers to masculinity that is expelled from hegemonic masculinity but acts as the symbolic authority over hegemonic masculinities. The scholars have explained this kind of masculinity in the racial context, where, for example, a white man expresses supremacy over a black man. Connell (1995) refers to marginal masculinity as that of the black man, who takes on a symbolic role according to white gender construction. In Connell's description, the three versions of masculinity constitute masculinities in all historical eras and portray the reality of manhood in the real world.

The study adopted the theory of the three kinds of manhood to examine the Bamasaaba men's experience through the lens of hegemonic masculinity since bravery is a central driving force for being considered *umusaani burwa* or 'brave man'. Bravery or courage is demonstrated in the act of pain endurance and is held in high esteem by all the Bamasaaba men (Wanyenya, 2013).

In Bugisu communities, qualifying to be a 'man' is thus demonstrated through the initiation process where one fulfils the obligation of being traditionally circumcised. As indicated earlier, this process is similar to that of the Xhosa people of the Eastern Cape in South Africa, with their concept of *indoda* (Mfecane, 2016). Any *umumasaaba* boy who goes to the hospital or desires to have pain reduced during the male circumcision process is considered a coward (Makwa, 2010). Therefore, according to these social groups' thinking, this 'man' will remain a 'boy' for not fulfilling the cultural obligation of the Bamasaaba. Similarly, according to the

explanation by Connell (1995), this 'boy' will acquire subordinate masculinity; that is, he will be expelled from the Bugisu communities by 'men'.

The significant contribution of Connell's (1995) concept of masculinities is that in every historical period, there is a plurality of masculinities within which rivalry or competition takes place. Helpfully, the idea of competing masculinities contributes to an understanding of the Bamasaaba concept of manhood as a contested designation in society. Connell's theory concludes that there is no monolithic definition of what it means to be *umumasaaba*. Instead, the Bamasaaba masculinities' plurality may be seen, arranged in a hierarchy where competition for legitimacy is possible (Petersen, 2003). The Bamasaaba are feared and respected by their neighbours for their aggressiveness and bravery in enduring the pain of TMC, which culturally identifies them as *basaani burwa*.

It is thus imperative to establish whether the implementation of the SMMCP has destabilised this concept of *basaani burwa*. The literature indicates a dearth of research on this topic, suggesting that the government silences all voices expressing SMMC criticism. The concept of *basaana burwa* may be framed and explained by the gender theory of masculinity, as discussed in the next section.

2.9.2 Contextualising Manhood

Wood and Jewkes (2001) argue that masculinity is socially constructed and cannot be exclusively relegated to biological characteristics. Responsive to this point, Mfecane (2010) explains that this implies that male gender attributes of domination and grandiosity are not innate in children but are expected of them and trained into them socially so that they can eventually satisfy these gender roles in society. According to Wood and Jewkes (2001), many scholars theorise gender as being socially constructed when accounting for factors that contribute to the theorisation of masculinity in men and boys. Krais and William (2000) argue that society is designed to encourage men and women's concepts, based on separate sets of gender expectations.

Different qualities are ascribed to each gender, and this ascribing of qualities is what constructs masculinity and femininity in society. These are the processes that lead to ideologies about the so-called innate power or abilities of men and women in society (Mfecane, 2010). Many

members of traditional communities (both in Africa and in the West) regard women as the weaker gender, subservient, obedient and passive, whereas men are regarded as the stronger authoritative gender.

Connell (1995) has propounded an influential theory on masculinity that essentially criticises the literature on gender roles. Connell argues that masculinities exist on a spectrum, and the phenomenon of masculinity cannot be generalised in social science studies. In taking issue with this, Mfecane (2016) argues that contemporary gender scholarship cannot apply to Connell's notion of gender roles because contemporary scholars do not investigate gender power and change as innate qualities. In deliberating on circumcision among the Xhosa people in South Africa, Mfecane's (2016) critique takes on hegemonic masculinity.

For Connell and Messerschmidt (2005), hegemonic masculinity defines the most 'honoured' view of masculinity, which young boys aspire to. Men gain this honour through persuasion or force, and once society accepts them accordingly, such men become the role models of what constitutes being a man in society. Mfecane (2018) explains that notions of masculinity are central to traditional circumcision rituals, as may be heard in the cry, 'I am a man!' following the operation. Thereafter, the person may ascend the social hierarchy and no longer faces being regarded as an outcast among men in society. The circumcision ritual, therefore, announces the leap from being a boy to being a man. According to Mfecane (2016), the circumcision process ensures that a male removes the pressure associated with being uncircumcised and shifts the focus to their adherence to men's responsibilities in the household community.

The performance of these masculine responsibilities alone does not qualify a person to be regarded as a 'man' if the person has not undergone the circumcision ritual. Mfecane (2016) confirms this by pointing out that one has to be circumcised and initiated into manhood before being regarded as a man. To extend the argument that masculinity is centred on the act of circumcision, Mfecane notes that when a person who has undergone male circumcision neglects gender expectations, they do not lose the honour of being called a man. Any man who has experienced TMC is bestowed a masculine status even when they do not fulfil a man's conduct. Other scholars have argued that circumcision also serves as a way in which males can defend their honour and masculinity in the community (Vincent, 2008). Nevertheless, in African societies, generally, masculinity refers to a set of qualities or characteristics, behaviours and roles associated with boys and men. Itulua- Abumere (2013:42) states

masculinity "consists of those behaviours, languages and practices, existing in specific cultural and organisational locations, which are commonly associated with males and are thus culturally defined as not feminine".

In this definition, masculinity relates broadly to a cultural identity that signifies a man as being a man. Furthermore, Chodorow (2002) notes that the word 'man' has both positive and negative cultural implications, which may not be reflected in feminism. In other words, as constructed and located within feminist theory, masculinity is open to criticism relating to men's behaviour, social practices, and values. All the same, masculinity can be used as a template to reflect and explain African adherence to TMC in many societies. Sociology enables one to view masculinity through the lens of class, culture, rituals, customs, and ethnicity, all of which significantly impact masculinity's social construction (Giddens, 2001; Turner et al., 2017).

Such social issues are relevant to African traditions and cultural practices. Thus, the apprehension of what defines the Bamasaaba men and women is embedded in the social practice of TMC. However, Gardiner (2004: 36) notes that there may not be equality in this 'embeddedness'. He states:

> Theories charged that cultural ideologies favoured men and that masculinity reflects ideologies that men as a group benefited from the subordination of women as a group, despite the great disparities that existed in the advantages accruing to individual men or subgroups of men concerning other men and women.

Much critical thinking and writing published about men and masculinity seek to understand how men's power is created and how it forms natural and political borders that are embedded in the organisational network of contemporary society (Freedman, 2002; Gardiner, 2002; Gardiner, 2004). The Bamasaaba have been socialised to accept the culture, traditions, and customs embedded in the social practice of *imbalu*. For this cultural and traditional group, the social practice of TMC is the medium through which cultural and religious values, knowledge, power acquisition and other responsibilities are instilled (Connell and Wood 2005; Elkin and Handel, 1989).

The study also used this theory to understand how the Bamasaaba men understand the cultural definition of manhood that serves as the main building block of most men's sexuality. Through an understanding of masculinity, men perceive and think about their sexuality (Fracher and

Kimmel, 1998). In this study, the theory of masculinities assists in explaining how men may respond to the implementation of the SMMCP. It is possible that through their sexuality, the Bamasaaba men affirm their sense of acquired masculinity and that this may influence the decision that boys and parents make about male circumcision (Fracher and Kimmel, 1998).

In discussing social constructions of masculinity, Kilmartin (1994) describes a particular form of construction whereby men who belong to a traditionally circumcising community consider themselves as 'real men'. This study refers to the social reality of the Bamasaaba's cultural and traditional practices of *imbalu* and how the Bamasaaba men use this practice to construct their masculinity. Khanakwa (2018) states that TMC is a traditional practice that is culturally motivated. The Bamasaaba believe that the Bamasaaba boys transform into *basaani burwa*' only after fulfilling the cultural obligation of *imbalu* (Wanyenya, 2013).

In these communities, bravery is the cultural driving force behind the designation *umusaani burwa* and is expressed through the act of pain endurance in the initiation process. Waldeck (2003) claimed that traditional male circumcision becomes a significant resource that determines gender roles ascribed to men, defining certain habits of social life. Some of the patterns are the acquired personality traits and responsibilities of being a man. After circumcision, the young man is able to display aggressiveness, strength, independence, hard work, physicality, stoicism and competitiveness – all the qualities he is expected to display after being circumcised traditionally.

Cooter (1995) demonstrated how African people are socialised to practise their culture, traditions and customs in their society. This may be seen in how the Bamasaaba strives to preserve their rite of male circumcision, which they experience as a spiritual and social practice with pertinent social, traditional and cultural benefits – all of which are absent from the clinical process of SMMC. Furthermore, beginning from childhood, the Bamasaaba learn to practise and create their social status through participation in cultural events, which shape them even before they have the self-awareness to understand who they are as individuals.

As Berger et al. (1967) argue, cultural groups construct knowledge for one another, collaboratively creating culture or a custom and tradition that has shared meaning for that particular cultural group or society. The Bamasaaba and other traditionally circumcising cultural groups are immersed in the culture of TMC as a tool for developing their social norms

in society. Brown and Armelagos (2001) argue that the customs and traditions are social constructs; instead, a practice like TMC pertains to a relatively large group and is characterised by specific coherent cultural norms and a plausible social role for the ancestors. Masculinity theory helps one understand Brown and Armelagos's claim, particularly how the Bamasaaba men use TMC to construct their masculinities.

It is necessary to understand TMC as a social construct before one can appropriately explain the Bamasaaba's response to SMMC implementation. Masculinity relates to social practices that show commitment to certain behaviours and relationships that seem to facilitate society's developments. The development process requires that people's freedom to practise and interact with their traditional or cultural practices in the community is recognised (Barber, 2004). The Bamasaaba believe that their ancestors introduced traditional male circumcision and that it plays an essential role in the development of their modern descendants.

To the Bamasaaba, *imbalu* is a central cultural practice that all the Bamasaaba must be knowledgeable about. Kipkorir and Welbourn (1973) acknowledge that any life event can be of central importance to society. TMC brings not only physical changes in young men but has profound social implications for the initiates. This traditional practice changes their focus, preferences and ultimate aspiration to dignity and respect in society (Kipkorir and Welbourn, 1973). A clear example is the new roles and responsibilities that Tanzanian young men assume after circumcision, exhibiting behaviours that conform to the adult code of conduct for responsible men in their communities (Mshana et al., 2011).

Nawa and Sanjobo (2011) concur with earlier observations that the Bamasaaba believe that the rituals performed during TMC involve bravery and manhood demonstrations. The Bamasaaba value the pain that the initiate experiences during the operation, as endurance of it confirms that the initiate is ready and worthy to become an adult male member of the community. The failure of SMMC to speak to the aspect of cultural identity and the assuming of new roles and responsibilities make it an operation devoid of all meaning and entirely inadequate to express all that is contained in the *imbalu* ceremony. The most profound aspect of the ceremony is the spiritual aspect. Nawa and Sanjobo (2011) state that in some communities that practise TMC, circumcision is a tradition that links the initiate with his ancestors and with God, reflecting, in some cases, an ancient covenant made between God and his people.

The discourse presented on medical male circumcision is that MMC modernises traditional practices and prevents disease. However, some scholars argue that the only way the Bamasaaba could relate TMC to the prevention of diseases is related to a historical story or myth that cannot be verified. According to the history of *imbalu* among the Bamasaaba, Masaaba, the first man to practise circumcision, had four male children who developed penile complications that caused them serious illness (Nalianya, 2014).

As a result of a myth, the Bamasaaba are said to have perceived TMC partially as an intervention – for disease prevention in the Bugisu sub-region. However, to the Bamasaaba, the link with disease prevention is tenuous. Among others, the primary direct reason why they engage in TMC is to prepare newly circumcised men for founding a family. Chanda et al. (2012) claim communities who traditionally practise TMC consider uncircumcised men as being unfit for marriage. Kibira et al. (2013) state that it is forbidden, especially among the Bamasaaba, for an uncircumcised man to marry and raise a family. One would expect this view to become irrelevant if an *umumasaaba* man grows up in a community that does not traditionally practise TMC and where he adopts the culture of that community. However, Senkul et al. (2003) report that in such cases, where none of the local people have been able to witness the ceremony and the man remains uncircumcised, the woman is supposed to inform the elders that her husband is uncircumcised.

In the case of the Bamasaaba men who show an unwillingness to undergo *imbalu*, the clan, together with the community leaders, will organise a meeting and plan to abduct the man and forcefully circumcise him (Nalianya, 2014). The act of forcing uncircumcised men resulted in some of the Bamasaaba men taking refuge in neighbouring regions such as the central region, especially in Kampala City. However, Wanyenya (2013) claims that this option does not work for these men since the relatives tend to follow the man to find where he is hiding to avoid shame; in such cases, these men may opt for medical circumcision. However, clinical circumcision carries the stigma of weakness and fear (Nqeketo, 2008).

The perception that traditionally or culturally performed male circumcision enhances women's sexual pleasure is a reason why most young men would hold this aspect in high regard. It is confirmed by Mlewa (2013:64), who points out:

> the importance and centrality of sex in young men's lives, enhanced male sexual performance, sexual pleasure and ability to satisfy women sexually, all considered socially desirable and perceived as conforming to the 'real man' syndrome.

There are diverse perspectives among the Bamasaaba men concerning the government's argument that TMC places women at risk of contracting HIV (MoH, 2010). In response to this, allegation Wanyama and Egesah (2015) argue that some health and political officials misunderstand TMC. Wanyama (2013) points out that this perception about TMC practices extends to some of the Bamasaaba in the Bugisu sub-region, who believe that *imbalu* rituals are a waste of time for teachers and school-going children whose educational commitments are impacted upon. Wilcken et al. (2007) have found that most the Bamasaaba do not attach value to education and consider traditional practices as more valuable. This underlying rhetoric – evident in the literature – seems to come predominantly from educated and charismatic Christians in the Bugisu sub-region.

The WHO 2009 report showed that adults in the Bugisu sub-region frequently ignore their children during the *imbalu* festive season, and the children, therefore, become distracted from their studies (WHO, 2009). Wanyama and Egesah (2015) assert that the festive season of TMC has resulted in many school drop-outs, especially among new traditionally circumcised men who perceive TMC as a qualification for marrying as real men. The academic community believes that repeatedly missing school sets one up mentally to give up on studies finally. Students, parents and cultural leaders are said to spend a great deal of time on traditional male circumcision events, and children are also said to abscond from school to join the celebrations. However, this position does not give due credence to the value of TMC as a socialisation event, in which valuable cultural and moral values are inculcated into boys aspiring to be real men (Cooter, 1995).

Wilcken et al. (2007) report that TMC is given priority, especially in the Bugisu sub-region. Vincent (2008) also states that the youth in some African societies have evoked an assortment of explanations and interpretations of TMC, ranging from socio-economic to cultural. These explanations and interpretations include the view that attributes general moral decline in society to the loss or decline of African cultural practices in this region. On the other hand, there is a very vocal group of the Bamasaaba who see practices associated with African culture as the reasons for the current health crisis in the Bugisu sub-region (Rudrum et al., 2017).

From their perspective on masculinity, Rudrum et al. (2017) compare the attitudes of men and women with regard to the implementation of the SMMCP in sub-Sahara Africa. These scholars argue that:

> Men have been a less prominent focus of HIV public health campaigns in sub-Saharan Africa, for reasons including women's greater vulnerability to infection, as well as discourses of femininity that position women as responsible for family and community health (Rudrum et al., 2017: 228).

Shand et al. (2014) conducted a study on men and HIV testing, treatment and care in sub-Saharan Africa. They quote Keeton (2007), who seems to concur with Rudrum et al. (2017), stating that in the majority of HIV policies, men are frequently perceived as the problem.

The government designed the SMMCP as an HIV-prevention tool, one that requires the participation of both men and women (Rudrum et al., 2017). The discourse on HIV prevention potentially provides an opportunity to disrupt certain gendered assumptions on masculinity. Shisana et al. (2010) argue that to understand masculinities and HIV transmission, there is a need to situate the epidemic within gender-inequitable dynamics, at an individual level, and within the larger male-centric power structures that drive the epidemic.

Shisana et al. (2010) argue that progress has been slow because of issues that go beyond HIV prevention or beyond activities focused on persuading individual men to change their attitudes and behaviours. Nonetheless, African people are aware that in the implementation of the SMMCP, the health sector intends to widen the roll-out and to require men to achieve changes in gender norms (Cornwall et al. 2011; Shand et al. 2012). However, men have become reluctant to accept the implementation of such health policies, which has affected behaviour change and access to services beyond men's position in society (Cornwall et al., 2011).

2.10 Summary of the Chapter

This chapter examined the literature on MC's historical origin, the concept of *basaani burwa*, and the rise of SMMC in Africa as a globally propagated policy. Furthermore, the chapter contextualised masculinity as a social orientation that strongly informs the practice of

traditional circumcision. According to the literature reviewed, two positions emerge: the first is that the implementation of the SMMCP undermines the concept of *basaani burwa*. The second is that masculinity in the context of the Bamasaaba is an integral part of cultural identity. The various groups who evaluate TMC fail to understand the profound role it plays in both individual and group identity formation.

The government promotes SMMC to reduce HIV transmission, wholly overlooking the many aspects of TMC that accompany the operation (Allen and Heald, 2004), not least contextualising masculinity. Yet, it is in the very process of positioning masculinity that traditions, culture and customs forge the identity of communities. By honing in on this lacuna, this chapter sought to establish the need for a study that interrogates African governments' perspectives about health policies in their countries. These include policies that attempt to combat the scourge of HIV transmission and the resulting campaigns of medical circumcision as an anti-HIV measure.

The literature reviewed reveals that while most African governments' health policies affirm the effectiveness, safety, and desirability of policies. The SMMCP for optimum public health fails to consider the holistic nature of TMC. Their failure to comprehend this, or to give any recognition to the value of TMC, is what gave rise to this empirical study which attempts to establish, among other things, the effects of SMMCP on the concept of *basaani burwa.* Until this is established, studies will continue to extol the virtues of medicalised circumcision and will pay no heed to the traditional practice of male circumcision. People's resistance to SMMCP would remain a problem. As Howard-Payne (2015:41) puts it:

> The cultural significance that MC carries, its medicalisation and use against the risk of HIV infection for adult men, has implications for the individual meaning-making of such an intervention for those who practise religious male circumcision.

Although the literature reviewed in this chapter shows the clinical science behind the campaigns to implement reformed health policies on male circumcision is irrefutable, it has also clearly revealed unresolved cultural issues at the heart of the matter. Such policies, noble as they are in intent, cannot be understood or managed without a more in-depth understanding of the way local people, in this case, the Bamasaaba, ascribe meaning to the social practice of

TMC. I sought to contribute to this intellectual discussion by generating a methodology that would yield data-embedded explanations of the factors involved in this practice.

CHAPTER THREE

3 RESEARCH METHODOLOGY

3.1 Introduction

The objective of this study was to explore the Bamasaaba's response to the implementation of the SMMCP and to analyse its cultural impacts. This involved examining the social and political implications of the SMMCP while seeking to understand how the Bamasaaba conceptualised masculinity. This chapter describes the methodology used in this qualitative study. Firstly, it describes the research sites in order to situate the study. Secondly, it provides an explanation of a qualitative research design and its methods. An outline of the study's guiding principles and the techniques used for data collection and management are delineated. Finally, the chapter expounds on the ethical considerations and limitations of the study.

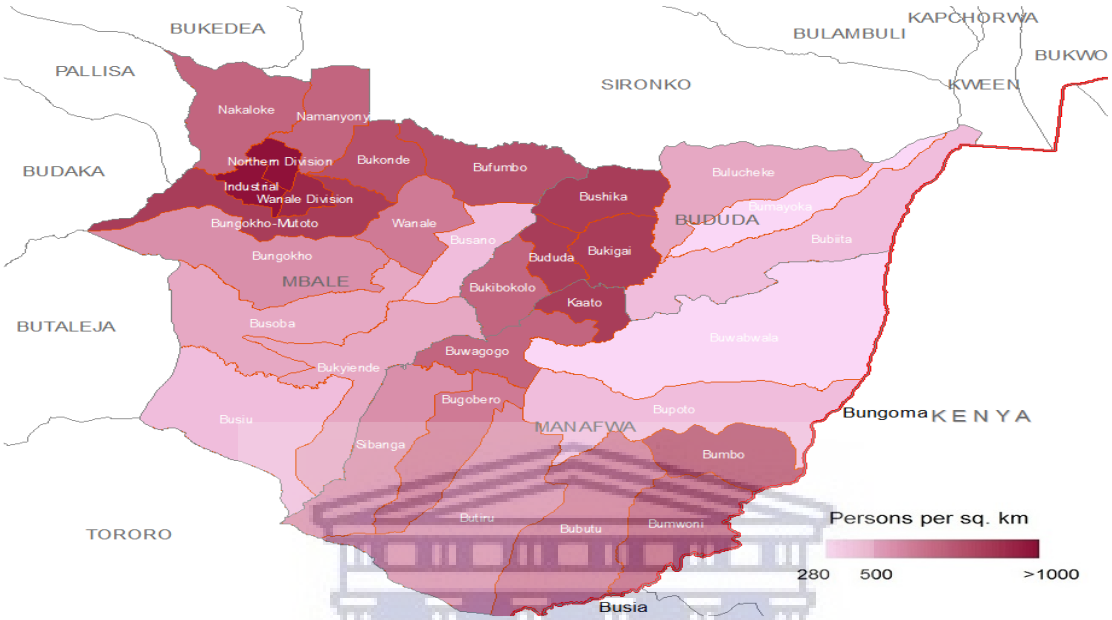
3.1.1 Research Site

The centrality of the research site made it essential for me to select the Bugisu as the research site. I was motivated by two key aspects of this choice of location. The first relates to my familiarity and shared background with the Bugisu community. The predominance of Lumasaaba language speakers in the area made it convenient for me to communicate and to gain access to this area. In consultation with some government officials, the second factor relates to my discovery that the Bamasaaba insists on practising cultural male circumcision in the face of the many obvious health benefits of SMMC for their region. I was curious about their understanding of the two practices and why they persist in practices that may pose health risks.

3.1.2 Description of the Research Sites

The study focused on the Bamasaaba residing in the districts of Bududa, Manafwa and Mbale. The map in Figure 3.2 shows the location of the research sites.

Figure 3.2: The Map of the Bugisu Sub-Region



Source: Mbogga (2012).

These three districts, among others, form the Bugisu sub-region, and the Bamasaaba remains the most significant population in this region. These districts are presented and described in the sections below.

3.1.3 Description of the Bududa District

Bududa, the second research site, is bordered by Sironko District to the north, Kenya to the east, Manafwa District to the south, and Mbale District to the west. The district headquarters of Bududa is located approximately 36 kilometres (22 miles) to the south-east of Mbale, the largest city in the sub-region. I took photographs in Figures 3.3 and 3.4 on the first visit to Bududa District and route to the *imbalu* ceremony for one of the 2016 initiates in Bududa District. The photos (Figures 3.8 and 3.9) provide a visual guide of this research site.

Figure 3.3: The Surroundings of Villages in Bududa District

Source: Primary data.

Figure 3.4:The Route to the Imbalu Ceremony in Bududa District

Source: Primary data

3.1.4 Description of Manafwa District

The following two photographs were taken during a visit to the Magale Town Council to describe the research sites further. This area is located in Bubulo East County in the Manafwa District, formally known as the Namisindwa District since 1 July 2017. The rationale for creating the new district was to bring services closer to the people, create jobs and reduce youth unemployment (Mulondo and Karugaba, 2015). This district's topography is remote and hilly, making it prone to soil erosion and landslides during the rainy season. The gravel roads need frequent maintenance, and the primary activity is subsistence farming. This site is a rural area with a small trading centre which has just been elevated into a town council.

Figure 3.5: Magale Town Council, a Research Site

Source: Primary data.

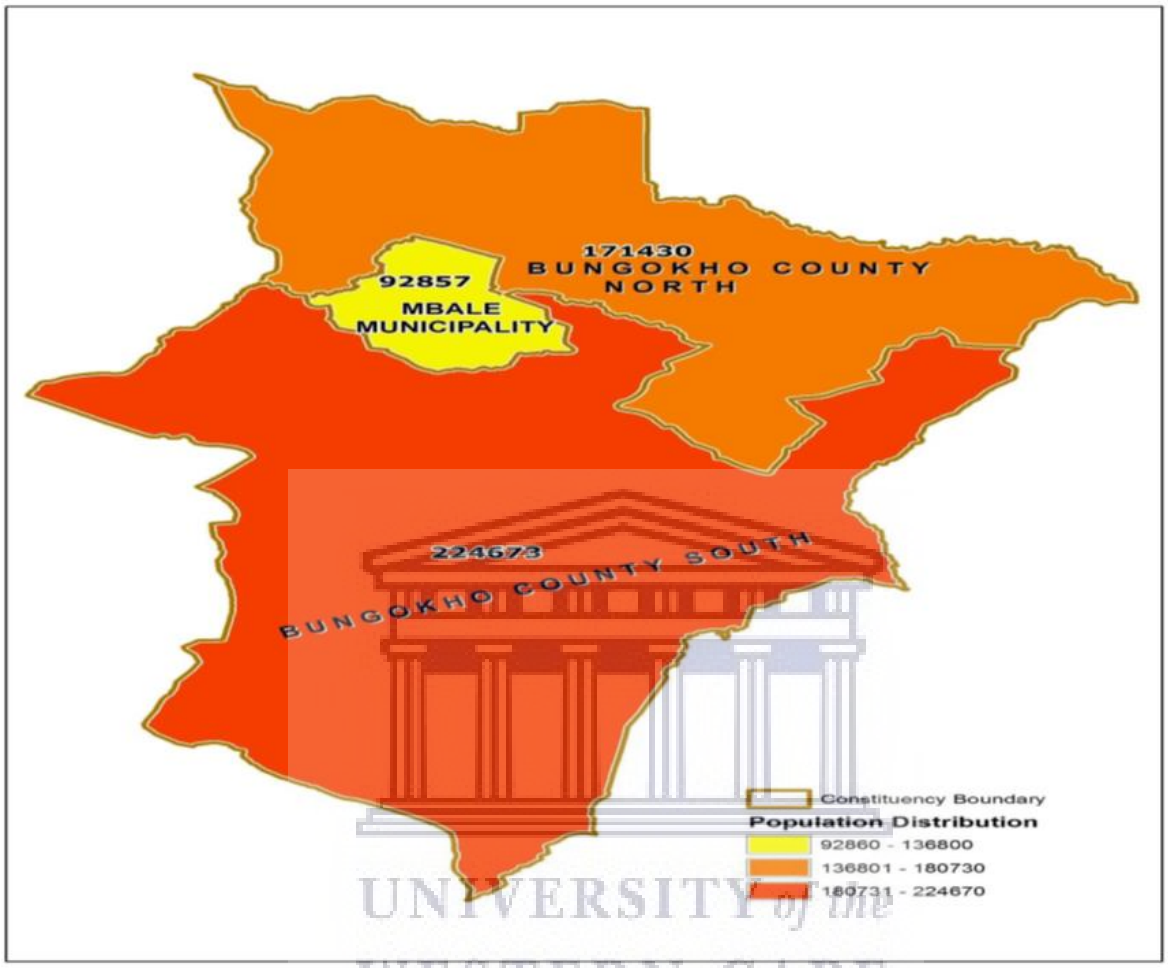
Figure 3.6: Bubutu-Buwambingwa Road, Magale Town Council in Namisindwa District

Source: Primary data.

3.1.5 Description of Mbale district

Mbale District is a district in Eastern Uganda. The district takes its name from the largest city in the vicinity, Mbale, which serves as the main administrative and commercial centre for the eastern region. Sironko surrounds Mbale District to the north, Bududa to the north-east, Manafwa to the south-east and Tororo to the south. Other communities that border Mbale are the Butaleja District to the south-west and Budaka District to the west. Mbale serves as the central city for all the areas named in this study. Figure 3.7 is a map of the Mbale district indicating one of the research sites' geographical setting.

Figure 3.7: The Map of Mbale District



(Uganda Bureau of Statistics, 2017:8).

In this district, I collected data in one village called Musoto. Musoto is a village located in the Bukasakya sub-county, Bungokho County. Photographs in figure 3.8 and 3.9 were taken on the first visit to the Mbale district. As indicated before, the pictures provide an impression of the research site.

Figure 3.8: One of the Research Sites in Mbale

Source: Primary Data

Figure 3.9:The Village of one the Initiates

Source: Primary Data.

3.2 Research Design

Research design is the framework of research methods and techniques chosen by a researcher (Mouton and Babbie, 2001). Mouton and Babbie (2001) state that social science research involves mapping out a research design, the guiding tool that will assist the researcher in obtaining the most valid outcome for the problem under investigation.

The design allows researchers to hone in on research methods suitable for the subject matter and set up their studies for success. In addition, Stephens et al. (2020) also define a research design as a systematic approach that a researcher uses to conduct a scientific study. It is the overall synchronisation of identified components and data, resulting in a plausible outcome. There are four standard research designs used by researchers depending on an arrangement of conditions or collection. These types are Descriptive (e.g., case-study, naturalistic observation, survey), Correlational (e.g., case-control study, observational study), Experimental (e.g., field experiment, controlled experiment, quasi-experiment) and lastly, review (literature review, systematic review) designs. Taking the above into account, this study is, therefore, descriptive in nature.

Noting the various approaches in social sciences, which include qualitative, quantitative and mixed methods research approaches, the qualitative research approach, which allows for the detailed description of the data, was best suited to investigate the response of the Bamasaaba to the implementation of the SMMCP.

In this qualitative study, the researcher was the primary tool for the data collection process. It is for this reason that I describe the process and the findings in the first person. I adopted a deductive research approach, learning from the participants' specific experiences to establish general principles and, possibly, to generate new theory on the topic under review. According to Stephens et al. (2020), deductive means reasoning from the particular to the general. Using this approach, I wanted to establish the link between the medical and traditional practices of male circumcision from the perspective of gender theory of masculinity, to obtain more general circumstances. In this deductive approach, I adopted the learning strategy that enabled me to

make general statements based on specific observations. The study regarded the participants as the principal agents for describing and explaining a particular social phenomenon as constructed and experienced. As a researcher, I took the position of listening to learn from their explanations.

The term *qualitative* suggests an emphasis on the meaning individuals make of their daily experiences in societies (Neuman, 2014). In this study, a qualitative research design worked as a system of inquiry, helping me to holistically understand the social or cultural problem under investigation. For this reason, qualitative research was conducted in participants' own natural settings and involved a combination of in-depth interviews and focus groups (FDs).

Having read Neergaard and Ulhøi's (2007) explanation of the merits of an interview schedule (tool) as a guideline in qualitative research design, I designed an interview schedule that acknowledged the context in which the research was conducted. The qualitative research design and loosely structured interview schedule were appropriate to the objectives of the study, in which I sought to obtain in-depth and detailed data that would yield insights deeper than might be gleaned from quantitative data.

Using a descriptive qualitative approach, I intended to record the participants' attitudes, feelings, and behaviours. I also wanted to create openness by encouraging participants to expand on their responses in ways that could open up new topic areas which I might not have initially considered. This meant that the interview schedule acted as a guideline and not a prescriptive tool. It allowed me to deviate from the set order and wording of questions and add more questions as participants' responses gave rise to new ideas and avenues of investigation.

In general, three principles underpinned the research design. Creswell (2003) identifies the three principles as the nature of the problem under investigation, the experiences of participants, and the nature of the readership or audience the study intends to address. Since I am from the Manafwa District myself and have had the experience of undergoing TMC, I limited the scope of the survey to the Bugisu community. I also intended to address an academic readership and individuals involved in developing and implementing health policies on MC. It was crucial to use a qualitative research design as it provided a platform for the participants to share their experiences through in-depth interviews and focus group discussions.

As in all qualitative research, I had to be cautious about imposing my assumptions, biases, limitations, definitions or even research design on the participants. Qualitative research strives to elicit people's responses to questions in their own context and geographical location. The researcher's role was to observe, listen and record information from the participants in their setting. Qualitative research design assumes that reality exists as the participants see and experience it in their social and natural environment. Thus, I understand that it is problematic to avoid our biases, especially having personal experience with TMC. Still, I ensured that the records contained accurate information and truths as seen and understood by the actors to avoid biases.

Language played an essential role in ensuring that the participants understood what I communicated and understood them. Parker (1992) points out that language, including the choice of language in which one decides to communicate, is structured to mirror power relations in society. I considered it significant to conduct this qualitative research in the language participants understood. Parker's view (1992) is supportive of this; he states that language represents both what individuals think and how they construct meaning out of their experiences. For this sort of depth and detail, I would need to hear participants in their language. I used the qualitative research design in an attempt to capture a sense of how participants experience the traditional practices of *imbalu* and how they construct meaning from their experiences.

3.3 Research Methods

This section on research methods is presented in two parts. Initially, it looks that the research site and then focuses on the research process: the tools and procedures followed for knowledge production.

Although a description of the research site was discussed at the beginning of this chapter, it is essential to discuss the selection of methods and the process of gaining permission to interview participants in these sites.

3.3.1 The Process of Selecting the Research Sites and Gaining Permission

I was able to make the first visit to Uganda in January 2016, when I went straight to the Bugisu cultural headquarters for consultations on selecting study sites. At the traditional leader's office, they advised me to seek permission from the Regional Health Office (RHO) and *Inzu ye Bamasaaba* (the Bugisu cultural office). I first had an introductory meeting with the *Umukuuka We Masaaba* (the King of the Bugisu Kingdom) and the regional medical officer (RMO) at Mbale Regional Hospital.

The meetings with the *Umukuuka We Masaaba* resulted in the identification of three districts that had registered a low uptake of clinical or medical male circumcision. The information received from these meetings indicated that the Bududa and Manafwa districts, deep in the rural areas, had a solid adherence to the cultural practice of male circumcision. The fact that the Mbale District holds cultural and historical importance to the Bamasaaba for the practice of *imbalu* was an impetus to locate my study in this area.

The cultural leaders provided information in the form of a socio-economic profile through the office of *Umukuuka We Masaaba*, located in the Mbale District. The districts are politically structured according to Local Councils one to five (LC1 – LC5). On the advice of Umukuuka We Masaaba and the Regional Health Officer's office, I contacted the District Local Council Five (LC5) from all three selected districts. I then visited each to register my presence and my intention to conduct a study in their area. I gave a detailed explanation of the project. I made the chairpersons aware of the Regional Health Officer's recommendation and the Bugisu cultural office to allow the research to proceed.

These districts, as indicated earlier, were selected based on their low uptake of SMMC. The chairperson of LC5 in each district welcomed me and acknowledged the contribution that such studies could make to developing health policies in their communities. These political officials expressed that the study could produce advice on strategies that would help them to scale up the implementation of safe medical male circumcision for HIV prevention while simultaneously maintaining the cultural practice of *imbalu*. At these meetings with LC5 chairpersons, they advised me to visit their counterparts at Local Council 3, who would introduce me to the LC1 chairperson in each district.

The chairperson of LC5 in the Bududa District introduced me to the LC3 in the Bududa Town Council. The chairperson of LC5 in the Manafwa District introduced me to the LC3 in the Magale sub-county. Lastly, the chairperson of LC5 in Mbale introduced me to the LC3 Bukasakya sub-county. I was later introduced to a range of local councils at the village level in various sub-counties. The consultation meetings took place at the village local council offices. Those involved were LC1, Bushinyekwa, LC1, Magale Town Council and LC1, Musoto Village. In every village, the participants waited with high expectations because the leader had told them that I had come from one of the 'most prominent overseas universities.' To break the ice, I introduced myself and spoke to them in Lumasaaba.

The local council chairpersons probed my background, especially wanting to know how and when I was traditionally circumcised. My surname did not suggest any of the clans in the Bugisu communities. Interestingly, the local council members clearly stated that they would not allow the study to proceed if I had gone to the hospital for MMC, which the local leaders referred to as *imbalu ye khulubawo*. They put me through a test by saying *lera urewo inenkekho,* meaning that I should appease the ancestors by providing the local beer, *kamalwa* or *busela.* Providing the elders with alcohol would certainly not prove my status as a circumcised man; however, it is a tradition among the Bamasaaba that serious discussions with elders are done around a pot of *kamalwa*. I promised them that I would provide the beer once the study began, and we would discuss serious issues surrounding *imbalu* and SMMC. I held good on this promise and had such an event with them in a focus group.

In all the meetings with the LC1s, members seemed to regard me as a sort of returned 'prodigal son,' since I had been away for a long time and was now back. However, when I explained the intended aims and objectives of the study, the clan leaders made it quite clear that they did not entertain the idea of clinical or medical male circumcision because it is not part of their culture. For this reason, the chairpersons from these local councils requested that I provide them with the outcome of the study. They said that a survey of this kind might offer a solution to health officials' problem, exerting pressure on them to abandon their traditional practices of *imbalu*. On that basis, the clan leaders acknowledged the significance of the study. During these consultative meetings, it was surprising to me to find that some clan leaders were ignorant of the very existence of the SMMCP. Others knew of it but were highly critical of it, maintaining that it was at odds with the area's cultural principles.

As noted, the clan leaders operate under the leadership of *Umukuuka We Masaaba*, who are merely ceremonial leaders working under the political supervision of the local councils LC1 to LC5. I learnt that politically, LC1s could head one village consisting of over ten clans.

After obtaining the LC chairpersons' blessings, cultural and clan leaders, I set out to meet with traditional surgeons in the three selected districts. I followed the same procedures of consultative meetings while seeking permission to approach the leaders of the traditional surgeons to present a list of what I sought to do and seek their advice. I explained the study's aims and objectives to establish a point of entry to the primary source of information. The LC1 chairperson introduced me to at least one clan leader from the selected village in each district.

3.3.2 Selection of Participants

I selected seventy (70) participants from the three districts for both in-depth interviews and focus groups (FGs). I decided on 40 participants to form individual interviews and 30 for seven FGs. They were from Bududa, Manafwa and Mbale districts due to the limited scope of the study. All participants recruited for this study were men who were traditionally circumcised-men who are responsible for all matters related to the cultural practices of *imbalu* in the Bugisu region. First, I identified the elders whose knowledge and opinions were significant to the problem being investigated. In each area, I opted to select persons who are in some way or another involved with and knowledgeable about traditional male circumcision. I also selected one significant knowledgeable participant to question as a key informant.

The study adopted a non-probability sampling technique to select participants. Salganik and Heckathorn (2004) define a non-probability approach as a sampling technique that involves a body of feedback based on the researcher's selected sample capabilities; they describe it as a non-static process. Bryman (2016) states that non-probability sampling is always associated with qualitative research. Examples of this type are judgmental or purposive sampling, snowball sampling, quota sampling and convenience sampling. For Bryman (2016), purposive sampling and judgemental sampling are the same. Essentially, in all forms of non-probability sampling, members of a given population do not have an equal probability of being included in the sample. However, in random sampling, participants are selected because they are likely to have the necessary knowledge and experience that will help to answer the research questions.

I elected to use multi-stage sampling, combining purposive sampling and snowball sampling techniques to select the participants (Bryman, 2016).

The purposive sampling technique ensured that the participants had significant knowledge or understanding of male circumcision. I ensured that selected participants knew that their participation was voluntary and that each one signed a written consent form. In some cases, purposive samples were obtained through the group's field investigations, which ensured that only men who displayed specific attributes were selected for interviews. For example, this happened when I needed clarification about some significant issues raised by the selected participants.

To select the cultural leaders and traditional surgeons, I relied on the purposive stakeholder technique. I earmarked certain traditional surgeons as likely to be sufficiently experienced and knowledgeable about the region's traditional practices. These leaders are critical role players for the practice of *imbalu,* as they disseminate and uphold the values and customs embedded in the practice. I was especially interested in these people due to their positions in their communities, so I specifically requested that they participate. The three traditional surgeons who participated knew both the challenges of TMC and SMMC in their communities. I conducted individual in-depth interviews with these people, mostly in their homes or offices.

I followed up purposive sampling with snow-ball sampling. Salganik and Heckathorn (2004) contend that snowball sampling or chain sampling, chain-referral sampling, or referral sampling is a non-probability sampling method (used when the sampling frame is unknown) where existing research participants help in the selection of the next participant from among their group's members. Subsequently, the sample group is said to develop like a moving snowball. As my sample grew, I accumulated enough information for the study. I obtained members for the focus groups as identified research participants suggested other participants for each group.

I then approached these participants on 6 August 2016 at the opening ceremony in the Bumutoto Cultural Centre. It was relatively easy to identify these men because they were dancing in clusters formed according to their districts. Every group had a leader who volunteered to participate and promised to identify others. Every participant I identified could also identify another. I obtained their contact details and the dates of their traditional ceremony.

The parents of the initiates willing to participate were also approached for verbal and written consent.

All participants and their parents signed the informed consent forms. Although the study did not adopt an ethnographic approach, I spent time moving from village to village to become acquainted with the environment and gain the elders' trust. During this time, I had opportunities to mix with different people at the market, trading centres, spaza shops and other places where men gather to socialise in the evenings, with the sole aim of gaining their trust and support. In the course of fieldwork and after interviews, I interacted with the selected participants at local drinking places called *mubilabu* (plural) in the Lumasaaba language to make more contacts. *Mubilabu* is where men gather every evening to drink *kamalwa*.

Using the office of the LC1 chairpersons, I quickly became familiar with the geographic location of all the villages and their leaders. Sometimes the villagers mistakenly thought that I was one of the health officials posted to their village by the regional headquarters in Mbale. In each village, the LC1 chairperson communicated with the Bamasaaba men regarding my presence, indicating to them that I was interested in speaking to men. The LC1 chairperson would whisper to the local men that the government had granted their son permission to work with men on TMC and SMMC issues. These LC1 chairpersons openly invited men to participate in the study voluntarily.

I limited the scope of my enquiry to three villages, one per district. Two of these villages had a significant number of people resisting the implementation of the SMMCP. The third is historically significant because it was said that there the first Gisu man was circumcised, marking the origin of *imbalu* among the Bugisu. The study focused on a selection of men who were circumcised, but I did not verify whether they had followed the process of traditional or clinical circumcision. Due to the stigma associated with clinical male circumcision in the Bugisu communities, it would have been challenging to identify men who would admit to being medically circumcised.

As previously stated, the study involved the cultural leaders, clan leaders, traditional surgeons and medical officers from the three selected districts. I considered it appropriate to recruit these people because they were knowledgeable about the traditional and medical practices of male circumcision in their areas. Among the men I targeted, three were medical officers, recruited

from the villages to give their views since they were both medical men and the Bamasaaba men and would understand both points of view on circumcision. These medical officers were not selected from hospitals as had been proposed initially because of various technical issues relating to the Regional Research Committee's ethical clearance.

3.4 Data Collection Procedure and Management

As indicated earlier, to holistically understand the social issues surrounding the Bamasaabas' response to the implementation of SMMCP, the study obtained data using individual interviews and focus groups, as discussed below.

3.4.1 In-Depth Individual Interviews and Focus Groups

The interview is the standard means of obtaining qualitative research information (Holstein and Gubrium, 1995). In this study, I conducted in-depth interviews and focus group discussions with selected the Bamasaaba men to allow me to obtain detailed, personalised information (Hancock and Algozzine 2006). The semi-structured and, at times, the unstructured interview format was particularly well-suited for the study. I set questions for both the individual interviews and the focus groups. See Appendix 9.

3.4.1.1 In-depth Individual Interviews

Mack (2005) argues that social science scholars commonly use in-depth interviews as a qualitative research instrument. The most significant reason for its popularity is that it gives a 'human face' to the investigation. Individual, in-depth interviews allow for an exploration of complicated issues and enable the researcher to develop an understanding of the meaning participants make of their daily life (Bryman, 2016). Through in-depth interviews, participants were able to express themselves on topics in a way that ordinary life rarely affords them. Mack (2005) argues that many people find it easy to express their opinions and experiences when someone listens to them with focussed attention and interest. One can obtain a depth of response that is not always possible in everyday conversations.

The in-depth interviews allowed me to elicit a comprehensive picture of participants' perspectives on MC. The in-depth interview format increased my ability to understand and

relate to my respondents, thus giving me the insight, I sought about the Bamasaabas' response to SMMC.

Among the participants was the key informant, *Umukuuka We Masaaba*, the chief custodian of the culture and traditional practices of *imbalu* in each district.

In addition, three other participants, all heads of cultural and traditional surgeons in the three districts, were recruited as key informants due to their role in traditional practices in their communities. The distribution of participants across districts and categories is illustrated in Table 3.1.

Table 3.1: Participants in In-depth Individual Interviews

Cultural Leaders	**Traditional Surgeons**		**Key Informants**	**Medical Officers**	**Clan Leaders**		**2016 Initiates**
Bugisu	District			Hospital	District		
-	Bududa	3	1	-	Bududa	5	1
-	Manafwa	3	1	-	Manafwa	5	1
5	Mbale	4	2	2	Mbale	6	1
5	**10**		**4**	**2**	**16**		**3**
					Grand Total		**40**

I interviewed the participants using the saturation point approach. According to Manson (2010), a researcher reaches saturation when new information no longer contributes knowledge to the phenomenon under investigation. From the total number of 40 participants, I interviewed 24 more than once a week. I maintained a relationship with these participants over the course of the study because they were knowledgeable and available whenever I required further information. Others were interviewed only once due to their commitments since it was a harvesting season. Many participants were involved in harvesting maize, coffee, beans and millet on their farms. I occasionally spent time with these men and had informal conversations with them while they were busy on their farms. These casual and unplanned meetings helped me to gain clarity on the issues raised during individual interviews and FG discussions.

The participants freely expressed their views about the implementation of the reformed health policies on male circumcision, without interruptions from me or any other disturbances. In interviews, I adopted a facilitative role by clarifying the participants' issues, engaging and guiding them to explain in detail. The process helped the participants by allowing them to expand on their observations relating to both medical and traditional male circumcision, an aspect that the health sector has hitherto neglected. This process helped me understand how indigenous Bamasaaba men feel about the implementation of the SMMCP.

Throughout the process, I assumed an amiable but respectful attitude to convey a positive tone and help the participants feel at ease. Throughout the process, I maintained a listening and attentive stance, which seemed to elicit a wealth of information and ideas as participants felt listened to and appreciated. All the interviews were audio-recorded with the participant's permission and consent, and most lasted between 45 and 60 minutes.

3.5.1.2. Focus Group Discussions

I obtained data from seven organised focus groups (FGs) with the participants. Mack et al. (2005) define a focus group as a qualitative research method used to obtain data from a group of participants when discussing a particular topic. I had initially designed the study to involve mostly one-on-one interviews but found that the information collected through in-depth interviews was insufficient for drawing general conclusions about the Bamasaabas' responses to the SMMCP. I felt that group discussions would broaden the discussion and establish commonality and priority areas among the interviewed men.

Bloor et al. (2001) consider focus group discussions to be the most appropriate method by which to provide stimuli information to the participants discussing the problem under investigation. I found that the FGs assisted me to articulate questions relating to people's behaviour and views, which are often taken for granted collectively. Researchers organise focus groups as a socially legitimated session for participants to engage in reflective self-examination. The thoughtful self-examination provides them with an opportunity to look back at the past carefully, to think critically about social phenomena and to reflect on what they might previously have taken for granted. Focus groups have the added advantage of providing

pauses and refection time between each individual's spoken words; there is less pressure to talk continually and more time for reflecting.

Those who participated in the FGs were presumed to have long-standing experiences with the cultural practice of MC in the region. I took considerable care to ensure that no member of the group dominated the discussion. With this technique, I understood how the implementation of SMMC impacts the cultural practice of *imbalu* and the people's way of living in the Bugisu communities. I used the interview schedule to keep the members' discussions focused on the research topic.

Mack et al. (2005) state that FGs contribute to a broad understanding by providing well-grounded information on certain practices' social and cultural norms. FGs also allowed me to understand the pervasiveness of the Bugisu people's social norms and values and their influence on their response to current health policies in their communities. For this reason, in the final stages of the research, I used the focus groups to provide information that would complement what had been obtained from individual participants.

To form these groups, I ensured prior communication with the LC1 chairpersons and traditional surgeons' leaders, who also acted as contact people from each village. To select members of each focus group, the LC1 chairpersons identified the cultural leaders, clan leaders and traditional surgeons who were likely to be eager to participate. Participants such as traditional surgeons tend to move between homes and districts in groups or clusters, making interviewing them in groups a lot easier.

It was challenging to secure individual interviews with all prospective initiates who dance in groups during *imbalu* celebrations. The Clan Leaders also led village groups amongst whom one could easily find and interview them rather than attempting to locate each one in their own homes.

The LC1 chairpersons are familiar with the people and the communities where they offer political and community services. These chairpersons were instrumental in setting up appointments, and they assisted in identifying potential participants. They also helped to arrange the venues for the group discussions. Circumcised men who felt comfortable participating in groups were approached in advance and given a detailed explanation about the

objectives of the meetings. In the end, I organised seven groups for discussions, which helped me to understand the overall opinions of the selected communities.

I arranged all seven FGs with participants of disparate ages and socio-economic status. Fortunately, social barriers did not prevent participants from freely expressing their views. The standard size of each group was between three and six members. After forming these groups, the LC1 chairpersons contacted me, confirming venues and times. Venues were selected that would ensure a degree of privacy and confidentiality. Therefore, it was essential to give the responsibility of mobilising participants to the LC1 chairpersons.

Two focus groups represented each district, with one having three focus groups. Participants in the focus groups are indicated in Table 3.2.

Table 3.2: Focus Groups and their Members

No.	***Category***		***District***
1	Three religious surgeons		Bududa
2	Four clan leaders		Bududa
3	Six initiates		Bududa
4	Four traditional surgeons		Manafwa
5	Six clan leaders		Manafwa
6	Three clan leaders		Mbale
7	Three traditional surgeons		Mbale

The time allowed for focus group discussions was one-and-a-half to two hours. To facilitate discussions, I used skills gained from previous group discussions when working as a research assistant at the University of the Western Cape (UWC). My goal was to ensure that the discussions kept on topic, and I prompted them with exciting issues that had arisen in interviews or other focus groups. I listened carefully and identified significant points of agreement and disagreement during the discussions. All the group discussions were lively, engaging and entertaining, with most participants eager to contribute. This made my role as a mediator very easy.

The following section discusses data management, analysis and interpretation.

3.5 Data Management and Analysis

I collected much data from the recorded in-depth interviews, group discussions and field notes, which were then organized and saved into folders. I critically reviewed the data, then organised and interpreted it to identify answers to the research questions. I reflected daily on what the day had offered in the field. Every day was a learning process for me, marked by positive and encouraging occurrences and negative and disheartening experiences. From these experiences, I refined the research process and strategies and made better sense of the data, making sure to keep the research questions uppermost in my mind. From the first research encounter with the participants, I subjected emerging ideas under reflection, which helped to sharpen my approach in subsequent interviews.

I also listened to the audio-recorded files daily to identify areas that needed further probing. Seeking greater clarity was an ongoing feature of the research process as it helped me to identify patterns of ideas emerging from the data. Various statements continued to echo in my mind throughout fieldwork. For data analysis, I adopted the general procedures recommended in Smith and Firth's (2010) model, with its five steps for data collection and analysis. Based on this model, I coded the transcriptions to generate and categorise data, as shown in Table 3. 3

Table 3.3: The Process of Coding Interview Transcripts

Code	Category	Description	District
	PROSPECTIVE INITIATES		
001	Initiate -1	Individual interview	Bududa
002	Initiate -2	Individual interview	Manafwa
003	Initiates	Focus group interview	Mbale
	CLAN LEADERS		
004	Clan leaders -1	Focus group interview	Bududa
005	Clan leaders -2	Focus group interview	
006	Clan Leader -1	Individual interview	
007	Clan Leader -2	Individual interview	
008	Clan Leader -3	Individual interview	
009	Clan Leader -1	Individual interview	Manafwa
010	Clan Leader -2	Individual interview	
011	Clan Leader -3	Individual interview	
012	Clan Leader-4	Individual interview	
013	Clan Leader-5	Individual interview	
014	Clan Leader -1	Individual interview	Mbale

015	Clan Leader -2	Individual interview	
016	Clan Leader -3	Individual interview	
017	Clan Leader-4	Individual interview	
018	Clan Leader- 5	Individual interview	
019	Key informants (Clan Leaders)-6	Focus group interview	
	CULTURAL LEADERS		
020	Cultural Leader-1	Individual interview	Bugisu-Region
021	Cultural Leader-2	Individual interview	
022	Cultural Leader-3	Individual interview	
023	Cultural Leader-4	Individual interview	
024	Cultural Leader-5	Individual interview	
025	Cultural Leader-6	Individual interview	
	CLINICAL OFFICERS		
026	Medical Officer -1	Individual interview	Mbale Hospital
027	Medical Officer -2	Individual interview	
	TRADITIONAL and RELIGIOUS SURGEONS		
028	Religious Surgeons	focus group interview	Bududa
029	Religious Surgeon	Individual interview	Manafwa
030	Religious Surgeon	Individual interview	Mbale
031	Traditional Surgeon -1	Individual interview	Bududa
032	Traditional Surgeon -2	Individual interview	
033	Traditional Surgeon -3	Individual interview	
034	Traditional Surgeon -1	Individual interview	Manafwa
035	Traditional Surgeon -2	Individual interview	
036	Traditional Surgeon -3	Individual interview	
037	Traditional Surgeon-1	Individual interview	Mbale
038	Traditional Surgeon -2	Individual interview	
039	Traditional Surgeons -3	focus group interview	
040	Traditional Surgeon -4	focus group interview	

On completion of the fieldwork, I transcribed the audio-recorded interviews into English. This stage proved to be the most tedious component of the research project. Still, it was also enriching because it kept me connected to and well-informed about the findings, forcing me to consider the precise way to transcribe Lumasaaba terms. I listened to the recorded interviews repeatedly to accurately transcribe the slang of everyday language or idioms that needed rephrasing in English to capture their essence. I tried to ensure that the transcripts were exact and contained accurate information by frequently checking the speech errors, pauses, interruptions, changes in volume and emphasis placed on specific issues.

To provide a quality check of the English translations, I employed the services of language experts from Uganda Bible House, Kampala, who were recommended. I extended the precautions taken during fieldwork to the transcription and analysis part of the study, proceeding in two ways. Firstly, I read through each transcript many times to determine preliminary findings. The re-reading of the transcripts enabled me to detect patterns, categorise data, and distinguish between different views about SMMC implementation and its implications for cultural practices. The process also helped me to construct associations in data and began to see which categories were, in essence, of the same kind. Using the interpretive approach, I was able to detect patterns, threads and commonalities within the data to explain the problem under investigation (Bryman, 2016).

Secondly, having transcribed all the audio-recordings, I saved the transcripts in Microsoft Word documents. I went through them again, using the software Grammarly to check for grammar and spelling errors once I had ascertained that the information in the transcripts correlated precisely with that on the recordings. I then generated categories to analyse the data. These categories formed a critical step in the data analysis process. It involved my uploading the 'cleaned' transcripts onto the computer application Atlas TI for analysis. I used this software to code, categorise, sort, summarise and synthesise many issues arising from the data (Bryman and Burgess, 1994; Bryman, 2016). I applied this process to categories until I was convinced of their meaning and relevance to the study.

During fieldwork, this facility helped me to detect and reflect on emerging findings. The focus group discussions also enabled me to conduct follow-ups on the results originating from the data analysed. In other words, the analytical strategy shaped or structured a specific view of the data, which allowed me to formulate a more general expression of the categories suggested by the data. Blake (2007) and Bryman (2016) argue that the interpretation of data is attained through a combination of personal knowledge and textual scrutiny, and the memory of field experience. As stated before, I spent a great deal of time with the Bamasaaba men and had informal conversations with them while they were working on their farms. All of these encounters left a general impression on my mind and yielding specific units of data.

3.6 Ethical Considerations

I conducted this research under the auspices of the University of the Western Cape, Department of Anthropology/Sociology in the Arts Faculty. I duly obtained approval after submitting my proposal to the Arts Higher Degree Committee. I received ethical clearance from the Senate Research Ethics Committee of the University of the Western Cape. Having obtained the relevant documentation from the UWC Research Ethics Committee, I designed letters addressed to *Umukuuka We Masaaba* (the King of the Bugisu Kingdom) and the SMMC programme director Mbale Regional Hospital.

The purpose of the letters was to seek authorisation to conduct the investigation in their establishments. The letters addressed to the director of the SMMC programme and the medical administrators at Mbale Regional Hospital assured them that I would not video or take photographs of activities in the hospital for safety and ethical reasons. The *Inzu ye Bamasaaba* gave their permission by signing consent. The study also obtained formal permission in writing from the office of *Umukuuka We Masaaba* to allow the data collection process. However, the SMMC programme director at Mbale Regional Hospital rejected my proposal and directed me to their research office. With the cultural institution's approval *(Inzu ye Masaaba)*, I proceeded to collect data outside of the medical setting.

The Mbale Regional Research Ethics Committee mistook the study for a clinical trial and did not approve the proposal. This feedback came at the time when I had completed the collection of data from the clan leaders, cultural leaders and traditional surgeons. The *Inzu ye Masaaba* then advised me to submit another application to the Children's Hospital of Uganda Research Ethics Committee, which I did. I paid the required research fees, but the research office did not finalise the application. For this reason, I was not able to conduct interviews in any medical setting. However, I obtained individual verbal permission, signed consent forms from the participants in the in-depth interviews and focus group discussions, and was granted permission by the participants to audio-record the interview sessions.

Informed Consent Forms

Informed consent forms were signed by all the participants who took part in the interviews and focus group discussions. Due to the sensitivity of the participants' information, I was compelled

to negotiate 'informed consent, especially with the 2016 initiates. I thus engaged participants in a continuing process of discussion and negotiation throughout the entire period of interviewing. I continued to negotiate consent by frequently asking the participants if they were still willing to continue with their participation in the study. I pursued this process in acknowledgement of the uncertainty and sensitivity of the problem under investigation. *Umukuuka We Masaaba* signed the final consent form as the Bugisu Cultural Committee representative and granted permission for the research to be conducted. In the end, all participants gave written and verbal consent to participate in the study.

3.7.2 Privacy and Confidentiality

The privacy and confidentiality of participants and the information they shared were significant for the study. The participants were assured that their privacy would be safeguarded and confidentiality would be maintained if they decided to participate in the study. To this end, I confirmed that I would use the data in a manner that could not cause harm to participants or anyone close and that I would destroy all raw materials after completing the thesis. After obtaining permission from the gatekeepers, I organised pre-session meetings with participants to discuss these tenets in detail and reassure those who had already signed their consent. I gave the following assurances: Instead of names, I would use numbers to identify comments. I informed the participants that the data they provided was to be kept securely by me and utilised only for the purposes of the investigation.

I informed focus group participants about the topic and methods to be used, and all confirmed their participation before discussions began. Several researchers argue that one cannot, in fact, guarantee confidentiality in a focus group, even with confidentiality forms; however, there are things one can put in place to give participants a certain level of anonymity (Rosanna, 2006; Christian, 2007; Bryman 2016). I thus asked the participants to sign a nondisclosure agreement together with the informed consent forms. I had to inform the key contact men to notify the referred participants to give themselves pseudonyms before arrival. Hence, no one in the focus groups knew the true identity of others in the group.

I was aware that over-disclosure is a real danger in group discussions as people can become enthused by the conversation. Therefore, I tried to lay the ground rules by telling the participants that what they discussed should not be disclosed beyond the group. In addition, I

tried my best not to create unnecessary tension within the groups by setting myself up as an expert; instead, I assured them I was a listener and a learner and would pass no judgements on their comments. This ensured that participants were comfortable sharing their thoughts. I also avoided setting up potential hierarchies in the groups, particularly in the icebreaker and warm-up exercises. For example, I was careful not to start with political or socio-economic questions as the groups were politically and socioeconomically diverse. I also avoided asking participants about their circumcision status, which could have caused tension, especially for those who might have secretly undergone MMC.

3.7.3 Protection and Voluntary Participation

Prior to the commencement of the sessions, I informed the participants that participation was voluntary and that they had the right to withdraw at any time, even after they had signed the consent forms. I informed the participants about the nature of the research and established a clear boundary between them and me. I also fully advised the traditional surgeons and initiated boys that I would not make video recordings during the ceremony.

The *Umukuuka We Masaaba* (King of the Bamasaaba kingdom) was informed about the need for a translator in the interview sessions, especially amongst traditional male circumcision practitioners. The possibility existed that these men may have encountered difficulties in understanding different dialects when responding to the questions. This happened especially in focus groups where men with different lumasaaba dialect were mixed in a discussion. Ultimately, the consent letters highlighted that all participants' identity would not be revealed or recorded in any documents and that I would destroy all field notes after the finalisation of the thesis. In this way, I ensured that the research participants remained unknown.

3.7.4 Honesty and Integrity

Honesty and integrity are essential components of ethical research. During collecting data and reporting the results, I was aware of my possible element of ideological and recorded power, which I disconnected from the actual investigation while in the field. This process helped me to address the overwhelming sorts of inquiries that applied to the participants and me. Ruby (1980) argues that self-reflection on compelling conditions is the way to strengthen the capacity of research and to enhance the meaning of results. I believed that reflecting on my own biases

would indicate that I had made a genuine attempt to investigate the issues in question. As part of maintaining integrity and honesty, comments were transcribed and are recorded in this study exactly as they were spoken, barring hesitations and 'fillers' in speech.

I also assumed a value-free neutrality position, which required me to have an open disposition by relating to the participants as a researcher and not a known member of the community. For example, my own experience of TMC in 1990 could have influenced my attitude towards the implementation of the SMMCP. I understand that it is difficult to "bracket" subjective experiences and understandings of the cultural experience, and sometimes one has to just acknowledge it. However, I attempted to define the exact position of a researcher and strove to maintain a sense of neutrality by bracketing my own opinions where necessary.

3.8 Limitations

Data collection for this study was limited only to the Bamasaaba men, providing no room for women's opinions, which may have imposed certain limitations on the kind of data collected. This is no small limitation, given that through SMMC, the government aims to protect both men and women against HIV infections. A significant number of studies have reported that women have a considerable influence on their partner's circumcision status in other parts of Africa. In the Bugisu region, women have specific roles during the *imbalu* ceremony, brewing the *kamayeku* (unique local alcohol) and presenting it to the initiates before they are circumcised. Therefore, recruiting and interviewing women would have helped to gain insight into what they thought about the implementation of the SMMCP.

Another limitation of this study was that I did not interview medically circumcised men in the Bugisu communities (or none that declared themselves so). The study reflects only the perceptions of traditionally circumcised the Bamasaaba men from Bududa, Manafwa and Mbale Districts. Including men who had undergone medical circumcision could have provided a more comprehensive picture of the Bamasaaba men's response to the SMMCP. As it stands, this study describes the views of only traditionally circumcised men in the Bugisu community – those who had undergone *imbalu.* Enquiry into the views of the Bamasaaba men who have experienced SMMC is left to future researchers.

Lastly, the study's location and conditions limited findings to the practice of TMC in the Bugisu sub-region; therefore, the results cannot be generalised to the broader national context. The study's relevance comes at a time when the HIV pandemic requires a fundamental resolution regarding ways to overcome this serious challenge. Implementing SMMC aims to address these challenges, but the fact that it runs contrary to the cultural practices of TMC severely limit its implementation. The study aims to contribute to a sociological understanding of the Bamasaaba's response to the implementation of the SMMCP that will be helpful to all interested parties.

3.9 Summary of the Chapter

This chapter has presented the methodological framework, explaining the qualitative research design and highlighting the methods used to collect data for analysis. The chapter has described how these methods were used to obtain in-depth information concerning the response of the Bamasaaba to the implementation of reformed health policies on male circumcision. Also presented in this chapter are detailed information on the site of research, the spread of the participants, the research instruments used and the various stages of the research process, such as data collection and data analysis, as well as ethical considerations and limitations of the study.

The following chapter presents and analyses the data.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter organises, presents and analyses the data obtained from selected participants from the Bududa, Manafwa and Mbale Districts with regard to their views on safe medical male circumcision (SMMC). Traditional surgeons, cultural and clan leaders, medical officers and 2016 initiates formed the cohort of participants who answered unstructured questions in individual interviews and focus group discussions. I present and analyse data simultaneously using a qualitative computer application known as Atlas TI. This was used to classify and organise data according to emergent categories for presentation.

4.2 The Bamasaabas' Response to the Safe Medical Male Circumcision Policy (SMMCP)

The first category of data to emerge comprised the views of traditional surgeons and cultural and clan leaders regarding the implementation of the SMMCP. The chapter presents responses obtained from these key informants and those of the medical officers (medical personnel) who formed part of the community. Since the clinical officers were interviewed outside the medical setting parameters and on their home ground, it is worth noting that their responses represent their independent opinions rather than the Ministry of Health's views. Lastly, I present reactions from the 2016 initiates.

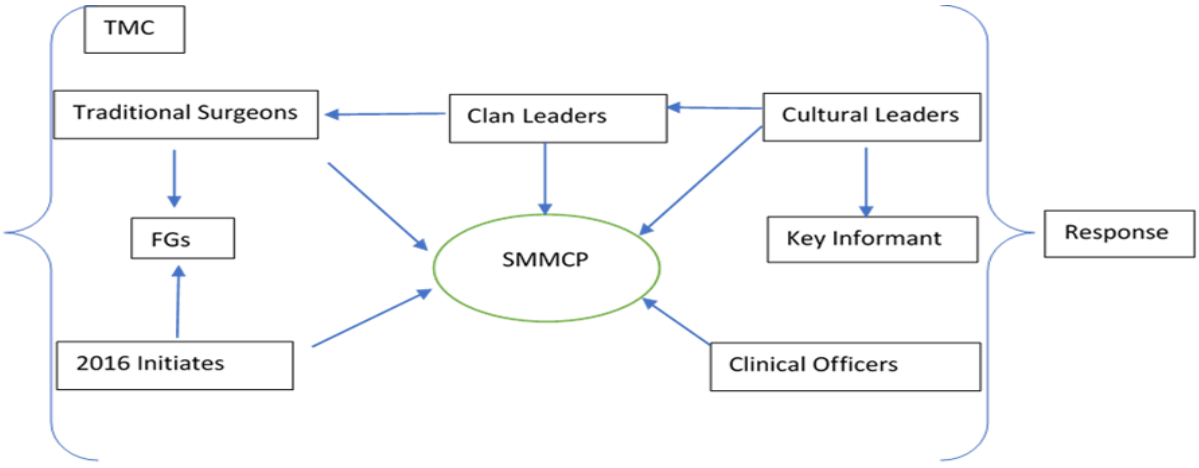
The Bamasaaba have organised the Bugisu sub-region under one cultural institution known as *Inzu ye Bamasaaba*, headed by the ceremonial, cultural ruler called *Umukuuka We Masaaba,* which means 'the palace of Masaaba'. This is the headquarters of the 'Bugisu Kingdom', also known as the Bugisu sub-region. The *Umukuuka* is the King of the Bugisu sub-region, who, together with the cultural leaders selected from different clans, forms a cabinet that oversees cultural activities such as *imbalu*. The *Umukuuka* is the sole custodian of the cultural practices of *imbalu* in the Bugisu sub-region and was recruited and interviewed in a special interview session as a key informant. See figure 4.10 below

Figure 4.10: Umukuuka We Bamasaaba at Bumutoto Cultural Ground, Mbale

Source: Google Images.

As mentioned in chapter three, the deductive approach was used to structure or determine the framework to analyse data. Essentially, I used a chronological structure to present, interpreted and analysed the interview transcripts. The reason for adopting this approach was that the interview explored reasons for the Bamasaaba's response to the implementation of the SMMCP in Uganda. Therefore, data was presented and interpreted according to the chronological representation of the interviews, as shown in figure 4.11 below

Figure 4.11:The Chronological Presentation of Data from Participants



4.2.1 Responses of Cultural and Clan Leaders

Otiso (2006) states that traditions, culture, and customs provide a fascinating impression of Uganda's current societal changes. Where rural ethnic groups are experiencing urbanisation, Western cultural practices heavily influence culture, causing a gradual loosening and diluting of cultural norms. However, in rural areas, relatively untainted by the influence of Western cultural practices, traditional practices remain strong, partly as a consequence of the authority held by cultural and clan leaders. In this section, the data presented reflects the cultural and clan leaders' views on the implementation of the SMMCP amongst the Bamasaaba. The participants in this category gave some indication of the reforms that are taking place in the cultural practice of male circumcision.

These reforms primarily concern matters of hygiene. Initiates are now expected to bathe and dress the wounds right after the removal of the foreskin to prevent infections such as tetanus and other conditions. A Cultural Leader said:

> *I believe that our tradition is reforming and now moving to a less primitive era. Today each initiate uses one knife, and as medically prescribed, the initiates may take a shower and treat the wound right after the traditional rituals*
>
> (Cultural Leader No. 3.).

The matter of washing immediately after getting circumcised is a new development and shows the influence of the SMMCP on traditional practices. Lilleston et al. (2017:1050) stated, 'The changing context, including the increased prevalence of and access to SMMC, requires a reassessment of the factors that affect MMC acceptance.' The participants stated that the implementation of the SMMCP had affected circumcisions in the Bugisu sub-region. The interviewer wondered whether this meant that the Bamasaaba accepted SMMC, but in this regard, a Cultural Leader said:

> *Not really, some policies, yes, but others no. You see, when the government implements health policies, you should not refuse all of them. Some are not bad; they do not kill. The health policy introduces medical male circumcision, which will oppose and remove the norms of our culture and traditions, and we treat it as such. So, the Safe Male*

Circumcision Policy is one of those lousy health policies for the Bamasaaba. How can you advise the local Bamasaaba to go to the hospital for imbalu? *Maybe if someone has got a medical problem … but you cannot say, stop the culture. That is where there is a problem with this government policy. The Bamasaaba want assurance that health policies are not bad. Even I do not see anything wrong with them. Still, I do not tell us to stop the traditional way of doing circumcision since hospital circumcision is where women are allowed to circumcise*

(Cultural Leader No. 2.).

On the same point, another cultural leader also had a negative view of the reformed health policies. These two participants shared similar thoughts to the implementation of the SMMCP, which promotes the uptake of SMMC in Uganda. He said:

The response is bad because of the points I have made before about those policies; the purpose of those policies does not to allow the boy to benefit and become leaders who are proud of who they are because tomorrow he might be the next Umukuuka. *The children should not just take it for granted that getting circumcision is for HIV prevention. That is why we should not assume that getting circumcised will make one not acquire HIV and AIDS*

(Cultural Leader No. 4.).

These participants express negative sentiments about the health policies on male circumcision but could not tell why they resent the policies. The only reason the participants capitalise on is the cultural practice.

In some cases, participants had mixed reactions with regard to the implementation of the SMMCP in the Bugisu sub-region. A participant pointed out that poverty could affect one's choice of practice, as traditional circumcision was expensive for families who have to foot the bill for the festivities. A Cultural Leader said:

One of the reasons for the changes in imbalu over the years is poverty. People no longer have the food to have celebrations for three days and sacrifice so many animals to be used for the festivities

(Cultural Leader No. 5.).

However, due to the consequences men face should they undergo SMMC, most choose to continue with the traditional practice of male circumcision, despite poverty. The majority of participants believed that the Bamasaaba men who had been circumcised in the hospital remained 'boys' and were thus rejected by the community. One of the Cultural Leaders stated:

> *We reject any man circumcised in the hospital because he did not follow the cultural norms of the Bamasaaba; he is not even allowed to pass before the initiate who obeys the culture. He will not be given a leadership position in the Bamasaaba culture, for example, to become* Umukuuka *(the king) even when he is able and has the capability. He is still a boy. He is not allowed to take any political post or position in Bugisu because a boy cannot lead men in our culture. For example, during the elections of the Member of Parliament representing the Bamasaaba, we had a potential candidate who contested with* Umukuuka We Inzu ye Bamasaaba*. Still, the Bamasaaba realised that this other contestant received medical male circumcision. So, he lost, and we chose* Umukuuka We Masaaba. *He also lost money from the statehouse and the pride of being called* Umukuuka *because of going to the hospital for male circumcision*
>
> (Cultural Leader No. 1).

The majority of the participants interviewed believed that there was no need for public education regarding the SMMCP since such advertising would not address the negative views regarding the health policy in their region. For this reason, some participants noted that even if the government provided the educational information, the Bamasaaba would not be motivated to consider SMMC. A participant stated that in their village, *imbalu* only is practised – not SMMC. A clan leader said that limited information about the health policy was available in rural areas. A Clan Leader from the Manafwa District stated:

> *I know that the* Bamasaaba bengila *imbalu (the Bamasaaba get circumcised). I don't know about safe male circumcision in this village. Maybe other people do, but not me*
>
> (Clan Leader No. 1.).

The Clan Leaders and Cultural Leaders were unsure whether a lack of community awareness had contributed to the mixed views of local people to SMMC in their region. There was also scepticism regarding the efficacy of MMC for preventing HIV. A Clan Leader went as far as saying that if there were any proof that MMC prevented HIV, he would support it:

In reality, I will not say that I support these new policies on male circumcision. The reason for me not accepting them is that I have never seen any practical evidence of male circumcision being a preventive measure for controlling the risk of HIV infection. I am very sure that if I had an idea of how male circumcision can prevent HIV infection, I would leave the tradition and take my children to the hospital for a circumcision

(Clan Leader No. 2).

The Bamasaaba stated that traditional male surgeons perform male circumcision in the community, witnessed by many people. Those who are aware of SMMC know that trained male or female medical officers perform it in the privacy of a hospital. One of the participants said that this might be the reason why the Bamasaaba had mixed reactions towards the SMMCP – people do not know what happens in a hospital. To them, the process lacks transparency. The majority of participants concurred that doctors needed to explain what happens in the hospital with potential patients. Some participants wanted to know if any rituals were performed in the hospital as if these were allowed, that might motivate them to take up SMMC. The Clan Leader from Mbale said:

Our traditional circumcision is still essential and has not changed in any way because we have preserved the places where we perform rituals of male circumcision. We stand in the open for everybody to witness imbalu, *but we don't know what happens in the hospital. The doctors said that they take boys to the theatre for an operation. We understand that any person who goes to the theatre is a patient, but we cannot be patients just because of male circumcision. I think they must come and educate us to be aware of what happens there*

(Clan Leader No. 4.).

When I asked the Cultural and Clan Leaders whether SMMC could replace TMC, the responses were negative. Participants did not believe that SMMC would one day replace *imbalu* in the Bugisu sub-region. They even give MMC its own name to distinguish it from 'proper' circumcision, calling it *imbalu ye khulubawo* ('circumcision on the bench'). Wantsusi (2011) states that the Bamasaaba men believe that only women go to the hospital when not sick to give birth lying on a hospital bed. Comparing SMMC with the birthing procedure, the

participants said they could not go for SMMC ‘as if we would give birth’. One of the Clan Leader asserted:

> *Ehe, I can't imagine* umusaani burwa *going for medical circumcisions, like a woman going for labour. The* imbalu *can be made safe by educating the traditional surgeons to sterilise the knives used to circumcise the boys, avoid infections, and not eradicate the whole practice*
>
> (Clan Leader No. 5.).

Furthermore, the Clan Leader from Bududa District said that the SMMCP was put in place to encourage people from other tribes to carry out circumcision for the prevention of STDs like HIV – it was not for their tribe. In addition, the participants believed that public awareness campaigns regarding male circumcision as a preventive method are not relevant for the Bamasaaba since they undergo TMC.

Participants also stated that the Bamasaaba have not understood the implementation of SMMC in the Bugisu sub-region very well due to insufficient advertising and awareness of the practice. Some noted that the health centres and hospitals did not promote the practice in any meaningful way. They felt that the advertisements would be more effective if they helped to establish some sort of link between SMMC and TMC so that people could view SMMC in relation to something they were familiar with. As it was, they had no context for the idea of SMMC and no way of understanding it. Cultural Leaders referred to a poster seeking to promote MMC, depicted in Figure 4.12 below.

Figure 4.12: The SMMC Campaign Poster in Uganda

Source: Primary data (photograph taken from a billboard).

The participants stated that posters of this kind do not have any value for them. The participants asked what a gold medallist has to do with the Bamasaaba and how such an advert could make them substitute SMMC for their current practices. A Cultural Leader asked,

> *What can the Bamasaaba learn from this kind of advert to abandon their tradition and adopt clinical male circumcision*
>
> (Cultural Leader No. 2.).

The participants believed that the government's implementation of their health policy on male circumcision should not interfere with the local people's traditional and cultural practices. They suggested that the public awareness campaign for SMMC should not discredit or affect the practice of TMC for the Bamasaaba. One participant said that many questions remained about SMMC and that some thought it might expose young people to HIV infection rather than protect them from it. This was because some boys had started going to the hospital for SMMC with the misconceived idea that it guaranteed protection from HIV. The majority of the men interviewed believed that, as a result, the implementation of SMMC has resulted in a relaxation of condom use. A Clan Leader in Manafwa said:

> *I, for one, the way I understand these issues of medical male circumcision and HIV and AIDS, I think the Bamasaaba ought not to agree to the implementation of the safe male*

circumcision because there is a high, misconceived perception that male circumcision is a preventive strategy. People will stop using condoms for protection

(Clan Leader No. 4.).

All the participants stated that the Bamasaaba undergo TMC as a cultural practice. As such, if health benefits such as circumcision's potential to reduce the spread of HIV are promoted, people will automatically misunderstand the policy and believe that circumcision of any kind guarantees protection – resulting in more unprotected sex. The Cultural Leader in Manafwa stated:

Absolute nonsense! The young men and women in the Bugisu will not protect themselves from the infection of HIV because they have heard that medical male circumcision prevents them from being infected

(Cultural Leader No. 2.).

The cultural values attached to TMC are significant for young people in the Bugisu sub-region. These values range from individual behaviour to understanding the societal norms such as the way boys are expected to behave or act, conduct themselves, their manners etc. Traditional Surgeons play a significant role in the process of instilling these social values into boys, especially during the ritual called *khusabisa* (adoration prayer to ancestors). The Cultural Leaders unanimously agreed that there are cultural values attached to TMC for the Bamasaaba, especially during the last rituals performed during *khusabisa,* which aims to transform the boys into responsible people within the communities. In this regard, a Cultural Leader said:

Medical circumcision is not suitable for our people because, after the practice, the parents don't know what to do with regard to treatment. The doctors do not teach boys the values of receiving circumcision, yet, traditional surgeons do the treatment and perform the last ritual called khusabisa*. The traditional surgeons give these boys the cultural values and norms of being traditionally circumcised or men. The values such as: Do not start up a fight with another person, work for your food, do not peep at women, if your peers engage in a fight, separate them, and do not steal, among other values*

(Cultural Leader No. 4.).

Some Cultural Leaders and Traditional Surgeons, and the Medical Officers interviewed acknowledged the effect of the SMMCP on TMC practices. The government's health policies were cautiously watched, especially those relating to male circumcision, lest they wipe away the Bamasaaba cultural practices. However, participants acknowledged that SMMC had had some positive effects on TMC.

> *Yes, I am aware of it [the SMMCP] but cautious. The government is worried that if people circumcise locally, people will contract HIV like in the past. The government will lose people, but from history, in our culture, we know that imbalu did not kill anyone. Today, the traditional surgeons must sterilise the knives, and perhaps, the surgeon himself must be healthy. For generations, we have never experienced any serious problem with our tradition of imbalu*
>
> (Clan Leader No. 4).

The fact that knives are now sterilised showed that the message of safety had penetrated TMC. However, this is a significant transformation of *imbalu* practices. The previous rituals performed on the knives before they are used on the boys have turned into a mere sterile medical practice. Therefore, in these men's view, Traditional Surgeons could not be accused of endangering lives or spreading HIV.

A Clan Leader also indicated other ways that the traditional practice had changes, although not only in response to SMMC. Data presented reveals that it is not only the modern practices of the SMMCP, which impact cultural practices. Other social factors, such as poverty, have played a significant role in the change. He said:

> *Yes, changes are there; in the past, they could slaughter many animals and chickens for the boys before circumcision. Not nowadays. One of the reasons for the changes over the years is poverty. People no longer have the luxury to have celebrations for three days and use animals for sacrifice during the festivities season*
>
> (Clan Leader No. 6).

A significant number of participants reflected critically on the implementation of SMMC in the Bugisu sub-region. Westercamp et al. (2012) argue that SMMC has the potential to influence individual cultural beliefs and sexual behaviour. The participants acknowledged that

the government's generalisations regarding SMMCP could negatively impact on the individual's ability to adhere to cultural practices. Clan Leader No. 1, from the Manafwa District, expressed a concern that TMC now has many challenges caused by educated community members. He said:

> *First and foremost, the attitude of the people who have been at school … feel the cultural practices are not acceptable, so barbaric and primitive. They circumcise children instead, so with time, we shall not have boys to circumcise. Definitely, in future, the traditional surgeons will have no boys to circumcise because the government is circumcising most of them as infants. The issue of circumcising little children who have not reached the recommended age is that we will only have a few boys to cut traditionally because they are done in the future*
>
> (Clan Leader No. 1.).

Given the general absence of attention to the rationale and potential impact of utilising SMMC services, it is not surprising that there is widespread disagreement about its implementation. One of the cultural leaders recruited as a key informant raised a concern that rampant corruption exists in the current government. This corruption extends to ministries, such as the Ministry of Health. This view of the ministry as corrupt simply reinforced the prevailing tone of scepticism and distrust expressed by the majority of participants.

In the section that follows, I present data obtained from a selected key informant.

4.2.2 Responses of A Key Informant Regarding SMMCP

This section presents views of a key informant on how he and the Bamasaaba feel about the implementation of the SMMCP in the Bugisu sub-region. I selected this man as a key informant because of his strong track record with the region's cultural activities. He has had international experiences that come in handy in developing the cultural institution in Masaaba land. This participant believed that the issue of SMMC was surrounded by public distrust of the government, resulting in a very negative view of the SMMCP. This informant recounted that the majority of the Bamasaaba regarded the government and the Ministry of Health with suspicion, based on the assumption that it was attempting to redefine the cultural practices of *imbalu*. He said:

Today's Ugandan government has its political interests in the Bugisu. I think it is happening to all African governments interested in gains and forget people's cultural attractions. Individual attachments cause this to socio-economic events within each particular country. They are only aiming at spending the money from the World Bank meant for HIV and AIDS programmes at the expense of our cultural practices, especially in the Bugisu region. In my opinion, you may get others who are going to think like me; for a country's economy to grow, they need specific social stability in the country. I honestly tell you that Uganda's government has an alternative motive for having this male circumcision done in a certain way to misappropriate the money meant for HIV and AIDS programmes. The government has an organised plan that extends beyond caring for the people of Uganda

(Inzu ye Bamasaaba).

His view casts an interesting political slant on the matter and reveals a prevailing view that implementation of the SMMCP might serve the political and economic interests of individual political leaders, especially those from traditionally non-circumcising communities. According to this participant, these leaders are probably uncircumcised or clinically circumcised and would want to eradicate *imbalu* as something that unites and strengthens a tribe that is not their own. One of their motives may be that they are regarded as 'boys' by the traditionally circumcised communities, and therefore, in a sense, wish to harm those who regard them as such. This idea seemed to emerge from the kinds of comments made by this participant.

The participant stated that he regarded the apparent objectivity of the implementation of the SMMCP with suspicion. He expressed concern about the increased media messaging that described *imbalu* as a violation of children's rights, unhygienic, primitive and barbaric. He said this might be part of the government's conspiracy to increase its effort to eradicate TMC. His comment was:

I have been thinking about the promotional messages on safe medical male circumcision in the media, and I have started to believe that the government is trying to eradicate the practice of traditional male circumcision in the Bugisu sub-region. I stand to be corrected if I am wrong. The government is trying to get control over the cultural practices of the Bamasaaba. I see that the government manages and regulates

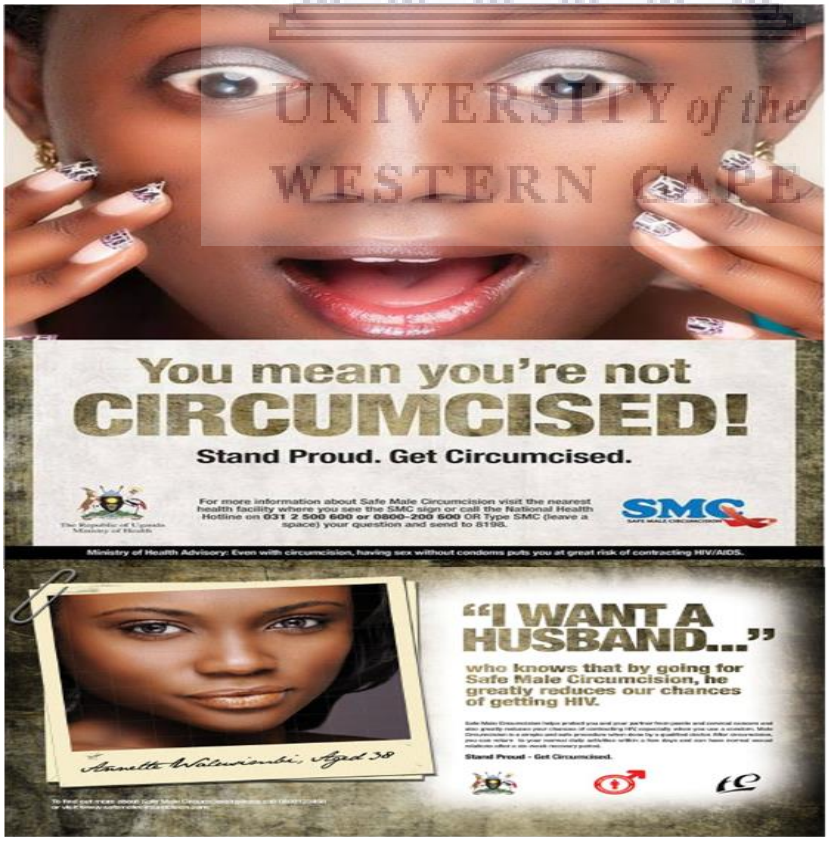
imbalu through health institutions. The government cannot do this in Kingdoms like Buganda

(Inzu ye Bamasaaba).

Mories et al. (2019:146) claim that "MC is just one of many factors that influence a woman's choice of a male partner". These scholars continue that religion, race, social class, personality, overall attractiveness, ability to provide for the woman and her children, ability to satisfy the woman sexually, and basic hygiene are supplementary values attached to male circumcision.

In relation to these matters, the participant stated that the government of Uganda is aware that the Bamasaaba women do not want to have a sexual relationship with uncircumcised men and so might encourage men to undergo SMMC for hygienic reasons. Like the majority of the participants, this key informant confirmed that the materials used for the SMMC campaign send messages that are anti-traditional male circumcision and portray men as a social risk to women. The participant referred to a poster shown in Figure 4.13.

Figure 4.13: The SMMC Campaign Poster in Uganda



Source: (MoH, 2014).

This participant stated that many women might misinterpret the message on this poster:

> *Women may misinterpret the message on this poster and start advising our children to undergo clinical male circumcision, which contradicts the traditional and cultural practices of the Bamasaaba*
>
> (Inzu ye Bamasaaba).

The informant reacted to the words on the poster that stated, *'I want a husband who knows that by going for Safe Male Circumcision, he greatly reduces our chance of getting HIV*.' The participant said that women influenced men to get circumcised. From this statement, I realised that not interviewing women might have influenced the data collected in this section. Interviewing women would have allowed them to express their reactions regarding the implementation of the SMMC in Uganda. The women in the Bugisu region have a right to be empowered through education and to take part in certain cultural activities. However, they are not allowed to perform male circumcision. The general belief is that women are excluded from the cultural practices of male circumcision in the Bugisu sub-region also influenced their exclusion from this study. However, it was interesting that the participant in this category explained that the cultural institution has programs that empower women but did not indicate which kind of empowerment. The key informant said:

> Inzu ye Bamasaaba *is not an institution for only culture or men. We also have programmes like education for empowering women. To add on, I say that people have mistaken* Inzu Yam Masaaba *as an institution for the only imbalu. A minister of gender in* Inzu ye Bamasaaba *is preferably a woman. We have even youth in the institution, which a woman represents, it cuts across, and another thing is that a woman is also* Umumasaaba
>
> (Inzu ye Bamasaaba).

In South Africa, among the Xhosa people, women's participation in *ulwaluko* is considered taboo (Mdedetyana, 2019). He states that the Congress of Traditional Leaders of South Africa has in the past rejected any suggestion of women's involvement in the matters of traditional male circumcision. Similarly, womens' role in the Bugisu communities has been reduced to cooking and preparing for the related ceremonies. At the same time, men are responsible for

the customary practices and the decisions required in the process. The participants claimed that the Bamasaaba men might misunderstand the messaging on most adverts as opposing their authority. Women may choose to have relationships with only medically circumcised men in the communities. He added:

> *The Bamasaaba men may also misunderstand the information on the poster by thinking that the women will only want to have a relationship with the men who have undergone safe medical male circumcision and forget our culture*
>
> (Inzu ye Bamasaaba).

The participant believed that this poster demonstrates women's decision-making power regarding the type of circumcision men should undergo. Besides, the participant claimed the Bamasaaba might misinterpret the communication on this poster, which implies that it is not circumcision in general that women prefer, but only men who have undergone SMMC. He stated that such ideas are propagated by political leaders who exercise their power without consulting knowledgeable people in the Ministry of Health. He commented:

> *The government of Uganda has one problem: They want to show their political power to control and manage all situations, regardless of the cultural implication*
>
> (Inzu ye Bamasaaba).

The government of Uganda has many officials who are not traditionally circumcised. The participants claimed that anybody who is not traditionally circumcised is excluded from the general cultural activities of *imbalu* in Bugisu communities. This means that the president of Uganda forms part of the community that is directly excluded from participating in the cultural activities of *imbalu*. According to Connell (1995), these men like President Museveni hold what he calls complicit masculinity. The type of masculinity applies to men who are not entirely participating in or acknowledging the patterns of hegemonic masculinity. However, they directly benefit from the patriarchal dividends of men who feed off womens' general subordination in society.

The participant expressed the view that the government had no right to force them to do what they did not want to do, as the Bamasaaba. On this very point, the key informant stated:

I think these people in the government forget that they don't have the right to force the Bamasaaba to do the male circumcision, which they do not want. All the Bamasaaba regard their tradition of imbalu as a prestigious culture, and we are ready to defend it. To us, President Museveni is a boy, and he cannot tell us what to do when it comes to our forefathers' tradition. The health policy of male circumcision as a health intervention for HIV is not for the Bamasaaba; it is for them who are still boys. Let them take it to those who are not circumcised, but not to us

(Inzu ye Bamasaaba).

The excessive pressure exerted by the campaign, which fails to acknowledge the value of traditional circumcision, appears to have exacerbated distrust between the Bamasaaba and the government, especially the Ministry of Health. This distrust has greatly influenced the response to the SMMCP in the Bugisu sub-region. This interviewee's political comments appeared to reflect a widespread perception that there is probably a socio-political agenda on the part of government health institutions in their implementation of the SMMCP. The participant stated that corrupt officials from the Ministry of Health caused mistrust, which suggests that many of the Bamasaaba, who tend to follow influential Cultural Leaders such as this participant, believe that political leaders have a hidden political agenda trying to enforce MMC.

This participant was concerned that the Ministry of Health had publicly endorsed the SMMCP, which would affect the way local people respond to the intervention. On the other hand, numerous other participants believed that education campaigns should be the central means by which the mistrust between the Bamasaaba and the government could be addressed. The majority of participants argued that the obligation to gain public trust, especially the Bamasaaba in the Bugisu sub-region, ultimately rests with the Ministry of Health and the health practitioners.

4.2.3 Comments from the Focus Groups (FGS) Regarding the SMMCP

This section presents data from responses in the focus groups (FGs). The majority of the participants in these groups acknowledged that changing social and economic conditions, such as HIV and AIDS, had wrought changes in cultural practices. They nonetheless concurred that the Bamasaaba had maintained a negative view of SMMCP and were unlikely to change this. In their discussions, they noted that the Bamasaaba perform male circumcision to uphold their

cultural practices rather than for medical reasons. The participants frequently alluded to the relevance of TMC, as most members of the FGs believed that TMC is still relevant and that they would not opt for SMMC. In the focus group discussions, Participant 2 said:

> *No, imbalu is still relevant. I wouldn't go for clinical male circumcision just because it prevents HIV infection. The fact is that I have to know how to keep myself from getting HIV, using the previous methods like the A-B-C method of preventing it. I realise that these methods are going to be ignored by circumcised people, especially our Bamasaaba. I am worried that the Bamasaaba will be infected in enormous numbers because the government is telling them that male circumcision can prevent HIV by 60%. My question is why the local Bamasaaba people are among those with high infections, yet most men are circumcised?* '[Young boys will think] *What would be the use of doing hospital male circumcision and then utilise the condom as a method for HIV and AIDS protection?*
>
> (P2 Focus Group No. 1).

Other participants claimed that they do not see the use of promoting SMMC because it carries no value to the people of the Bugisu sub-region. These participants pointed out that the Bamasaaba had always practised TMC and used condoms to protect themselves against sexually transmitted diseases. The strategy of implementing SMMC with a belief to prevent HIV had changed the pattern of people's behaviour, resulting in an increased level of HIV infections among the Bamasaaba.

The researcher asked the FG participants if they knew why the government was implementing the SMMCP. One of the participants used body language to express that he was not sure of what to say in response to the question. The participants were clear that defending their culture and the customs of the Bamasaaba was more important to them than their health. A Clan Leader in FG3 stated:

> *It is essential to protect our culture from being destroyed more than diseases. So, it is best to circumcise traditionally than medical circumcision. Medical circumcision is for those who do not traditionally circumcise. People must continue using the old methods of protection before they are misled*
>
> (P2 Focus Group No. 3.).

Most members in the FGs insisted that they would never go for SMMC and were curious to know why the government, through the Ministry of Health, was emphasising the SMMCP in the Bugisu sub-region, which already practised circumcision. One would argue that probably the Bamasaaba do not know the intentions of the government implementing the SMMCP in Uganda. This is the reason why one of the participants stated:

> *Through the Ministry of Health, I would like to know why the government is emphasising hospital circumcision, particularly in the Bugisu. The hospital male circumcision is not for real men. I don't believe in circumcision being for the protection of HIV and AIDS, and people should utilise condoms to be on the safe side*
>
> (P7, Focus Group No. 3).

In considering why SMMC is poorly received in the Bugisu sub-region, it became clear that people had various reasons for their preference of TMC. TMC had a very strong significance for all participants and prevented any serious consideration of SMMC. It seemed likely that if the Bamasaaba were not practising TMC, they would consider adopting SMMC. However, as things were, with TMC still so strongly adhered to and believed in, participants in the focus groups had no use for SMMC. It did not meet their cultural requirements. A participant stated:

> *Well, I encourage clinical male circumcision for grown-up men from other parts of Uganda ... in any case, as a method for preventing HIV transmission. However, I do not think the Bamasaaba men ought to view it in that way. They ought to encourage parents to circumcise boys for cultural fulfilment. I do not believe it is wise for the Bamasaaba to circumcise their children well medically*
>
> (P4, Focus Group No. 2.).

Some participants believed that there were misapprehensions regarding the safety of medically circumcised men when it came to HIV. However, the participants could not explain which type of misunderstanding they referred to. A participant clarified why he would not have his children medically circumcised:

> *It is our culture to be circumcised. But I tell you today that people will develop the attitude that, 'Now I am clinically circumcised, which implies I can have sexual intercourse irresponsibly. I am now on the more secure side.' So, by then, he will contract*

HIV and AIDS since he has a negative mindset that he won't get any infection. The health experts have told us to instruct boys how to protect themselves on this issue. We tell them that they should use protection

(P1 Focus Group No. 1.).

The view was that SMMC came with none of the cultural benefits of TMC, where young men were given normative advice on how to behave and were encouraged to act responsibly as men. Some participants stated that the government was 'blacklisting' TMC. The majority of the FGs members noted that the government's perception that TMC transmits HIV was a sure sign of their desire to eradicate TMC in favour of SMMC. The participants were adamant that they aimed to maintain and protect their cultural practice of *imbalu*. For this reason, they were strongly in favour of making the tradition safe, thus proving the government wrong. A participant said:

We must prove them wrong – those who have said that traditional male circumcision spreads HIV. The traditional surgeons are even more careful. During the promotion of hospital circumcision, they say that you must do 'the safe male circumcision, making ours look dangerous. If I take my son for circumcision in the hospital, he will think that my father is permitting me to engage in sexual relations since I'm on the safer side in the hospital

(P5 Focus Group No. 1.).

Scholars such as Bonner (2001) argue that clinical male circumcision is an HIV prevention strategy but that circumcised men cannot regard it as a natural condom. Members of the FGs felt that the mistaken view of SMMC as an HIV preventative could be ascribed to the government's so-called education campaign, which suggested that SMMC and HIV prevention went hand in hand. In this way, they felt the education campaign backfired and encouraged irresponsible behaviour. Some participants complained that the educational campaign neither promoted TMC nor advocated the essential aspect of condom use. The participants expressed concern that the Bamasaaba had begun to misconstrue SMMCP as a process offering them a 'natural condom', which is a myth.

4.2.4 Responses of Traditional Surgeons to the SMMCP

This section presents data from interviews with the traditional surgeons who perform TMC on boys to initiate them into manhood. Kostizak et al. (2020) argue that societal norms are the unwritten rules that guide individual behaviour, determining, to a large extent, what members of a particular society think, believe and practise. The participants stated that the *imbalu* procedure is done to shape the knowledge, beliefs, arts, laws, customs and capabilities found in Bugisu society. They held that the implementation of the SMMCP conflicts with these cultural practices.

These participants indicated that the way in which the government had gone about implementing public health programmes on male circumcision had triggered tension between the Bamasaaba and the health sector. The reason they cited was that the strategies used to campaign for HIV awareness programmes tended to denigrate their cultural practices. Deacon and Thomson (2012) argue that African communities experience TMC as essential to men's experience, marking a critical transition from boyhood to manhood. As such, it is an assertion of their identity in opposition to Western and colonial influence. The comments of this group of participants exemplified this point of view. To them, TMC was an inseparable part of the Bamasaaba identity and cannot be stripped away from them. They were strongly opposed to SMMCP, basing their view on the government's use of politics, religion and marketing campaigns to promote SMMC and in so doing to eradicate TMC.

All expressed a lack of trust in government health programmes and claimed that the government was not entirely honest about their intentions with the SMMCP. The participants' concern was that the existing healthcare system seemed to be at war with the traditional practice of *imbalu*. They felt that the government does not have honest health personnel; if they had integrity and respect, they would implement the health policies as expected of them. Instead of this, they couple their health policy with a programme of seeking to eradicate TMC. Thus, to these participants, the two systems could not exist side by side; every SMMC marketing message was simultaneously a message to wipe out TMC, intending to eradicate an essential element of the Bamasaaba identity. The majority were concerned that through these campaigns, the Bamasaaba may well lose part of their culture. There is a significant lack of trust in the government of Uganda on the part of the Bamasaaba, who claim that the health sector is corrupt. A Traditional Surgeon put it this way:

You see, the government officials do not speak the truth when it comes to issues like this. Take a simple look at what happened to the global funds; members of the Ministry of Health misappropriated the money meant for health programmes such as HIV prevention strategies. Many other wrong things are going on in the government, but what can you do?

(Traditional Surgeon No 3.).

According to these men, the government does not recognise the critical role that traditional surgeons play in determining the implementation of the SMMCP. The participants commented that for this reason, the Bamasaaba had developed mixed reactions to the SMMCP. The majority of participants felt that they had an important contribution to make to the acceptable implementation of SMMC since they were experts in TMC. Yet, they were not consulted, resulting in conflict with the reformed health policy. The participants stated that the Bamasaaba are not happy that government health policy developers failed to consult Traditional, Cultural and Clan Leaders about this health policy. They made frequent claims, such as the following:

The government consulted the elite class, who do not have an attachment to the cultural practice of the Bamasaaba

(Traditional Surgeon No. 5.).

The interviewer probed further to ascertain the extent of the impact of the SMMCP on TMC. The participants' responses to the question indicated that it had had a significant effect; some of it was positive. For example, it had resulted in safer and more hygienic procedures during TMC. This fact alone added reinforcement to their argument that there was no need for a marketing campaign to persuade boys to have circumcisions performed in the hospital. Their *imbalu* had all the advantages of cultural and social relevance while also being safe and hygienic.

In addition, a young man who underwent cultural practice was more likely to adhere to safe sexual practises for the prevention of HIV since there was no confusion about the need to use a condom. SMMC was inadequate, in the view of these men, at preventing HIV. One of the Surgeons stated:

I am not sure about the significance of hospital circumcision being a preventive measure for the spread of HIV. However, there have always been preventive measures for any diseases that would arise. The people would give out guarantees at places where circumcision was allowed to take place so that we do not mix the sick people with healthy ones during circumcision

(Traditional Surgeon No 7.).

The participants felt that the government of Uganda should take partial responsibility for the health of Ugandans but that it must remain respectful of the people's way of life. In this regard, it becomes problematic if the Bamasaaba do not show responsibility for their health. This is where the government gets the opportunity to impose any health policy on them. They asserted that there must be a clear understanding between traditions and medical practices. A Traditional Surgeon from one district proposed:

The government of Uganda must take the lead on this issue so that Ugandans are not confused between tradition and medical practices, to preserve our cultural practices and at the same time not expose our people to HIV risks

(Traditional Surgeon No. 2.).

Some of the traditional surgeons said that the majority of the Bamasaaba were not informed about the government's implementation of the health policies on male circumcision. A Traditional Surgeon gave voice to his perspective, expressing a lack of knowledge about SMMC. In this case, the majority are considered to decide for the minority, especially when developing the policy. The Bamasaaba forms a minority group that does TMC compared to other cultural groups the government aimed to protect from HIV and AIDS in Uganda. It is not surprising that these people were not consulted when developing and implementing the SMMCP. Interestingly, his view was that those who promote it were not themselves circumcised, which implied a lack of respect for such people:

No, I have not heard of them. I don't think the health officials have reached the elders. I have never walked around and heard somebody telling me that the government has consulted me about the health policy on male circumcision. If they did, it just ended up being practised at the health centres. I believe some of these health workers are not circumcised, so they fear to speak about imbalu to men. The owners of imbalu have not

yet received any information about the health policy but what I know is they talk about hospital circumcision. I understand that these people know that the Bamasaaba cannot accept it because it will erase our culture

(Traditional Surgeon No. 5.).

Ediau et al. (2015) argue that being circumcised in adulthood, resumption of sexual intercourse before wound healing, inconsistent condom uses and having sex under the influence of peers are significant risk factors. The majority of participants concurred with this view, revealing that the public believes SMMC promotes risky sexual behaviour among the Bamasaaba. Some participants pointed out that one of the strengths of traditional service providers was that they convey a message of responsibility and maturity, which SMMC did not. They believed that through traditional means, cultural practices could be maintained. If the government were not so opposed to them, they could work in consultation with health personnel and play a more active role in public health issues.

Instead, the participants claimed government health officials were just concerned with playing political games with the Bamasaaba and making money. One of the Traditional Surgeon articulated his disenchantment:

It's related to issues of politics, religion and business. Let us follow up with the people making empty promises to us. They come under the umbrella that they are going to work within our culture and Bukukaship. Still, once we elect them into office, they begin to de-campaign our cultural practices by implementing some useless policies to make money and please their boss, the president. The donors and investors are also coming from outside, bringing in their politics, religion and cultures through government – the government of Uganda

(Traditional Surgeon No. 3.).

Some participants believed that the Bamasaaba made decisions about which type of male circumcision to opt for based on the views of the traditional practitioners such as themselves. Traditional surgeons help shape people's cultural and personal identity, which makes the SMMCP a challenge to their authority in their view. As much as HIV and AIDS remain a social problem in Uganda, the participants do not consider it a significant reason for choosing appropriate male circumcision practice in this area.

In addition, the fact that the government trains female doctors to perform male circumcision in the medical setting makes the procedure doubly unacceptable. Almost all participants objected to females getting involved in male circumcision. A Traditional Surgeon asserted:

> *When it comes to matters of imbalu, there are some rituals that a woman is not culturally allowed to participate in. For example,* Bukhebi, umkhasi sakhusheba umsinde ta'awe – *it is taboo in our culture for a woman to circumcise a man*
>
> (Traditional Surgeon No. 4.).

The traditional surgeons believed that to overcome these concerns, the government needed to understand the significant value placed on traditional practices by the Bamasaaba. They said that when the government developed and implemented health policies, they ought to engage in an in-depth consultation with local people so that their programmes could be aligned with people's understanding. The participants claimed that current health policies create an uncomfortable social environment with regard to traditional male circumcision in the Bugisu sub-region.

In its campaign to combat HIV infection, the Ministry of Health observed that it had attempted to regulate the traditional practice of male circumcision. Permits were now issued to traditional surgeons to show that the government was in control of the Bamasaaba's traditions and cultural practices. Figure 4.14 shows a license issued to a traditional surgeon.

Figure 4.14: The Traditional Surgeon's Practicing Permit

Source: Primary Data.

According to the surgeons, health professionals now provide training to traditional surgeons who undergo a series of tests before being allowed to practise TCM. The participants pointed out that through the district health office, the government ensured that traditional surgeons passed these tests before the cultural council would license them for one year. The health department conducts this training for all traditional surgeons from the eastern region, who are traditionally authorised to circumcise boys from Bugisu and the western part of Kenya. The participants questioned why the health department trained traditional providers of TMC when *Inzu ye Bamasaaba* are the ones to issue the certificates.

The traditional surgeons stated that the government's authorising of the certificates indicated that they are entirely in control of the traditional practices of the Bamasaaba. The certificate shown in Figure 18 was issued by *Inzu ye Bamasaaba*, the cultural institution governing the cultural practices of *imbalu* for both the Bamasaaba and Babukusu of western Kenya. The participants said that traditional surgeons must produce the licence before the father or uncle

allowed them to touch the initiate. Further, it was noted that this was not a requirement in the past.[1]

The participants also stated that traditionally, the *inyembe* (knife) is a unique, secret and respected implement that requires sacrifices to be performed on its behalf before the traditional surgeon can use it. The participants were concerned that traditional surgeons now use multiple knives that can mistakenly end up in the wrong people's hands. For this reason, the traditional surgeons preferred a trusted relative, preferably the father, to keep the knife 24 hours before the circumcision for safe-keeping. The participants questioned the authenticity of the blades since they were now using multiple knives. They said that it had become costly to perform sacrifices for all those knives. In the words of a Traditional Surgeon, he said:

> *It has become costly to own as many knives as possible because you cannot use one knife on several initiates, as you cannot know each initiate's status. Traditionally, a surgeon is supposed to have only one knife because there was no fear of HIV and AIDS back in the day. Today, you have to perform rituals for every* inyembe *before using it because using only one knife is very risky. We must give the* inyembe *that is going to cut the boy to the parent within 24 hours. The parent protects it until the time of circumcision. And after circumcision, the surgeon gives the knife back to the parent, who will keep it until we perform the last rituals*
>
> (Traditional Surgeon No. 5.).

From the foregoing statements, some participants drew further evidence that the government wants to eradicate *imbalu* to control the Bamasaaba politically. On the other hand, traditional surgeons acknowledged they needed to incorporate health reforms into their practices so that they did not become totally irrelevant and unsafe. These they were willing to integrate. A study by Madraa (1998:54) reported,

> "Traditional surgeons for circumcision use (a) sterile or one knife for each candidate instead of the old tradition of one knife for many candidates."

[1] Permission was obtained from the traditional surgeon to use the certificate containing his name and practice number in the study.

This shows evidence that traditional surgeons have heeded the call to practise their tradition more hygienically. Most participants were certain that all surgeons now use a separate *inyembe* on each initiate. At the same time, some said that surgeons sterilised and sharpened one knife before using it on the next initiate. On this matter, there was no clear agreement. However, what seemed clear was that surgeons adhered to hygienic and safe practices – as reported by them.

Participants also raised the issue of religion, which now played a more substantial role in the choice of whether to undergo traditional or medical circumcision. Some religious people have considered their traditional practices to be evil. One of the Surgeon said:

> *Religion has played a significant role in overthrowing traditional male circumcision because they say the tradition is satanic, which discourages the religious the Bamasaaba, particularly the born-again Christians*
>
> (Traditional Surgeon No. 2.).

The researcher asked the participants to what extent they still performed these rituals. Many said that only a few people now practised the rituals because of poverty and religion. According to Madraa (1998), community leaders' involvement in the implementation of the SMMCP had contributed to the early success of efforts to combat HIV infections. However, the findings in this study show quite the opposite. Community leaders now oppose SMMC and feel side-lined by the policy. Data indicates that the government officials did not consult with the Bamasaaba about the health policy. When formulating the SMMCP, the government might have predicted resistance to the reform, particularly from the Bugisu communities, which might have contributed to its refusal to consult with the community leaders.

The following section presents the views of the initiates themselves.

4.2.5 Responses from two 2016 Initiate to the SMMCP

The two 2016 Initiates interviewed separately did not present much new information on TMC and SMMC's issue in the Bugisu sub-region. One claimed that 'the West' intentionally misled the general population in African countries, intending to eradicate traditional practices. Both stated that African people, especially the Bamasaaba, act recklessly without keeping in mind

the end goal. They concurred that the implementation of the SMMCP was encouraging the youth to engage in risky sexual behaviour. One of the Initiates said:

> *The government of Uganda shouldn't overstate what medical male circumcision can do to prevent HIV. They should be reasonable in the way they inform the people regarding safe male circumcision for HIV prevention so that they can try to dispose of the myth that 'circumcised men have natural condoms'. Tell people to use other existing methods of protection and not rely only on clinical male circumcision since they say it reduces the chances of getting HIV infection. They must be watchful of how they implement this. They shouldn't simply tell people, especially the Bamasaaba, and let them keep running with the thought. The government may end up causing more damage than the benefits of safe male circumcision*
>
> (2016 Initiate No. 2.).

The participants said that such campaigns should carefully consider how local people understand comparative information, especially when deciding on techniques to convey their message. These participants seem not to understand that the government has specific health policy goals and considers the majority of the population when developing these policies.

The participants also pointed out the value of pain in TMC, which did not form part of SMMC and therefore rendered it culturally unacceptable. One participant, still aspiring to be a man through TMC, stated:

> *I genuinely do not trust that you can compare a traditionally circumcised man to a person who went to the hospital. This man did not experience pain and did not know what it means*
>
> (2016 Initiate No. 1.).

This participant added that the whole community respects men who had endured the pain of a real knife. The participants expressed their eagerness to show the world how brave they were. They repeated the idea that the Bamasaaba commonly accepts that a man demonstrates bravery through *imbalu.*

In addition, they could not understand how any form of male circumcision could protect a person against HIV infection. One of the Initiates stated:

> *I cannot imagine how the possibility of removing the foreskin prevents one from the risk of HIV. When you have sex with someone, there will be physical contact and some fluid discharge, which subjects you to any infection dangers*
>
> (2016 Initiate No. 2.).

These boys stated that anyone who culturally practises traditional male circumcision is unable to consider medical male circumcision because of cultural and religious restrictions. Most of these participants demonstrated that they would reject SMMC implementation in the Bugisu sub-region, given that SMMC is just a genital cutting, without cultural values attached to it. The initiates in the two districts they represented concluded that they would not undergo safe male medical circumcision for any reason. One pointed to the shame associated with undergoing hospital circumcisions:

> *I won't conflict with my cultural and traditional practices; I want to be a man. I don't want my friends to laugh at me*
>
> (2016 Initiate No. 1.).

The participants viewed SMMC through the same lens of culture and social acceptability as all other participants had, reinforcing the idea that SMMC is a threat to their traditional and cultural practices. Refusal to acknowledge the role or significance of SMMC seemed to be the way that the Bamasaaba assert their resistance to pressure to conform to Western values and to abandon culture.

In the next section, we will establish the Clinical Officers' position regarding Bamasaaba's response to the implementation of the SMMCP in the Bugisu sub-region.

4.2.6 Responses from two Clinical Officers to the SMMCP

In Uganda, the Clinical Officers are responsible for patient consultations and drug prescription in line with Uganda's Clinical Guideline and the WHO protocol. They also provide mentorship to the nurses and laboratory staff and assess inpatient care and management (WHO., 2006).

However, according to these participants, more responsibilities such as carrying out minor surgeries like male circumcision are added to their general hospital duties. The participants continue to state that the majority of male medical clinical officers belonged to the Bamasaaba communities and were traditionally circumcised.

The two Clinical Officers interviewed seemed to find themselves in a difficult position concerning the implementation of the SMMCP since, as the Bamasaaba men, they shared the same values and cultural preferences as the other participants. In contrast, as trained medical men, they understood and accepted the goals of the SMMCP. They upheld the cultural values of *imbalu* as it was practised, while professionally, they promoted the government's health policies. As with everyone else interviewed, these men's views expressed their religious, social and individual personalities. They acknowledged that they found the experience of being both upholders of culture and trained medical people challenging.

The Clinical Officers thus negotiated their way through policy awareness programmes in their communities through their dual personae. Their professional goals consisted of supporting strategies to encourage the Bamasaaba to adopt SMMC. They were aware of weaknesses in government medical messaging, saying campaigns should carefully consider how village people understood comparative information. They pointed out that the idea that HIV transmission could be reduced by 60% after SMMC was simplified by the Bamasaaba and understood as the notion that SMMC completely protected the individual from HIV. This error contributed to the high rate of HIV infection among the Bamasaaba.

Unlike the Traditional Surgeons, Cultural Leaders and 2016 Initiates, the Clinical Officers seemed to believe that both traditional and medical circumcision contributed to the prevention of HIV and AIDS. One repeated the idea, already mentioned by others, as a myth that any form of circumcision was a ‘natural condom’.

> *I have been in a circumstance where I had unprotected sex, and fortunately, I overcame it due to circumcision. I honestly trust that it's viably contrasted with somebody that is not traditionally circumcised; otherwise, I would have ended up in a troublesome circumstance. I believe that this was my 'natural condom.'*
>
> (Clinical Officer No. 1.).

It is quite alarming that a medical practitioner believed what many others had identified as a myth on a personal level. Gwandure (2011:91) states that health professionals and researchers have a habit of downplaying 'the role of tribes, ethnic groups, religions, folktales, myths, taboos, rituals and general beliefs in the Sub-Saharan Africa. It seems that this was true in the case of this medical officer, who had absorbed the same popular notion as untrained people when it came to circumcision and HIV protection. Clinical Officer 2 contradicted Clinical Officer 1 as follows:

> *Well, I encourage clinical male circumcision for grown-up men from other parts of Uganda – in any case, as a method for preventing HIV transmission. However, I don't think the Bamasaaba need to view imbalu as providing them with a 'natural condom'. It is a myth, I tell you. They ought to urge individuals to circumcise and use protection for HIV and AIDS. I don't think it is a smart thought*
>
> (Clinical Officer No. 2.).

Participants stated that some men assumed that they were safe after being medically circumcised. The Bamasaaba tend not to utilise condoms after circumcision so that whether they undergo SMMC or TMC, they engage in highly risky behaviour. This contradicts the cultural and social norms attached to the cultural practice of *imbalu* in the Bugisu sub-region. The Clinical Officers stated that it is ideal for men to use condoms to be protected from HIV, regardless of their circumcision status. Clinical Officer 2 said:

> *It implies that when you are circumcised, you will not utilise different measures to prevent HIV and AIDS infection. So, it is best to circumcise traditionally or not circumcise those who don't circumcise but continue using old protection methods. I realise that it will help our people rather than be misled*
>
> (Clinical Officer No. 2.).

The participants stated that the way medical officers have been trained to implement the SMMCP had, in fact, negatively influenced the response of the Bamasaaba. They said that the campaign to promote SMMC failed as a means of education among the Bamasaaba as it ignored what people already knew and were doing. Instead of acknowledging that TMC, properly conducted, could be of value, it brought something entirely new, failing to link it to existing knowledge. One Clinical Officer said:

No! I honestly say that our campaign has not done much in educating the Bamasaaba about male circumcision for HIV prevention. Sir, tell me, other than the knowledge I got from the training, reading the articles, and involving me in the healthcare activities, what message have I learned from these posters apart from just knowing that there is a policy called SMMCP? I wouldn't even know that there is anything done inside the hospital or health centre. I would suggest that those companies contracted to create these adverts … must think of what is best for the Bamasaaba if we want them to respond positively to the implementation of the new health policies on HIV

(Clinical Officer No. 2.).

The other Clinical Officer also noted a general lack of awareness beyond government health institutions of the public health policy offering male circumcision. Clinical Officers forget that in Bugisu, it may be difficult for the Bamasaaba to take this awareness serious since it degrades their traditional practices of *imbalu*. *Imbalu* is a deeply entrenched and age-old practice that has stood the test of time among the Bamasaaba. Initiates undergo this rite to believe that it will transform even the most wayward boy into a dignified, self-respecting, and socially responsible man. The Clinical Officer said:

In Mbale, the principal place, I have seen a signpost on safe male circumcision at the main hospital entrance, which says 'safe male circumcision. I believe there is a chance that some people have not seen this sign even if they are coming to Mbale town every day

(Clinical Officer No. 2).

These participants gave their personal opinions and stated that the use of SMMC might not be successful, especially for the Bamasaaba. The participants are government officials, but they also seem to be opposing the implementation of the SMMCP for the Bugisu sub-region. They believe that men undergoing SMMC may be stigmatised. One Clinical Officer said:

I don't think men should use male circumcision as a preventive technique for HIV and AIDS in the Bugisu sub-region. Safe male circumcision can lead to stigma and beliefs that are not going to work for Uganda's problem of combating the HIV epidemic. The

policy will create some form of stigma for uncircumcised people, especially the non-Bamasaaba living in the Bugisu

(Clinical Officer No. 1.).

He added that in the process of implementing the SMMCP, they tell the public of the advantages of the policy and the disadvantages of the traditional practices of male circumcision. The participants said that the messages conveyed by the Ministry of Health build certain incorrect perceptions in the minds of the Bamasaaba. The Clinical Officer continued:

As Clinical officers tend to build a particular perception in the local people's minds that look like male circumcision, we are the only way to solve the health problems relating to HIV. Take an example of testing for HIV. In people's minds, if someone hears that one has not tested in the past, let us say five years, people tend to think it is funny. The people will start to suspect you of being afraid or being already infected and that you do not want friends to know you have it

(Clinical Officer No. 1.).

The Clinical Officer backed up other participants' claims that many traditionally circumcised men believe that they have 'natural condoms. Unfortunately, this myth has resulted in the majority of men behaving irresponsibly and having unprotected sex with multiple partners. They believed that the practice of SMMC would not change this perception; the net result would be the same – irresponsible sexual behaviour. All the SMMCP would do was stigmatise the men who opted for it. In addition, they said that the government was spreading the message that uncircumcised men had an increased risk of contracting HIV. They felt the government's messaging lacked the proper emphasis. One stated:

The policy implementers should find ways of changing people's mindset about HIV prevention … a subtler strategy, than saying that uncircumcised people have a higher risk of getting infected with HIV. I believe that this is causing some kind of stigma for uncircumcised people in Mbale

(Clinical Officer No. 2.).

The government of Uganda promotes SMMC as its preferred strategy for HIV prevention. These participants said that people regard the government's initiative as a violation of human

rights, based on the high-value people attached to TMC. However, while respecting this history and culture, it's also essential to implement new ways of addressing the evident clash between *imbalu* and medical practice. The researcher asked the Clinical Officer whether, in their view, traditional male circumcision would continue alongside clinical circumcision. One stated:

> *Clinical and traditional male circumcision cannot run concurrently, and so with time, clinical may outrun traditional due to civilisation. The Bamasaaba need to be civilised, and this is the aim of the government implementing some of these policies in the Bugisu sub-region*
>
> (Clinical Officer No. 1.).

However, this Clinical Officer added that the government could not simply ban TMC, which would mean suppressing the cultural practices of the Bamasaaba. The action of forcing the Bamasaaba to adopt SMMC would cause civil conflict because traditional methods are still relevant to the Bamasaaba. This should be allowed to be happening slowly in some aspects of the practice. Historically, mothers and female relatives were traditionally denied information about Initiates but it is public nowadays yet, the practice remains relevant to the Bamasaaba. The Clinical Officer pointed out:

> *Yes, traditional male circumcision is still relevant to the Bamasaaba because it is our traditional practice. Therefore, forcing us to stop might cause civil conflict. I see that a few health aspects are coming to make it safer. The Bamasaasa do not like safe medical male circumcision because they do it in the hospital without experiencing pain. Otherwise,* Inzu ye Bamasaaba *can regulate imbalu to be done during school holidays so that our children are not affected. If it reaches the period of circumcision, the children do not study, especially when* kadodi *sounds. We found that there is something that we must do; otherwise, it may affect the future generation*
>
> (Clinical Officer No. 2.).

As stated earlier, the participants said that as health workers, Clinical Officers were in an awkward position regarding the implementation of the SMMCP. Their ambivalence about the procedure comes through quite clearly in their comments, in which they seem to support TMC in some instances and then to favour SMMC in others. Professionally, they had a duty to promote the use of SMMC as a tool for preventing HIV transmission, thus potentially

compromising their cultural values attached to *imbalu.* The role of Clinical Officers conflicted with their gendered positions as 'real' men in their society. Interestingly, it was these two participants' comments that most emphasised the issue of SMMC as an HIV preventative. They pointed out how the public perceived SMMC as a value for HIV prevention but irrelevant to the Bamasaaba. The latter already practise circumcision and therefore do not need SMMC.

4.3 Summary of the Chapter

This chapter has covered the participants' perceptions regarding the SMMCP and has included various suggestions from the participants for its improved implementation. The data shows that the Bamasaaba is highly sceptical of the SMMCP, seeing a political move to fragment and disempower the Bamasaaba. According to the participants, the government's discouragement of TMC did not occur in isolation and was certainly not a purely medical matter. Instead, it was part of a comprehensive political agenda for economic and political gain on the part of politicians.

In addition, participants felt that SMMC has no value regarding its stated goal of lowering HIV transmission, as the consensus seemed to be that whether a boy undergoes traditional circumcision or hospital circumcision, the result, among the Bamasaaba, is that the newly circumcised man adopts the erroneous idea that circumcision is a 'natural condom', guaranteeing them protection from HIV. This results in irresponsible sexual behaviour and is part of the reason why HIV infections are so high in the Bugisu sub-region. Without the moral, social and spiritual lessons that are imparted through traditional male circumcision rituals, the operation becomes devoid of all meaning and promotes undesirable behaviour.

The Bamasaaba men interviewed were unanimous in valuing their culture and traditions and saw no place for SMMC in the region. However, the participants stated that their practice of *imbalu* had adapted to accommodate the main advantages of SMMC – TMC was sufficiently hygienic and safe as a result of the adaptations they had made to the procedure. Moreover, traditional circumcision rituals carried the weight of the entire culture and embodied spiritual, moral and social values and significance with which no hospital circumcision could ever compete.

Data also shows that for the Bamasaaba, SMMC was not well presented, and that awareness about it was relatively low in the region. Where people were aware of it, they found the messages irrelevant and the procedure obscure and shrouded from public view. The fact that women surgeons could circumcise men was a further point against it, as this was contrary to strong cultural beliefs. They felt that the government had failed to consult them about the implementation of the SMMCP and that the public awareness campaign might have looked very different if they had. It showed no acknowledgement of prior knowledge or strongly held beliefs and was therefore dismissed by most.

This chapter has laid the ground for the evaluation of the Bamasaabas' responses to the implementation of the SMMCP. In Chapter Five, the influence of SMMCP on cultural practices is explored.

CHAPTER FIVE

THE INFLUENCE OF THE SMMCP ON THE CULTURAL PRACTICES OF *IMBALU*

5.1 Introduction

In the previous chapter, an observation was made that the implementation of the SMMCP had influenced the practice of traditional circumcision. This chapter closely examines the ways and the extent to which the SMMCP has affected the cultural practices and rituals of *imbalu.* Traditionally in Bugisu communities, several cultural and traditional rituals are performed during the *imbalu* process. A key element, for example, is that there should be the shedding of blood and the slaughtering of animals. Ngxamngxa (1968) states that the shedding of blood and killing animals during initiation marks young boys' ceremonious dedication to their ancestors.

Chapter Five thus covers the aspects of beliefs, religion and rituals, especially with regard to the slaughtering of goats and the eating of meat at the graveside of ancestors before the Bamasaaba circumcise boys in Bugisu communities. Responses to questions (Appendix 9.8) in this regard were acquired during focus group discussions and individual interviews. This chapter presents the results obtained from Cultural and Clan Leaders, Traditional Surgeons, two Clinical Officers, and two 2016 Initiates from the three selected districts.

5.2 Responses from the Cultural and Clan Leaders

In this section, I present and analyse data from the selected Cultural and Clan Leaders concerning the influence of the SMMCP on the cultural practices of *imbalu*, which the Bamasaaba consider both spiritual and cultural. Heald (1982:19) states that the practice of *imbalu* is essentially spiritual:

> Boys are said to be 'caught' by the *kimisambwa kw'imbalu* [singular: *kumusambwa*; plural: *kimisambwa*], the ancestral power of *imbalu*. *Imbalu* is the most significant of the Bamasaaba ancestral powers since it is the only one which is universal throughout Bugisu and associates all the Bamasaaba with a common ancestry and the powers this cultural practice transmits.

The participants believed that *imbalu* (TMC) involves spiritual entities that guide the initiates to be brave during the removal of the foreskin. In the same way, Khanakwa (2018) explains, it is believed that before the *lmbalu* ceremony, initiates are taken to a secluded sacred grove (*mwisirindwa*) for spiritual rebirth. The Traditional Surgeon functions as the spiritual leader of the ceremony. One of the Cultural Leaders stated:

> *Yes, yes, that spiritual power is there, and if you are a* mumasaba, *eeeeh … when they produce you, they tell you over and over that we, the Bamasaaba, circumcise. So, any child who is a* gishu *grows up knowing you have to be circumcised. Aah, for example, why I say it is spiritually motivated, you might see children moving, too. The boy will cry for circumcision after seeing friends; he cries tears because he also wants, so that spirit of motivation is there, and it is always there for us as the Bamasaaba*
>
> (Cultural Leader No. 2.).

Some participants specifically stated that SMMC is not for them as the Bamasaaba, who culturally practise male circumcision. Almost all participants suggested that the government take this health policy to the communities that do not practise TMC. The reason for offering this is that the Bamasaaba have a feeling that if male circumcision can prevent HIV and AIDS, then traditionally circumcised men are also protected. A Cultural Leader had this to say:

> *Yah! This policy is not for us; let the government take it somewhere else. We, the elders in Bugisu sub-region, have requested the government not to implement these health policies for the Bamasaaba because we have seen that our culture is lacking support. We should do something which may add more moral value to our culture and traditions. The government rushes to get donor funds to implement health policies that are contrary to our culture. In the first place, the government did not come down and ask or consult the elders, especially* Inzu ye Bamasaaba, *the sole custodian of our culture in the Bugisu sub-region, about such health policies*
>
> (Cultural Leader No. 6.).

As mentioned earlier, the participants alluded to the fact that Western practices constitute an underlying reason for the tension between traditional and medical procedures. Inglehart and Welzel (2005) argue that traditional values and methods persist in the face of modern values

despite the economic and political changes due to modernisation. Yet this co-existence is evidently not without tension.

While there was a general desire among the participants for what they called 'the old days, where cultural practices were untouched by modernised techniques, all acknowledged the benefits of modern life. They also acknowledged that modern medical practices could do a lot to fortify the health of local people.

Nevertheless, the relationship between modern medical practices and practices that affect both the physical and spiritual component of human beings is an uneasy one among traditional people such as the Bamasaaba. They cannot separate the physical from the spiritual, emotional, and social aspects of certain key aspects of their culture. This is especially the case with *imbalu*. Some cultural leaders acknowledged that the SMMCP was a strategy for introducing medical practices that would solve some of the underlying problems associated with TMC, such as injuries acquired during the initiation process. But, one participant disagreed, pointing out that the traditions and cultural practices of TMC had been practised for generations without any problems or infections occurring. In addition, he mentioned that the Bamasaaba have traditional treatments for the circumcised boys that helped with wound healing and cleared up any incipient infections. This local treatment is known as *inguwu*, a botanical medicine used for treating and healing the wound after TMC. This Cultural Leader stated:

> *Men and women looked for local medicine to use and help our new men to prevent the infections and heal the wounds after circumcising traditionally. For example, these botanical medicines, for example,* inguwu, *can kill these germs that could make the boys not heal quickly. Suppose they saw that* inguwu *was not helping them. In that case, they could use other trees like* ingameri *and mix them with* inguwu *to speed up their children's healing after undergoing imbalu. And after healing the wound, this is when they could again open another circumcision season in the Bugisu region*
>
> (Cultural Leader No. 3.).

The participants remarked that due to their cultural practices, the health policies that aim at regulating the traditional techniques of male circumcision are met by mixed reactions from people in Bugisu. They believed that instead of supporting MMC, they would like to see several

other services. These include safe-sex counselling, voluntary counselling and testing (VCT), family planning, community education and food relief. One of the Cultural Leaders stated:

> *With the Bamasaaba, generally, the response is very poor. If I am to give it a percentage, 20%. Still, I think this is because they do cultural male circumcision. The government is urging people to be circumcised medically, and I think it will catch up. The problem I see is forcing the Bamasaaba to abandon their imbalu because it is their culture. This is not a one-day thing whereby you say people can change immediately but slowly*
>
> (Cultural Leader No. 2.).

Wawer et al. (2009) suggested a need to target communities practising traditional male circumcision because many circumcision practices do not conform to safety and efficacy standards for MMC. However, the majority of the participants believed that government health policies undermined the Bamasaaba's cultural practice of male circumcision. This could be some of the reasons why a certain group of the Bamasaaba are not prepared to adopt health principles or adapt their cultural practices. A Cultural Leader stated:

> *Sometimes the government brings policies that undermine the people's culture. The health policy like the Safe Male Circumcision Policy – what is safe about it? We have been undergoing imbalu* ye Bamasaaba *for generations in Bugisu, and we have never had any problem with it. That is why the Bamasaaba resist the new policy. If the current health policies are not bad, why minimise the Bamasaaba traditional practices and culture? They are abolishing imbalu* ye Bamasaaba, *traditional male circumcision. Oh, yes. They are, therefore, wrong. The bad thing is someone telling you to stop*
>
> (Cultural Leader No. 5.).

Another crucial reason for the Bamasaabas' resistance to the implementation of the SMMCP is the issue of women performing male circumcision, as mentioned in the previous chapter. Katisi and Daniel (2015) recommend that attention be paid to teaching a high level of cultural awareness and sensitivity to medical personnel so that they may grasp and address cultural taboos during their implementation of biomedical interventions. All the participants stated that it was taboo for female medical doctors to perform male circumcision according to their culture. One summed up their position:

Among the Bamasaaba, it's a taboo to be circumcised by a woman, which is one of the reasons we do not concur with the health policy that encourages people to be circumcised in a hospital because there are female medical officers that carry out the exercise. We don't want it

(Cultural Leader No. 2.).

Wilcken et al. (2010) report that up to 90% of men in the Bugisu sub-region had been traditionally circumcised. It is essential to distinguish between MMC and traditional male circumcision, which creates two unpredictable situations. Firstly, it becomes problematic to tell elders traditionally circumcised that their traditional practices afforded them partial protection against HIV and AIDS. Secondly, in majority of the Bamasaaba families, all-male members have undergone TMC. However, the discourse presented by health practices, TMC remains unsafe regarding HIV and AIDS infections and problematic to tell traditionally circumcised men that they were infected due to TMC. The participants stated that they are proud of their culture of initiating boys to experience the transition from childhood to manhood. One said:

Except for a few cowardly men, a significant number of the Bamasaaba men receive TMC, which is how tradition should be. We are proud to see every boy in Bugisu being culturally circumcised, initiating him from childhood to manhood. That is why we do not even accept uncircumcised people in our society. If you are circumcised, it means that you have taken responsibility, and if one agrees to circumcise, it makes him a grown-up man. Therefore, you have to do things with consideration to show that you are a mature person. That is one of the advantages of circumcising; you are recognised for doing something, but not as a boy

(Cultural Leader No. 1.).

A study by Sarvestani et al. (2012:8) found that 'Catholics and Anglicans oppose the excessive festivities surrounding TMC', the over-consumption of alcohol, and promiscuity. In this study, born-again Christians were referred to, with the understanding being that they agreed with circumcision, but only when stripped of most of the rituals performed during *imbalu* ceremonies. The majority of participants in this study, belonging to a mainline church such as Anglican and Catholic, or being Muslim, had no problem with the cultural and spiritual practice

of male circumcision. So-called "born-again" Christians were seen as a small minority of the Bamasaaba, and it was assumed that these people had not undergone TMC, as revealed in the comment of this Cultural Leader:

> *Oh, yes, I want my boy circumcised traditionally at home. Tomorrow this very person might become somebody like an* Umukuuka, *but he would have missed the opportunity if he goes to the hospital. Hence, the most important thing is to make our culture reliable. For example, if someone goes to the hospital and happens to sit around the drinking pot* (kamalwa), *people will not accord you respect even if you are a born-again Christian. It is worse for your clan if you went to the hospital for circumcision; no one will pay attention to you when you talk if you did not stand firm under the knife. They will listen to you because of that toughness you endured during circumcision*
>
> (Cultural Leader No. 4.).

The problem of HIV transmission was prominent in the minds of the Cultural Leaders, who acknowledged that the rates of infection were high among the Bamasaaba men. They said that traditional surgeons had to be very careful. They concurred that one of the most extraordinary effects of the SMMCP was that it had kept awareness of HIV high and had forced traditional surgeons to change some of their behaviour. As a result, they now sterilised their knives. One stated:

> *For example, I said that when this sickness of HIV came, those who circumcise have to use the medicine. They treat or sterilise their knives compared to the past traditional surgeons, who could use one knife to circumcise all the boys. They have adopted a method where they clean the blade before you go and cut others, or there must be one knife for each child. So, you can see that adaptations are there*
>
> (Cultural Leader No. 2.).

Some participants recommended that the government consider the potential positive effects of the cultural practice of male circumcision while they implement the SMMCP. They also said that before any boy decides which option to take, he and his family should carefully consider the cultural, educational, social, economic, political, psychological, physical and spiritual implications of both options. They were confident that despite the ever-present push toward

modernity, hospital-based circumcisions could never offer all the social and spiritual benefits of TMC.

All clan leaders concurred that *imbalu* is spiritually motivated and has been so for generations. A Clan Leader stated:

> *You can tell when the initiate reaches the courtyard, he loses his senses and goes to a different world. He will stand still, without shaking or blinking, as they circumcise him. In the end, the circumciser will blow the whistle before the initiate sits on a traditional stool. In the case of any mistake, the circumciser checks and corrects the error. The boy will refuse even when there is a small skin, and this is because the spirits will have left him knowing that they have finished the ceremony. That clearly shows that one is possessed*
>
> (Clan Leader No. 1.).

Heald (1982:26) reports, "there are objections to the view of the ritual process of TMC, which tends to set up a hierarchy and division between observers and participants". According to this author, TMC cannot transfer values, nor can it shape the attitudes of the initiates. In opposition to this view, the Clan Leaders in this study strongly asserted that they do not want the SMMCP to be implemented in the Bugisu community because it has no cultural value. A Clan Leader said:

> *I say that the Bamasaaba refuse the safe male circumcision because it has no cultural value. The reason why you see the government calling us to workshops at the district … they seem to be neglecting our circumcision; they think that circumcision of the Bamasaaba might lead to the spread of disease. Still, we shall not allow the government to oppress us because it wants to agree with us, but it will never happen*
>
> (Clan Leader No. 4.)

At this point, it is clear that the Ministry of Health in Uganda has positively endorsed the implementation of SMMC for HIV prevention. Although the overall response of the Bamasaaba towards SMMC has been negative, participants nonetheless acknowledged that it had influenced TMC and that significant changes had been brought about because of it. It is tempting to suggest that if SMMC could be promoted as part of the cultural practice in the

Bugisu sub-region, maybe the Bamasaaba would have responded positively to the strategy. This could probably explain the changes that have occurred to the TMC practice. A Clan Leader said:

> *I think if I compared to today … back in the day, many people attended such a ceremony. But some people, now they ignore it, sometimes you see that without the sound of the drums people are very few, which means that with time the response will be good for health policies in Bugisu. But for now, the Bamasaaba do not want it*
>
> (Clan Leader No. 3.).

From the Cultural and Clan Leaders' perspective, SMMC is not for them as the Bamasaaba community because they already practised circumcision – and one that had vital cultural and traditional elements attached. It became clear during discussions that the cultural practice of male circumcision defines the identity of the Bamasaaba men.

In the next section, data is presented and analysed from the Traditional Surgeons of the three selected districts.

5.3 Responses of the Traditional Surgeons

In terms of the influence of the SMMCP on the cultural practice of *imbalu*, Traditional Surgeons were united in their views. When I asked the traditional surgeons whether they believed that *imbalu* was spiritually motivated, they confirmed that it was. One of the traditional surgeons said that this is the reason why some people believe that the cultural practices of *imbalu* are evil:

> *Some confused the Bamasaaba, especially* balokole *(born-again Christians), who believe that imbalu is spiritually evil. No, it is not! I say that the spirit of our ancestors possesses the initiate after he has been adorned by the flour to strengthen him*
>
> (Traditional Surgeon No. 7.).

In addition, these participants stated that spirituality forms part of the calling of Traditional Surgeons. Bailey et al. (2007) state that traditional surgeons are spiritually selected and perform rituals before starting to accompany a senior surgeon as an assistant, hoping to become a

circumciser in future. The participants stated that surgeons receive payment in the form of chickens or as little as UGX 5,000 to 40,000 (R25 to R200), making it clear that they are not financially motivated to do what they do. One of the Traditional Surgeons said:

> *In fact, from a long time ago, traditional surgeons are chosen by spirits. The spirits randomly select people from individual families. These families possess the ancestral lineage of traditional practices of male circumcision. The spirits choose one or two men from this family to become traditional surgeons, which you must accept as a calling*
>
> (Traditional Surgeon No. 3.).

One of the participants indicated that the Bamasaaba believed that the entire tribe originated in Israel, so the circumcision they practised was the same as that of Jesus Christ. The participant said that the original Bamasaaba people left Israel with their cultural practice of male circumcision, settled in Ethiopia, and moved towards Mount Elgon's slopes (Mount Masaaba). This long history was a point of pride, as was the cultural and spiritual significance of TMC.

They were therefore opposed to the SMMCP, particularly in the Bugisu region. A Traditional Surgeon said:

> *No, for us, we do not agree with this safe male circumcision policy. The reason, our circumcision has remained a culture and traditional practice since a long time ago. We did not follow government health policies; now, the government came and gave us new rules regarding circumcision. For us, we don't agree to take a child to the hospital*
>
> (Traditional Surgeon No. 9.).

Another Traditional Surgeon confirmed that TMC is cultural and spiritual in nature. Locating TMC in a religious context, the traditional surgeons added that both the Bible and the Quran talk about circumcision. The participants justified their practice by quoting the Old Testament of the Bible, where 'the Lord God said if you are not circumcised, you will not enter the kingdom of God,' according to a Traditional Surgeon. He said:

> *In our faith, we believe that when you circumcise, you have entered or accepted the custom of our grandfather, Abraham. Our holy book states that the Lord commanded him to circumcise, and he obeyed the command, and then it pleased God. So, God called*

him to make an everlasting covenant with his children and his children's children. They were to be circumcised, for the uncircumcised 'will not enter the kingdom of God, and 'I have made you the grandfather of the believers. So, you see, we do this to fulfil God's command

(Traditional Surgeon No. 4.).

Nonetheless, one of the Surgeons indicated a fairly reconciliatory attitude to MMC, stating that if it were adequately promoted, with acknowledgement and respect for TMC, it might have a place among the Bamasaaba. He clearly indicated that TMC is not practised in order to reduce sexually transmitted diseases, as SMMC is; instead, it is practised for cultural and spiritual reasons:

We can accept these health policies if the government can tell us another reason for it because they may help us. I don't want to break our cultural norms. If you fail it, you face disciplinary action; we know that the importance of imbalu is to help a boy go from boyhood to manhood, not to reduce the risk of getting HIV and syphilis

(Traditional Surgeon No. 12.).

The participants reiterated the idea that the SMMCP may be safe and hygienic, but it had no place among the Bamasaaba. The primary reason why many preferred a traditional circumciser was the prestige associated with traditional circumcision among the Bagisu. I asked the Surgeons for their views on the way that SMMC was performed. One said:

No problem for me, but the Bamasaaba do not accept these government policies because they are interfering with their tradition. They say they went through the pain, so their children have also to do so, to be men. If he has five children, at least, he circumcises one child traditionally to fulfil the culture because we have our rituals. But if he is a Muslim, it is impossible to say that you circumcise him in a Gishu *way. Okay … I had a child I produced from a woman from Butiru. I went there asking them to give me my son, and I took him to the hospital, but they refused, saying he is our firstborn, we have to fulfil our rituals. So, they culturally circumcised him*

(Traditional Surgeon No. 8.).

The statement by the participant came as a surprise to the investigator and wanted to probe more to find reasons why this traditional surgeon would like to take his son for SMMC. In his response, he stated that in the Islamic faith, one is not compelled to do TMC. This may be the reason why scholars such as Sarvestain et al. (2012) believe that organised religion brings changes to traditional practices. These scholars refer to the Islamic faith, whose adherents circumcise their sons at the age of seven days. The participants stated that some parents believed that it was safer to circumcise babies in the hospital.

The traditional surgeons were the only ones to express outright resistance to the implementation of the SMMCP in Bugisu.

The following section presents the views of the focus groups.

5.4 Responses of Members of the Focus Groups

In the focus group discussions, I was particularly interested in responses regarding the SMMCP's impact on TMC. I also wanted to understand how the Bamasaaba maintain their cultural practice of TMC while the SMMCP is campaigning so vigorously in the Bugisu sub-region. The government of Uganda has increased its public health awareness regarding SMMC through government health institutions, cultural institutions, local councils, the media and other means of communication.

The participants expressed their views through group discussions in Mbale, Manafwa and Bududa. Like the interviewees, the members of the focus groups believed that TMC is still culturally relevant. A participant stressed how intertwined the practice is with the very identity of the Bamasaaba:

> *Imbalu* ye Bamasaaba *is culturally relevant among the Bamasaaba. It's an identity to us, and its uniqueness makes the Bamasaaba very proud, so, without this tradition, the Bamasaaba is no longer relevant. We are nothing without imbalu, and we are ready to protect our imbalu despite the implementation of the reformed health policies in our region*
>
> (P3, Focus Group No. 7.).

However, some participants felt that the implementation of the SMMCP had the power to eradicate the cultural practice of the Bamasaaba. One was strongly critical of the traditional leaders, who, he said, were not doing enough to uphold TMC in the face of mounting pressure to adopt SMMC. As stated before, the primary reason for the traditional leaders being reluctant to adapt TMC is the heavy political interference into cultural practices of TMC in Uganda. From this stance, one of the group members said:

> *The government will abolish the cultural practice of the Bamasaaba if we consider the SMMCP. The Bamasaaba themselves are not standing by it due to expenses and the difficulty found with TMC. So, they may opt for the hospital, and even the clan leaders do not protect the culture. They are just greedy and do whatever comes. Money is what they abide by*
>
> (P2, Focus Group No. 4.).

Participants were adamant that there is still much support for their cultural practices in the Bugisu sub-region. They believed that the government was trying to redefine the culture of the Bamasaaba by implementing SMMC and introducing unacceptable innovations such as the practice of females circumcising men. The majority of the participants in the focus group condemned this idea. One said:

> *Culturally, it is not acceptable for women to perform male circumcision on a man in Bugisu*
>
> (P6, Focus Group No 4.).

In general, reactions to the issue of females carrying out circumcisions on the Bamasaaba men were unanimous. One person – influenced, perhaps, by his circumstances – pointed out that it was a reasonable practice, as long as the female doctor performed the operation on non-Bamasaaba. This man, who identified as strongly Christian, said:

> *People study. I have my daughter who is doing medicine, and she was not born a doctor. Now that this is what she was training to do, there is no problem for her to circumcise somebody in the hospital, especially to a non-Mugisu man; it is her job. We, as Babukusu, according to our constitution, have two forms of circumcision. One is that there is male circumcision of* bitsenze *and another one of the hospitals (clinical male*

circumcision). I talked about that one, and I also turned to religion. So, I am saved. Then you cannot take your children for TMC because the Bible does not put it like that, and you will go to the hospital

(P5, Focus Group No. 3.).

Having heard this input, many of the participants tried to strike a compromise between TMC and SMMC. These participants maintain that instead of going to the hospital to be circumcised by women, boys could undergo TMC and treat wounds medically. Participants in the other groups revealed that they, too, were born-again Christians. Like the non-Christians, they said that women should not perform circumcisions on men (presumably, Bamasaaba men) but said that they would prefer SMMC for their children. These born-again Christians stated that the rituals performed during *imbalu* went against their Christian beliefs.

However, whether Christian or not, the Bamasaaba do not support a woman carrying out male circumcision either in the hospital setting or out of the clinical setting. A Clan Leader said:

I am a Pentecostal Christian, but a woman cannot circumcise my son. I do not have any problem taking my son to the hospital for male circumcision, but I will point out that a woman should not touch my son. I know that our culture will not be affected, and I am not saying that TMC should stop. But as for me, I am the minister of God, and I am a born-again Christian, so my son should match my status. If not, I will tell the boy to come from the house, and they cut him in the courtyard while we are praying for him. However, though all this exists in our circumcision, I don't support women to circumcise because I have never seen it

(P2, Focus Group No. 7.).

Khanakwa (2016) states that most scholars in social science view *imbalu* as a 'practice through which significant aspects of social identity are inscribed upon the human body, such as gender, generational, social and sexual maturity. The participants stated that the Bamasaaba demonstrate their social identity by participating in the practice of *imbalu*. In addition, another participant in the same focus discussion observed:

Imbalu has for many years made us who we are, and our people respect each other for this. For example, we must traditionally circumcise boys to be the real Bamasaaba

men. If you were my fellow elder and you are passing somewhere, I could not pass without waiting and greeting you; you see that our bukuuka*ship was coordinated right from the village to the sub-county. When they were together in Mutoto Cultural Centre, the small clans would turn up and show their respect by joining the occasion. I see the Bukhukaship of these days is there to implement government policies. They are paid millions from the statehouse to run government programmes, I swear.*

(P4, Focus Group No. 5.).

Most of the participants from Mbale and Bududa Districts claimed that the more educated Bamasaaba are happy with the male circumcision policies implemented by the government and have adopted them. Some, however, said that the Bamasaaba are not satisfied with the situation and have not welcomed the SMMCP. Some said that while the health policies have excellent aspects, they need to take more cognisance of traditional practices and show the people how they may retain these practices while still conforming with acceptable health standards. I asked how SMMC, as performed in the hospital, differed from TMC operations. A participant from Mbale asserted:

Some of the Bamasaaba believe that there is no difference between medical and TMC since the result is to be circumcised. However, in Bugisu, boys get more benefits if they go through the initiation process. They are respected, encouraged to love others, desist from adultery, and keep healthy, among others, which is not done by the health personnel in the hospital

(P5, Focus Group No. 2.).

The participants said that these days, many of the cultural practices advocated by the Traditional Leaders (the *bukuuka*) have disappeared because of modern cultural influences, money and religion, with most Christians choosing to circumcise their children in the hospital. The participants stated that political influence was being exerted on the current *bukuuka* and that they tended to focus only on receiving money from the statehouse. The pressure they experience in return for money has forced some cultural leaders to compromise traditional values and advocate for medical male circumcision. The participants also indicated that cash from the statehouse would stop once the health policy gained enough support from the people. A participant in Bududa District stated:

Now we accept clinical male circumcision, and this never existed during the time of our forefathers. If we just follow a system like that, you will find that a child who went to the hospital for circumcision and one who was circumcised traditionally do not have a similar outcome; the child who is clinically circumcised has not undergone all the stages of initiation. Now, suppose such a person is elected to lead others as umukuuka or even as a clan leader. In that case, he will not know anything about the Bamasaaba rituals, and he will end up accepting all that is brought by the government and dump our culture. So among these new health policies implemented in Bugisu, there are none I am supporting because, in our culture, they have never been there

(P3, Focus Group No. 5.).

In response to the question of what the Bamasaaba are doing to adapt traditional practices to accommodate the health reforms, participants said that traditional surgeons periodically convene at the district health centre for training. In addition, the Bamasaaba had adapted their traditions by largely dropping the use of botanical medicines for the healing process.

Sendegeya (2010) reports that most Ugandans respect those who have received academic, postgraduate and professional qualifications from a university or other institution of higher learning and that such people tend to promote themselves as being more knowledgeable than their peers. The participants concurred with this view, stating that educated Bamsaaba have forgotten their culture and adopted Western culture. They were not surprised that these Bamasaaba choose government health policies that undermine their cultural practices since educated people mix with people of different cultures. One of the participants stated:

The educated Bamasaaba have forgotten and adopted Western culture by circumcising their sons in the hospital. Regardless of the possibility of cutting off the foreskin, it remains risky. When you have sex with someone, there will be physical contact and some fluid discharge, which subjects you to the dangers of any kind of infection

(P1, Focus Group No. 6.).

What became clear was that participants who most strongly upheld the cultural and spiritual values of TMC would not consider SMMC and would dismiss the implementation of government health policies for socio-cultural reasons. Given that SMMC is just a type of

genital cutting without cultural values attached to it, it conflicts with the cultural practices of the Bamasaaba. One participant said:

> *As I have said, I wouldn't conflict with my cultural and traditional practices. I will instead use a condom each time I have sexual intercourse with a person when I don't know her status*
>
> (P6, Focus Group No. 6.).

Data in this section has demonstrated that due to the pervasive power of Western cultural influence, many people hold mixed views of the SMMCP. On the whole, focus group participants preferred TMC as a cultural practice in their society, but some saw its eventual usurpation by SMMC as inevitable. For the time being, they would resist it as much as they could.

5.5 Responses of Two 2016 Initiates

Data in this section presents an analysis of the initiates' responses to the question of how the policy of SMMC had influenced TMC. A report published by USAID (2012) state that most young men (81%) said they would prefer traditional male circumcision compared to only 19 per cent who said they would select the SMMC. In this study, the 2016 Initiates shared the same opinions showing that they strongly valued and clung to the practice of *imbalu*:

> *Some of the Bamasaaba value SMMC, but imbalu will continue throughout the generations since it's prestigious to us, the Bamasaaba*
>
> (2016 Initiate No. 2.).

Both acknowledged that the implementation of SMMC in Bugisu had discouraged many of the Bamasaaba from undergoing *imbalu*, but they were adamant that this was not for them. The comments reveal how a strong sense of masculinity embodied in TMC and how much this aspect means to the Bamasaaba men. One said:

> *I cannot receive circumcision from the hospital or sterilised before being circumcised because injections weaken my manhood*
>
> (2016 Initiate No. 1.).

While acknowledging that the practice of *imbalu* may undergo changes mainly due to its growing expense – and 'other factors' – the initiates felt that it would remain relevant because of its enormous spiritual and social significance and the role it plays in shaping men's identities. Initiate Number 2 stated:

> *I believe that imbalu will keep its values and relevance, though methodologies may change due to poverty and other factors. The imbalu still has value despite these new health policies that were imposed on us by the government. Many the Bamasaaba men feel the TMC still has costs, and its values shall prevail, especially for those who follow the norms and rituals*
>
> (2016 Initiate No. 2.).

The Initiate from Mbale was more tolerant than the other initiate and pointed out that character is something inborn or nurtured and not imparted in a single event such as *imbalu*. Therefore, for this initiate, whether one undergoes surgery traditionally or in a hospital, what matters is supporting the person through prayer to help him become a better man. He said that you could advise a person on how to behave during the ritual of *khusabiisa umufulu* (a hand-washing ritual). Still, when a good character was not already present, the person would not change. He added:

> *Even if a father would just wake up and circumcise his son without following those traditional rituals like* khusabiisa umufulu, *they are still well-mannered. We, who do it the old way, can offer a prayer to God, saying, see, this child is getting circumcised, help him to be fair and behave well … and so it happens. That is why I say the character is from within, and thus it will remain, and those who wish to use it shall use TMC while others can take on other methods, like going to the hospital*
>
> (2016 Initiate No. 1.).

Both Initiates, however, expressed regret that because of the pervasive and well-funded programme of pushing SMMC, *imbalu* would inevitably weaken, especially when coupled with its growing expense for cash-strapped families. Religion, too, would play a part in bringing down TMC, which was so often coupled with perceptions that those who practise it are not only non-Christian but also in need of 'civilising'. They observed the rapid rise of

American-style charismatic churches and the strong grip these churches had on the minds of the people, turning them away from culture and traditions.

Thus, it becomes clear that the SMMCP was not the sole cause of changes in the practice of *imbalu.* The practice was being battered from all sides – by poverty, the pressure to conform to 'civilised' standards, and by spiritual condemnation by many contemporary churches that have mushroomed all over Uganda. These forces were weakening the practice of *imbalu*, along with changes of attitude brought about by the strongly anti- traditional government health campaign. For this reason, it was considered significant to obtain the views of Medical Officers with regard to the medical practice of MC as opposed to TMC, as presented in the section that follows.

5.6 Responses of two Medical Officers

This section presents data from the two Medical Officers who participated in the study in their personal capacity. These Medical Officers seemed more aware that *imbalu* as a practice had lost its value but promoting unacceptable behaviour in society. For example, they raised the issue of promiscuity and the excessive drinking that usually occurred during *imbalu* season. As professional Medical Officers and the Bamasaaba men, they conducted something of a balancing act in the way they approached male circumcision, extolling the benefits of SMMCP and yet supporting TMC as an integral part of the culture. They were also highly aware of the issue of HIV transmission and said that they focused a lot on trying to convince initiates that no form of circumcision would guarantee protection from HIV. They confirmed that both the Bamasaaba and non-Bamasaaba men who adhere to safe sexual practices would be better off than the Bamasaaba men who circumcised traditionally but did not act responsibly:

> *As traditional Bamasaaba men and professional medical personnel, we become careful when helping those children know that we are moving towards modernisation. I do this without compromising the acceptable values of the society. At the same time, I must remind them of the risks brought by HIV. I tell them not to let the chapatti overtake the girls and let the boys also protect themselves. Secondly, they are giving out condoms freely. Do not risk having unprotected sex without putting on a condom to prevent the infections of HIV. If you do not have a condom, then nothing should happen. We hear this over the radio, and the youth are taught this at school*

(Medical Officer No. 1.).

Since as medical men, they were highly aware of the benefits of SMMC, yet as the Bamasaaba men, they wanted to preserve their culture; they found a compromise in urging society and TMC practitioners to move toward more hygienic and correct practices. They pointed out that HIV transmission is a global problem and that the only proven way to bring down its rate of transmission was 'abstain, be faithful and condoms' – the ABC method. One of the Medical Officers stated:

> *No, say we are continuing to let our boys know that culture is culture, but there is HIV. Boys and girls should not think that imbalu will protect them from AIDS. Like the boys … that tradition of male circumcision should not ruin your life. It even applies to girls; they should be careful. Boys should have sex with condoms after healing from imbalu. Let us give proper guidance to them because our tradition says that* nakhakabila akwa khu' mwada kwee tsofu, *which means, do not blindly follow advice; you will fall into the path of an elephant*
>
> (Medical Officer No. 2.).

These participants strongly supported the moral teachings that accompany TMC. They were also the first to point out the strong influence that women had over an initiate's choice of SMMC or TMC. These participants felt that although circumcision has a positive effect on HIV transmission, it also had a subtly negative impact on the morality of society as a whole. The promotion of MMC has resulted in circumcised men engaging in more sexual activity than those who were not circumcised despite the "moral teachings". This was because the Bamasaaba women prefer having sexual intercourse with circumcised men, particularly traditionally circumcised men. Medical Officer no. 2 also stated:

> *Women prefer traditionally circumcised rather than uncircumcised or medically circumcised men. We clinical personnel are expected to contribute so much in creating change in the traditional practice of imbalu, but because of our cultural differences, it is not possible. But I have observed that women have a vital influence on decision-making. They advise the boys to either have traditional or hospital circumcision*
>
> (Medical Officer No. 2.).

However, their main concern was HIV transmission and the personal sense of responsibility that men and women needed to take for their health. They linked this sense of responsibility to the overall morality of society. They pointed out that the SMMCP was introduced to reduce the spread of HIV, but that for cultural reasons, people still preferred TMC – which was often associated with reckless behaviour despite the "moral teachings":

> *The policies came into being due to the epidemic of HIV. The health policies help everybody, a* mumasaba *and non-*mumasaba*, but the* mumasaba *will prefer imbalu for cultural norms. The Bamasaaba practice of imbalu entails the great dance of* kadodi*, and it is crazy during that period*
>
> (Medical Officer No. 1.).

As discussed in chapter two, TMC is widely practised for religious and cultural reasons, often within the first two weeks after birth or at the beginning of adolescence as a rite of passage into adulthood (Wanyenya, 2013). Yet, the other Medical Officer spoke along the same lines, pointing out how TMC had become degraded because of the behaviour of so many during *imbalu* season:

> *There are immoral behaviours like rape and other unthinkable things that prevent the non-Bamasaaba from enjoying the cultural dance. There is a lot of drinking without getting tired; dances are everywhere. The imbalu benefits are few. It mostly promotes immorality in our society. It is the individual's responsibility to safeguard himself or herself from HIV by not getting involved in this kind of primitive behaviour*
>
> (Medical Officer No. 2.).

As mentioned by the Medical Officer in the quote above, the ritual of *imbalu* creates a festive atmosphere, where music blares through the streets, people dance and plenty of food and local beer (*kamalwa)* are served by the parents of the initiates. The *kamalwa* is always served when the boys have finished to be traditionally circumcised. People drink without getting tired, as seen in figure 5.15 below

Figure 5.15: Drinking Kamalwa (local beer) after Imbalu Rituals in Bugisu

Source: Google Images.

Due to this kind of behaviour, the cultural or social meaning attached to TMC has been compromised. This was an aspect that neither the Cultural Leaders nor the Traditional Surgeons referred to; they acknowledge the minor changes that TMC had undergone as a result of the SMMCP but did not acknowledge that the event itself was subject to corruption by the behaviour of the people involved.

For this reason, both the Medical Officers felt it would be better if the Bamasaaba were to work out a compromise between TMC and SMMC. How exactly this compromise might work was not spelt out. Still, given the high value they placed on HIV prevention, they likely had in mind a hospital circumcision followed by exposure to moral teaching and some ceremony at home to mark the occasion. Excessive drinking and reckless behaviour, however, would still need to be addressed.

5.7 Summary of the Chapter

This chapter has presented and analysed data relating to the effect of the SMMCP on the practice of TMC and the role of culture in resisting or accepting that influence. This aspect was presented through three core headings that emerged; the spiritual and religious influence of

TMC, the effect of the SMMCP on the choices of many, especially with regard to the prevention of HIV, and the role of women – both as clinical surgeons, and as strong influencers over the choices of young men regarding which form of circumcision to undergo. A fourth theme hardly alluded to by most emerged in the medical officers' words; the fact that *imbalu* itself has been subject to a form of compromise and degradation by the recklessness of people during *imbalu* season.

Spiritually and socially, SMMC can never compete with TMC, which is traditionally accompanied by strong messages of moral guidance even though this moral guidance is not strictly adhered to. Spiritually, the ceremony seems to reach to the core of people, linking them, according to their belief, with the ancestors and thus their history as a people and their identity as individuals. However, this very aspect makes the rituals of *imbalu* unacceptable to Christians, who tend to paint the event in broad brushstrokes, simply calling it 'evil', according to some of the participants. Many acknowledged that because of the growing number of charismatic churches and the number of people who now identified as born-again Christians, TMC was under threat.

The SMMCP, as a policy, has also strongly influenced both the practice and the popularity of *imbalu.* The operation procedures have changed in response to this influence, with Traditional Surgeons now sterilising knives or using several knives. According to the participants, the policy's more pervasive effect is to turn some people away from *imbalu* – although to what extent could not be established. Most felt that this influence was still something for the future; for the time being, people preferred TMC. Obviously, the cultural leaders and traditional surgeons resisted this influence the most, while the initiates and medical personnel interviewed were more open to it.

The majority of the Bamasaaba considered it taboo for females to perform circumcisions or to become traditional surgeons. Cultural leaders and traditional surgeons strongly resisted this aspect. The medical officers interviewed pointed out that women had a strong influence on the choice that men make with regard to circumcision and that women, in general, preferred men who had been traditionally circumcised.

Each of these findings in itself constitutes a source of pressure on the practice of traditional circumcision. The spiritual aspects of the ceremony, considered by some to be its greatest

strength and value, were also its greatest source of conflict. An increasing number of people now find it unacceptable since it is incompatible with their beliefs. The pressure exerted by the SMMCP was relentless. It was a well-funded campaign that might eventually weaken the appeal of TMC, especially when coupled with the expense of the traditional event and the objections of many on spiritual grounds. The reckless behaviour of people during the *imbalu* season also rendered it weakened from within and was an aspect that clearly needed more guidance from the clan and cultural leaders.

In the opinion of some, these leaders are motivated more by money than by wishing to serve and guide the people. However, in its favour, *imbalu* still strongly appeals to the way that men have structured masculinity, particularly since it involves pain, a group identity (*imbalu* is always undergone in groups) and moral teachings addressed specifically to men. This aspect of speaking to the identity of men and the entire community seems its greatest strength and a source of tremendous resistance to all forms of pressure.

The next chapter presents data that sheds light on the social and cultural effects of the SMMCP on TMC.

CHAPTER SIX

THE SOCIAL AND CULTURAL IMPLICATIONS OF THE SMMCP

6.1 Introduction

The previous chapter presented findings and analysed the influence of SMMCP on the practice of traditional male circumcision. This chapter presents and analyses data specifically on the social and cultural implications of the SMMCP, with data collected from the same five categories of people interviewed in the previous chapter – the clan and cultural leaders, the traditional surgeons, the mixed members of the three focus groups, the 2016 initiates and the medical officers. In addition, the key informant, the *Inzu ye Bamasaaba,* forms the sixth category of participant in this chapter.

Together, these participants reveal their perception of the social and cultural implications of the SMMCP for the Bamasaaba people.

6.2 Responses of Cultural and Clan Leaders to the Social and Cultural Implications of the SMMCP

The researcher asked the Cultural and Clan Leaders about the changes that TMC had undergone in recent years, especially as a result of the SMMCP. Responses indicate uncertainties. Some were of the view that TMC is currently losing its value, as expressed in this comment:

> *If you do enough research, you will see that our TMC is losing value because of the implementation of the so-called modern health practices. You find that no matter what we do, our traditional circumcision is waning. We are not following our* umukuuka, *who has been responding to the* bukhuka-*ship for a long time. For us, the Bamasaaba, we never had a specific* umukuuka *who was politically motivated, but every clan had its clan leader. Moreover, these clans were headed by* umuyinga, *who respected each other*
>
> (Cultural Leader No. 3.).

Some participants told the researcher that certain people, especially the elite, are now taking their children to health facilities for male circumcision, which signals that they are abandoning tradition and adopting the new policies implemented in the Bugisu sub-region. Taking children to the hospital by this category of the Bamasaaba means advocating for transition within the traditional practices. Ultimately, such information can inform the strategies to make TMC safer than fully advocating to utilize the resources available to support Uganda's gradual transition towards SMMC.

The participants revealed that more educated people no longer perform all the rituals involved in *imbalu,* claiming it wastes time and resources. In many cases, the traditional counselling of initiates – one of the most significant aspects of the cultural practices of the Bamasaaba – is now excluded. The participants informed the researcher that the counselling of initiates is no longer critical to some of the Bamasaaba. Yet, traditionally this forms an essential and integral part of the rituals practised during *imbalu*.

A Cultural Leader commented that the importance of the counselling sessions given to the boys during the initiation process is what builds their character. He said:

> *The counselling sessions during the TMC process is to build the character of boys. This time is when useful and valuable information is given to the boys since they are about the values of life. We use these processes to instil important family values before marriage and friendship into boys who are going to be circumcised. This helps them in their lives. Some values instilled in the boys include do not steal and work hard. They also bring a hoe, give it to the boy and encourage him to dig and make money. The traditional surgeon provides a panga with to him for harvesting food for his family, and then the boys receive an axe for cutting firewood used for cooking. The surgeon then gives water for cleansing and shows the new man that he needs to bathe and be clean and for his animals. They also provide a new straw to qualify the new man to partake in the elders' local brew. The new man will receive the knife,* inyembe*, as a symbol, meaning that he has become a man through the knife, and his male children should also be circumcised to be men. Nowadays, a pen and book are then brought to encourage the new man to be educated, which is the key to making money in today's world, among others, which profits them in their future*

(Cultural Leader No. 2.).

The researcher asked the Cultural Leaders from *Inzu ye Bamasaaba* (the Bugisu cultural institution) about the implications of implementing the SMMCP. The participants responded that they were praying for more educated people to write down the history of the Bamasaaba. Considering the limitations of implementing the SMMCP in traditionally practicing communities and the promise of TMC for reducing infection transmission, this study aims to characterise TMC practices in Uganda. This includes the cultural implications by using comprehensive information obtained from individual interviews and focus group discussion (FGD). The implementation of this health policy has had a significant effect on the cultural practices of *imbalu*. One of the Cultural Leaders stated:

> *It must continue. We pray for the educated Bamasaaba like you to write our history for the future generation. The foundation we are trying to create should be able to help a child of the next generation in about 50 or more years. The implementation of these new health policies can remove or replace our culture and traditional norms. We want our cultural practices to be there forever. I have observed that the Western culture brought about by the health policy has diluted our culture of imbalu. Oh yes, the imbalu of today is not the imbalu of the past because of this so-called modernity. We are adding the health policies that will affect our practice if we do not record it for future generations*
>
> (Cultural Leader No. 6.).

Other Cultural Leaders said that history should not repeat itself in the leadership of the Bamasaaba. The participant here means that there have been numerous attempts to abolish TMC in Uganda, particularly by the British missionaries (Assimwe, 2011). The participants felt that because of what is happening today politically, their culture and uprightness were deteriorating. One said:

> *Long ago, we had the* omuyiga *(traditional leader of the Bamasaaba), and the government removed that kind of leadership and replaced them with cultural leadership, now our* Umukuuka*. We want our cultural leadership to remain. That is why our Bamasaaba anthem says forever and ever so that the next generation will know that grandfathers and great-grandfathers also got circumcised traditionally. It is the*

only icon that we cherish as the Bamasaaba, and we cannot afford to lose our tradition. The government health policies should not cause the removal of imbalu, in my opinion. The health policies are good, but they have the potential of replacing imbalu with hospital male circumcision

(Cultural Leader No. 3.).

The above comment seemed to form a poignant plea for the government to recognise what the Bamasaaba people have and not seek to destroy it. It appears that it was unwittingly doing this simply by promoting SMMC since traditional circumcision formed such an 'icon' in the people's minds. In his explanation of manhood, Vincent (2008) states that the meaning of manhood is found in maturity and in learning the ways of being a responsible and just adult. This sense of responsibility, the leaders felt, was now on the wane, partly because of the social influence of modernity, which the SMMCP represented to them. These participants explained that circumcising boys was a process of teaching them unity as men. Without this process of teaching, boys become wayward, as demonstrated by the many men today who are selfish and violent, especially towards women. In addition, there is no unity among their children, and people no longer know their relatives. One of the Cultural Leaders had this to say:

The boys are not like those of the past. In the past, the aspirants were always advised and prepared before getting circumcised. The aunt prepared a house called likombe, *where the boy will stay with the friends during the treatment and also trying to understand each other for the good of having agemates (bamakochi). These agemates used to respect themselves, which is weakening today. Like I said, respect remains a norm within our culture; to respect* bamakochi, *women, surgeons and elders, according to our cultural insights*

(Cultural Leader No. 3.).

The Cultural Leaders interviewed claimed that the SMMCP had a negative social impact on cultural practices, drawing people away physically and also teaching them to devalue the practices. Without this influence, TMC would remain a strong institution, ensuring that the boys receive good moral teaching. Significant aspects of TMC are neglected by the SMMCP, which focuses solely on the prevention of HIV, according to Howard-Payne (2015). To this, I would add that the SMMCP also subtly implies that TMC is anti-modern, outdated and uncivilised, as revealed by the clan and cultural leaders. The participants claimed that the health

personnel of the SMMCP openly criticise and discredit the cultural practice of TMC. The Bamasaaba were, as a result, antagonistic towards and suspicious of health professionals and politicians, who use campaigns to portray TMC as a risky practice. Appearing to confirm this stance, the health sector describes TMC as a harmful and primitive practice (Ministry of Health, 2006).

The Cultural Leaders, in essence, felt that the government and its policy of SMMC were going 'too far. They would support hygiene and safety messages but would not support anything that carried with its subtle messages against their culture, in which they perceived the SMMCP. One said:

> *The government now promotes medical male circumcision and tells us not to recognise TMC. Those people from the Health Ministry are saying that if you get circumcised at the hospital, you will be safe from HIV. The government is saying that TMC is primitive and that hospital circumcision is modern, but for us, what we see is that it is not an issue because we have been healed even before. The government should not come down and say, let there be no existence of this culture. It must raise the hand to support the culture of the Bamasaaba. But if it comes to say that it should exist, it would be against our culture*
>
> (Cultural Leader No. 1.).

Some participants also said that the generations-old institution of the *bukhuuka* (traditional leadership) was never tainted by politics or religion – it was a cultural institution. They said that they, as leaders, needed to put aside political issues and elect somebody who has both knowledge of and an interest in the cultural practices of the Bamasaaba. The participants added that the SMMCP was highly politicised as a result of the influence of investors and large Western institutions such as the World Health Organisation. The cultural and clan leaders believed that the task of implementing SMMC was suggested and funded by developed Western countries, which in effect determined what was enforced in Uganda, and made some groups beneficiaries and others not.

As a result, these participants were highly suspicious of the SMMCP as a political tool. They felt that the government was manipulating the health policy in order to gain power and control over the cultural practices of *imbalu*, and through that, to control the Bamasaaba. They said

that foreigners, especially from the West, came under false pretences to influence their cultural institutions of *bukuuka*-ship and impose Western culture. They contrasted this with the great value they attached to the *imbalu* ceremony. In line with what Cultural Leader 3 number said previously, Cultural Leader number 6 said:

> *Imbalu promotes the unity of the clan since it brings all the family members together, and since an obligation has been fulfilled, the clan is happy. However, we feel the new policy will create separation. There will be no unity among the Bamasaaba; therefore, we are pleased with our TMC and cannot adopt the latest health guidelines*
>
> (Cultural Leader No. 6.).

The Bugisu region is considered the birthplace of TMC in Uganda. Common belief holds that the first male circumcision was performed in the region centuries ago. Even today, at the start of each circumcision season, the first cohort of candidates is circumcised in the Bugisu region. This tradition is part of the cultural belief system to such an extent that those who are not circumcised traditionally are strongly stigmatized within their communities. For this reason, the participants felt that there are more advantages than disadvantages to *imbalu,* stating that no one had ever been killed because of *imbalu* and that it promoted family and male unity, strengthening the entire culture. In addition, the practice is an obligation fulfilled by all the Bamasaaba, whether they live in the Bugisu sub-region or out of it.

Despite their strong defence of the culture and the value of *imbalu,* these participants were not unaware of its difficulties and inconveniences. There were mixed views regarding the method preferred by most Bamasaaba. The more educated Bamasaaba, they said, preferred SMMC as practised in hospitals since the traditional practices were often unfamiliar to them and experienced as harsh by their more educated children. A Cultural Leader said:

> *It is awkward to go through it the traditional way; you are subjected to dancing for three days. The initiate must step on harsh surfaces, plus it is expensive to feed people through this process*
>
> (Cultural Leader No. 4.).

In an attempt to give a historical account of *imbalu,* Khanakwa (2016) states that the Bamasaaba have exercised this cultural practice since the 1800s, drawing on the tradition of

the circumcision years, known as *kamengilo* (the circumcision period). Reiterating this, the participants pointed out that *imbalu* had been part of the culture for generations and that, according to tradition, it was initiated by spirits. A participant said:

> *Imbalu started with spirits, whereby a Mugisu man married a woman from another tribe, but their male children kept dying. This Mugisu man began to seek answers, and the spirits advised him to circumcise all the boys to survive. Since then, all the Bamasaaba circumcised their boys. As a leader, I can only recommend TMC for the Bamasaaba for their male children*
>
> (Cultural Leader No. 6.).

The participants stated that *imbalu* incorporated a profound symbolism for the Bamasaaba, creating hierarchical and social differences by marking generation, gender, manhood and political position in Bugisu communities. For this reason, it was central to the culture, and these participants were quite clear that they would never take their male children for SMMC. One said:

> *We cannot take our children to hospitals when our ancestors circumcised traditionally. I think we should move forward with the tradition of our ancestors*
>
> (Cultural Leader No 4.).

Nabafu (2000) defines initiation as all the rites of passage performed by the Initiates. The participants stated that the Bamasaaba are beginning to ignore these rites of passage because of modernisation and being implemented by the SMMCP. They were worried that significant markers of the ceremony such as *issonja* (the preparation dance), the three days of dancing, the festivities and the ritual of preparing millet flour for *kamayeku* (the beer) were being eradicated because of the influence of the SMMCP.

The *imbalu* dance differs from district to district. For example, in Manafwa district is on the border with Kenya, and the *Imbalu* dance is commonly known as *Tsinyimba.* These Bamasaaba are committed to their cultural dance of *Tsinyimba*, as shown in the photo in Figure 6.16.

Figure 6.16: Imbalu Aspirants Dancing Tsinyimba in Namisindwa District

Source: Google Images.

It is believed that in the Bugisu communities, the boy ready for *Imbalu* should be the age prepared to marry and ceremonies such as *Issonja* and *innemba* were used to identify suitable suitors for marriage. Other rituals were also done with a specific purpose, which is no longer done. The participants said that initiates are thrown into the event without the proper rituals being observed; for example, they are strewn with cake flour instead of locally grown millet flour. One said:

> *The traditional male circumcision aspirants prepare, and they are adorned with pure millet flour made out of yeast. We use the residue of this flour to brew* kamayeku *for our ancestors.* Kamayeku *is drunk by traditional surgeons and elders on the day the boy is circumcised. The act of using cake flour is not our tradition*
>
> (Cultural Leader No 5.).

Furthermore, the participants believed that many other changes had been introduced as a result of the health policies now imposed on traditional practices. Hence, current *imbalu* practices are different from those of the past. Although there have been changes in custom and rituals, TMC in Bagisu remains uncontested. No matter what has changed around traditional male circumcision, the bottom line and the most important factor is that the boy must undergo traditional male circumcision to be considered as part of the circumcised community. However,

the participants insisted that the Bamasaaba are gradually ignoring the rites. A Cultural Leader said:

> *I tell you today that the Bamasaaba are gradually ignoring the rites performed during imbalu. Some are misusing our cultural norms by not respecting the imbalu calendar of circumcising only in even years. At the same time, other Bamasaaba do not follow the right procedures and observe the rituals, which is phasing out our heritage*
>
> (Cultural Leader No. 6.).

There was a great deal of unanimity among these clan leaders with regard to the social and cultural implications of the SMMCP in the Bugisu sub-region. Most decried the loss of essential rituals performed during *imbalu* ceremonies for initiates. A Clan Leader said:

> *There is a change between the traditional practice of imbalu in the old days and the imbalu of today. Some people might have told you that the Bamasaaba are ignoring most of the rituals performed during imbalu ceremonies for initiates because of modernisation brought about by foreign policies. The boys drink with their peers and go out clubbing before circumcision instead of following the real rituals.*
>
> (Clan Leader No. 2.).

Out of all the ethnic groups in Uganda, only four tribes practice traditional male circumcision as part of their culture. Traditional male circumcision is embraced by various faiths such as Islam and Christianity. These tribes are concentrated in East and Western Uganda. These participants stated that *imbalu* defines the Bamasaaba:

> *I believe that since it is our culture that defines who the Bamasaaba are, we should stand behind our culture. We must defend it by not allowing the SMMC, which is threatening to kill the traditions. I pray that our culture does not die out entirely and becomes a tourist attraction for Inzu ye Bamasaaba to generate income out of it*
>
> (Clan Leader No. 4).

The WHO (2007) acknowledges that SMMC might never wholly replace TMC in some African communities. This is backed up by many studies that report resistance to SMMC in Southern and East Africa (Lukobo and Bailey, 2007; Sallis et al., 2008; Asiimwe, 2011; Baron et al.,

2014; Atukunda et al. 2015). It was also borne out by the participant's confidence in the enduring place of *imbalu* in modern society. It is clear, however, that this endurance comes with a battle that is not easily won.

The Cultural and Clan Leaders stated that the Bamasaaba have no problem with SMMC as long as TMC is left to be practised in peace. The participants added that they would not agree to any enforcement of the SMMCP. One Clan Leader said:

> *Imbalu of the Bamasaaba is a cultural practice, and traditional surgeons circumcise all boys who belong to this cultural group traditionally. We even grab those who try to dodge circumcision forcefully. As the custodian of imbalu rituals, I will not allow the prestige of the Bamasaaba to be wiped out. As long as we have not interfered with the non-Bamasaaba's rights, they must live our imbalu in peace*
>
> (Clan Leader No. 1).

The participant feared that some of the Bamasaaba believed that *imbalu* traditions would die out in the future, given the rate at which politics, religion, and the new policies are being implemented. These participants believed that SMMC is not a need for men in the Bugisu sub-region. It appears as though the participants viewed this HIV prevention strategy as inconsequential. For this reason, the cultural and clan leaders believed that the traditional practice of male circumcision would maintain its dominance over medical male circumcision in the Bugisu sub-region.

6.3 Responses of A Key Informant to The Social and Cultural Implications of the SMMCP

The participant referred to in this section reflected on the cultural practice of using traditional medicine after the removal of the foreskin during *imbalu*. The Bamasaaba use herbs called *inguwu* to treat the wounds, enabling boys to heal in a few weeks. The key informant was concerned that this kind of the Bamasaaba innovation has ceased due to medicalisation and modernity. The participant indicated that modernity was threatening their position and customs when it came to beneficial traditional practices.

This participant noticed that the approach used in government HIV prevention strategies had conditioned them to seriously consider medical interventions that stand opposed to their traditions and cultural practices. The participant believed that by 'sugar-coating' the implementation of SMMC, stripping it of all cultural connotations, the government of Uganda is medicalising and impoverishing *imbalu.* The health policies conflict with the meaning and values attached to TMC as a cultural practice for initiating boys to manhood. In so saying, this participant feared that the traditional techniques such as male circumcision of the Bamasaaba are rapidly moving towards medicalisation.

He reflected on how some of the Bamasaaba men now consider supporting SMMC as a health intervention. This has resulted in the Bamasaaba having mixed reactions to the implementation of the SMMCP. The key informant stated:

> *The Bamasaaba men have had mixed feelings about the implementation of the reformed health policy on male circumcision. The strategy at the hospitals is 99.9% as far as HIV prevention is concerned. I believe one is free to take it. I know that there are not Bamasaaba who want to add to a population that is already HIV infected in our community today. We should help the government utilise all the medicalised options, especially those requiring men to be responsible for their health to combat HIV in the Bugisu sub-region*
>
> (Inzu ye Bamasaaba).

This key informant continued to reflect on how traditional practices such as TMC have become medicalised. Despite his note of sadness at what he saw as the inevitable passing of a tradition, he saw the value of SMMC and supported it for the overall benefit of combatting the spread of HIV. He seemed to see this as a worse threat than the fading of *imbalu* ceremonies:

> *I believe it is only a sign that society has moved from doing things the original way you found in the past. The Bamasaaba elders and other circumcised men spent a significant amount of time with boys aspiring to be men during the imbalu period. I think TMC practices ought to change. Those circumcising their children traditionally ought to embrace medical male circumcision since it is safer and secure for boys in modern society*
>
> (Inzu ye Bamasaaba).

The participant continued to reflect on the way in which modernisation has affected the cultural structures identified with manhood, childcare, sexual relationships and the identity of the Bamasaaba men, all of which are significant findings for the current study. The participant alluded to the modernisation of TMC and how it has adjusted; as a result, especially concerning the performance of masculinity in Bugisu communities. Some aspects that represented endurance of pain, for instance, were now being dropped or softened, such as the injunction to demonstrate vigour through almost continuous dancing barefoot on the hard ground over three days. He said that these adjustments had been made grudgingly and were not undertaken willingly by all; instead, the changes were forced on them by the process of modernisation. The key informant insisted:

> *As I said, imbalu is something that has a long history, something that for centuries has been highly esteemed by the Bamasaaba, which has been brought into the 21st century and turned into a confounding issue. As much as the Bamasaaba men have not accepted the modern practice of male circumcision, they are forced to adopt it. Masculinity performance is too complicated in Bugisu society because what made you a man then is not what makes you a man today*
>
> (Inzu ye Bamasaaba).

The participant considered how the medicalisation of cultural practices and modernity had changed young men's and women's understanding of their bodies, specifically the penis, in modern Bugisu communities. This has caused timely changes in TMC practices, such as minimizing the TMC related festivities, using one knife per candidate, and acceptance of local health staff supervision in some cases have become mandatory in Bagisu. The young men in modern society have become aware and claimed more rights over their bodies. The key informant continued:

> *I think entire cultures are moving towards believing that people's genitals and private parts are their own. Children should not shower together, siblings or boys and girls going to the river to swim together - it is a social change. We are attempting to ensure that people's view of things that are out there remains with them. We are trying to ensure that modern children are protected. People are now masquerading at everything; they do not examine their private parts anymore. We grew up doing that. I*

remember we could go to Tsutsu and Manafwa River to swim. Boys played with their penis and cut the thin membrane below the head of their penis using namakye *(giant ants) or* lubembe *(kuju grass). This is the time boys would discover whether they had problems with their genitals or not. This seems to be the most concerning issue where people are no longer open about themselves*

(Inzu ye Bamasaaba).

The participant further discussed medicalisation and modernity in the context of the urbanisation of modern Uganda. The participant claimed that difficulties regarding the practice of *imbalu* were also experienced because of urbanisation, which made it challenging to hold *imbalu* ceremonies. It was observed that some of the Bamasaaba residing in the urbanised area seem to have changed their attitude towards traditional practices of *imbalu*. The key informant commented:

During modernisation, traditional practices weaken to clear the way for medicalised modern practices

(Inzu ye Bamasaaba).

The participant frequently predicted a shift toward the medicalisation of traditional practices, which was necessary, given the high rate of HIV infection, yet regrettable, given that it took the emphasis away from the cultural institution. He stated:

You see, when I was still a young boy living in a rural area, I learned through the traditional practices of the Bamasaaba. However, now that I am medically orientated, knowing matters of cleanliness should be enhanced, this seems to be my number one priority. Furthermore, it must be practised by a traditionally and medically trained person. Yes, we had qualified traditional practitioners; however, you know, they did not have certificates or a declaration of practice. Such innovations are not harmful if they are to be infused with the traditions of the Bamasaaba of the new era. If it is now practised by certified personnel, there is certainly a plan of action to save a man that could have been hurt in the process

(Inzu ye Bamasaaba).

The participant frequently mentioned Western medication when he discussed the social and cultural effects of SMMC on the Bamasaaba traditions. The Bamasaaba understand the emergence of medicalisation and modernisation to be a Western idea of intrusive practices into African cultures. The participant recognised that as the Bamasaaba men acquaint themselves with SMMC, the practice of *imbalu* would be more and more affected. People would drop their cultural practices and adopt a foreign culture through their acceptance of the health policy. In time, men would lose their respect for the culture and hence for one another – a dangerous path. This participant felt that men from culturally circumcising communities who accept the implementation of the SMMCP are compromising their cultural values. He said:

> *See let me tell you, my son – TMC might lose its value if medical male circumcision is attached to it. The population of the Bamasaaba who practise TMC today are seen as antiquated and primitive. [The perception is] that this is why, when these men hear something to do with the hospital method of male circumcision, they … turn off and are not interested at all*
>
> (Inzu ye Bamasaaba).

This statement exposes the conflict between traditional and medical modernised practices. It is clear that the more educated participants advocated for the medicalisation of TMC in the Bugisu sub-region, just as the less educated ones predicted they would. However, generally among the Bamasaaba, there are still those who demand that their children proceed with the traditional practices. This is more important to them than health considerations because cultural practices speak to their identity, as a man and as the Bamasaaba.

Scholars such as Kepe (2010) and Peltzer and Kanta (2009) support the government's idea of infusing a more medical understanding of male circumcision into the practice. They support the idea that the use of SMMC instruments reduces the dangers associated with the removal of the foreskin during TMC. However, their recommendations seem to speak to the more educated class only and have not penetrated the rural areas. Vincent (2008) states that the TMC practices of the local people are a discordant element in the overwhelming tide of Westernisation, even for those who accept a more medicalised form of male circumcision.

Inglehart and Baker (2000) remarked on the dramatic changes in gender roles in society, with women now taking up the same occupations as men. The key informant reflected on the

effect of medicalisation and modernity on traditional practices and the fact that women now perform circumcision in hospital. The key informant said:

> *I guess the Bamasaaba men and women are still very traditional. … I do not have an idea and assume there is no conflict between the traditionalists and the medical practices. I know that people do not desire to transform imbalu into a medical method rather than a traditional and cultural system. But it has become so complicated that women now perform circumcisions on men in the hospital. Nevertheless, these men and women are afraid of HIV; therefore, if you tell somebody that this can reduce your chances of getting HIV, I think the Bamasaaba will probably adopt it*
>
> (Inzu ye Bamasaaba).

Bailey et al. (2001) report complications associated with male circumcision performed in traditional settings, stating that the season of TMCs gives rise to numerous stories in the media of severe complications and deaths in East and Southern Africa. However, the key informant denied this, arguing that the Bamasaaba have practised TMC for generations and have never reported any casualties. As he said, preventing HIV infections is not their fundamental objective as Cultural Leaders:

> *Our fundamental objective as cultural leaders are to maintain the welfare of our traditional practices. We are attempting, by all means, to make a point to the government, but their reaction is somewhat worrying. We try to bring in many changes; however, many things would be practical, yet it will not improve everything. It must be a procedure in which our people learn and realise that our way of living matters*
>
> (Inzu ye Bamasaaba).

USAID reported that three-quarters of the young men sought treatment for their wounds, with 39 per cent seeking treatment using the medicalised modern practice and 23 per cent seeking treatment within the traditional methods. The average "length of time to healing was 45 days, with the maximum reported time being 140 days within both practices" (USAID., 2012:1). The participant also considered the decreasing gap between traditional practices and medicalised male circumcision in the Bugisu communities, remarking:

I do realise that traditional surgeons from Manafwa, Sironko, Bududa, Bulambuli and Mbale Districts are involved as required with the medical sector in these areas. I know a traditional surgeons' association in the Bugisu sub-region is framed to be simply one more arm of prescription. The truth is that traditional practitioners should have their area, and they have to have the capacity to cooperate by getting the license from the health sector to operate. There is still a considerable measure of hatred between the two groups of people, but we try to mediate to solve the problem

(Inzu ye Bamasaaba).

As Wanyena (2013) pointed out, *imbalu* for any Mugisu man means the period when boys undergo training, transition, education and discovery of their cultural identities as *Basaani*. The key informant held this view. He reinforced this idea by noting that the Bamasaaba are feared and respected by their neighbours for their bravery in enduring the pain of TMC, which culturally identifies them as *Basaani Burwa*.

However, this informed participant seemed the most conflicted of all the participants, having a deep understanding of the medical benefits of SMMC and a concern for the welfare of his people while still striving to maintain and promote TMC.

6.4 Responses of Traditional Surgeons to the Social and Cultural Implications of the SMMCP

This section presents data collected from traditional surgeons relating to the question of the social and cultural implications of the SMMCP. As might be expected, this group of participants was the most antagonistic to SMMC and even claimed that when SMMC is not done correctly in the hospital, parents sometimes call them to re-circumcise these children traditionally. This is what one Surgeon stated:

It is not OK because hospital circumcision is not safe. Sometimes parents take their children to the hospital, and doctors spoil the children, then bring them to us to correct the doctors' mistakes. I think that becomes the most painful circumcision for the children. Parents start regretting why they went to the hospital. By the way, being circumcised at a hospital is not safe at all because they use blades that can easily chop

off the boy's penis. I have a newspaper showing the picture of a man whose penis was cut off by a doctor in the hospital

(Traditional Surgeon No. 2.).

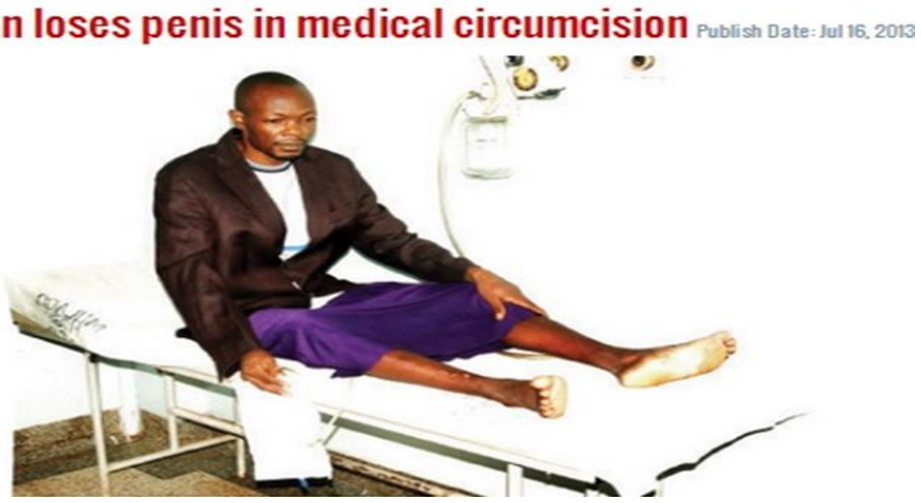
To add fuel to their antagonism toward the medical procedure, these Surgeons had collected information reporting on accidents that supposedly occurred during SMMC. One brought out an article published in *The New Vision* by Kiwuuwa and Masaba (2013). The state-governed newspaper editors claim that a man was enticed by posters offering safe male medical circumcision, but what followed was a tragedy. Kiwuuwa and Masaba (2013) said the hospital-based circumcision led to gangrene in the patient's penis. Using this evidence, all the traditional surgeons reported that SMMC was not as safe as portrayed by the government. One asked the obvious question:

If male medical circumcision is safe, why do accidents happen in the hands of the trained medical professionals?

(Traditional Surgeon No. 7.).

The participants stated that the government had rushed the man to a plastic surgeon for penis reconstruction. Still, as the article reported, the man may never be able to enjoy sexual satisfaction. Figure 6.17 shows a photograph from the item in question.

Figure 6.17: The Figure Indicating that SMMC Could be Dangerous



Source: Kiwuuwa and Masaba (2013)

The participant who showed the article claimed that this kind of accident had never happened with the traditional practices of the Bamasaaba. These participants believed that if this kind of problem occurs, it means that the spirits are neither happy nor present at the time of circumcision. The possibility of botched procedures may be one of the challenges faced by the SMMCP.

Bailey et al. (2007) report a similar incident in Kisumu, Kenya, involving a botched procedure, stating that this is one of the challenges faced by the SMMCP. In this study, the participants noted that the Bamasaaba had practised *imbalu* for generations without experiencing botched procedures.

Some Traditional Surgeons said that medical circumcision led to more promiscuous behaviour than TMC because of the misconception that a man circumcised medically is protected and can potentially satisfy his partner sexually. However, the same idea prevails among those who have undergone TMC; in this case, they are exposed to moral and social teachings, which may counteract this sort of behaviour. In addition, the men who undergo TMC generally do so at an older age – at least, this was the case traditionally. With SMMC, boys of a very young age were becoming circumcised, which encourages younger and younger boys to become sexually active. A Traditional Surgeon said:

> *I tell you, today, people will develop the attitude that being medically circumcised implies that they can have sexual intercourse irresponsibly. In the past, we used to tell the boys to marry and have sex because only mature boys got circumcised in our culture. These days because of the safe male circumcision, we are circumcising small children whom we cannot tell to marry. But these children start to say I am circumcised now … and start engaging in unprotected sex. He will then contract HIV since he has a negative mindset that he would not get any infection. We have been told to instruct them how to protect themselves on this issue. We tell them that they should use protection*
>
> (Traditional Surgeon No. 17).

A study by Greely et al. (2013) suggests safety issues related to TMC may increase the risk of HIV infection. For this reason, the researcher asked whether TMC promoted the transmission

of HIV. The majority of the participants gave a resounding no to this suggestion, saying that the government was using this claim to promote SMMC. To defend themselves against this view, these participants spoke about how conscientious they are during the TMC process. It is like the participants in this regard seem to be sentimental towards TMC, without considering the social reality of HIV and AIDS and the impact it may have on the communities. They also pointed out how the SMMCP could backfire, promoting sexual activity because of the misconceptions that people have about its effect on HIV:

> *The traditional surgeons are even more careful because we have been told that TMC is a risky practice, which is not valid. During the promotion of hospital circumcision, they say that you must do the safe male circumcision making ours look dangerous. If I take my son for circumcision in the hospital, he will think that my father is permitting me to engage in sexual relations since I'm on the safe side in the hospital*
>
> (Traditional Surgeon No. 10).

The Traditional Surgeons claimed that through their governments, the Western community is intentionally misleading the general population about TMC in African countries and that informing people that SMMC offers them safety from HIV transmission is misleading. Traditional Surgeons insisted that the Bamasaaba men act recklessly on the basis of this claim. They articulated the point that society may not have the capacity to control their people's sexual conduct. One Traditional Surgeon said:

> *I am concerned that men may act recklessly without keeping in mind the end goal. When a specific standard or actuality is presented, individuals begin believing stories and myths before it is even cleared up after numerous years*
>
> (Traditional Surgeon No. 7.).

A study by Mbonye et al. (2016) suggests that MMC can reduce men's danger of getting HIV from infected female partners by approximately 60%. This could be misleading since the HIV infection mainly involves having unprotected sexual activities with HIV and AIDS infected persons The participants felt that the government should not overstate this, as it has consequences. The previous participant said:

The government of Uganda should not overstate what medical male circumcision can do. They should be reasonable in the way they inform the people regarding safe male circumcision for HIV prevention so that they … dispose of the myths that circumcised men have natural condoms. Tell people to use other existing methods of protection and not rely only on medical male circumcision since they say it reduces the chances of getting HIV infection. They must be watchful on how they implement this, and they should not merely tell people, especially the Bamasaaba, and let them keep running with the thought. The government may end up causing more damage than the benefits of safe male circumcision

(Traditional Surgeon No. 7.).

The participants stated that the government should encourage cleanliness rather than emphasise HIV prevention. Some participants also said that they would not go for MMC because the government might be implementing SMMC with hidden motives. They might be seeking to control the Bamasaaba politically by eradicating the cultural practices of *imbalu*. In the words of one participant:

I think there is unquestionably some intentions behind the claim that hospital circumcision will prevent HIV. In any case, people cannot just use hospital circumcision alone as a way of prevention. Furthermore, I simply think … trying to say that it should be done is not sufficient. There must be hidden intentions behind the implementation of hospital circumcision

(Traditional Surgeon No. 2.).

Another participant noted that some cultural and traditional practices are changing due to modern innovations. Modern society is opting for SMMC, which involves using sterilised equipment, it is less painful than TMC, it lowers the costs involved, and limits the chances of getting complications. SMC is also time-saving and reduces the risk of exposing young men to HIV. In doing this, the traditional practices may adopt changes. Also, the Traditional Surgeon said:

The traditional practices have changed and are disliked by the new generation. The traditions are reforming and now moving towards modernised techniques where initiates use their [own] knives. The new generation is following medical prescriptions,

avoiding cultural rituals. For example, the initiates may take a shower right after the practice

(Traditional Surgeon No. 11.).

In itself, the issue of cost, an outcome of modern conditions of unemployment, also came up as an area where TMC was subject to pressure from modernisation. Using data from a sample of Xhosa men, who practise traditional circumcision in South Africa, Venkataramani and Maughan-Brown (2013:1668) found that "participants in the poorest households delayed circumcision by two years if a household member experienced the loss of income". Similarly, the participants in this study said that *imbalu* ceremonies are costly in the Bugisu sub-region. These participants stated that parents who had no income would delay the traditional process by one or two years.

The researcher asked whether the participants thought that TMC would lose its value due to SMMC implementation. The participants' responses showed that they are afraid that *imbalu* would lose its value and meaning to society in all likelihood. The participants stated that some parents from the poorest households were not able to provide items for performing the rituals, which either impoverished or delayed the ceremony. Some parents simply ignored the values of the rituals and circumcised their children without fulfilling all the requirements.

Poverty gave the SMMCP great power, enabling organisations such as the AIDS Information Centres (AICs) to entice poor parents with free SMMCs for their children. The participants argued that these poor parents were tempted by the fact that the procedure was free but did not know what to do after circumcision. One said:

The poor parents are enticed with free medical circumcision but do not know what to do as regards traditional aspects of male circumcision. The boys are not taught about the values of being circumcised, yet, traditionally, the surgeons do the treatment and give these boys the importance of being circumcised

(Traditional Surgeon No. 9.).

The participants stated that traditionally, the Bamasaaba have never circumcised children under the age of fifteen. The participants noted that the AIDS Information Centre (AIC) comes in pickups ('bakkies') to the villages, collects small children, takes them for circumcision at the

health facilities, then returns them to their parents. When the researcher asked the participants why parents gave their consent, a Traditional Surgeon said:

> *The parents accept it because it is free, but sometimes AIC does not come back to check how the patients are doing. Occasionally, they come back after two weeks when the parents are stranded with the children*
>
> (Traditional Surgeon No. 4.).

Some participants believe that SMMC had been instituted with the express purpose of eradicating TMC and not because it is safe. These traditional surgeons believed that Western culture was purposefully incorporated into the health policies to weaken and eventually kill African culture and improve Western influence. Assimwe (2011) gives weight to this idea, explaining that the colonial administrators and missionaries attempted to eradicate the cultural practices of *imbalu* through Christianity, and lately, through human rights awareness programmes.

While some felt that the SMMC implementation would eventually eliminate TMC, most said that even when SMMC finally gained ground, the Bamasaaba would continue practising TMC.

These participants referred to organisations such as WHO and UNAIDS to back up their claim that socio-political factors such as HIV and human rights were being used to replace TMC with SMMC in the Bugisu sub-region. Colonialism and missionary activities had left a legacy of Westernisation, and the SMMCP, to them, was just a continuation of this legacy. However, these participants had a strong belief that traditional culture had the power to withstand such an onslaught. The Traditional Surgeon from Manafwa District stated:

> *The Western culture brings about these laws to weaken and eventually kill the African culture [rather] than to improve on them. The people's traditions are too strong and cannot be removed easily. Let me give you an example. The Kukusabini used to circumcise the women, but the government stopped them, saying they are violating the rights of women. Today the Kukusabini take their girls to Kenya to circumcise them and bring them back to Uganda when they are healed*
>
> (Traditional Surgeon No. 14.).

Some Traditional Surgeons said that the policies could not affect cultural practices if the Bamasaaba were united because male children are being born every day. The participants stated that since *imbalu* is spirit-led, the initiate becomes brave once the spirit enters the boy, and he faces the operation calmly. Participants expanded on the spiritual aspect, explaining how Traditional Surgeons are called to carry out their practice:

> *The spirits followed me from the mother's side, and I was seriously sick, then my parents moved me to the hospital, but there was no sickness in my body. Therefore, for them to know that this child will be a traditional surgeon, the spirit entered me at night in a dream, and I said, 'Papa, somebody is circumcising me often.' They took me to a spiritual healer who performed rituals, and I was given* inyembe *(the traditional knife). My parents did not want me to circumcise. They did not even tell me about it until it manifested again when I became a primary school teacher. Then I started running madly every season for TMC in the Bugisu region. The traditional healer told me that I am supposed to practise male circumcision traditionally. So, we cannot run away from this; it involves many things*
>
> (Traditional Surgeon No. 11.).

The researcher was curious to know to what extent the past rituals were still carried out today. Unlike some of the other participants, the Traditional Surgeons were positive and claimed that many rituals have continued. For example, when a man's newly initiated nephew comes to his home, he slaughters a goat or a hen for him and gives him a cow to begin his life after initiation.

This section has presented and analysed data from Traditional Surgeons, with responses indicating their total resistance to the implementation of the SMMCP. The following section offers insights from the focus groups.

6.5 The Response of Focus Groups to The Social and Cultural Implications of the SMMCP

In the focus groups, participants had fewer vested interests in upholding the rituals and practice of TMC and had mixed reactions to the matter of SMMC's social and cultural influence on *imbalu*. Some suggested the use of both traditional and medical practices to meet modern standards of living. They were aware that modern concepts of public health have significantly

distorted the historical and cultural aspect of TMC, causing tension between the practices of TMC and SMMC.

However, the practice of *imbalu* is resilient. Scholars such as Gusfield argue that "in assuming that new economic and political processes face an unchanging and uniform body of institutional procedures and cultural values, the linear theory of change greatly distorts the history and variety of civilisation" (Gusfield, 1967:352). In the case of the Bamasaaba, economic and political processes come up against a strong and resilient practice that embodies the essence of Bamasaaba constructions of masculinity and the Bamasaaba identity in general.

Some participants in the FGs proposed that public health workers should be better prepared to deal with the tension that emerges while they are implementing the SMMCP. Participant 4 of the FG in Manafwa said:

> *My friend, I see it is challenging. The public health workers, especially those in the Bugisu, should prepare to deal with the tension that emerges while implementing safe male medical circumcision. This may convey a vital element for the people who may want to embrace both traditional and medical practices of male circumcision*
>
> (P3, Focus Group No. 3.).

The participants stated that they depended on simple, unambiguous traditional methods to deal with the tension caused by the emergence of SMMC in the region. Some of these participants reiterated the traditional surgeons' claims that the benefits of SMMC had been exaggerated in order to degrade TMC. In acknowledging the pressures on traditional practice caused by the implementation of SMMC in the Bugisu sub-region, one of the participants said:

> *With the pressure exerted on the cultural practices, imbalu may be weakened or fade away if we are not careful. The implementation of male medical circumcision has gained ground*
>
> (P5, Focus Group No. 7.).

Other participants claimed that because of modernisation and the effects of SMMC, *imbalu* had been transformed into a mere procedure, like the medical intervention, emphasising the cosmetic aspect and penis modification for sexual pleasure. In justification of this claim, most

participants said that these aspects, so valued in the modern age, do not traditionally form part of the values embodied in *imbalu* in Bugisu communities.

They also pointed to the fact that status – expressed through material wealth – was now a far more significant consideration than ever before. In the past, *imbalu* conferred status on the newly circumcised man. Nowadays, on top of having to undergo TMC, one needed to acquire material wealth to gain status and be considered a man in Bugisu society. This, in the view of the participants, was just a fact of life, one that they neither seemed to support nor decry:

> *I need to have a powerful car, the most fabulous house and material evidence before the Bamasaaba can regard me as powerful among men. And I need to have authority with the qualities of a good leader in society. That is what can create an impact on the lady's perspective of my manhood, and that is the thing that is regarded as manhood by modern ladies*
>
> (P4, Focus Group No. 5.).

Participants discussed the contrast between TMC as practised by the Bamasaaba residing in urban areas and TMC as practised by those in rural areas. They felt that in this regard, the implementation of SMMC had positive spinoffs for parents in cities. One stated:

> *It is about culture and where you are situated. For example, a boy who grew up in the urban areas, e.g. Kampala or Jinja, and has experienced childhood in the town … you have never seen anybody doing traditional circumcision; you will not go either. In some cultures, some do it, and some do not, depending on where you live. For instance, my children do it traditionally, but my brother, who is married to a Musoga woman, does not bring his sons home for imbalu – he takes them to the hospital. He circumcises his children in the modern style since his children experienced their childhood in Jinja town. These boys will never compel their children to do it traditionally when they grow up*
>
> (P3, Focus Group No. 2.).

Studies conducted in Lesotho, Tanzania and South Africa by Skolnik et al. (2014), Odoyo-June et al. (2017) and Ortblad et al. (2018) respectively back up the assertion of these participants that urbanisation has strongly affected the practice of *imbalu.* These authors highlight SMMC

acceptability and uptake in younger, urban-dwelling men with higher education in older, rural populations. Certain group members of the FGs indicated that SMMC is accepted by the Bamasaaba residing in urban areas. However, traditional and cultural reasons were grounding for these men, who saw in TMC something of far greater value than medical benefits. A participant acknowledged that where one lived made the most significant difference to this view:

> *I think it will be distinctive whether you are in an urban situation or rural conditions. The rural … tend towards being more traditionally practical, and here cultural reasons would be more grounding than medical reasons. However, in a town like Mbale Central, where everything is multicultural, many people are losing their cultural practices to modern practices such as medical male circumcision for health reasons*
>
> (P6, Focus Group No. 6.).

Participant 6 in focus group number 6 said that cultural structures amongst the Bamasaaba have now accommodated modern use of medicine and helped resolve some of this tension by adapting to these new realities. Ironically, it seems that for many people, their reason for adopting SMMC may be social and cultural, as noted in the following statement:

> *The Bamasaaba response to SMMC is visible for social and cultural reasons … as long as it is not … intensively promoted by government structures through media and other means. I think it might eventually take over if left to gain ground in our communities*
>
> (P6, Focus Group No. 6.).

Gusfield (1967) states that people are bound to make assumptions in negotiating the tension between tradition and modernity. The participants said they did not assume but had witnessed the effects of the implementation of the SMMCP, which has resulted in conflict with traditional practices. The participants observed that health policy implementers try to present a wide range of alternatives to traditional techniques, thus attempting to shape it into ambiguous and much diluted attempts. These participants saw this desire to water down traditional practice as Western-inspired. The prevention of HIV transmission was just a pretext for undermining what Africa possessed and valued.

Participant 1 from the focus group discussion in Bududa had a low opinion of Western influence when it came to the essential practice of ceremonial circumcision and said that referring to male circumcision as 'Western-style meant it was for cowards. Participant 2 from focus group 7 concurred, stating:

> *Western people have not understood the vital role of male circumcision. They are introducing the Western-style of male circumcision. We, the Bamasaaba, especially the Bamasaaba men, have been circumcising from generation to generation. I do not think they have anything new to teach men, and they must embrace our culture so that we can educate them more about how to become a real man*
>
> (P2, Focus Group No. 7.).

Scholars such as Skolnik et al. (2014) claim that modernised medicine is regularly viewed as a part of Westernisation, with the WHO and UNAIDS presenting modern medication as an alternative to African societies' various traditions. The majority of the participants stated that it made no sense to try to introduce modern practices into the culture or tradition. Such practices were viewed with trepidation by local people. Participant 2, from focus group number 5, said:

> *I cannot say that I encourage it since I have never observed any proof that says that male circumcision can prevent the danger of getting HIV, especially if a man has unprotected sex with an infected woman. Some African communities might resist medical interventions for fear of eroding their cultural and traditional practices*
>
> (P2, Focus Group No. 5.).

Given the longstanding, well-documented history of TMC, the Bamasaaba appear to derive great fulfilment from maintaining their traditional practices (Wanyama, 2013). Participant 3 from focus group 1 commented on this very issue, stating:

> *I think the Bamasaaba men and women will feel that their cultures, traditions, beliefs, and customs are being undermined. I mean, imbalu has been practised for generations by Bugisu men. The medical method has just started in the Bugisu region and yet is developing quickly*
>
> (P3, Focus Group No. 1.).

The participants stated that in the past, everyone who belonged to the Islamic religion used to practise TMC, which seem to be not the case in modern society anymore. The claim by the participants confirmed Leadbeatter's (2012) assertion that historically TMC is linked to religious practices in African culture. A participant said:

> *In the Old Testament, the Bible says you are not permitted in paradise if not physically circumcised, but this changed in the New Testament. Men need to have male circumcision for religious reasons and will never have a motivation to change*
>
> (P8, Focus Group No. 7).

Discussing the cultural influence of SMMC, participants in some focus groups became very animated and alluded to reports of failed TMC, which the traditional surgeons had not mentioned. They discussed the matter of whether the Bamasaaba generally trusted TMC for their society. Participant 3 had certain criticisms of some of the stipulations of TMC, stating that cleanliness and hygiene could still be improved. In addition, he said:

> *There is no cleanliness at all! I do not like that one should not drink tea with sugar, and one must eat eggs with the eggshell for a specific time frame. This has stopped these days. Since I am not comfortable with such things, I am happy. I do not believe these are the correct thing. That is why I am stating that they may include more significant health considerations for male circumcision. At the same time, it is being done traditionally. Oh yes, they should consist of an agent of the health system for the safety of the initiates*
>
> (P4, Focus Group No. 3).

The above suggestion is an interesting comment on how SMMC and TMC may seek to find common ground. In this, the Bamasaaba may consider the SMMCP's implementation to adopt some health aspects into traditional practices of *imbalu* to make it safer for the Initiates.

As they discussed the effects of the medicalisation of traditional practices, some men announced that their children would have no option but to adhere to the cultural practice of *imbalu*:

You experience it traditionally. It is not just initiation; there are such a variety of things that are educational for the boy, to make him into a young man. So, my son needs to be traditionally circumcised. I suggest that it is not wrong to enhance traditional practices by including qualified health personnel to help traditional practitioners. The cultural way is the best. Not the medical male circumcision

(P3, Focus Group No. 6.).

Participant 8 from focus group 4 seemed to agree with this participant. He was happy about adopting some medical procedures to make TMC safer and more modern. He stated:

I agree that imbalu is vital in Bugisu, but it needs medical intervention to make it modern and safe. The way Bamasaaba did imbalu some time back was traditional, without considering Western ways. Currently, for us to spare the lives of the Bamasaaba men, we have to include Western-trained personnel such as nurses, medical officer, and community health care officers, particularly those who have experienced the medical or medical procedure. So, take Bamasaaba that are qualified, who have done it traditionally, to be the ones helping to educate men and women to use protection. I believe that it will enhance the lives of humankind in Bugisu, particularly the Bamasaaba men who may misunderstand male circumcision as natural prevention of HIV

(P8, Focus Group No. 2.).

Participants in the focus groups also discussed various advantages of medicalised practice and recommended that the Bamasaaba incorporate some aspects of SMMC into TMC to make it a joint approach. For this group of participants, an option was for the Bamasaaba men to use traditional-medical male circumcision as a transition for young men into adulthood, but with a medical surgeon present:

I think imbalu and safe male circumcision could be one practice that the Bamasaaba use to initiate boys to manhood. If not, Inzu ye Bamasaaba *must form some rules to regulate imbalu methodology to guarantee safety since the majority of the Bamasaaba demand to do TMC. Maybe traditional surgeons ought to consent to work with medical specialists as an inseparable unit*

(P2, Focus Group No. 7.).

The participants also stated that the government of Uganda should be involved in male circumcision by educating traditional surgeons through the Ministry of Health. The participants justified their suggestion by stating that traditional surgeons have practised *imbalu* for generations with no harmful effects. Most notably, a significant number of participants requested that government officials reach out to the Bamasaaba in general and clearly outline the critical dangers of *imbalu* in their communities. These participants similarly considered that this would ease the tension or conflict that existed between traditional practices and medicalised male circumcision in the Bugisu sub-region.

However, other focus groups members did not care about the tension or conflict between TMC and SMMC. This group of participants believed it was impossible to merge the two practices since the two forms of male circumcision are based on different ideologies. A group member stated:

> *I believe that blended male circumcision will meet with different sentiments from the Bamasaaba men. Furthermore, I think the social contrasts are likewise going to assume a critical role, you know. These two forms of male circumcision are done differently and for different reasons. The few Bamasaaba men and women will promptly welcome it, while the majority will not like it*
>
> (P2, Focus Group No. 6.).

Some conceded that although the SMMCP might be useful for society, the way in which it was implemented was not right. The issue of a lack of consultation came up again and again. A participant in the Manafwa focus group alluded to this, recommending a process of consultation with traditional leaders for the benefit of society:

> *Medical male circumcision is a good thing to do, yet the way that it has been implemented is not right. The legislature should involve the traditional groups such as clan leaders and other elders in the community, discuss with them, set up standard practices, and say this should be done to maintain people's culture and health.*
>
> (P3, Focus Group No. 2.).

From the presentation of data in this section, some participants in the focus group discusions indicated their reservation with regards to the implementation of the SMMC, especially in the Bugisu sub-region. Even though some participants indicated willingness to medicalise the cultural practices of *imbalu,* they also feel this could be the beginning of the erosion of traditional practices.

The following section presents and analyses data obtained from the 2016 Initiates.

6.6 The Response Of 2016 Initiates to the Social and Cultural Implications of the SMMCP

Responses from the 2016 Initiate group ranged in perspective, from a critique of SMMCP to an appreciation of its possible merits and concern about misunderstandings surrounding it. This section reflects these tensions and contradictions.

The 2016 Initiates admitted that increasing instances of HIV transmission are fuelling the implementation of the SMMCP, which they see as a colonial policy of the WHO and UNAIDS aimed at eliminating *imbalu*. This particular perception finds resonance in studies by Maposa (2011) and Asiimwe (2011), whose work examines efforts of 'the colonial masters' to eradicate TMC in African countries.

These participants stated that they are unsurprised at the Bamasaaba's reactions to the implementation of the SMMCP, as SMMC was not experienced as a life event for the Bamasaaba. They were sceptical about why the health policy restricted TMC yet promoted the SMMC, supposedly for HIV prevention. These participants frequently reflected on the social relevance of TMC and declared that they would never accept SMMC. One asserted:

> *No, I would not go for medical male circumcision just because it prevents HIV infection. We, the Bamasaaba, do imbalu for cultural reasons. If we are to prevent HIV, we will use the ABC method of preventing it. I realise that these methods are going to be ignored by circumcised people, especially us, the Bamasaaba. I am worried that the youth will be infected in big numbers because they have been told that medical male circumcision can prevent HIV by 60%*
>
> (2016 Initiate No. 1.).

Hodges et al. (2002) also refer to the possibility of increased HIV transmission as a result of SMMC. The views of the initiates showed that academics are justified in raising this concern since so many Bamasaaba believed SMMCP makes them resistant to the virus. This myth emerged as one of the main problems with SMMC, expressed by most participants. A 2016 initiate stated:

> *I imagine that many people who are medically circumcised are being encouraged to begin acting riskily. They would not use condoms since they believe that the danger of contracting HIV is lower when you are circumcised*
>
> (2016 Initiate No. 2.).

Following the participant's quote above, it seems as though any form of male circumcision (TMC and SMMC) should not be promoted just for health reasons. This is especially true if the Bamasaaba misunderstands the campaign of 60% safety assurance from HIV and AIDS infections. Initiate 1 had the same view:

> *I believe the implementation of medical male circumcision is somehow encouraging risky sexual behaviours in the youth*
>
> (2016 Initiate No. 1).

Kibira (2013) examined associations between risky sexual behaviour and circumcision status amongst men, finding that circumcised men engaged in risky sexual behaviours after undergoing medical circumcision. This tendency was borne out in input from a participant who remarked that men are now using circumcision as a reason to sleep around:

> *I think many people will then start to utilising it as a reason to sleep around and say, 'Well, look, I am circumcised.' So that is the reason why I do not support the SMMC. They must not emphasise it as part of a coordinated effort for safe sexual practices observed by the Ugandans. Otherwise, the Bamasaaba may misunderstand SMMC as a natural condom*
>
> (2016 Initiate No. 2.).

Nonetheless, almost all the participants in this category indicated that they frequently reflected on the social and traditional implications of SMMC and tended to talk about it positively when it came to society as a whole. When it came to themselves, the Bamasaaba felt exempted. In the words of one Initiate:

> *The SMMC is good but not for the Bamasaaba because we have our imbalu. Non-circumcising societies need to go with medical male circumcision. I said it before, and it is the time that most organisations join the Bamasaaba who are traditionally circumcising. They can adopt medical male circumcision, no problem. However, I am concerned, if most Ugandans do medical male circumcision, the government may declare medical male circumcision for all people*
>
> (2016 Initiate No. 1.).

The myth that circumcised men cannot acquire HIV needs to be broadly dispelled. Unless this issue is addressed, women will suffer further stigma and discrimination as vectors of HIV. And, dangerously, circumcised men may be falsely assumed to remain HIV-negative. The young men also felt that some Ugandans, especially the Bamasaaba, recognise the gravity of the HIV pandemic, as expressed in the following statement:

> *I believe we are aware of the HIV pandemic. Despite everything, we are not considering hospital circumcision important. I do not know that many individuals will go out and say, 'Let me get circumcised because I would prefer not to transmit HIV.' In contrast, the Bamasaaba do imbalu to accomplish social or religious purposes*
>
> (2016 Initiate No. 1).

These young men also felt that the government had the right to pass and implement health policies. The Bamasaaba should understand that the government was striving to save its people, regardless of cultural differences. However, they felt that the government should consider their request to protect cultural and traditional practices. The initiates indicated that cultural leaders needed to be at the forefront of the fight for their rights:

> *It is the government's right to pass policies, but cultural institution like ours should fight to preserve our cultural practices. Our people look up to them to*

see that the government does not do anything to affect the preservation of our traditional ways

(2016 Initiate No. 2.).

Their adherence to culture was expressed in numerous ways, and the initiates were willing to see it adapted in peripheral ways only for people's safety. These boys only preferred medical practices to allow them to heal faster. Still, they insisted that TMC is faster and could be done in a clean and safe environment by the traditional surgeons if regulated. The initiate in Bududa said:

They say that imbalu is unhealthy, but it is not true. The Bamasaaba like to practise their culture. It needs to be made safe and good for the people

(2016 Initiate No. 1).

The young men suggested that instead of trying to replace TMC, the government should rather think of strategies that modified and supported the *imbalu* practices of the Bamasaaba.

The participants in this category warned that if the government tried to stop *imbalu,* the Bamasaaba would be divided and degraded, a development that has already begun in the Bugisu sub-region. The participants were adamant that each area would want to practise male circumcision in its way. They pointed out that if *imbalu* were appropriately practised and supported by both local people and the government in its proper, comprehensive and traditional way, with hygiene, the *imbalu* season would act as a drawcard for Ugandans and this event tourism would add value to the culture of the whole country. This was particularly mentioned in one of the quotes by cultural leader number four, dreaming of making it a unifying factor for all Ugandans.

6.7 Summary of the Chapter

This chapter has presented and discussed data obtained from all the participants on the social and cultural implications of SMMCP and its impact on the traditional practice of *imbalu*. The data reveal three salient points; firstly, participants believed there was no need for them to adopt SMMC. Secondly, the Bamasaaba have mixed feelings about the implementation of the SMMCP, with some seeing its value and others having no place for it. Third, cultural

institutions and government were doing little to prevent stereotypes and failed to work toward an enhanced, comprehensive and safe form of male circumcision that was hygienic and safe. The training and registering of traditional surgeons clearly went some way towards regulating the practice. Still, the acknowledgement of the vital role played by the TMC among the Bamasaaba was insufficiently recognised, in the view of most.

Criticism was levelled at the cultural institutions, which did little to advise the government on the cultural value of *imbalu*. The result is that stereotypes and beliefs are coupled with the neglect of concrete guidance for society. The participants felt that negative responses towards the SMMCP are still rife among the Bamasaaba. Some suggested merging the two forms of male circumcision to simultaneously protect the cultural practice and ensure healthy practices. However, not all would concur with this idea since the underlying ideologies of each form were so different.

The following chapter presents a discourse on masculinity as constructed by the Bamasaaba through TMC and how it plays into its response to SMMCP.

CHAPTER SEVEN

THE BAMASAABAS' CONSTRUCTION OF MASCULINITY THROUGH TMC AND IN RESPONSE TO THE SMMCP

7.1 Introduction

In this chapter, the Bamasaaba's responses to both TMC and SMMC are subject to analysis through the lens of gender theories of masculinity, as espoused by Connell (1995). Messerchmidt (2019) reflects on how Connell (1995) builds a hegemonic masculinity theory that rests on four non-hegemonic masculinities: complicit, subordinate, marginalised, and protest masculinities. Connell's approach provides an essential framework against which to view the Bamasaabas' understanding of masculinity. Messerschmidt (2019: 86-87) explains the theory as follows:

> Connell argued that hegemonic masculinity is constructed with four specific non-hegemonic masculinities: first, complicit masculinities do not embody hegemonic masculinity yet through practice realise some of the benefits of unequal gender relations and consequently, when practised, help sustain hegemonic masculinity; second, subordinate masculinities are constructed as lesser than or aberrant and deviant to hegemonic masculinity, such as effeminate men; third, marginalised masculinities are trivialised and discriminated against because of unequal relations external to gender relations, such as class, race, ethnicity, and age; and finally, protest masculinities are constructed as compensatory hyper-masculinity that is formed in reaction to social positions lacking economic and political power.

The unstructured interviews provided insights relating to the Bamasaabas' views on the concept of masculinity. The chapter aims to determine the impact of current medicalised practices on the Bamasaaba's understanding of this central concept. Results were obtained from Cultural Leaders, Clan Leaders, Traditional Surgeons, Clinical Officers, 2016 Initiates, Focus Groups (FGs), and the key informant representative of *Inzu ye Bamasaaba*.

In the section that follows, data from the cultural and clan leaders are presented and analysed.

7.2 Cultural and Clan Leaders' Perspectives on Masculinity in Relation to TMC and SMMCP

The Cultural and Clan Leaders said that boys are subjected to certain conditions during the initiation process that entitled them to be called 'men'. For instance, they undergo pain, and, in addition, circumcised men and elders are encouraged to admonish the boys freely. In some communities, especially in South Africa, these harsh conditions have resulted in hundreds of boys dying, and it was not reported. According to Makwa (2010), the men's admonishments emphasise that all Bagisu males must undergo *imbalu* to prove themselves before they will be recognised as 'real men' with the right to get married, produce children. The participants pointed out that SMMC does not involve this critical aspect of transforming boys into men. It becomes interesting that the group that supports the transformation of cultural practices see this as not being entirely correct.

The Cultural and Clan Leaders stated that any of the Bamasaaba males who had not fulfilled initiation conditions would not qualify to be called men. The notion of masculinity for the Bamasaaba is embodied in the concept of *Umsani Burwa*, which is similar to the Xhosa notion of *indoda* (Mfecane, 2016), meaning a traditionally circumcised person. Among the Bamasaaba, 'manhood' means that parents agree to circumcise their male children traditionally so that they can experience pain, as tradition demands. The cultural leaders acknowledged that facing one's inherent dread of pain is a significant aspect of the cultural process of *imbalu* and is what makes boys men. This Cultural Leader said:

> *Men will maintain a strategic distance from medical male circumcision because it reduces pain, which is the vital aspect of being a man. In light of the pain … I am terrified of the pain, though I had traditional male circumcision. Until today, I do not know how it happened, and maybe that is why it is believed that male circumcision is spiritually motivated*
>
> (Cultural Leader No. 6.).

According to most participants, a non-appreciation of the function of pain in TMC has made medical professionals critical of the cultural practice. Nyamweza et al. (2016) point out that public campaigns to discredit *imbalu* and promote SMMC focus on the fact that SMMC is a 'minor' operation, which is 'not painful'. The participants pointed out that in Bugisu

communities, men are discouraged from undergoing SMMC for the very reason that it reduces pain. Pain endurance is a critical construct of masculinity for the Bamasaaba. Boys demonstrate courage, bravery, toughness, hardness and strength, the same way as it is presented in Kivel's (2006) concept of the manhood box (see pg 41). They hope that TMC will one day be appreciated by all Ugandan men:

> *Of course, the most important element of imbalu to the Bamasaaba is pain. The Bamasaaba associates the pain of imbalu with bravery, and a man needs to be brave and strong. Furthermore, if most Ugandans do traditional male circumcision, it will reveal that they do declare it a critical cultural practice*
>
> (Cultural Leader No. 3.).

Khanakwa (2016) states that only when boys stand upright, withstanding the pain of *imbalu* and undergo the relevant rituals, are they qualified to be called 'real men'. However, with their emphasis on the demonstration of masculinity mainly through pain endurance and other TMC rituals, the Bamasaaba may simultaneously be failing to recognise the gravity of the HIV pandemic. The participants confirmed that the Bamasaaba have not responded well to HIV educational campaigns or policies that promote SMMC.

The Clan Leaders stated that the rituals and the tradition of slaughtering form part of the ceremony and worship and communicate with God, enabling the young men to withstand the pain of *imbalu*. A Clan Leader in Bududa stated:

> *Pouring blood through slaughtering animals like goats, cocks, bulls, and hens in our culture means boys' dedication to our ancestors. We do this for boys to stand upright and withstand the pain of imbalu. The ritual of bloodshed, stepping on the gravesite, roasting meat, roasting* matooke *(bananas) and eating at the gravesite means sharing with the dead and creating a relationship with your ancestors to give you the courage to stand the pain of the knife as a brave man. For example, the boy or boys on the day of traditional male circumcision are taken to step on* his father's khusirindwa (the grave)*, if no more, or the grandfather, to say this is my day of blood sacrifice and pain endurance*
>
> (Clan Leader No. 3).

The Clan Leader from Manafwa concurred that pain endurance is a fundamental component of the rite of passage from boyhood to manhood in TMC. In addition to pain endurance, he said that initiates had to endure other forms of extreme discomfort, such as being deprived of water and having their bodies covered in substances to make them look like animals:

> *During the initiation process in the Bugisu, there are different things that we do which are more painful than the actual cutting of the foreskin of a Mugisu man. Things like smearing the boys with millet flour, mud, animal dung and clay soil to look different from men and be like animals in the bush*
>
> (Clan Leader No. 1.).

The young boys mainly endure the discomfort by smearing them from head to toe with local herbs and other mixtures, and they are brought in front of a jubilating crowd to "face the knife" under everybody's careful gaze. The pictures below show how these boys are made to look different from other men dancing a combination of *Bitsenze* and drumming popularly known as *Kadoodi*. See Figure 7.18 below.

Figure 7.18: The Ritual of Smearing Boys During Imbalu Ceremonies

Google Images

Figure 7.19: Imbalu Aspirants Dancing Isonja in Bududa District

Source: Google Images.

Similarly, boys from Bududa perform their cultural dance known as *Isonja* or *Bitsenze* before they are traditionally circumcised. See Figure 7.19 above.

Mhlahlo (2009) reports a similar aspect during Xhosa boys' initiation in the Eastern Cape in South Africa. He states that the initiates are presented as animals and that this symbolic identification with animal forms part of the process of being transformed into a man. The participants emphasised that all of this was demanding on the body and mind of the young man. Also, any boy unwilling to go through these conditions, who elects to undergo SMMC to escape pain, will not be regarded as a man. Clan Leader 3 said:

> *If a boy has any desire to undergo safe medical male circumcision because of the fear of pain, he will not be regarded as a man in Bugisu. We always tell the boys that they should not stress about the pain; it is the thing that makes him* umusaani burwa, *a real man*
>
> (Clan Leader No. 3).

In general, the participants showed that hegemonic masculinity among the Bamasaaba is constructed by defeating pain and enduring TMC as a cultural practice. In a follow-up question, the researcher asked whether it was possible for SMMC to make one a man. One of the participants in an individual interview pointed to an interesting aspect of SMMC. He said that

it caused a deeper kind of pain than merely physical, yet was still unable to qualify a boy as a man:

> *A man can defeat pain after male circumcision, which must last for a specific period for specific cultural reasons. Safe medical male circumcision is a surgical practice for HIV prevention, which causes emotional, psychological and spiritual pain but does not make one a man*
>
> (Clan Leader No. 4.).

Howard-Payne and Bowman (2017) state that medicalising male circumcision may create tension between tradition and medical practices. The meanings associated with the two approaches differ, particularly in terms of masculinity and the traditional rite of passage to manhood. The follow-up question was whether a medically circumcised man could be regarded as a real man. Responses were mixed. According to some males, circumcision has connotations of masculinity while respecting how a man's body is naturally created. Other participants appeared to have evaluated the issue and said SMMC was a display of manhood adjusted to the medical setting. The participant who said this continued:

> *I think that medically circumcised men may be great men. In my opinion, manhood means being healthy, clean and strong to protect your family*
>
> (Clan Leader No. 7.).

However, this comment was not in line with the majority of thinking. All, including the man who made the above comment, were unanimous that it was unacceptable for a woman to perform male circumcision in the hospital setting. Schenker (2007) states that trained male or female personnel take only thirty minutes to perform SMMC in the hospital setting; whereafter nurses dress the wound. This is obviously contrary to the Bamasaaba's cultural practice of male circumcision, which is an exclusively male preserve and where women play a supporting role only, which is unrelated to the actual practice of circumcision. A significant number of participants appeared to feel that current health policies undermine their masculinity, notably if they are to be circumcised by female doctors in the hospital.

However, one of the clan leaders said that he would support a redefined or reviewed health policies on male circumcision. Clan and Cultural Leaders who were identified as born-again

Christians were at odds with the majority in expressing strong criticism of TMC; they said that it promotes tension, hierarchical separation, unhealthy forms of control, and violence among the Bamasaaba men.

7.3 Traditional Surgeons' Perspectives on Masculinity in Relation to TMC and SMMCP

The section examines data obtained from Traditional Surgeons. It assesses their views for discourse markers that reveal what constitutes 'masculinity for them.

In general, this group saw the existence of SMMC as a threat to their social dominance as circumcised men. For them, manhood was a domain entered into only via blood sacrifice and pain endurance which found expression in well-defined gender roles in society. According to these cultural practitioners, it is only through the TMC ritual that male members of the community learn self-control and later acquire power, strength and social control. Having this view of what constitutes masculinity, the Traditional Surgeons responded negatively to the implementation of SMMC. In the words of a participant:

> *I think the people's reaction towards the health policy is very negative since they feel that their culture emphasises that a man should face the pain of the knife traditionally to acquire prestige and power among his fellow the Bamasaaba men, is being threatened. Moreover, this is what makes the Bamasaaba who they are, and we believe in the right way to do things – but not the government way*
>
> (Traditional Surgeon No. 1.).

Another Traditional Surgeon reiterated the idea that the only socially acceptable form of male identity was achieved through blood sacrifice and pain and faced with bravery. The concepts included in the manhood box on page 41 by Kivel (2006:2), which he considered socially valued roles and expectations that constitute conventional masculinity. On this very issue, the Traditional Surgeon stated:

> *Pain is dependably there, and it takes a brave one to stand it. Notwithstanding, when you are working, you encounter pain. There is nothing that does not generate pain, and even when you overeat, you experience excessive pain. According to the Bamasaaba, pain*

during circumcision is a minor thing so that men will not evade pain. Maintaining a strategic distance from pain is not essential in this issue since it is temporary. However, with safe medical male circumcision, there is less pain at cutting, but you encounter pain during the healing process

(Traditional Surgeon No. 4.).

Van Vuuren and De Jongh (1999) conducted a study that corroborates these Traditional Surgeons' input. The former points out that in Xhosa culture, what 'makes a man is his ability to endure harsh conditions. Similarly, one of the Traditional Surgeons from Manafwa referred to the pain of TMC as its most crucial aspect since it symbolises future hardships. This view of manhood underscores the idea that the pain endured during TMC both exemplifies and prepares one for endurance, bravery, stamina and stoicism – all constructs of masculinity according to Mfecane (2016)– over the long term. The participant said:

I think pain is more vital because it shows a boy the harsh conditions and hardships a man should go through. This is the reason why you can consider what transpired that day for the rest of your life, and it is taboo in the Bugisu to forget your surgeon

(Traditional Surgeon No. 8.).

The participants' views represented in this section converge around the idea that masculine hegemony is gained through the pain of TMC. Their belief in the function of ritual pain to inculcate personal control and eventual control of one's family and social situations is strongly suggestive of the hegemonic masculinity that prevails among the Bamasaaba. To return to Messerschmidt's definition (2019:87), TMC has the effect of entrenching "the concept of alleged discrete and distinct "bearers" of hegemonic masculinity". Instead, TMC is recognising that all participants constitute unequal gender relationships, which are collective orchestrators of hegemonic masculinity. According to the traditional surgeons, TMC itself is such a 'bearer' of hegemonic masculinity.

7.4 The Focus Groups' Perspective on Masculinity in Relation to TMC and SMMCP

This section presents data collected from the focus groups. Data is analysed for information it might yield on the concept of a constructed masculinity within the framework of

Messerschmidt's theory on forms of masculinity. Questions sought to uncover areas of conflict that could arise between SMMC and TMC in the performance of masculinity.

Hearn (2004) argues that hegemonic masculinity refers to both cultural representations and everyday practices of toughness, aggression and bravery, which are not in any way related to the unequal institutional structures described by other scholars. Thus, the first question these participants responded to was whether traditional practices of male circumcision brought about inequalities that might be detectable in everyday life. Participant 5, in FG 4, stated:

> *We are all equal; however, when you are not traditionally circumcised in some societies, you are not viewed as a man; you are viewed as a boy*
>
> (P5, Focus Group No. 4.).

Humphries et al. (2015) assume that masculinity and male sexual identity are interlinked and possibly influence SMMC uptake; an understanding of these factors and how they manifest in various contexts is crucial to overcoming this as a barrier to uptake. The idea that masculinity can be acquired and that as an acquisition entitles the bearer to social esteem or respect is an expectation that involves the rest of society. This view of the social 'proof' of masculinity emerged from an FG in Bududa where participants spoke of undergoing TMC to obtain their manhood status in others' eyes, which remains a barrier to SMMC uptake. Participant 1, from the focus group, stated:

> *To me, the significance of traditional male circumcision is an acquisition of masculinity. This is because the new men coming out of* mwikombe *(initiation school) are highly esteemed. This man can do things that the elders in that particular society do*
>
> (P1, Focus Group No. 5).

Thus, for this participant, social esteem and the respect of others is an essential component of hegemonic masculinity, acquired only through the specific practice of TMC. However, more complex and nuanced views of what constitutes masculinity were also expressed by participants, who began to reveal more profound and sometimes contradictory statements as conversations went on. In revealing other aspects of what constitutes masculinity, participants showed themselves highly aware of changing norms in society, with the elements of time and social progress featuring strongly. Some felt that TMC alone does not produce real men able

to cope with the demands of the 21st century. They pointed to the general moral and social deterioration in society, where traditionally circumcised young Bugisu men misbehaved and disrespected everybody in the home after undergoing TMC. One participant stated:

> *You find that before boys are circumcised, they help with errands around the house, like cleaning the compound and fetching water. However, when they are circumcised, their behaviour is entirely unacceptable. When you request that they do this, they begin grumbling, and others start the habit of smoking and drinking. I do not think that is being a man. Your activities should fulfil your obligations. You should realise that as a man, you should be responsible, not irresponsible*
>
> (P 8, Focus Group No.1.).

An 'outsider' perspective such as this opened the discussion and led to lively debates on how masculinity manifests post-TMC. A slightly more complex perspective on the notion of masculinity began to emerge in several groups. Eventually, the question was posed as to how outsiders to TMC tradition would perceive the Bamasaaba's ritual of initiation into manhood and its effects. This question became an essential element of the investigation since responses cast light on the execution of manhood as displayed socially post TMC.

Participants stated there were various routes through which they could demonstrate their responsibilities as men. Most explained these in general terms, indicating that men had to demonstrate the 'social qualities of individual manhood' after TMC, as one put it. Although TMC guaranteed initial social acceptance as a man, the qualities of manhood had to be lived and expressed after TMC in order to maintain this social acceptance. A focus group member stated:

> *Undergoing a safe medical male circumcision can make you a man. This is about the social qualities of individual manhood; I think it does not have any effect. I mean, it depends on whether you practise what you are told to be after imbalu or not. It is merely stereotyped. Everything falls under the social viewpoint. I am not one of those individuals with a specific mentality that if you have removed your foreskin, you are a man. An essential issue here is whether you are practising what you have been taught during the initiation process*
>
> (P 6, Focus Group No. 4.).

For the Bamasaaba, according to these participants, masculinity is achieved firstly through undergoing TMC, but its ongoing expression is found in powerful physical wellbeing, risk-taking and bravery.

The TMC ceremony itself demanded these qualities through the harsh conditions it presented to initiates. Some felt these conditions were unnecessarily harsh. Participant 8, who identified himself as a pastor, supported *imbalu* while rejecting the extreme conditions, stating:

> *The reason why our children are dying is an attempt to prove that they are men after the traditional male circumcision process. There are cruel conditions during the* kadodi *dance; the Bamasaaba must refrain from these brutal conditions to make the imbalu practice enjoyable. I do not mind my children undergoing safe male circumcision to avoid this commotion. They must alter this tradition into a protected one; after all, they all are men*
>
> (P 8, Focus Group No. 7.).

This participant continued to differ from other members of his focus group by stating that manhood was not bound to TMC. In this case, it became clear that the underlying ideology, in the form of strongly held religious views, shaped this man's overall assessment of masculinity and how it is acquired. His views were echoed by another who identified as a Christian. These men, it seemed, broadened the definition of masculinity by shifting the focus from the event to the personal qualities that needed to be developed to become a real man:

> *It is not the traditional male circumcision; it is the thing … the way the Bamasaaba culture defines imbalu among the Bugisu. The Bamasaaba's culture says that imbalu makes you a man. However, as a Christian, I will say that imbalu has created a patriarchal society, particularly in the Bugisu*
>
> (P 8, Focus Group No. 2.).

This participant picked up an important indicator in any discourse on masculinity, namely the concept of patriarchy. Most agreed that Uganda is a patriarchal society but that not all communities performed TMC; therefore, patriarchy in not created by TMC. However, as the above participants added, boys acquire patriarchal characteristics in the process of transforming

them into brave and mature men. Almost all the participants in this focus group had similar views on the matter of TMC and the patriarchal tendencies in their society. One put it this way:

> *It is simply an issue of being traditionally circumcised and becoming a man in a man's world. I believe it is a way of religion and culture … but not to obtain the power of control or to enforce patriarchy in the Bugisu society*
>
> (P 6, Focus Group No. 6.).

Similarly, Robertson (2007) stated that patriarchal power prevalent in most societies influences some men to exhibit the qualities of complicit masculinity. In this form of masculinity, men who do not personally demonstrate dominant or patriarchal qualities go along with prevailing views without challenging them and therefore entrench hegemonic masculinity. A small group of participants in the focus group repeatedly raised the issue of patriarchy. One participant said that TMC is the tradition of placing men in positions of control in Bugisu communities. He said:

> *In my opinion, I view imbalu as the mechanism of putting men in certain positions of control. In particular, I think men acquire the power to control women and other men who are not traditionally or uncircumcised men in the Bugisu communities*
>
> (P2, Focus Group No. 4.).

From this participant's perspective, it is primarily through *imbalu* that men acquire authority to exercise control, especially over the women in their society. Since not all Ugandan men go through *imbalu*, it appears that participation in the ritual reinforces and upholds patriarchy without creating it.

Despite some acknowledgement that the qualities of manhood are developed over time, participants repeatedly returned to the theme of pain endurance and the central place of TMC in making one a man. Immediately after the operation, young men typically beat their chests while others hold the fresh wound and rub it firmly in both hands with surgical spirit or water to indicate that they are brave men. Participant four from a focus group in the Manafwa District strongly believed that manhood is picked up in the process of *imbalu* since the rituals effect a change in the soul that is deeper than the social demonstration of masculinity. Participant six

concurred, explaining the contrast between traditionally circumcised men and medically circumcised men as follows:

> *Traditionally circumcised men are more intense than medically circumcised men, who feel isolated and less of men. You can identify traditionally or medically circumcised men naturally through their conduct or characters in society*
>
> (P1, Focus Group No. 6.).

All of the participants in this group expressed deep support for the practice of traditional male circumcision in their communities. The majority stated that they would rather circumcise their male children in their backyard without performing the rituals of *imbalu* than take them to a hospital for male circumcision. One participant said he did not practise the TMC rituals but was circumcised at home where he could undergo pain and demonstrate the acquisition of manhood. However, he later adjusted his claim, stating that whether men are traditionally or medically circumcised, they all face the same social challenges as men in modern society. He said:

> *Oh, my God, imbalu is significant in Bugisu, yes, no doubt. However, there is no distinction between the two when it comes to social challenges; I see traditionally circumcised men and medically circumcised men going through the same difficulties to provide for their families. I think their employment is the same. As the Bamasaaba, we need to stop thinking that we are better than people from other places because of the rituals we perform during the imbalu ceremonies*
>
> (P8, Focus Group No. 1.).

As conversations progressed, participants often broadened their discussion. They conceded that TMC was no guarantee of the ability to function as men in society, as all men are expected to go through the same challenges. Other elements of manhood that were raised had less to do with personal qualities and more to do with the role played by a man in his family and society. This indicates that the definition of masculinity was still centred mainly around demonstrable actions and roles played rather than personal qualities. Participants pointed out that uncircumcised men had houses, spouses and children, and circumcised men had similar things. Participant 6 expressed this view:

I think it must be about how you fulfil a woman's sexual desires, her conjugal rights, and how you characterise yourself in public is what matters most. The entire issue for the Bamasaaba men is about getting rid of the foreskin, which keeps on blowing the whistle in their mind that discloses to them that they are now circumcised men. They put their mind off their goals and feel content with what they have

(P 3, Focus Group No. 5.).

Most participants in the focus groups agreed that women in the Bugisu sub-region would look for men who had survival qualities. In addition, participants stated that real men would look forward to fulfilling their family responsibilities and taking good care of their women and children. These qualities, as participant 6 in focus group number 3 pointed out, are just as visible as whether or not one has a foreskin:

It is mainly how I can accommodate my better half, plant a seed, take our children to school, and take good care of them, too. The foreskin or not ... every one of those things is seen as well. So, whether you have your foreskin or not does have anything to do with manhood at present

(P6, Focus Group No. 3).

Some went as far as saying that focussing exclusively on male circumcision, whether through TMC or SMMC, was a waste of time when it came to the question of acquiring masculinity in modern society. Wanyama and Egesah (2015) stated that TMC rituals have social, spiritual, physical and psychological implications. These aspects come into play primarily through relationship-building, which occurs through ongoing contact and interactions with family members, friends and society at large. In support of these scholars, one of the participants in a FG stated:

I think the Bamasaaba men are wasting time on traditions, subjecting boys to moving from one house to another. Men are all the same; it is the matter of your identity, whether you are a man. Whether you are circumcised or not, it is similar; it is how you see life and individuals around you and how you mingle. I imagine and figure out what a lesser man is. My advice to the Bamasaaba is to take your children to school and forget about imbalu and umusaani burwa. *Be a real man in modern society*

(P5, Focus Group No 7.).

Many participants regretted that *imbalu* was no longer valued as it used to be as a rite of passage to manhood. They acknowledged that masculinity has become defined in relation to specific behaviours that demonstrate hegemonic masculinity. Some observed how the Bamasaba had started to recognise medically circumcised men as real men without requiring them to go through traditional initiation rituals. They pointed out that some medically circumcised men were more mature than those who had been traditionally circumcised. A participant remarked:

> *The Bamasaaba … tell me, have you not seen medically circumcised men who are more mature than the so-called traditionally circumcised men? I have seen the individuals who are circumcised acting like crazy people. So, doesn't imbalu have any importance? It is about the mental development of a person; it is not about circumcising a person*
>
> (P13, Focus Group No. 4.).

Other participants believed that since the nature of the procedure does not allow one to experience pain, one does not transition to manhood. According to the Bamasaaba, an integral part of attaining manhood is to withstand pain while going through the ritual. The issue was contentious, and participant 9 strongly disagreed:

> *No, what are you talking about? I do not think medical male circumcision will characterise somebody as a man; a man is characterised by his decisions and what he believes in. The Bamasaaba men who are medically circumcised do not know who they are. Moreover, some men who missed their ancestors' blessings are settling on the terrible decisions they made in life. They act in a non-masculine manner and do not assume the full obligation of being men*
>
> (P9, Focus Group No. 4.).

Interestingly, this participant concurred that his decisions characterise a man and what he believes in but that these personal qualities depend on having undergone TMC. In effect, he sees the inner qualities of manhood, such as the ability to make good decisions, as inextricably linked to TMC – without TMC, he seemed to be saying, there may be no ability to act like a man.

For Participant 7 from the focus group in Manafwa, masculinity is quantifiable in relation to one's capacity to draw female sexual partners. For him and those who agreed with him, manhood is unquestionably associated with the presence or absence of a foreskin since the Bamasaaba women were more likely to reject an uncircumcised Mugisu man as a sexual partner. The woman might report any uncircumcised man to the elders. Participant 7 in this group said:

> *A few ladies will disclose to you straight that I do not engage in sexual relationships with a man with a foreskin, condom or not. They do not care how you feel and sometimes report the man to the elders. 'It is not clean,' and so forth*
>
> (P7, Focus Group No. 7.).

The participants stated that if identified as uncircumcised, the Bamasaaba men are forced to circumcise traditionally. For this reason, they claimed some men choose to undergo SMMC. The participants reported that some non-Bamasaaba men who live in the Bugisu sub-region experienced TMC of their own accord to find acceptance in the Bugisu society. Interestingly, Grund et al. (2019) found that seven studies reported high-consistency evidence for a positive relationship between male circumcision and women's sexual satisfaction. The measures were heterogeneous across all these studies, including the level of sexual satisfaction revealed.

On this point, many participants concurred. They noted that for this reason, some men in communities that do not practise TMC have opted for SMMC; they believed that it enabled them to satisfy their partners sexually. They agreed that historically in Bugisu lore, *imbalu* was strongly influenced by women since it was a woman who influenced the first Mugisu man to circumcise their children. The men agreed that women played a strong role in pushing them toward circumcision but denied that a woman would ever persuade them to undergo SMMC. One participant stated:

> *A woman from Iburwa influenced our ancestor to be circumcised. This history keeps on repeating, where men from other tribes are receiving traditional male circumcision because of the Bamasaaba women. I have seen some of the Bamasaaba men also running to the hospital for a circumcision. I will rather say no to hospital circumcision because I will lose my dignity as being a proud Mugisu man as I am currently*
>
> (P 18, Focus Group No. 4.).

Considering the part women play in influencing men to undergo TMC, the participants agreed that women's influence was not uncommon in the Bugisu sub-region, even among the non-Bamasaaba men who culturally did not need to circumcise. Some noted that certain men chose to go for SMMC to please their sexual partners. However, most reiterated that they would oppose their partners for suggesting SMMC. One argued:

> *For me, it will be something new as a traditional man. I will oppose that one, and I do not care if the relationship ends. It is my body and my life; the woman cannot decide what I must do with it. She cannot even suggest SMMC to me as a Mugisu man. Our women know that we do imbalu for cultural, not for medical reasons, in the Bugisu sub-region*
>
> (P 16, Focus Group No. 4.).

In another discussion, participants confirmed that the Bamasaaba women could not generally influence a man to circumcise medically. The participants asserted that both the Bamasaaba men and women are proud of their culture of *imbalu* and would subscribe to rigid standards to preserve it. Participant 4 expressed the view of typical hegemonic masculinity in saying:

> *As a traditional Mugisu man, I would say no to my female partner, proposing that I experience male medical circumcision on the grounds of pride and to maintain that ego of* umusaani burwa *[brave man]*
>
> (P 4, Focus Group No. 1.).

In the same way, Mark et al. (2012) and Rennie et al. (2015) state that in settings where circumcision is practised for cultural reasons, it was reported that males would disapprove of medical circumcision because of the pride and ego men acquire during traditional circumcision. Some of the participants touched on the subject of pride and ego in remarking that as men who originated from a community practising TMC, they are considered unique and that there was a fundamental difference between traditional and medically circumcised men:

> *I do believe being traditionally circumcised makes a man unique. I do consider them as lesser men for not demonstrating their braveness in public. I discover that they are or they are not (traditionally circumcised) as the case may be. The same applies to my friends that I have seen medically circumcised; it truly affects them socially*

(P 2, Focus Group No. 6.).

The participants frequently used the reference *umusaani burwa* (brave man) when referring to the concept of masculinity and TMC. This tendency is echoed in what Mfecane (2016) found concerning Xhosa notions of masculinity embodied in the idea of *indoda* (man). The participants frequently expressed that masculinity is incorporated in the prestigious honour of being considered *umusaani burwa.* However, the acquisition of masculinity was deeper than attaining honour, which is a social construct; for most, it was a spiritual change that took place deep within and manifested later as pride, strength, stoicism, etc. – all the qualities of hegemonic masculinity. A participant articulated it thus:

> *It is most likely the procedure they experience, I imagine. You know, similar to the cultural contrasts. I know it is significantly more than just having the foreskin removed. I believe it is kind of a soul-changing experience that we experience to be Umusaani Burwa. So, it is likely more than the experience of not having a foreskin.*
>
> (P3, Focus Group No. 7.).

Participants returned to the element of bravery, claiming that the practice of TMC is part of the transitional experience that confers the quality of courage in the soul. Gilmore (1990) and Courtney (2000) stated that acquiring manhood involves high-risk demands in which men show signs of strength, aggression and impassiveness. Confirming this observation and adding to the idea of a profound inner conversion, a participant stated:

> *This is about being a brave man with the strength and ability to endure pain. During the imbalu process, the dancing, they put you under certain conditions, whereby you can see that here I can assume full responsibility as a real man. The lessons that we get from elders transform us, and after being initiated and returning from* mwikombe *[the initiation school], you return as a changed individual*
>
> (P6, Focus Group No. 3.).

Terms such as ‘soul-changing (focus group 7, above) and ‘return as a changed individual’ (focus group 3, above) speak to the spiritual transformation that is thought to take place during the *imbalu* ritual. In using these phrases, the participants suggest that masculinity is a condition that is ontological in nature.

Different groups restated the demand that men in Bugisu demonstrate their male character through the cultural practice of *imbalu*. A participant said:

> *Being circumcised in the Bugisu region is an obligation for men to demonstrate their muscular character. In our culture, that is the major significance of imbalu. While in* mwikombe *(initiation school), they show you about self-control, confidence and regard, which is the essential significance of being a man in the Bugisu community*
>
> (P5. Focus Group No. 1.).

Thus, in various ways, these participants expressed the idea of bravery, self-control and confidence being spiritually conferred, reinforced through teachings, and demonstrated in practical ways through traditional circumcision. It combines all three aspects that make this ritual central to the Bamasaaba constructions of masculinity.

The following section presents data obtained from the key informant as the custodian of the cultural institutions in the Bugisu sub-region.

7.5 The Key Informant's Perspective on Masculinity in Relation to TMC and SMMCP

This participant focussed on the importance of preserving the Bamasaaba culture through the practice of male circumcision in the Bugisu sub-region. He believed that the traditional practice of penis alteration demonstrates manhood and positively reinforces patriarchy. The Bamasaaba look up to men in cultural leadership to take complete control over their cultural practice of *imbalu*. He stated:

> *In a distinguished Mugisu man, hegemonic masculinity is accomplished through traditional male circumcision. Oh, yes, to me, it is about manhood rather than anything else. If you need to be a man, you must receive traditional male circumcision in our society*
>
> (Inzu ye Bamasaaba.).

It was quite impressive that the key informant was able to articulate what hegemony meant to him. As indicated in the quote (Inzu ye Bamasaaba), mentioning *hegemonic masculinity* and explaining what it means indicates that it would be difficult to convince the believers of TMC to adopt the SMMC. The participant observed that while the Bamasaaba has not accepted modernised practices such as SMMC, the government is imposing these. This had forced changes in how the Bamasaaaba construct masculinity. He expressed his concern as follows:

> *As I said, imbalu is a tradition with a long-standing history, something that for centuries has been highly esteemed by the Bamasaaba, which is brought to the 21st century and turns into a confounding issue. As much as the Bamasaaba has not accepted the modern practice of traditional male circumcision, they are forced to adopt it. Masculinity performance is too complicated because what made you a man then is not what makes you a man today*
>
> (Inzu ye Bamasaaba.).

According to Khumalo-Sakutukwa et al. (2013), culture significantly affects individual perceptions and acceptability of SMMC because of the meanings people attach to the procedure. Studies have shown that certain ethnic groups who historical practice traditional rituals, attached to male circumcision, disapprove of SMMC (Kitara et al., 2013; Ortblad et al., 2018). At the same time, the participant strongly resisted these changes and stressed that it was only TMC that had the power to make one a man – not SMMC:

> *In Bugisu, when you do male circumcision for cultural or traditional purposes, everybody will say that you are a brave man who qualifies you as a real man now. I want you to get me right; it is when you do it for traditional reasons, as it were*
>
> (Inzu ye Bamasaaba).

He observed that boys often misbehave after undergoing initiation rituals, explaining that their unruly behaviour was a result of their experiencing the procedure while still too young. In the past, *imbalu* was for mature boys who were ready to get married:

> *In the past, imbalu was made for the boys who were ready to get married, the boys who had passed the adolescent stage. But these days, we are circumcising children under 15 years of age who are still living under their parents' care. The traditional and religious*

surgeons are teaching the boys not to be rebellious because of being circumcised. Our responsibility as a cultural institution is to ensure that the children continue living their everyday lives after traditional male circumcision. Our children must know that it is wrong to say that 'I am circumcised, and now I am a man, I can do anything,' which may make parents lose some regard

(Inzu ye Bamasaaba).

The participant recognised that TMC had been subjected to change, not all of it positive. He referred in a neutral way to the fact that the Bamasaaba men had become more aware of certain other definitions of manhood that centred mostly around the acquisition of material possessions. He pointed out that many prosperous men are admired as 'real men' without anyone knowing their circumcision status. Therefore, in this modern era, he concluded that real men could not be defined by the presence or absence of the foreskin. The issue for him had become 'confounding', and he expressed some regret about the changes:

As I said before, I think it is relatively recently that the cultural practices have been interfered with. The cultural practices of the Bamasaaba have existed throughout history, and it is something that has been esteemed. It is in this 21st century that it turns into a confounding issue. The people, due to internal and external migration, have become more liberal. It is exceptionally complicated because what made you a man then is not what makes you a man now. Currently, people are materially oriented, as I mentioned before. It is about cash, a huge house, a nice car and not the foreskin, or traditional and medical circumcision

(Inzu ye Bamasaaba).

In modern society, traditions have changed to accommodate new forms of social cohesion, redefining the way social events are conducted. This has significantly affected the traditional practices of *imbalu* and the way the Bamasaaba construct their masculinity. The participant said that *imbalu* had become robbed of its earlier significance by these changes:

Nowadays, it is continuously just about undergoing and finishing the debt of the Bamasaaba. However, in the past, boys had to learn about the responsibilities of being a man [masculinity]. They also learned how to treat other people, especially women, and get the opportunity to find out about the general public and make a strong relationship

with agemates [bumakhoki]. *We would learn how to keep the secret code of manhood, socialising and networking that would make you take care of business after the initiation process. Being circumcised was just a portion of the whole cultural process in Bugisu*

(Inzu ye Bamasaaba).

This participant was concerned that the implementation of the SMMCP would weaken the influence of an already negatively affected institution which enabled the Bamasaaba to perform and construct their masculinity in Bugisu communities. As Kepe (2010) points out, TMC is the enactment of a social reality, whereby the cutting of the male body, the stamping of the feet and the beating of the chest symbolises the rite of passage from childhood to adulthood (Kepe, 2010). The key informant backed up this claim, stating that the Bamasaaba have a particular way of constructing masculinity culturally and traditionally. It is done through specific rituals performed during TMC and socially confined to men. He raised an interesting idea that while physical masculinity was clear at birth, fuller masculinity is entered into through the rituals of TMC:

I believe that masculinity is inborn. The boys are masculine when born, but it is ignited through unmistakable rituals during the initiation process. Therefore, when I do not traditionally circumcise, I will feel, to a lesser extent, a man if I am not traditionally or culturally circumcised

(Inzu ye Bamasaaba).

The participant remarked that TMC remains a powerful custom that includes born-again Christians, despite their general unwillingness to traditionally circumcise their children. Wilcken et al. (2010) state that traditional male circumcision is carried out as an initiation ritual and a rite of passage into manhood. They further state that "the integration of medical male circumcision with traditional manhood initiation rituals still lacks acceptability" (Wilcken et al. 2010:8-9). The participant pointed to the truth of this claim, saying that the Bamasaaba men who participate in SMMC fear being stigmatised by their peers:

It is essential for masculinity, and men who go for medical male circumcision fear being stigmatised by their peers. Medical male circumcision does not make one a man because the necessary rituals are not performed in the hospital. Again, for one to be a real man, one must withstand the pain and harsh treatment during the process of male

circumcision. You are smeared with flour a muddy soil, and you stamp on hard ground while dancing. You should not drink water since it results in frequent urinating and so forth, so all these diverse elements make you a man, and it is all exhausting

(Inzu ye Bamasaaba).

The key informant stated that whether circumcision was viewed medically or culturally, the physical act of circumcision in itself has limitations concerning its ability to contribute to hegemonic masculinity:

If you concern yourself about your foreskin, you are going to work with a chip on your shoulder, as you are the main individual who knows whether you have a foreskin or not

(Inzu ye Bamasaaba).

Contradicting what others had said in this regard, he pointed out that it was impossible, from the outside, to detect whether a man was circumcised or not:

In the first instance, you have to trust people fully; I mean the general population strolling around, you cannot tell whether they are traditionally circumcised or not

(Inzu ye Bamasaaba).

The participant stated that the practice of TMC had been subjected to alternative modern approaches, such as receiving education on health, life skills, religious and new cultural matters. Still, the Bamasaaba are hesitant to approve some of these changes. The researcher was curious to know whether the key informant was medically or traditionally circumcised, but the participant did not reveal this. He said that the choice of which option to take is often influenced by geographical location and whether the SMMCP had gained social acceptability in one's immediate society:

It is a stigma to say yes or no, and you are going to find others who will not tell whether they are medically or traditionally circumcised. The response to the reformed health policy will rely upon where it is implemented. For instance, some individuals in the Bugisu sub-region will choose medical or safe male medical circumcision because they are now modernising the cultural practices of the Bamasaaba. Simultaneously, people in other areas in the Bugisu sub-region may not choose to respond because it is the culture

of the Bamasaaba, and it does not need any improvement. Instead, they will choose it if the focal points and impediments of male circumcision are disclosed to them in a clear way

(Inzu ye Bamasaaba).

The key informant maintained his strong concern for how the Bamasaaba would acquire and define their masculinity should SMMC gain ground. His fear was that widespread adoption of SMMC would cause the Bamasaaba society to devalue the important rituals performed during TMC and leave men with no clear understanding of what it means to be a man.

To gain a more comprehensive picture of how masculinity was constructed either with or without TMC, it was important to speak to the men who saw the value in both practices – the Clinical Officers.

7.6 Clinical Officers' Perspective on Masculinity in Relation to TMC and SMMCP

This section presents data obtained from the Clinical Officer who provide SMMC in the hospital setting. In Uganda, these Clinical Officers are not qualified medical doctors but trained to be medical assistants to trained medical doctors. As has been established, these men lived a balancing act between advocating SMMC while personally supporting TMC or at least appreciating its value. They acknowledged that SMMC conflicted with their beliefs and cultural practices as the Bamasaaba men, thus impacting how they constructed their masculinity. A Clinical Officer said:

I consult with the Bamasaaba on the role of manhood after traditional male circumcision and apply it in my profession. Being a Mugisu male who values our traditional practices with specific beliefs, social and cultural values, as a father and as part of the medical team, I try to balance and promote my community members' success

(Clinical Officer No. 1.).

Rudrum et al. (2017:233) argue that "several healthcare messages on male circumcision are developed for specific communities". For example, being a man means undergoing safe medical male circumcision in communities that do not traditionally circumcise. In these

communities, “men may desire to be attractive to women, and women want their men to be medically circumcised men” (Rudrum et al., 2017:233). Similarly, the medical officers stated that they become conflicted when considering how to construct their ideas of masculinity, especially when they have to convey to their own patients that ‘being a man means undergoing safe medical male circumcision.’

The Clinical Officer stated that SMMC does not help a boy understand what it means to be a man in reality. Professionally, they were compelled to convey the idea that the operation suffices to make a boy a man, according to the traditional concept of circumcision having this transformative power. For them, however, its most significant value was in HIV prevention and not its ability to confer manhood:

> *In my profession, medically circumcised men are qualified to be men, but traditionally, I believe they are not. I must serve my community diligently, but I am caught up in the middle. We cannot pretend that there is no danger of getting infected with HIV or STDs that need to be prevented. At the same time, tradition and culture is our way of life*
>
> (Clinical Officer No. 2.).

The Clinical Officer noted it is, in fact, a novel and not generally accepted idea that SMMC can confer manhood – an idea, it seems, propagated by government policy and not received by the people. Simultaneously, reflecting on bravery, which is so central to TMC, the officers pointed out that it takes a brave man to choose to undergo SMMC in Bugisu due to its stigma. The Clinical Officer in Manafwa said:

> *The Bugisu sub-region takes a real man to undergo SMMC because it is positively associated with stigmatisation. After undergoing medical male circumcision, you lose friends who discriminate against you. A real man settles on the correct choice or decision. If male circumcision implies strength and abilities, then the man should be able to make good choices*
>
> (Clinical Officer No 1.).

It seemed that in the end, these men did not believe that either system of circumcision had the absolute power to confer manhood. Clinical Officer number 2 stated that he had no problem with his children undergoing SMMC and believed that a responsible man puts the needs of

others in the community before his own. If a man behaved in this way, he felt, the community members would reward the man with expanded social standing and influence. The Clinical Officer in Manafwa appeared to have high regard for traditional practices but also valued his profession for the benefits of medical science. This acceptance and regard for both systems are revealed in the following comment:

> *Yes, I would undergo medical male circumcision if I was not traditionally circumcised because I need to show them that there is no difference. I need to reduce the high number of AIDS infections in my nation*
>
> (Clinical Officer No. 2.).

In Uganda, the social norms of religion, culture, and tradition heavily influence men's decision to undergo SMMC. Uganda, in particular, is a predominantly Christian nation with a lot of modern practices brought by religion. This participant had embraced modern techniques as another way of performing masculinity. Both participants stated that they were not against TMC but that the procedure required modern input. One said:

> *I am not against TMC, but it requires modernisation, and I think the solution is integrating it with SMMC. The majority of the Bamasaaba men are traditionally circumcised, but we are combined with people from other cultures who also want to be circumcised for health reasons*
>
> (Clinical Officer, No. 2.).

For this participant, the recipients of SMMC did so for health reasons such as cleanliness and prevention of STDs, an argument which the Bamasaaba men could also use to construct their masculinity in modern society. Although this medical officer was traditionally circumcised, he stated that he did not like the conditions under which TMC is done, especially with regard to health. In relation to TMC's power to confer manhood, he said that one's understanding of manhood depended on one's cultural beliefs and general awareness.

Both concurred that the survival of the SMMCP in the Bugisu sub-region would depend on the importance that local men ascribed to health and disease prevention along with a renewed definition of what it means to be a man:

I do not know, but the successful implementation of the SMMCP in our region will depend on the Bamasaaba's health awareness and how they value their tradition. Nevertheless, suppose the men in Bugisu continue to believe, and it is deeply rooted that TMC offers them cultural values of being men. In that case, SMMC remains at a tremendous disadvantage and vulnerable in the Bugisu

(Clinical Officer No. 2.).

Like other participants, the Clinical Officer believed that SMMC was somewhat irrelevant to constructing masculinity since Bamadsaaba men already had a means by which they acquired and demonstrated their masculinity. For this reason, they believed that the TMC would remain the circumcision of choice. However, they both felt that TMC's power depended on the individual man's belief and seemed to imply that it held no extraordinary power in itself. They recognised that it was an actual ceremony for preparing a young man for the future world of hardship and pain and that pain endurance was an essential element of it. However, for them, hegemonic masculinity could be constructed in other ways, too. The Clinical Officer in Manafwa said:

I think male medical circumcision remains an individual choice, but TMC is an obligation for all the Bamasaaba men who have specific reference to pain endurance for masculinity. We believe that it makes us prepare for future challenges, and some may state it is a waste of my time, particularly the healing timeframe. Again, it is a personal question; it is the thing that you see as the advantage of it. I do not think all men will continue to have traditional male circumcision with the availability of medical male circumcision, which is now included as part of the understanding of hegemonic masculinity and the experience of sexual satisfaction

(Clinical Officer, No. 1.).

When speaking from within the Bamasaaba belief system, the participants viewed the SMMCP as a threat to how the Bamasaaba men perpetuate hegemonic masculinity. They suggested that the government consider both traditional and medical male circumcision's potential benefits and not strive to implement only the latter. Like many other participants, the medical officer concurred that the construction of personal masculinity was something that, in the end, each man had to do for himself.

7.7. Summary of the Chapter

This chapter has presented mixed responses to the question of how TMC and SMMC contribute to the construction of hegemonic masculinity. In general, what emerged was that the Bamasaaba men are strongly attached to the practice TMC, which was the central invigorating or 'igniting' event for the acquisition of masculinity. As a participant pointed out, gender is determined at birth, but masculinity is conferred through an event that combines spiritual transformation, vigorous teaching and practical demonstrations of masculinity. Simultaneously, some felt that the event itself could not change a man and make him responsible; most concurred that the event was central and the only way to 'access' hegemonic masculinity, which had to be worked out in person from then on. In Messerschmidt's terms, the practice of TMC conferred hegemonic masculinity, while SMMC conferred only 'a marginalised' masculinity (Connell 1995).

This chapter confirmed two observations made in Chapter One; that ambivalence prevails among the Bamasaaba men regarding SMMC. The Bamasaaba men perceive a strong need to uphold and continue practising TMC. It became clear from all participants' comments that this event holds iconic and symbolic power and is regarded by many as the lynchpin of society, holding all things together, as it were. Given the patriarchal nature of Ugandan society, the welfare of Ugandan men may be said to occupy a central place in the interest of the nation. On a smaller scale, this centrality of the welfare of men is enacted and ensured through the practice of TMC. This being the case, SMMC is resisted or considered irrelevant.

However, there are exceptions to this statement. Twenty-first-century life involves globalisation and exposure to other cultures, and increased access to higher education. Even less-educated men see the value of the SMMCP for promoting safe and hygienic practices and have adapted TMC to comply with standards of hygiene. Its value, to them, is the positive adaptations it has wrought upon TMC. However, for conferring manhood, it has no value. Participants demonstrated, whether wittingly or unwittingly, that the construction of masculinity is largely dependent on ideology or underlying belief systems. This chapter shows that amongst the Bamasaaba, some do support the implementation of SMMC for the modernisation of circumcision and the spiritual neutrality of this option.

It was interesting to the researcher that during focus group discussions, participants who at first declared the centrality of TMC for the practice and acquisition of manhood later expanded their definitions of masculinity as discussions deepened and revealed more nuances. This phenomenon suggests that the concept of masculinity is constructed socially and depends on the input of many. It is also worth pointing out that formal discussions around a topic such as this are rare in the Bugisu society; men have few occasions where abstract concepts such as the construction of masculinity are given serious consideration. It seemed that the very act of engaging in the discussion had some power to expand people's definitions and assumptions.

The chapter has sufficient evidence to indicate that collectively the Bamasaabas' views of TMC are largely determined by its power to confer hegemonic masculinity, which they highly value. Therefore, apart from the masculinity boys acquire 'naturally', the practice of TMC remains a strong tradition among the Bamasaaba and is used as the principal means by which young boys are imbued with the constructs of hegemonic masculinity. The implementation of SMMC neither contributes nor affects the construction of masculinity, which significantly depend on whose view is entertained.

The robust belief system of the Bamasaaba in the region has created a profound sense of attachment to TMC and antipathy toward the SMMCP. The cultural aspects of hegemonic masculinity, and the belief system with its spiritual and cultural symbols, are not easy to derail because of how deeply entrenched *imbalu* is in society. The rhetoric of fighting HIV infections through SMMC, despite its truths, is watered down because the Bamasaaba already practises circumcision and have no need for SMMC for this purpose. TMC remains strong because, in this one event, both group and individual identity are shaped and reinforced. Through the rituals associated with *imbalu*, a young boy experiences himself as a man for the first time, a person set apart from animals, spirits, and women.

CHAPTER EIGHT

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

Chapters Four to Seven presented the findings based on interviews with participants. The study examined the Bamasaabas' response to the implementation of the SMMCP from a sociological perspective. Results were generated through qualitative research methods and yielded insights into various issues relating to the research questions.
The research questions were:

- What is the response of the Bamasaaba to the implementation of the SMMCP?
- What are the social and political implications of the SMMCP for the Bamasaaba?
- What effect does the SMMCP have on the cultural practice of *imbalu*?
- How does their understanding of masculinity affect the Bamasaaba's response to the implementation of the SMMCP?

The findings are discussed in the following sections.

8.2 Discussion of Findings

The Bamasaaba see SMMC and its effects through the lens of the belief system that prevails in their community. However, the answers to questions posed to them show that many also saw the relevance of health policies in relation to male circumcision. Others – particularly the clan and cultural leaders and the traditional surgeons – were dismissive of SMMC and saw no relevance in it with regard to their long-established practice of *imbalu*.

The findings are presented according to the respondents' views that emerged from the data analysis. These are the Bamasaabas' reaction to the implementation of the SMMCP and its political and social implications for male circumcision; the influence of medicalised practices on TMC; and the concept of *umusaani burwa,* which gives rise to a discussion on masculinity

and the various ways in which the Bamasaaba uphold the principles of *umusaani burwa* while attempting to accommodate the SMMCP in the Bugisu sub-region.

8.2.1 Reactions to the Implementation of the SMMCP

The data presented in previous chapters reflects the mixed feelings of the participants with regard to the SMMCP. The majority of the Bamasaaba feel strongly that there is a need to maintain the long-established tradition and cultural practices associated with *imbalu.* Simultaneously, a few wish to modernise the approach in light of health-related knowledge now widely accessible. Global health reforms heavily influence and reform or modernises traditional practices. Their underlying goal is to counteract the spread of HIV in developing countries. However, as Vincent (2008) points out, global health reforms come with conditions that suggest that their enforcement, through nationally implemented regulations, will ultimately degrade cultural practices in Africa.

According to Bayer (1991) and Bollinger et al. (1995), the search for a lasting solution to HIV transmission started in the 1990s when the pandemic began killing people globally. Bayer and Colgrove (2002) show that the extent of the HIV pandemic requires government health departments to develop health policies that open the way for innovative health-related initiatives. In 2006/2007, UNAIDS and WHO suggested global health practices that gave rise to the development of the SMMCP, which adheres to the essential values of SMMC.

The majority of these reformed health policies have neither favoured local people's social interests nor acknowledged the centrality of certain traditional practices to the identity of certain groups. This study's findings show that despite their willingness to accommodate some aspects of the SMMCP, most participants felt that the government should not exercise excessive power over local people, especially when it comes to traditional practices. There is evidence that the government may soon begin imposing mandatory SMMC upon communities in a bid to modernise male circumcision at the expense of traditional practices and have them conform to health standards that will aid in the prevention of the spread of HIV.

Hansen and Groce (2001) argue that governments' approaches to HIV prevention have conditioned African people to accept medicalised practices that do not favour their traditions and cultural practices. The findings show that through the implementation of the SMMCP, the

government of Uganda is medicalising *imbalu* to conform to the policy. A significant number of scholars, however, have suggested that public health interventions can accommodate cultural practices.

This notion is confirmed by the current study, which has found that male circumcision practices in Uganda can include both traditional aspects and SMMC to avoid outright conflict between the two sets of priorities. This may be perceived as an automatic case because TMC is not illegal, so adapting it may help to address the belief that undergoing SMMC is a taboo among men in the Bugisu communities. A combination of these two forms of male circumcision may enable young men to undergo TMC while maintaining standards of hygiene. This implies accommodating a certain amount of tension between the two approaches without allowing either to dominate the other. This requires the collective involvement of all community members.

At the same time, the study found that many of the Bamasaaba men resist the precepts of the SMMCP, holding any intrusion into traditional practices by modern concerns to be unacceptable. This resistance presents a challenge to health workers whose priority is to counteract the spread of HIV and to implement the SMMCP amongst the Bamasaaba. This has severe social and psychological implications for the young men of this group. The failure to undergo *imbalu* rites results in mockery by the *bamakoki* (initiation agemates), who have been traditionally circumcised. The government's push for SMMC is exposing medically circumcised men to derision and stigma for the rest of their lives. Such medically circumcised men acquire what Connell (1995) calls 'marginal masculinity', explaining that such individuals are excluded from the symbolic authority of hegemonic masculinity.

The implementation of SMMC introduces a construct of the Western concept of hegemonic masculinity, which may not apply to the Bamasaaba men in the African context. The Bamasaaba men are constructing their masculinity based on traditional male circumcision, acquired through demonstrating bravery and pain endurance. This means that undergoing SMMC will qualify men with marginal masculinity, which is excluded in the composition of hegemonic masculinities. The compliance with the SMMCP disrupts this foundation of masculinity according to the Bamasaaba's worldview and effectively renders many unable to construct a socially sanctioned and recognised masculinity for themselves. The result is a

systematic branding of individuals, which has the power to affect not only individuals but also the entire collective society negatively.

Bernier and Clavier (2011) argue that to curb the spread of HIV, the removal of the foreskin is insufficient to guarantee the health of a man's sexual partners. This statement is corroborated by the findings of the current study, which show that the individual also has to make a primary and critical choice with regard to his sexual behaviour. Thus, the SMMCP on its own is entirely insufficient to affect the intended benefit, which is to curb the spread of the HI virus. However, the government of Uganda has political hegemony over the implementation of the SMMCP and has extended its political domination into the realm of culture. This intrusion into cultural practices has naturally resulted in a strong reaction.

The current study was interested in the discourse on masculinity as affected by the conflict between TMC and the requirements of the reformed health policies. Baron et al. (2014), McLeroy et al. (1988) and Sallis et al. (2008) suggest that health policy developers and implementers have to consider the tensions that have arisen between SMMC and TMC. The findings are that the Bamasaaba men are responsible for their health-related behaviour. The government should allow them the freedom to practice TMC without over-imposing SMMC. The participants, especially the 2016 TMC initiates and their clan leaders, felt that nobody had the right to control their bodies with regard to the cultural and medical practices of male circumcision.

The participants claimed full responsibility for the results of the choices they make about their bodies. They have a strong preference for TMC, which, partly through the pain it involves, fulfils the important value of establishing their perceived masculinity. These men believed that SMMC could not offer them a pathway into manhood as this approach involved the use of anaesthetics to dull the pain. According to Forbes (2009), this process was recommended by Dr Lewis for SMMC patients who have genital diseases and alleged harmful effects of masturbation. The evidence of this current study shows that both the government and the Bamasaaba are failing to manage the conflict that exists between medical and traditional approaches to male circumcision. Those who have suggested the integration of TMC and SMMC have not effectively resolved the conflict on a wide scale. A study by Wilcken et al. (2010) in South Africa found that the integration of medical practice with TMC lacked acceptability by men undergoing TMC.

This failure notwithstanding, there are Bamasaaba men who remain undecided about whether to adopt SMMC practices or not. In effect, each member of the Bamasaaba tribe makes the decision for himself, although it is unlikely that the decision is ever truly made individually since the ritual is accompanied by a strong sense of group identity, where the decision is mostly a group one. Ansell (2014) states that certain health behaviours are the outcome of specific environmental situations. In the case of the Bamasaaba, self-determination may play a minimal role in the context of responding to the implementation of SMMC, with their responses usually being shaped by the traditional control of the group over the individual. Nonetheless, the issues are sufficiently significant. Some men are influenced by the Western emphasis on individual responsibility. Each man is forced to consider both approaches' benefits and be free to choose and live with the consequences.

Some participants stated that they would not comply with all the requirements of SMMC; instead, they would modify their traditional practices by incorporating selected modern hygiene practices. For instance, they suggested that they sterilise the knife after each use on an initiate and wash their hands before and after touching each initiate. Wilcken et al. (2010) point out that the adaptation of cultural practices of the people can have social implications. The evidence from this study indicates that the Bamasaaba who choose to adhere to cultural structures are nonetheless adapting *imbalu* to fit in with contemporary society. One of the social implications concerns the cultural values attached to *imbalu*.

Choosing to adhere fully to SMMC practices is seen as an act of challenging the hegemony of the Bamasaaba culture concerning their traditions and religious practices. Mdedetyana (2019) states that participators in the SMMC approach are marginalised and discriminated against in South Africa. In the same way, the current study found that any man undergoing SMMC-style circumcision among the Bamasaaba is in danger of being rejected, isolated, and disowned by family and community members. The participants stated that accepting medical procedures means creating a breach of the organisational and operational systems of the Bamasaaba. This action alone is seen to disrupt the independence and self-determination of the people with regard to their traditional methods. This disruption becomes a critical issue for the Bamasaaba, as it is closely linked to their precarious identity in the face of the behemoth of Western culture.

The study found that some of the Bamasaaba see no problem in implementing aspects of the SMMCP, as long as they are able to maintain their traditions and cultural values. These traditional and cultural values are always expressed through specific actions, particularly ritualistic ones. The majority of the Bamasaaba suggested that the SMMCP be implemented as a useful practice of cleanliness and general hygiene in 'other' communities, which do not traditionally practise male circumcision. Although the Bugisu sub-region is a diverse community, the majority of the community members practise TMC. The traditional surgeons likewise indicated that they and their families had chosen to exclude full participation in the SMMCP since they undergo male circumcision for cultural purposes rather than for medical reasons.

It is interesting to note that apart from Islamic communities, Jewish communities, too, practice TMC for religious reasons. Uganda is one of the few African countries with a small Jewish population, referred to as the *Abayudaya*. Berg (1997) states that *Abayudaya* is a Luganda concept referring to people of Judah who settled in the Eastern part of Uganda, specifically in the town of Mbale. Nevertheless, the study has uncovered an unconfirmed theory that the Bamasaaba have an ancestral connection with *Abayudaya*. The Jewish people (*Abayudaya*) believe that God will not accept an uncircumcised male (a man who has not received the circumcision of the flesh) because they would have broken God's covenant with his people, as described in Genesis 17:14 of the Bible.

Similarly, Khanakwa (2016:118) states "the Bamasaaba's belief about *imbalu* is that it links men to their ancestral world". The current study found that the Bamasaaba believe that if any man dies without receiving TMC, his spirit comes back after he dies to torment his living countrymen. To prevent this misfortune, men will even carry out a posthumous circumcision on an uncircumcised male's remains in the rare event that an individual die in such a state. The cultural leaders of the Bamasaaba concurred that undergoing TMC creates a covenant between the Bamasaaba men and their ancestors and is necessary for the wellbeing of the group.

The spiritual value of TMC has been underestimated by proponents of SMMC, which may recognise the value of the teachings associated with TMC. However, this is not the subtle understanding that in *imbalu*, there is an actual transformation that occurs within the soul of the man, akin, one might almost say, to a religious conversion. At some point, the boy becomes a man – not just in a social sense but in an ontological sense. This essential turning from

boyhood to manhood is reinforced by the teaching and by the experience of enduring pain, which in itself has a dual function, both demonstrating masculinity and mentally preparing one for a life of challenge and hardship. In holding this dual function, the pain too assumes a symbolic status.

It is interesting to note that this spiritual aspect of *imbalu* is both its chief strength and the primary reason why those who identify as Christian find it unacceptable. The rejection of TMC by Christians shows that the decision as to whether or not to undergo TMC or SMMCP may be motivated more by ideology than by considerations of hygiene, health or sexual pleasure.

It is also worth noting that apart from ideological or spiritual considerations, geographical location, too, plays a role in the decision. In the Bamasaaba society, as in all traditional African societies, the opinions of the group have tremendous persuasive power in shaping the actions of the individual. If everyone around one is engaging in a certain activity, the chances are high that any random individual in that community will follow suit. Thus, for men in rural locations, TMC holds sway, while in urban communities, the practice is not as central. Urban communities naturally tend to be the locus of more educated and professional people. Still, even those who are less educated in urban communities are likely to feel some latitude when it comes to sending their children for TMC. They may opt for SMMC for economic reasons (avoiding the expense of the three-day celebration, or because SMMC has been offered for free) or simply because it is more convenient to do so.

The findings reveal that the government tends to exaggerate the benefits of SMMC in an attempt to make it the most dominant and influential practice in society. The evidence indicates that the implementation of SMMC may be seen as an expression of Western hegemony over African tradition and culture, which in some cases is adapting *imbalu* to conform to the requirement of good hygiene. Many of the Bamasaaba interviewed seemed to find the discourse on SMMCP problematic, as it stresses the individuality of the person rather than the values of the group.

8.2.2. Political and Social Implications of the SMMCP's Influence on Traditional Practices

The participants reflected on the dangers of social and political control over traditional practices by the government, expressed during the implementation of the SMMCP. The findings show that many viewed the implementation of health policies as a pretext for the real aim of controlling the Bamasaaba politically. Some of the Bamasaaba seem to be promoting the use of medical practices during male circumcision, which contradicts their region's cultural practices. This indicates that health programmes based on modern scientific principles are relatively easy to justify but may be used to usher in the social and political control of traditional people.

According to Morgan (1998), this is possible because, through their ministries of health, governments can mask their political programmes using the neutral language of technology or medicine. In the beginning, such policies and programmes may seem like compassionate initiatives, motivated by the desire to protect and maintain health. In this way, they may entice people into an acceptance of the medical practice of male genital modification. However, such programmes entirely ignore the cultural values that give these groups their cohesion and their power. Buse et al. (2009) find that the implementation of the SMMCP has significant effects on African culture and society as a whole. This study found that SMMC has compromised the indigenous understanding of the traditional and cultural practice of *imbalu*.

The study indicated that there is no doubt that the traditional practice of *imbalu* supersedes the medical practice of circumcision in the minds of the Bamasaaba people. However, as observed, some of the more educated clan leaders indicated an acceptance of a more medical approach as the most appropriate way to overcome the social and health problems that exist in their community. These clan leaders are advocates of change and call for a more modern approach to *imbalu*. This acceptance by certain clan leaders lends power to health workers who seek to make SMMC the dominant means of conducting male circumcision. The health workers have the backing of the government and, therefore, the political power. Interestingly, in this study, the cultural values attached to TMC are not considered irrelevant by medical personnel who are themselves products of the Bugisu society. It is only at the national level that TMC is considered irrelevant and even 'primitive' by those whose priorities are just health and hygiene.

Many participants strongly believed that the government of Uganda was attempting to control the Bamasaaba by implementing medicalised male circumcision under the camouflage of HIV prevention. The participants reflected on the traditional and cultural background of some of the political leaders, especially President Yoweri Museveni. They considered the implementation of the SMMCP to be a form of social-political control of the Bamasaaba by people who do not practice traditional circumcision and therefore have no understanding of its value. To back up their views, they asked why the HIV prevention programme was coordinated by the state rather than by the provincial or local health departments.

According to the WHO and UNAIDS in 2006/7, the recommended health policy includes SMMC for adult men in developing countries whose communities traditionally do not practise male circumcision. However, under the guise of making TMC safe, political leaders have implemented it in communities with a strong tradition of male circumcision, such as the Bamasaaba. The SMMCP advocates SMMC for the explicit purpose of medicalising traditional practices and making them safe. The participants indicated their disappointment that political leaders and others from the non-traditionally circumcising communities have portrayed the traditional and cultural practices of *imbalu* as primitive and barbaric. There is a political or power-related component to this clash between the two views of TMC, even when the intention of the SMMCP is not overtly political.

It is possible that political leaders have perverted the intentions of bodies such as the WHO and UNAIDS by using their recommendations to exert state power over minority groups in their countries. Nalianya (2014) reports a controversial statement by President Yoweri Kaguta Museveni. He boldly told the Bamasaaba and Kusu people of Western Kenya to stop the primitive practice of TMC and conduct circumcisions in a medical setting. The Minister of State for Gender and Culture, Peace Mutuzo, issued another controversial statement on 15 May 2017, calling for eradicating *imbalu* in the Bugisu sub-region (Angurini, 2017). In her statement, she stated that the people of the Bugisu must desist from 'their dehumanising and backward habit' of practising *imbalu*, which evokes risky sexual behaviour (Angurini, 2017).

The Minister's statement provoked much debate, with views broadly expressing the following points: First, political leaders who come from non-traditionally circumcising communities are misrepresenting the traditional practices of the Bamasaaba; and second, according to the Bamasaaba, women are not allowed to make public comments about the cultural practice of

imbalu. The Minister's statement caused the Bamasaaba men to feel undermined and disrespected. Her remarks had the unintended consequence of exacerbating an already prevalent distrust of government, and in particular, the government's HIV prevention programme. This study's findings reveal that the Bamasaaba are deeply distrustful of political leaders who think they can eradicate TMC.

Dirlik (2003) states that maintaining traditional practices has social value, although the long-term effect may prevent the development and progress in society. It appears that some proponents of a more modern approach to traditional practices make allowances for cultural views and practices but that the public statements of those who hold political power show no evidence of a more conciliatory approach in the case of the Bamasaaba. Many of the participants had noticed the changes brought about by the SMMCP, despite their protestations. This observation confirms Kaufman's claim that the implementation of health policies has brought about better education and economic and political changes that are inevitable but are likely to pose a threat to minority groups in developing countries.

The cultural value of TMC amongst the Bamasaaba is that it unites all the Bamasaaba living in different districts, counties and countries (Asiimwe, 2011). The study found that the cultural leaders, clan leaders, and traditional surgeons together form an essential part of the social and cultural structure of the Bamasaaba. In addition, the Bamasaaba men may occupy both political and non-political positions such as *Umukuuka We Masaaba* (King of the Bamasaaba) only because of having undergone TMC and entrusted with these positions they are regarded as custodians of the culture.

The findings also clarify that conducting cultural or traditional rituals within a medical setting would fly in the face of the requirements of the culture and undermine the significance of the ritual. The widespread adoption of the SMMCP would probably destroy the rite of passage from boyhood to manhood for the Bamasaaba, with consequences for their collective identity and the identity of the individual men who undergo the procedure in a hospital.

Ballard and Elston (2005) were concerned about the fact that the medical sector has extended its jurisdiction beyond health and disease control and has intruded upon cultural traditions. Society is a beneficiary of healthcare, but people still have the right to reject medical processes that seek to transform traditional practices such as male circumcision. For the Bamasaaba, the

rejection of SMMC is reinforced by their realisation that medical personnel wish to impose their norms over the cultural norms of *imbalu*. Though given the power behind the drive to modernise TMC, it is almost inevitable that the objective of modernising the traditional practices of *imbalu* will gradually be realised. The process will not be smooth, however.

Studies by Chatters (2000), Jackson and Scambler (2007) and McKinlay and Marceau (2000) indicate that African people have resisted several major health programmes on cultural and traditional grounds. Programmes that are still commonly opposed include organ donation, the amputation of infected body parts, and the performance of post-mortems, all on the grounds of religious beliefs. The findings of this current study show that SMMC policy developers did not consult with indigenous people during the process of developing the health policy on male circumcision. The participants indicated that the government might have avoided resistance by the local people had they engaged in a lengthy consultation process, in which compromises may have been made.

From the findings, it is apparent that the implementation of the SMMCP is receiving mixed reactions from the Bamasaaba because male circumcision is an important cultural and religious practice; change is met with resistance. The beliefs of groups such as the Bamasaaba have to be considered if African governments wish to implement the SMMCP successfully throughout the continent (UNAIDS, 2013). As has been made clear, the Bamasaaba regarded the imposition of the SMMCP as a challenge to their belief system, which is closely bound up with identity. Therefore, it is not surprising that they see the programme as having political motivations since it has the possibility of destroying their identity as a people, with all of the political implications that this carries.

8.2.3 The Medicalising of Traditional Male Circumcision

In the previous chapter, I discussed the medicalisation of traditional male circumcision, which was defined and found to be essential for understanding the sociological aspects of development in under-developed countries. Various theoretical frameworks attempt to explain the demographic and epistemological changes wrought by the process of modernisation. Some may help in understanding the issues that surround the clash between modernity and traditional cultural practices such as TMC. Schifirnet (2012) believes that modernity works well in

urbanised and industrialised countries where people have a sufficient understanding of social and medical issues and where cultural practices do not hold such sway.

The study reveals that UNAIDS is engaged in a massive drive to bring about health reforms in under-developed countries, but that this drive has had the effect of 'medicalising' some traditional African practices, particularly where the practices may have a bearing on the spread of HIV. African governments have adopted the UNAIDS' approach and are reformulating health policies in line with their guidelines. As a result, there has been the tendency to completely disregard minority groups in Africa whose identity is closely aligned with their practice of TMC. The implementation of the SMMCP in Uganda is perceived as a threat by the Bamasaaba as it undermines long-held religious and cultural beliefs.

The findings show it is mostly the Bamasaaba living in urban areas which have adopted modern medical practices for *imbalu*. This has resulted in cultural conflict between those living in rural areas and those living in metropolitan areas. Morgan (1998) states that in the process of medicalising or modernising TMC, governments ignore African communities who conceptualise TMC in non-medical terms. This suggests that the development of appropriate sociological explanations and paradigms would be in order. The development of such models might well have effects that go beyond the area of male circumcision since the medicalisation of traditional practices has already influenced a number of non-medical occupations. Findings show that traditionally non-medicalised communities are also exerting an influence on medical procedures. Government health policies are implemented on a national level and are activated in a top-down approach. Eventually, they find expression in rural development programmes. The institutions that shape these programmes operate at the highest level and include parliament, the Ministry of Health, local governments and cultural institutions such as the *Inzu ye Bamasaaba* (the Bugisu Cultural Institution) depend on collaboration and cooperation with one another.

Pratt (2001) cautions that medicalising cultural practices are introducing Western medical procedures at the expense of traditional ones. The Ministry of Health and various other health organisations refer to medicalisation and modernity as the transition of society away from a cultural understanding of health issues and conditions to more scientific knowledge of this area (MoH, 2010). The findings of this study reveal that the government of Uganda is introducing Western medical practices at the expense of traditional practices such as *imbalu*. This finding

is in line with Baronov's (2010) and Asiimwe's (2011) finding that socio-political factors like colonialism and missionary activities left a legacy of a strong Western influence.

The findings suggest that medical personnel face opposition as the clash between medicalised modernity and tradition unfolds. Medicalisation and modernity are particularly relevant to people who embrace both tradition and medical practices, as was found to be the case with some participants. Participants who were health professionals themselves seemed to express the most ambivalence about traditional and modern techniques of male circumcision. Interestingly, those who identify as born-again Christians use SMMC as their rite of passage from boyhood to manhood in the Bugisu sub-region.

The implementation of the reformed health policies on male circumcision directly challenges the traditional structures of the Bamasaaba. Thus, medicalisation and modernity create a crisis for the Bamasaaba, especially those who feel most strongly about maintaining their traditional practice of *imbalu*. The researcher's view is that if cultural structures such as *Inzu ye Bamasaaba* successfully restructure their culture and traditions to maintain hygiene and safety, it would be difficult for the government to penetrate and control them politically, as their medical rationale for interference would have been removed.

The findings show that by transposing the cultural significance of TMC to the procedure, they undergo in hospital, some local people have endeavoured to reduce the discrepancies between the two approaches to this important rite of passage. They have attempted to maintain the significance without the associated communal practice. Benson (2010) states that the resolution of social problems is made by traditional communities using one of two approaches: the covert or emotion-based approach or the obvious or problem-focused approach. Both are explained in the section that follows.

8.2.4 *Umusaani Burwa* as a Dominant Concept

One of the objectives of the current study was to understand the way in which the Bamasaaba construct their masculinity in response to the implementation of the SMMCP. This study is the first to explore the discourse of constructing masculinity in the Bugisu context.

Imbalu may be seen as a tradition that creates a hierarchy of masculinities among the Bamasaaba men, with traditionally circumcised men accorded a higher status in the community than medically circumcised and uncircumcised men. This finding appears to explain how the Bamasaaba constructs their masculinity and why this is significant in relation to their response to the implementation of the SMMCP. Both aspects are central to this investigation as they reveal the importance of the cultural dimension in the Bugisu context, particularly the construction of masculinity within it.

Significantly, the results of the study suggest that among the Bamasaaba, *imbalu* continues to be hegemonic, especially for traditionally circumcised men. The implementation of the SMMCP is generally problematic for the cultural practice of TMC because, among the Bamasaaba, the dominance of *imbalu* continues to define 'manhood'. For an uncircumcised or medically circumcised male, the hegemony of this tradition is ostracising.

The study found that to avert the misfortune associated with being uncircumcised, traditional retired surgeons would even perform a posthumous circumcision before burial where it is deemed necessary.

Another cultural aspect that a circumcised male is entitled to participate in is attending and performing rituals as a representative of his ancestors. The traditional practice of *imbalu*, as a form of hegemonic masculinity, does not accept the addition of any foreign methods. Therefore, the recipients of SMMC are seen as men who represent a state of marginalised masculinity that is oppressed, stigmatised and lacking in the critical components of communitarian personhood (Wyrod, 2008). A significant number of the Bamasaaba believe that *imbalu* confers communitarian personhood on the Bamasaaba men. Not only do traditionally circumcised men view medically circumcised men as persons who have abandoned their cultural practices, but women also see them as weaklings, according to men who participated in the study. This perception has led some medically circumcised men to migrate or find sexual relationships in communities that do not traditionally circumcise.

The analysis in this thesis upholds Connell's (1995) theory of hegemonic masculinity. The study specifically highlights the fact that the supremacy of *umusaani burwa* masculinity is maintained through consistent norms for men and boys. The rituals associated with *imbalu* are preserved as a platform for displaying manhood in these communities. Any man who fails the

test of manhood or opts for a medical practice is denied the right to participate in communal rituals, especially those associated with *imbalu*. On certain occasions, they are subjected to intrusive demands requiring them to prove their manhood.

This study found that the implementation of the SMMCP has not produced a shift in the Bamasaaba men's perception of masculinity. The evidence shows that a man still has to perform the traditional rituals of *imbalu* to be regarded as a brave man (*umusaani burwa).* Stigmatisation and social exclusion apply to all men who have undergone SMMC. Therefore, to implement SMMC in a culturally appropriate way, the government would have to give due consideration to constructs of masculinity as experienced by the Bamasaaba.

Amongst the Bamasaaba, the right to bodily autonomy is denied in the quest to maintain the supremacy of *umusaani burwa*. According to Scheper Hughes and Lock (1987), the body is not seen as an entity belonging to the individual man. The majority of participants insisted that the body of *umusaani burwa* (literally, a traditionally circumcised penis) belongs collectively to the cultural group and can be inspected at any time. This activity is primarily done when a man cannot convincingly explain his journey to manhood.

8.2.5 Procedures for Embracing the SMMCP

In order for government health officials to convince members of the Bamasaaba to participate in procedures associated with the SMMCP, they would have to give due consideration to both obvious and covert barriers to acceptance that currently exist amongst the Bamasaaba. These barriers might explain the ambivalence that the study reveals with regard to the implementation of the SMMCP.

8.2.5.1 Covert Barriers

Covert barriers are those involving the spiritual component and the emotional or pain component associated with the traditional practice of circumcision. The global and national pressure exerted on the Bamasaaba with regard to their cultural practice of *imbalu* may well be ignored by local people because campaigns for SMMC emphasise that the procedure is 'pain-free'. A pain-free procedure would remove the very component that is central to the process of becoming a man. The evidence from this study shows that standard procedures and

requirements of acquiring masculinity uphold the supremacy of the cultural belief that pain endurance is part of the definition of a man.

However, the Bamasaaba's opposition to the implementation of the SMMCP has its foundations in an intricate web of indigenous knowledge systems, beliefs and attitudes. The evidence shows that the majority of participants were not able to link the modern explanation of medical circumcision with TMC. To them, the two concepts – TMC and medical concerns – have nothing in common. SMMC was about hygiene and safety, while TMC was about spiritual power, transformation and identity as a man. As a result, the participants disregard SMMC as a relevant practice for the Bamasaaba.

Wabwire-Mangen et al. (2009) argue that over 90% of the Bamasaaba men are already traditionally circumcised. Yet, HIV transmission continues, showing that circumcision alone has almost no value in curbing the spread. Most participants saw the value in the principles of the SMMCP but believed it should be implemented in other parts of Uganda, as it presented no solution for their social and health problems.

Aggleton et al. (1990) claim that the African people view HIV and AIDS infection as a concern for 'the other'; this study confirms this claim. Participants express the idea in various ways throughout the research process. The implementation of SMMC has a long history of being negatively associated with 'the other' for cowards and men from non-traditionally circumcising communities. This perception might be seen as false, exposing the Bamasaaba to HIV infection and revealing that their obsession with the domination of *imbalu* practices is causing harm.

In this study, the concept of 'the other' mostly arose as part of the Bamasaaba's justification for resisting the implementation of SMMC practices. The participants revealed that circumcised men have become more sexually promiscuous since the implementation of the SMMCP. The promise that SMMC would reduce the incidence of HIV and AIDS transmission by 60% has been misunderstood by circumcised men, who seem to believe that once circumcised, they are invulnerable to sexually transmitted diseases.

A more obvious barrier to the implementation of SMMC relates to the problems once associated with traditional circumcision. The Bamasaaba are finding ways to deal with a lack of hygiene by using one knife per candidate, giving medical treatment for wounds, washing

hands, and maintaining general hygiene principles. These procedures are a natural way in which the Bamasaaba are adjusting to modern principles while maintaining all the essentials of TMC. They give further credence to the idea that the Bamasaaaba do not need SMMCP.

According to Park (2013), it is necessary to gain an understanding of cultural practices before developing and implementing health policies amongst any specific group, especially when the policies affect male circumcision (Park, 2013). The Bamasaaba are proving that the SMMCP may legitimately be regarded as having very little to contribute. From their point of view, there is no need to decimate the practice of TMC to keep it hygienic.

8.2.5.2 Generational Shifts

The study reveals that the adaption of TMC practice is mostly accepted by the young and the better educated. The older generation is reluctant to adapt traditional practices in any way and resist the infiltration of medicalised modernity. They make no allowances for the two approaches to be practised simultaneously.

The empirical evidence reveals that in the implementation of the SMMCP, the older generation may be excluded from consideration, as amongst this group, there are no initiates to circumcise. This implies that as the older generation passes away, the potential barriers to the implementation of health policies on male circumcision will fade. However, this does not mean that there will be widespread adoption of medicalised circumcision, only some form of adaptation to ensure that hygiene standards are rendered more acceptable.

According to data analysed for this study, some health organisations such as the AIDS Information Centre (AIC) are circumcising children below the age of 12, using the medicalised procedure of male circumcision. The social and public health consequences for these children may manifest during their adulthood. The government believes its actions are a necessary part of social change. It remains to be seen whether in the future these children will find acceptance amongst the Bamasaaba, and a lot may depend on where they choose to live. It was observed that circumcisions performed at a younger age had the unintended effect of promoting sexual activity among those who were emotionally immature and increasing general disrespectful and socially unacceptable behaviour, as young boys so circumcised believed that they were now

'men'. Several participants made the point that traditionally, TMC is performed on young men past the age of adolescence who are ready to take on the responsibilities of marriage.

8.2.5.3 Strategic acceptance of SMMC

On the one hand, data suggests that the government's health educational programmes are discrediting traditional practices and claiming that the protective aspect of SMMC can result in a 60% drop in the rate of HIV transmission. Some participants revealed that public health interventions capture people with this message that they misinterpret and use as a licence for sexually irresponsible behaviour. Choko et al. (2015) observe that the targeted beneficiaries of SMMC are beginning to trust government health programmes, causing many younger people to adopt SMMC as a cultural practice. The dangers of circumcising boys who are too young have already been pointed out.

Data also reveals that the successful implementation of the SMMCP depends on integrating it into the cultural practices of *imbalu* to avoid the conflict that currently exists between the two approaches. The health educational campaigns ought to include the recognition of cultural practices and aim to effect small but significant changes in these rather than the wholesale replacement of them. In addition, they ought to emphasise sexual behaviour change and promote the adoption of safer sexual practices. Howard-Payne (2010) and Stine (2008) have similar findings, both stating that African people under-rate their risk of HIV infection, believing that certain cultural practices will protect them. This study reveals that the majority of the Bamasaaba value the cultural practice of TMC, paying less attention to the risks of HIV.

8.2.5.4 Patriarchy and masculinity

Empirical evidence shows that some of the Bamasaaba acknowledge the social influence of their belief that associates TMC with masculine attributes. They see TMC being a component of the patriarchal power structure that prevails amongst them. The significance attached to the procedure of penis alteration illuminates the centrality of patriarchy in the culture.

Coughtry (2011) states that patriarchy is the societal framework according to which men hold greater power than women in most areas of life. The prevailing social system amongst the

Bamasaaba is male-centric, with no known matriarchal social elements in place. In societies such as theirs, women are treated in a manner that effectively enslaves them and relegates them to a lower position in all areas of life. The study found that in male-centric cultural and social systems such as that found in the Bugisu sub-region, control is firmly in the hands of traditionally circumcised men. It includes the male family members and clan members, with young men coming next in the chain of command over women who may be older than they are. The ritual of *imbalu* remains a long-standing tradition that affirms patriarchal values and a patriarchal understanding of life.

A small number of the Bamasaaba are calling for modernisation and believe that tradition is no longer relevant in the 21st century. However, for their views to hold any sway, the Bamasaaba would have to undergo a significant reorientation with regard to the perceived roles of men and women. When the Bamasaaba men in this study considered that the operating surgeon could be female in medical settings, they responded that this was sufficient to discredit the procedure.

'Task-shifting' would be required amongst health professionals if the SMMCP is to have any success amongst the Bamasaaba. Task-shifting means that the government would need to assign certain medical tasks to specific (male) specialists, even if it involves devolving duties to practitioners lower in the medical hierarchy because circumcision is a minor surgical operation. Ironically, medical professionals would have to accept that for medical circumcisions to be accepted and adopted, female medical personnel would have to be excluded from anything to do with the operation. Clinical male circumcisions would need to be exclusively a male medical professional preserve.

The maintenance of TMC shows that patriarchy still shapes the attitudes of the Bamasaaba and prevents contemporary public health concerns from exerting much influence on many of them.

8.3 Intermediate Conclusions

The findings indicate that the Bamasaaba under-estimate the risks associated with the use of a single knife on many initiates during TMC practices. The results also suggest that the Bamasaaba rely on 'othering' to justify their perceived exemption from compliance with SMMC principles. To them, this programme belongs to 'others' and should therefore be implemented elsewhere. Their attitude shows that individuals depend on the group for the

validation of their ideas. Thus, the group plays a central role in maintaining tradition, trust, and a strong social network amongst the Bamasaaba.

The Bamasaaba men as individual agents strive to accumulate hegemonic masculinity over time as there are potential benefits in doing so. The health of the Bamasaaba as a group is one of their main priorities, sometimes superseding concerns for the individual. Despite the social interventions that seek to dismiss the myth that only sexually promiscuous men benefit from SMMC-style circumcisions, the Bamasaaba's understanding of health and social issues is socially subjective.

8.4 Implications of the Study

Numerous researchers have conducted studies on the acceptability of SMMC on livelihoods and public health in countries with a weak economy. Some anthropological studies have emphasised the cultural and biomedical implications of Ugandan public health programmes. This study could play an essential role in opening up the debate on the role and value of the SMMCP, which is expressed through a comprehensive HIV prevention strategy devised and implemented by the Ministry of Health.

The sociology of globally implemented health practices has not been examined thoroughly, and sociology as a whole has made little contribution to the debate surrounding the implementation of the SMMCP. The sociological implications ought to be of particular concern to Ugandan stakeholders involved in the implementation of SMMC as a biomedical intervention in the Bugisu region. The current study demonstrates the importance of examining the understanding of the Bamasaaba and other indigenous people with regard to the implementation of the SMMCP. A lack of such understanding has been shown to affect the success or lack of it of the SMMCP-inspired policies and programmes.

Chapter 5 suggests a possible way to reframe the SMMCP principles for minority groups in Africa, such as the Bamasaaba. While this global health policy is deeply embedded in the language of contemporary public health programmes, it does not encompass the ideological framework of traditional communities. In Uganda, the government and other significant health organisations are the sole developers and implementers of the health policies on male circumcision. The negative view held by the government and these organisations with regard

to TMC has affected the Bamasaabas' response to the implementation of SMMC. Yet sociological factors such as the level of trust in government and public health implementers are not usually included as variables in studies on the feasibility of public health programmes.

This study has revealed that distrust in government influences how the Bamasaaba perceive the SMMCP campaigns. In the future, the development and implementation of health policies, especially with regard to male circumcision, may require the Ugandan government and other stakeholders to consult with the local people far more before attempting to implement a policy. Had sufficient groundwork been done to explain the rationale and to allay fears about the destruction of traditional practices, a way forward might have been found that was collaborative rather than combative.

The government should also consider how other government ministries apart from the Health Ministry could play an active role in sensitising to or educating people, such as the Bamasaaba, about the significance of using SMMC. The position of female doctors as medical officers in the implementation of the SMMCP requires serious consideration, as this was a significant concern. This study found that the effective implementation of the SMMCP would depend in part on the exclusion of female doctors and medical officers from the procedure, particularly in the Bugisu sub-region. However, this requirement would undoubtedly elicit strong reactions and is open to debate that Uganda is committed to human rights and gender equality.

The current study's theoretical value was addressed in Chapter 5, where the factors influencing the Bamasaaba's response to SMMC implementation are discussed. The idea of using the male body as the site of an HIV prevention strategy conflicts with traditional cultural notions attached to male circumcision. No sociological health theories exist to connect TMC meaningfully with the principles of SMMC. Neither government nor international health agencies have offered ways in which the principles of the SMMCP might be integrated into existing TMC practices. Hence, the Bamasaaba have found their ways to adapt TMC so that it might conform with health and hygiene requirements.

The findings indicated that the Bamasaaba might only respond to SMMC when they start viewing it as a valuable practice. Their current disregard for policies that urge them to submit to medically conducted circumcision fuels the conflict between the medical and traditional approaches to circumcision. This conflict includes the position of the Bamasaaba men with

regard to pain and the specific objectives set by the medical profession for the medical removal of the foreskin.

The study also considered the attitudes of the individual Bamasaaba men to their sexual behaviour in relation to HIV transmission. The current study is the most recent, if not the only research, to use a contemporary rationale for explaining the implementation of the SMMCP in the Bugisu context. This study thus contributes to existing cultural knowledge by identifying the primary significant sociological scope of social behaviour. These behaviours may be viewed as responses to the attempted enforcement of the SMMCP. The study also contributes to the existing body of knowledge by uncovering social issues that prevail amongst the Bamasaaba in respect of circumcision.

8.5 Limitations and Recommendations

One of the limitations of this study is that neither medically circumcised nor uncircumcised men in the community were interviewed; therefore, the study reflects only the traditionally circumcised Bamasaaba men's perceptions of the Bududa, Manafwa and Mbale Districts. The inclusion of men who had been medically circumcised may have provided a more comprehensive picture regarding the Bamasaaba men's responses to SMMC. However, the study was able to describe the philosophy of a large proportion of the men in the Bugisu community – those who had undergone *imbalu*. The views of the Bamasaaba men who have experienced the SMMCP circumcisions remains a topic for future researchers.

I suggest that further investigations of this kind include men from various traditional, cultural and religious backgrounds. As a result of its limitations, the findings of the study can neither be generalised to Uganda as a whole nor to other countries struggling to implement reformed health policies on male circumcision for HIV prevention. Uganda's environmental health and disease burden seem to constitute several contributing factors, which concurs with the findings of other studies in different contexts in sub-Saharan Africa. However, it might be meaningful to conduct a similar investigation in societies with similar social conditions to compare this study's findings with the findings of studies conducted in other countries.

The results indicate that despite resistance, children are being circumcised through the programme. The participants reported that parents are authorising these circumcisions

conducted by women through the AIDS Information Centre in Mbale. The exclusion of women from this study is something that could be addressed in future research so that the views of female doctors and medical officers may be made known. The opinions of doctors are, of course, significant as they hold positions of authority in society. However, the ethical approval of the research proposal depended on voluntary participation in the study, and it seems clear that females would have been very reluctant to participate in a study on such a sensitive topic.

The study recommends further sociological research that includes women and children as potential participants. Their inclusion would enable the researcher to record their responses with regard to the implementation of the SMMCP. These participants would be mainly female medical officers or doctors and children who have been recipients of the medical circumcision programme. The focus should be on increasing the transferability of the study and widening the descriptive scope to develop a substantive and grounded theory. The researcher suggests including on-site medical workers to interview the Bamasaaba men who choose to undergo circumcision in the SMMC context and uncover their rationale for doing so. This investigation examines the Bamasaabas' perspectives on medical and traditional circumcisions in their social, historical and cultural context, and the findings may augment those of related studies.

The thesis provides evidence that dialogue is possible, given the fact that many participants suggested a form of male circumcision that combines the best aspects of the two approaches. Cultural leaders, clan leaders and traditional surgeons are directly involved in the cultural and traditional rituals of *imbalu*. Families and the whole communities support the initiates as they negotiate the challenges of transitioning from boyhood to manhood. Proposing dialogue with them would not be problematic, as long as there is respect and understanding of the other party during formal discussions. Both sides would have to acknowledge the context and assumptions of the other party and separate essentials from non-essentials so that changes may be made to the practice of TMC while observing the principles of hygiene and safety.

Although it was not a principal aim of the study, the reference to Glasser's (2017) notion of inductive analysis contributed to understanding in this study. Further studies could make use of a sociological model of health to authenticate these findings in the context of social, environmental and economic factors. These aspects influence the health of a community and play a role in public health interventions. The use of a sociological model may provide an

additional instrument by which to understand the attempt to medicalise TMC and its effect on the Bamasaabas' way of life.

The primary recommendation is that health officials stop trying to enforce SMMC and instead aim to influence the practice of TMC by ensuring that specific health protocols are observed. Health educational campaigns should include recognising cultural practices and striving to effect small but significant changes rather than the wholesale replacement of them. Also, they ought to emphasise sexual behaviour change and promote the adoption of safer sexual practices.

In addition, the government should consider the manner in which other government ministries could play an active role in sensitising or educating local people on the significance of using SMMC. They need to find ways to bridge the political divide.

The findings also suggest that the Bamasaaba can assess and adapt their traditional practices to make them comply with health and hygiene requirements without undue external pressure. The awareness of the need to curb the spread of HIV is already established. For this reason, the government might do well to exert its influence in the area of maintaining sterile conditions during traditional circumcisions rather than insisting that young men undergo the procedure in hospitals.

Lastly, the study suggests that the government should consider designing a health programme that seriously targets health practitioners' and communities' understanding of both the TMC and SMMC. This may help to unravel the social intricacies that come into play when either of these approaches is applied. Using this background, the government should consider the request by the Bamasaaba that proposes a combination of elements in TMC and SMMC to create one unified male circumcision practice. This will help mitigate the multi-faceted tension between the implementation of the SMMCP as it is currently carried out and the practices of TMC.

8.6 Conclusion

This dissertation has drawn attention to the ambivalence the Bamasaaba men feel about the implementation of the SMMCP in the Bugisu communities. This ambivalence arises due to

various or divergent views individuals may hold simultaneously with regard to both tradition and modernity. The approaches of the SMMCP and TMC frame the act of circumcision differently, with the emphasis of the former on medical and health benefits and the latter on its inextricable link with people's culture and identity. The difference in views is expressed in tension and conflict, manifesting in the SMMCP programme's failure to enjoy widespread adoption.

Two factors in the findings of this study exacerbate this tension: the first is that there is a significant political component to the implementation of the SMMCP, sensed and resisted by the Bamasaaba; the second is that there is a profound exertion of long-held cultural influence in the response of the Bamasaaba to the implementation of the SMMCP.

The study has shown that despite numerous explanations offered to the Bamasaaba about the SMMC, most remain unwilling to adopt the medical approach to male circumcision. At the same time, they struggle to maintain their traditional practices of *imbalu* due to external cultural and political pressures brought about by a 'medicalised modernity' that is steadily encroaching upon traditional communities everywhere. Due to medicalisation and modernasition, some of the Bamasaaba men are advocating for social change in the cultural practice of male circumcision. The evidence shows that this small group have joined the government in calling for radical enforcement and upscaling of the SMMC.

Evidence shows that if the Bamasaaba do eventually accept the implementation of the SMMCP, there would have to be a potential shift in the notion of *imbalu* as a test of bravery and pain endurance. Furthermore, receiving SMMC as a biomedical intervention would drastically strip the process of its spiritual connotations as an act that demonstrates initiates' links with their ancestors. This issue would remain unresolved for those who hold to such beliefs.

The acceptance of the SMMCP would require that the Bamasaaba men reconstruct their cultural ideas of *umusaani burwa* ('brave man') and *bumakhoki* ('brother' or 'mate') and adopt a medicalised practice. Currently, the implementation of the SMMCP is seen as a threat to the extensively organised tradition of TMC.

The thesis has also revealed concerns about the circumcising of newborn babies under the SMMC programme in the hospital setting. The Bamasaaba see this as a step in the process of weakening cultural practices in the Bugisu area. Many believe that, in future, there will be no young men to circumcise traditionally. The Bamasaaba reflected that what was currently happening through the SMMCP was a continuation of historical efforts to eradicate *imbalu;* it was not entirely new to them. There is evidence that there have been many attempts to abolish traditional practices of male circumcision over the years (Assimwe, 2011).

The participants believed that the government of Uganda had the objective of developing and implementing the SMMCP to promote SMMC and eradicate the traditional, cultural practice of *imbalu*. This thesis has shone a light on the fact that cultural institutions and leaders have become increasingly politically motivated, often abandoning their role of protecting the traditions and customs of the Bamasaaba. These cultural leaders are paid and afforded security by the government to use their traditional influence to urge acceptance of the SMMCP in the Bugisu communities.

This divisive governmental influence has polarised the Bamasaaba men, promoting the formation of two cultural groups. One group now call themselves *Babukusu*, under the leadership of *Umukhongo We Babukusu*, who support the implementation of SMMC. The remaining majority group, consisting of the indigenous Bamasaaba under the leadership of *Umukuuka We Masaaba*, have mixed feelings on the implementation of the SMMCP.

In general, they resist what they see as cultural weakening and undue political interference in their affairs. They have demonstrated their unhappiness through resisting SMMC and believe that the strategy has unfairly positioned the Bamasaaba men as potential social risks to society. The empirical evidence indicates that the messages used to campaign for the up-scaling of SMMC infer that communities who do not accept it are potential agents of HIV infections.

Finally, the thesis has provided empirical evidence that the stigmatisation of medically circumcised men by men who are traditionally circumcised continues to exist. Even though SMMC is now a component of the government's national health policy, the evidence clearly distinguishes medical and TMC practices. The thesis indicates that the majority of the Bamasaaba men disregard and reject the implementation of health policies when it comes to male circumcision. Also, this thesis makes a clear distinction in its conclusion from conclusions

drawn by Colvin and Robins (2009) and Lissouba et al. (2010) in South Africa. These scholars suggest the extensive implementation of SMMC programmes would have no negative effect on African people's cultural and traditional practices. This study concludes the opposite; that health policies on male circumcision directly challenge the Bamasaaba's belief system and has the potential to weaken the cohesion and identity of the people as a group and as individuals.

The findings reveal that a significant process of social change is underway as the Bamasaaba struggle to retain the cultural practices of *imbalu* in the face of external social forces caused by modernisation. While these forces affect all areas of life, including education, religious practices, economics and health, the study found that *imbalu* stands as an independent and self-managed traditional practice. It is extremely resistant, given that it plays a key role in the identity of the male in a patriarchal culture. The study did not establish to what extent the patriarchal system had influenced the response of the Bamasaaba to the implementation of the reformed health policies on male circumcision. This could be a topic for further study, which could also investigate the position of women in the medical occupation with regard to the implementation of the SMMCP.

Despite its inherent resistance to change, the practice of *imbalu* has adapted in recent years, with the Bamasaaba having abandoned some of the rituals and traditions performed during TMC. However, these changes may not be ascribed to the influence of the SMMC programme since the changes began years before the implementation of the SMMCP. The study finds that the core belief system of the Bamasaaba, as expressed through the traditional ceremony of *imbalu*, remains fundamentally resistant to change, predicated as it is on hegemonic masculinity and deeply held spiritual and cultural beliefs. The Bamasaaba men continue to assert that only traditionally circumcised men are worthy of the term *Basaani burwa.*

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APPENDICES

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9.1 Letter for Permission

Dear Sir/Madam,
I am a registered PhD student at the University of the Western Cape (UWC). I will be investigating how the Bamasaaba are responding to the implementation of the safe medical male circumcision in Uganda. This study will aim at exploring the implication of SMMCP on the traditional practice of male circumcision and how the Bamasaaba are constructing their masculinities.

I will interview medical officers, traditional surgeons, cultural leaders and other local people such as clan leaders in the Bugisu sub-region. I will also audio record all the interviews responses of the participants. The interpreter will be present at all the interview sessions to render any assistance in case of language problems, especially with traditional practitioners, religious practitioners, and clan leaders.

Participation in this research is purely voluntary, and it is acceptable if any person does not want to participate in the interviews. I will thoroughly explain the purpose of the study to the participants before choosing participants. The participants' anonymity and protection are guaranteed; I will not record or attach the participants' names to the research report. I will also give a copy of the final report to the relevant offices if deemed necessary. Thank you for your cooperation.

DECLARATIONS

I, **Bernard Omukunyi,** declare that I have explained the information given in this document to Mr…….. (Name of participant) and encouraged them to ask questions with regard to the proposed study. I will explain everything in English with the help of the interpreter.

…….. ……..
Signature of the Principal Researcher **Date**

Acknowledgement of administrator/cultural leader

At this moment, I consent that Bernard Omukunyi thoroughly explained the foregoing information and am satisfied with the explanation given.

……
Name of administrator/cultural leader

……
Signature of administrator/cultural leader

……
Date

……

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Ph: +27 21 9592831
Fax: +27 21 9592830

9.2 Information Sheet

Topic: The Bamasaaba People's Response to the Safe Medical Male Circumcision Policy in Uganda

Principal Researcher: Omukunyi Bernard

The purpose of the proposed study

The study will explore how the Bamasaaba are responding to the implementation of safe medical male circumcision in Uganda. The study will be conducted by the student in partial fulfilment of the Doctorate in Arts, Department of Anthropology/Sociology at the University of the Western Cape.

Aim of the Study

The principal aim of this study will be to explore how the local Bamasaaba people are responding to the implementation of the reformed health policies on male circumcision in the Bugisu sub-region in Uganda and to understand how the Bagisu of the Eastern part of Uganda has maintained this social practice for generations.

Research Methods

I will interview medical officers, traditional practitioners, religious practitioners, district cultural leaders and other local people such as clan leaders in the Bugisu region. I will also audio record all the interview responses of the participants. The interpreter will be present in all the interview sessions to render any assistance in case of language problems, especially with traditional practitioners, religious practitioners and clan leaders.

Potential Risks and Discomfort

The ritual is often opened officially by cultural leaders at the Mutoto Cultural Centre. On 1 August, the ritual of *imbalu* brings a festive atmosphere, where the parents of the initiates serve music blares, people

dance and plenty of food, including a local bear called Kamalwa. The participants may miss some activities due to the participation in the proposed study.

Potential Benefits to participants and society

The study may involve strategies to manoeuvre new ideas linking traditional male circumcision to Uganda's government health policies. This may help traditionally circumcising communities, especially the Bagisu, to preserve their tradition, culture, and custom without conflicting with the current guidelines on clinical male circumcision. I may give a copy of the final report to the relevant offices if deemed necessary.

Payment for Participation

There will be no payment for participation in the proposed study. Participation in this research is purely voluntary, and it is acceptable if any person does not want to participate in the interviews. However, participation will help bring awareness to policy developers of the need to find strategies that manoeuvre new ideas linking traditional male circumcision to government health policies in Uganda.

Identification of Researchers

The proposed study will be conducted under the supervision of **Prof. Krishnavelli Nadasen,** the Lecturer at the Department of Anthropology/Sociology, Arts Faculty, and the University of the Western Cape. You can contact the principal researcher **Bernard Omukunyi** by email: bomukunyi@uwc.ac.za or 3011024@myuwc.ac.za for more information concerning the study.

UNIVERSITY *of the* WESTERN CAPE

DEPARTMENT OF ANTHROPOLOGY and SOCIOLOGY

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South Africa
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The Bamasaaba People's Response to the Safe Medical Male Circumcision Policy in Uganda

Principal Researcher: Omukunyi Bernard

9.3 Informed Consent Form for All Participants

I …… declare that I have discussed with Bernard Omukunyi, a PhD student at the University of the Western Cape (UWC) and agreed to participate in his study about the response of the Bamasaaba people to the implementation of the reformed public health policies in the Bugisu sub-region in Uganda. I have been fully informed about the purpose of the study and understand that the information I will give to Bernard Omukunyi will not in any way cause harm either to me or to any other person related to me.

I also understand that Bernard Omukunyi and his supervisor will handle the information obtained from me confidentially when writing his PhD thesis in Arts, Sociology. I fully understand that the field notes will be audio- and video- recorded. Bernard and I have agreed that the books and audiotapes containing information will be destroyed after writing and submitting the report for examination and publication. Most importantly, I have been fully informed that this is a voluntary initiative; therefore, I have a right to either participate or not participate in this research.

……
Participant's name

…….
Signature of the participant

9.4 Letter for Ethical Clearance

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

02 December 2015

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by Mr B Omukunyi (Anthropology and Sociology)

Research Project: ***The Bamasaaba People's Response to the Safe Medical Male Circumcision Policy in Uganda***

Registration no: 15/7/65

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics 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

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948.
F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

UNIVERSITY of the WESTERN CAPE

Faculty of Arts

01 December 2015

9.5 Confirmation of Thesis Title Registration and Ethical Clearance

This is to confirm that the PhD proposal and thesis title of **Mr Bernard Omukunyi** (**Student number: 3011024**) was approved at the ARTS post-graduate committee meeting (reference: ARTHD 2015/10) of 05 November and the Senate Higher Degrees meeting held on 18 November (reference: SHD 2015/12). Ethical clearance for his research was approved at the Senate Research meeting of 27 November 2015.

For further information, please contact the ARTS post-graduate

office. Kind regards

.....

Villeen Beerwinkel
Faculty Officer: Post Graduate Affairs Faculty of Arts
University of the Western Cape Bellville
7532
021 959 9257

Dean: Prof DJ Brown, djbrown@uwc.ac.za
Faculty Manager: Ms S Mcwatts, smcwatts@uwc.ac.za
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UNIVERSITY OF THE WESTERN CAPE
DEPARTMENT OF
ANTHROPOLOGY/SOCIOLOGY

9.6 Letter of Introduction

Private Bag X17
BELLVILLE
7535
CAPE TOWN
SOUTH AFRICA
Tel: (021) 959 2336

The Umukuuka
We Masaaba
Bugisu sub-region
Republic of Uganda

22 **July** 2016

Dear Sir/Madam

RESEARCH BY MR BERNARD OMUKUN

The title of his research is: ***The Bamasaaba People's Response to the Safe Medical Male Circumcision Policy in Uganda***

This confirms that **Mr Bernard Omukunyi (Student no. 3011024)** is a registered Doctoral Student at the University of the Western Cape, SouthAfrica.
Uganda.

To complete his study, Mr. Omukunyi must conduct interviews with specific stakeholders and personnel at Inzu ye Bamasaaba (Bugisu Cultural Institution), who can provide insight into the practice of male circumcision, have also been identified as those who can provide invaluable information regarding this practice in Uganda. **The Department of Anthropology** and Sociology hopes that the ***Inzu ye Bamasaaba*** will grant and allow Mr Omukunyi to collect the relevant **information during his fieldwork.**

Should you **require any further information regarding the** above, please contact me at 27 **21 959** 2336 or knadasen@uwc.ac.za

Yours sincerely

9.7 Letter of Permission

INZU - YA MASAABA

(Bamasaaba Cultural Institution)

P. O. BOX 14
MBALE – UGANDA
Website: http://www.inzuyamasaaba.org

OFFICE OF UWELUKOOSI
UMUKUUKA WE BAMASAABA

Secretary General: 0785 725017
0754 491142
Email: gwepondi@gmail.com
Email: umukuuka@inzuyamasaaba.org

5TH August 2016

The University of The Western Cape Department of Anthroplogy/Sociology
Private Bag X17
Bellville 7535
Cape Town South Africa
Tel: (021) 9592336

RESEARCH BY MR. BERNARD OMUKUNYI STUDENT NO. 3011024

You sent us Mr. Bernard Omukunyi a Doctoral student of your University Registration **(number 3011024)**to carry out the Research entitled **''The Bamasaba People to the Safe Medical Male Circumcision in Uganda''**

This student has been received and His Highness the Umukuuka has allocated him to the Minister of Culture and the Secretary General of Inzu Ya Masaaba to help him conduct the necessary interviews to assist him carry out his research in the practice of Male circumcision in Uganda. His attachment to Mr. Geoffrey Wepondi as a Lecturer at Uganda Management Institute in Uganda, will help this student get the necessary information to enable him put together his research.

When the student is done with his research he may provide the Inzu Ya Masaaba with a copy for future other research.

I wish him good luck in his pursuits.

Thank you.

Hon. Geoffrey Wilson Wepondi
SECRETARY GENERAL INZU YA MASAABA

Cc. His Highness Umukuuka Umukuuka II We Bamasaaba, Sir Bob SK Mushikoori
Cc. Prime Minister Inzu Ya Masaaba Cultural Institution

UNIVERSITY of the
WESTERN CAPE

The Bamasaaba's Response to the Safe Medical Male Circumcision Policy in Uganda

BY

Principal Researcher: Bernard Omukunyi

Supervisor: Prof. Krishnavelli K Nadasen

Institution: University of the Western Cape

Faculty: Arts and Humanities

Department: Sociology

Program: SOC 901 PhD

9.8 Data Collection (In-Depth Interview Schedule)

RESEARCH OBJECTIVES

This study's broad research investigates the Bamasaaba's response to the implementation of the Safe Medical Male Circumcision Policy (SMMCP) in Uganda. The following specific objectives underpinned this research aim.

1. To explore the Bamasaaba's response to the SMMCP;
2. To analyse the impact of the SMMCP on the Bamasaaba's cultural practices;
3. To analyse the social and political implications of the SMMCP on the Bamasaaba;
4. To understand how the Bamasaaba conceptualise masculinity.

Research questions

1. What is the Bamasaaba's response to the implementation of the SMMCP?
2. What is the influence of the Safe Medical Male Circumcision Policy's (SMMCP) on the cultural practices of *imbalu*?
3. What are the social and political implications of the Safe Medical Male Circumcision Policy on the Bamasaaba?
4. How does the discourse of masculinity influence the Bamasaaba's response to the implementation of the SMMCP?

This in-depth interview schedule aims at obtaining information from cultural and clan leaders about the response of the Bamasaaba to the safe medical male circumcision.

9.8.1 The Cultural and Clan Leaders (*Besikuuka*)

1. What is *imbalu*?
2. Why do the Bagisu perform *imbalu* rituals?
3. What are the rituals performed during August?
4. What role do you think *imbalu* rituals play in society?
5. What do you tell candidates during the smearing ritual?
6. Who is supposed to be in charge of the smearing ritual?
7. Can you describe to me the process of *imbalu* rituals?
8. What is your role as a man and cultural leader during *imbalu* rituals?
9. What kind of role do women play during *imbalu* rituals?
10. Who is a man in Bugisu?
11. How do you become a man in the Bugisu sub-region?
12. What reasons do the Bamasaaba give for undergoing traditional male circumcision (*imbalu*)?
13. What is Safe male circumcision?
14. What is the response to the safe medical male circumcision (programme) in your area?
15. Why do you think (that is) the response?
16. Can you go to the hospital for male circumcision?
17. What happens to a boy who undergoes circumcision in the hospital?
18. Were you consulted when the government was drafting the safe medical male circumcision policy in Uganda? Why?
19. What is your role in the implementation of the safe medical male circumcision?
20. Are there rituals performed after someone has undergone hospital male circumcision?
21. What is your reaction to boys or men who go to the hospital for male circumcision in the Bugisu sub-region?
22. What do you think is the general reaction of the Bamasaaba to the government new health policies on male circumcision in Uganda?

Mention any other factor that you think is currently affecting the traditional practice of traditional Male Circumcision in the Bugisu sub-region.

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9.8.2 Traditional Surgeons (*Bakhebi*)

1. Tell me the specific roles you play in *imbalu* circumcision rituals?
2. How did you acquire the work of circumcising boys?
3. Who taught you this work, and why?
4. Can you tell me how you carry out the operation?
5. How do you feel before and after circumcising the boy?
6. What role do you think *imbalu* rituals play in society?
7. How much is paid for this kind of work and why?
8. What happens if the boy you are circumcising touches you?
9. Are there traditional surgeons who are women? Why?
10. Who is a man in Bugisu?
11. How do you become a man in the Bugisu sub-region?
12. What reasons do the Bamasaaba give for undergoing traditional male circumcision (*imbalu*)?
13. What is Safe male circumcision?
14. What is the difference between circumcision at the hospital and *imbalu*?
15. What is the response to the safe medical male circumcision in your area?
16. Why do you think that is the response?
17. Can you go to the hospital for male circumcision?
18. What happens to a boy who undergoes circumcision in the hospital?
19. Were you consulted when the government was drafting the safe medical male circumcision policy in Uganda? Why?
20. What is your role in the implementation of the safe medical male circumcision?
21. Are there rituals performed after male circumcision in the hospital?
22. What is your reaction to boys or men who go to the hospital for male circumcision in the Bugisu sub-region?
23. What do you think is the general reaction of the Bamasaaba to the government new health policies on male circumcision in Uganda?

Mention any other factor that you think is currently affecting the traditional practice of traditional Male Circumcision in the Bugisu sub-region.

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9.8.3 The 2016 Initiates *(Bafuulu)*

1. What motivated you to demand *imbalu*?
2. Did you go to the hospital, or you were circumcised at home?
3. Can you narrate the activities you went through from the beginning of the circumcision year up to the time you were circumcised?
4. Can you sing some of the songs you performed during *imbalu*?
5. How did you feel when the circumciser was cutting you?
6. Why didn't you go to the hospital for male circumcision?
7. Narrate to me the activities that happened on the day you were circumcised?
8. Tell me what the elders told you during the smearing ritual?
9. What did the elders tell you on the day of circumcision?
10. Who is a man in Bugisu?
11. How do you become a man in the Bugisu sub-region?
12. What reasons do the Bamasaaba give for undergoing traditional male circumcision (*imbalu*)?
13. What is Safe male circumcision?
14. What is the response to the safe medical male circumcision in your area?
15. Why do you think the response is like that?
16. Will you agree to be circumcised by a woman? Why?
17. Why didn't you go to the hospital for male circumcision?
18. What happens to a boy who undergoes circumcision in the hospital?
19. Are there rituals performed after having the hospital male circumcision?
20. What is your reaction to boys or men who go to the hospital for male circumcision in the Bugisu sub-region?
21. What do you think is the general reaction of the Bamasaaba to the government new health policies on male circumcision in Uganda?

Mention any other factor that you think is currently affecting the traditional practice of traditional Male Circumcision in the Bugisu sub-region.

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9.8.4 Medical officers

1. How did you get circumcised?
2. Tell me the specific roles you play during circumcision in the hospital.
3. Can you tell me how you carry out the operation in the hospital?
4. Can you circumcise a boy outside the hospital setting?
5. What do you say about the practice of *imbalu* rituals?
6. What role do you think *imbalu* rituals play in society?
7. What happens to the Bagisu who dodge *imbalu*?
8. How should *imbalu* be performed?
9. Who is a man in Bugisu?
10. How do you become a man in the Bugisu sub-region?
11. What reasons do the Bamasaaba give for undergoing traditional male circumcision (*imbalu*)?
12. What is Safe male circumcision?
13. What is the response to the safe medical male circumcision in your area?
14. Why do you think that is the response?
15. Can you go to the hospital for male circumcision?
16. What happens to a boy who undergoes circumcision from the hospital?
17. Were you consulted when the government was drafting the safe medical male circumcision policy in Uganda? Why?
18. What is the role of women in the implementation of safe medical male circumcision?
19. What is your role in the implementation of the safe medical male circumcision?
20. Are there rituals performed after having the hospital male circumcision?
21. What is your reaction to boys or men who go to the hospital for male circumcision in the Bugisu sub-region?
22. What do you think is the general reaction of the Bamasaaba to the government new health policies on male circumcision in Uganda?

Mention any other factor that you think is currently affecting the traditional practice of traditional Male Circumcision in the Bugisu sub-region.

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9.8.5 The Focus Groups

1. Who is a man in Bugisu?
2. How do you become a man in the Bugisu sub-region?
3. What reasons do the Bamasaaba give for undergoing traditional male circumcision (*imbalu*)?
4. What role do you think *imbalu* rituals play in society?
5. What is the symbolic meaning of pain during *imbalu*?
6. Can a boy acquire manhood through the safe medical male circumcision among the Bamasaaba?
7. What cultural values do you think are attached to traditional male circumcision (*imbalu*) in Bugisu?
8. Can a woman perform male circumcision on a man in the Bugisu community? Why?
9. What is your view on traditional male circumcision practised by the Bamasaaba?
10. Why do you think some of the Bamasaaba boys and parents opt for clinical male circumcision instead of traditional male circumcision (*imbalu*) in Bugisu of late?
11. Mention some of the rituals performed by the Bamasaaba during and after the initiation of boys into men?
12. What is safe male circumcision?
13. What is the response to the safe medical male circumcision in your area?
14. Why do you think the response is like that?
15. Can you go to the hospital for male circumcision?
16. What happens to a boy who undergoes circumcision in the hospital?
17. Were you consulted when the government was drafting the safe medical male circumcision policy in Uganda? Why?
18. What is your role in the implementation of the safe medical male circumcision?
19. Are there rituals performed after undergoing the hospital male circumcision?
20. What is your reaction to boys or men who go to the hospital for male circumcision in the Bugisu sub-region?
21. What do you think is the general reaction of the Bamasaaba to the government new health policies on male circumcision in Uganda?

Mention any other factor that you think is currently affecting the traditional practice of traditional male circumcision in the Bugisu sub-region.

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9.8.6 Turnitin Report

PhD thesis draft for 2020 Submission

ORIGINALITY REPORT

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UNIVERSITY of the
WESTERN CAPE

9.8.7 Editor's Letter

Dust Jacket
1 Village Square
16 Hampstead Road
Harfield Village
7708
November 2020

Dear Madam/ Sir

ENGLISH LANGUAGE TEXT-EDIT OF PhD THESIS

This confirms that I have text-edited Mr Bernard Omukunyi's PhD thesis entitled 'The Bamasaaba people's response to the Safe Medical Male Circumcision Policy in Uganda' for syntax, cohesion and fluency of expression.

I hope that subject to adopting a few recommended alterations, the thesis fulfils the required language proficiency level.

Yours faithfully

Marilyn Braam (M.A. specialising in Language, Literature and Modernity (UCT, 2015))