XHOSA MALE CIRCUMCISION AT THE CROSSROADS: RESPONSES BY GOVERNMENT, TRADITIONAL AUTHORITIES AND COMMUNITIES TO CIRCUMCISION RELATED INJURIES AND DEATHS IN EASTERN CAPE PROVINCE.

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A thesis submitted in partial fulfillment of the requirements for the degree of Masters of Arts in Anthropology

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DECLARATION

I declare that "Xhosa Male Circumcision at the Crossroads: Responses by Government, Traditional Authorities and Communities to Circumcision Related Injuries and Deaths in Eastern Cape Province" is my own work. I further declare that it has not been submitted for any degree or examination in any other university, and that all the sources, used or quoted have been indicated and acknowledged by means of complete references.

Ayanda Nqeketo **September 2008**

Signature

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ABSTRACT

XHOSA MALE CIRCUMCISION AT THE CROSSROADS: RESPONSES BY GOVERNMENT, TRADITIONAL AUTHORITIES, AND COMMUNITIES TO CIRCUMCISION RELATED INJURIES AND DEATHS IN THE EASTERN CAPE PROVINCE.

Ayanda Nqeketo **M.A. Thesis, Department of Anthropology and Sociology**

A significant portion of South Africa's indigenous population has been practicing the ritual of male circumcision for centuries. In most of these cultures, the ritual serves as a rite of passage from boyhood to manhood, without which men are culturally forbidden from getting married or establishing their own households. Over the last few decades, however, male circumcision amongst indigenous societies in South Africa has been undermined by many factors. These include changes in value systems, schooling, urbanization, commercialization of cultural activities, and the emergence of new diseases. Recently, because of the many deaths of initiates, some of which are blamed on poor health standards in initiation schools, the government and other stakeholders have been crying for ways to make the ritual safer. Thus some, including government, are calling for a complete review of the way the ritual is performed, arguing that it ought to be adapted to these new challenges. In 2001, the Eastern Cape government, through Department of Health (ECDOH), passed a law known as the Application of Health Standards in Traditional CircumcisionAct, (No 6 OF 2001) of the Eastern Cape. This thesis is an attempt to understand how different stakeholders have responded to this intervention and what steps they have taken to indicate their responses. This study addresses several key questions. Firstly, is there a justifiable concern regarding the deaths and injuries of initiates during the traditional male circumcision ritual in the Eastern Cape Province? Secondly, is there awareness about the Application of Health Standards in Traditional CircumcisionAct, No 6 of 2001? Thirdly, did the local communities participate in the development of the Application of Health Standards in Traditional CircumcisionAct, No 6 of 2001? Fourthly, what are the barriers preventing the implementation the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001? Fifthly, who are the key stakeholders that should be involved to ensure successful circumcision reform? Data collection used a variety of research

methods, including in-depth interviews, observations, and review of secondary literature. A range of stakeholders was interviewed, including medical personnel, traditional authorities, and ordinary villagers. There are a number of conclusions emerging from this study. Firstly, on the issue of the escalation of injuries and deaths within Xhosa male circumcision, this study has concluded that all involved stakeholders do wish to see improvements in the situation. Secondly, on the issue of cultural rights, within which Xhosa male circumcision falls, versus the state's responsibility to ensure the health of all people, the study concludes that a balance between cultural and human rights has to be achieved, hence group rights should not be allowed to override individual rights. Thirdly, on the role of traditional authorities and their clinging to exclusive traditional tendencies, such as barring women from being involved in the discussions about the ritual, or the banning of Western medicine during initiation schooling, the study concludes that such use of medicinal treatment be accepted so as not to compromise the health of the initiates. In addition, the study concludes that women have the parental right to decide on who should be responsible for the aftercare of their children during initiation. Lastly, on the issue of intervention by health officials, it is recommended that when such health implications arise during the duration of the school, such health management be done by male health professionals who themselves have undergone the traditional initiation process.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE: INTRODUCTION

1.1. BACKGROUND AND STATEMENT OF THE PROBLEM

1.1.1. The Traditional Male Circumcision Ritual in Brief

Male circumcision is a common practice in many parts of the world, especially amongst indigenous people (Funani, 1990). Others go on to argue that it is probably the oldest surgical procedure known to mankind and that it almost certainly began as a religious rite (Mayatula and Mavundla, 1997). According to Mehtar and Faas (2001), in cases where it is used as a rite, circumcision is an essential step in the transformation of males from boyhood to manhood. In the Holy Bible, God's instructions to Abraham are that he and his descendants must all agree to circumcise every male among them, "to show that there is a covenant between them and God". Circumcision is also an old practice among Muslims. Although there is no clear directive on this subject in the Koran, Muslims practice circumcision on a massive scale, and the operation is traditionally performed from the age of four years up to the beginning of puberty, at around the age of 13 years (Radio 702 talk show: 26.07.95, cited in Mayatula and Mavundla, 1997). Therefore, with the Muslims and some Christian communities, as well as with various traditional societies around the world, the operation is regarded as having a significant religious and cultural value (Funani, 1990).

This thesis focuses on male circumcision as it pertains to the South African situation. Different African cultures, which practice male circumcision for cultural and religious purposes in South Africa include, amongst others: the Xhosa; Ndebele, Pedi, South Sotho and Venda (Shisana and Simbayi, 2002). According to Van Vuuren and De Jongh (1999), in most indigenous South African communities where the ritual is practiced, it coincides with physical puberty, either immediately, during early adolescence (13-14 years) or later, during the 18-20 year-old stage. It also needs to be pointed out that in South Africa, circumcision has gone through periods of decline and resurgence. For example, a number of writers noted that there is a tendency to abandon circumcision schools in times of war or conflict, because it is feared that initiates would be unable to escape in the event of an attack. During one such occasion, Shaka, a Zulu king who ruled during the nineteenth century, stopped it among the Zulus for military reasons (Funani, 1990). In other places, like Pondoland, it is argued that health

concerns were primarily responsible for the abandonment of circumcision among the Mpondo during the nineteenth century (Funani, 1990). Although the motivation for the prohibition of circumcision in Pondoland remains somewhat unclear, there are two possible explanations, which may not be mutually exclusive. Firstly, the ban on circumcision schools could have been initially intended to keep males unmarried for a longer period, and therefore, prolong their availability for service to the king (Stapleton, 1998). Secondly, the same author argues that another possible reason may have been that one of Faku's sons was not well enough to endure initiation; and to protect him from possible ridicule for not being circumcised; the king banned the ritual for the whole nation. However, circumcision trends have changed owing to the passage of time, migration of tribes, as well as rebirth of African societies. For example, the current generation of Amampondo does undergo circumcision rites.

In this thesis, specific reference is made to male circumcision amongst the Xhosa in the Eastern Cape Province.[1] According to Meintjies (1998b), Xhosa people have practiced traditional male circumcision and initiation of young men for centuries. The practice of circumcision was regarded as an educational institution where initiates were taught about courtship, negotiating marriage, social responsibilities, and their conduct as men. In the Xhosa cultural context, a male who has reached puberty or passed a particular age without being initiated through circumcision is regarded, socially, as a boy. This concept has created some problems in Xhosa communities, because of the stigmatization amongst peers. Male circumcision is essentially the formal incorporation of males into Xhosa religious and tribal life. An uncircumcised male cannot inherit his father's possessions, nor establish a family through marriage. He also cannot officiate in ritual ceremonies (Funani, 1990). So uncompromising are the Xhosa people on this issue, that no Xhosa woman would knowingly and willingly marry an uncircumcised Xhosa male (Dwane, 1979). To emphasize the importance of male circumcision among the Xhosa, it needs to be mentioned that a Xhosa male who is not circumcised is described, quite simply, as a boy, an *inja* (dog), or an *inqambi* (unclean thing) (Funani, 1990). Going for circumcision becomes a boy's transitional stage; it elevates him from

[1] The researcher acknowledges the fact that the Xhosa nation has different branches e.g. Bomvana, Baca, Gcaleka, Mpondo etc but the differences between these branches in terms of the ritual are not as pronounced to make any significance in terms of how the ritual is done. However in this thesis the researcher will loosely refer to Xhosa culture to include all these branches.

being described as an *inja* (a dog) to full manhood, communal pride, and individual worth (Mehlomakulu, 2000). Mkele (1990, cited in Mehlomakulu, 2000), on the other hand, points out that an uncircumcised male, past circumcision age may be overpowered by a group of men and circumcised against his will. From enduring the ordeals of circumcision, the initiates emerge with a new social identity, new moral responsibilities, entitlements, and emblems of manhood (Herdt, 1981, cited in Mehlomakulu, 2000).

1.1.2. Male Circumcision Procedure

In the Xhosa culture, it is generally the boy's decision to be circumcised, but he must first approach and get a blessing from his father or other close male relative, if there is no father. With the widespread occurrence of single parenthood, where for example there is no involved father, the mother may consult with the males of the clan, when the boy shows signs of delinquency (Mehlomakulu, 2000). It is the senior male relative among these who will then take circumcision matters forward

Preparations for circumcision include the appointment of a host (*ususothu*), the building of the lodge (*ithonto*), the nomination a trustworthy man known as *ingcibi* (traditional surgeon) to perform the circumcision procedure, and the appointment of an *ikhankatha* (traditional nurse) whose job is to take care of the wound until healing has occurred. The primary concern of the traditional nurse is to keep the wound clean and to do regular dressings. Depending on his clan, peers of the boy, which includes girls, often spend the night with him during what is known as *umguyo* (celebration), to help him not to think too much about the surgery that is to take place the following day. Again, depending on his clan, the night before circumcision, a boy may undergo another ritual known as *umngcamo* (tasting of meat), which is done to give him his last taste of meat for a while.

A traditional surgeon (*ingcibi*) normally performs the actual surgery, using a special knife known as *umdlanga*. These days, however, the traditional surgeon uses a simple sharp knife or a surgical scalpel in place of the *umdlanga*. The boy being circumcised has to sit still, with his legs wide open. The *ingcibi* then takes the prepuce (foreskin) of the boy with his hand and amputates it with the knife, using a sawing motion. Long-term ridicule from other men results from any movement, show of fear or visible response to pain, as cowardice. On being circumcised and in severe pain, the boy has to

scream, "*ndiyindoda*". "I am a man." Symbolically, this is an announcement and expression of his recognition of his new status (Mbita, 2000). Thereafter, the traditional nurse supervises wound care. Traditionally, leaves from plants, such as *isicwe* or *isigqutsu* (*Helichrysum pedunculare*) are used as bandages for the wound (Van Vuuren and De Jongh, 1996). These days, a mixture of leaves and other modern ointments are used to treat the wound. The care of the wound is intensive, with frequent dressing changes, several times a day (Meintjies, 1998b). As the wound heals, this is done less frequently. It is also common to have some initiates either helping each other to dress their wound or even dressing it themselves.

During the first eight days, the initiates (*abakhwetha*) are confined to their *ibhoma* (temporal dwelling) and are subjected to dietary and fluid restrictions. According to Witbooi (2005), during the first week of circumcision, initiates are traditionally not allowed to eat anything except parboiled maize and only salt less stamp mealies or samp, which are brought everyday from his home. These diets may vary depending on regions and modernization within the community. They also abstain from drinking water for at least the first eight days. Failure to adhere to these instructions, it is believed, leads to excessive wetness of the wound. This is a complication, because it is also believed that a dry wound heals faster (Witbooi, 2005). In most Xhosa clans, after approximately eight days, an animal, usually a goat or a sheep, is slaughtered for the initiate. This ritual is known as *ukojiswa* or 'to roast for', and signifies the end of the food taboos. This ceremony is strictly an all-male feast and marks the first day of an initiate's full meal without restriction. After this, an initiate may eat anything he wants (Mehlomakulu, 2000).

Beside the food restrictions, initiates are forbidden in several other fronts. For example, they are not to have contact with married women, (Van Vuuren and De Jongh, 1999). The belief surrounding that thought is that any contact with women during this period is associated with bad luck. Therefore, no married women can approach the initiates or go anywhere near the seclusion lodge. The avoidance of women is also to prevent the slightest form of sexual arousal, which may cause the circumcised skin to stretch, possibly causing pain and delay the healing process; hence initiates always carry a stick in order to hit the ground hard should any disturbing thoughts cross their minds (Funani, 1990, cited in Van Vuuren and De Jongh, 1999). It is believed that hitting the ground

distracts the mind from thinking about sex. There are also cultural beliefs, which influence the exclusion of women in the process of circumcision. Fear of initiates being bewitched is, for example, one of them.

At the end of the seclusion period, the initiate leaves for home, and the bush lodge is burnt to ashes to symbolize a new beginning (Mehlomakulu, 2000). The initiate is not allowed to look back at the burning lodge to show that he is abandoning his former ways and adopting new behaviors befitting his new role as an adult. An initiate receives a new blanket, and now is called *ikrwala* or new man (Van Vuuren and De Jongh, 1999). A coming-out ceremony, complete with celebrations, marks the return home of the new man. The ceremony is called *umgidi*. The new man is given new clothing to indicate his new start in life as a man.

1.1.3. Xhosa Male Circumcision Ritual at the Crossroads

Recently, male circumcision amongst indigenous societies in South Africa has been undermined by many factors. These include changes in value systems, urbanization, commercialization of cultural activities, and the emergence of new diseases. Combined, these broad factors have become a central threat to the ritual, including threatening the life of the initiates. On several fronts, medical and cultural, some are questioning the ritual, asking whether it should be reviewed according to changing times (Herald Newspaper, 17-01-2005). However, there are some concerns about this thought. For example, hospital circumcision is a medical procedure that is not culturally acceptable, as it takes away the value of circumcision as indicative of a man's worth in the group (Funani, 1990). This section, therefore, discusses some of the issues that constitute current challenges facing male circumcision.

Education

While no precise studies have attempted to look at the impact of the education system on male youth initiation schools in South Africa, the demands of the school calendar have an indirect impact on circumcision. For example, in the past, the seclusion period lasted from between three to six months, but now anything between two to three weeks is seen as enough. It is generally believed that two to three weeks is not enough for the healing of the wound. There are strong indications that schooling has become the site of

focus. There are obvious clashes between the demands of traditional rites and the demands of the Western culture, in this case represented by schooling. At a Council of Education Ministers' meeting in 2001, the council resolved to meet with traditional leaders to try to reconcile the interests of formal education and the traditional needs of initiation schools. In particular, the meeting between the two groups sought to synchronize the respective calendars, so that the two systems are not competing for the time of learners (CEM, 2001).

Urbanization

According to Mehlomakulu (2000), in rural areas, the circumcision rite is strongly influenced by the rural nature of the area, the recognition of supremacy of the chief, the season of the year, and strong tribal ties. In this section, an attempt is made to show how this rite is affected by urbanization of African cultures. According to (Meintjies, 1998), it is obvious that the rite has been transformed in terms of form and function, as affected by migration of rural people to urban areas, and the urban setting in general. Firstly, the migrant labour system has had a negative impact on this male ritual, because fathers or other senior males in rural areas do not have time to supervise initiates in the process, as it was the case in the past (Meintjies, 1998a), because they are absent for most of the year. Traditionally, older men visited the bush daily and would oversee and advise on wound care, augmenting the work of the *ikhankatha* (traditional nurse). Today, this is often left to young *amakhankatha* alone (Meintjies, 1998a). A related point is that, due to this absence of male figures, transmission of values, cohesion of the family, and the sense of morality are being significantly reduced (Mehlomakulu, 2000).

Secondly, the movement of families to urban areas has resulted in the loss of traditional and inherited safety mechanisms, precautions, and control mechanisms that would have been there in rural areas (Meintjies, 1998a). The all-encompassing and sheltering influence of the life of a tribe in the rural areas, for example, is replaced in townships by circumstances that tend to de-emphasize the lineage system (Mehlomakulu, 2000). According to Meintjies (1998a), urbanization is likely the primary reason that incidences of injuries or deaths of initiates are higher in urban and suburban areas. He contends that social dynamics, practices, and practitioners operating in urban areas, which are fundamentally different from those in rural areas, are the major factor in this dilemma.

In urban areas, for example, new ways of doing things, which modify the form of the ritual to suite the dynamics prevalent in the area, are being adopted. These dynamics, according to Mehlomakulu (2000), quite often dictate the when, how, why, who and where of the ritual. Due to space limitations and urban demands in urban areas, for example, the building material for the lodge nowadays is different from the one used in rural lodges, which is often made with thatch grass. Urban lodges are instead built using plastic, cardboard, or corrugated iron (Funani, 1990). These materials are likely responsible for poor aeration, which in turn delays healing of the wound. Additionally, as urban lodges are usually close to residential areas and public roads, initiates are often exposed to several challenges, such as their exposure to females, which may lead to possible arousal, and may result in a delay of healing. In addition, proximity to residential areas and public roads removes the sense of seclusion for the initiates, causing some of them to continue to engage in activities such as drinking, drug use, and so forth. In the end, this may affect their healing process[2].

Commercialization of culture

Commercialization of the ritual of circumcision is one of the key challenges that this practice faces these days. According to Mabote (1995), with the passage of time and the introduction of the cash economy in African transactions and affairs, circumcision has not escaped the impact of commercialization and abuse by certain people. For example, the circumcision procedure was formerly performed by elders, but now is increasingly being taken up by younger men, some of who do not understand the proper dressing techniques and are negligent in the area of cleanliness (Meintjies, 1998b). Whereas in the past, the practitioners would be respected, as they would be elderly members of the community, nowadays, they are younger, often unemployed men who take up the job for financial reward (Meintjies, 1998a). Traditional surgeons and nurses are now charging money instead of just helping for free or receiving rewards in kind, for instance, some of the meat slaughtered for the initiate. In other words, traditional surgeons and nurses no longer perceive their services as a traditional contribution or obligation.

[2] Personal communication, Dr Thembela Kepe, Cape Town, May 2005.

In some rural areas, such as Flagstaff in Pondoland, traditional surgeons and nurses charge between fifty and eighty rands for their services per initiate[3]. In urban areas today, parents are compelled to contribute between fifty and hundred rands depending on whether the surgeon is a close relative to the clan of the initiate[4]. In addition, people involved often seek to make quick money, thus ending up prepared to cut corners in how they do their jobs. This compromises the safety and care of the initiates. Additionally, due to the opportunities to make money, young boys, some as young as eight years of age, are at times kidnapped from their homes to increase the numbers in initiation schools (Mabote, 1995). When these boys refuse to go to circumcision schools, there are reports that the abductors assault them (Rankhotha, 2004).

Sexually transmitted diseases

Another major, but recently new, challenge to the ritual of circumcision is the spread of sexually transmitted diseases. According to Funani (1990), some boys, who are circumcised, have sexually transmitted diseases, something that was uncommon in the past, because sex was forbidden until marriage. While several of these are relevant, the focus here is on HIV/AIDS, one of the major killers of youth in South Africa (Groenewald et al, 2005). There are at least two ways in which HIV/AIDS is relevant to traditional male circumcision. Firstly, the traditional circumcision method, the use of a traditional knife on more than one initiate, is an easy way to spread HIV (Shisana and Simbayi, 2002). Here, the traditional surgeon would not sterilize the knife before going on to circumcise the next initiate. In several cases, initiates undergo the ritual in groups of between two and more, and are usually operated on by the same man, using the same knife. Secondly, for some initiates who go to the initiation school while having HIV/AIDS, their wounds may become infected, potentially aggravating their HIV/AIDS condition[5]. The consequences of this current state of affairs have resulted in an increase in hospital admissions, skin grafts, deceased initiates, and suicides.

[3] This is based on an interview with an *ikhankatha* (traditional nurse) in Flagstaff, June 2003.
[4] This is base on an interview with an *ingcibi* in Port Elizabeth, June 2004.
[5] Dr Xola Kanta, traditional circumcision workshop held in Umtata on June 9, 2004.

Table 1: Circumcision Statistics report over nine year period: Flagstaff Health District

INCIDENT	YEAR									
	1996	1997	1998	1999	2000	2001	2002	2003	2004	TOTAL
Hospital admissions	79	43	83	49	79	61	45	58	35	532
Amputations	11	3	13	2	4	7	7	14	2	63
Skin grafts	0	1	5	2	0	0	0	0	0	8
Deceased initiates	5	2	9	10	12	16	10	12	6	82
Deceased peers	0	0	0	3	0	1	0	0	0	4
Missing initiates	0	0	1	0	0	0	0	0	0	1

ECDOH -Qaukeni Local Service Area-Circumcision Annual Statistical Report (1996- 2004)

As it can be seen from the Table 1 above, many initiates have died or have been severely injured between 1996 and 2004, with at least 82 deaths and 63 penis amputations during the nine years. The figures, which are up and down from year to year, make it difficult to point to any pattern. However, there was a noticeable reduction in hospital admissions in this region during 2004. Obviously, these complications raise many challenges. Therefore, the next section discusses these challenges.

1.1.4. Responses to Challenges in Xhosa Male Circumcision

The recent increase in hospitalization and mutilations that occur for Xhosa initiates undergoing manhood initiation rites receives wide coverage in the South African media. To many, these all point to the need to regulate the custom. Thus, the intervention by traditional, non-governmental, as well as governmental, structures has been seen as necessary. This situation has led to growing concern on the part of the local communities, civic organizations, health care workers and, recently, politicians and traditional leaders within the Eastern Cape provincial government (Meintjies, 1998b).

In order to respond to this, the Eastern Cape government proposed a number of intervention strategies. For example, in 2000, health experts visited Malaysia as part of a global search for ways to stem the level of male circumcision-related fatalities (Pritchard, 2000). That visit yielded the proposition of the use of a Tara Clamp. This is a device invented and popularized in Malaysia, which has gained a reputation for preventing potentially lethal bleeding in circumcision rituals (Pritchard, 2000). The synthetic device protects the wound and enables it to heal within five to six days. Each Tara Clamp is removed after the wound has healed, and can only be used once. It thereby reduces risk of infections, which cause most fatalities, and the danger of diseases such as hepatitis B or AIDS, the latter being a major health problem in South Africa (Pritchard, 2000). Additionally, in 2001, the Eastern Cape legislature, as a form of intervention, proposed a law known as Application of Health Standards in Traditional CircumcisionAct, No 6 of 2001. This thesis is, in fact, about how this Act has been received and debated by different sectors of the community, such as government, traditional authorities, and communities in the Eastern Cape Province of South Africa. The aims and objectives of the thesis are discussed below.

1.2. AIMS AND OBJECTIVES

The aim of this thesis is to conduct an ethnographic analysis of the traditional male circumcision intervention by government, through the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001, of the Eastern Cape. More specifically, the thesis seeks to understand how different stakeholders respond to this intervention and what steps they take to indicate their responses. The study has the following specific objectives:

- To discuss the key elements of the Application of Health Standards in Traditional CircumcisionAct, No 6 of 2001.
- To consolidate the responses of traditional authorities to this Act.
- To analyze village /local community responses to the Act.
- To draw key policy lessons for best informed government interventions through legislation.

This study addresses several key questions. Firstly, is there a justifiable concern regarding the deaths and injuries of initiates during the traditional male circumcision ritual in the Eastern Cape Province? Secondly, is there awareness about the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001? Thirdly, did the local communities participate in the development of the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001? Fourthly, what are the barriers preventing the implementation of the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001? Fifthly, who are the key stakeholders that should be involved to ensure successful circumcision reform?

1.3. SIGNIFICANCE OF THE STUDY

Given the challenges facing the ritual of male circumcision, the study is significant as it can contribute to the debate and, perhaps, to solutions to the social aspects of this health-related traditional practice. While conducting the literature search for this thesis, it became evident that little has been written on the subject of male circumcision and how different stakeholders interact to review what is happening to the ritual within the South African context. This is probably due to the strong taboos attached to any discussion on the subject in many cultures, including the Xhosa culture. Therefore, this thesis attempts to contribute significantly to the research on male circumcision within this specific context.

1.4. LIMITATIONS OF THE STUDY

The study had several limitations. Firstly, during the study period, there was little documentation on the subject in South African literature. This is probably due to strong taboos attached to any discussion of the subject with outsiders of specific tribal groups that practice circumcision rites in the country. Secondly, the study focused mainly in the following areas Qaukeni, Mthatha, East London, and Cape Town to the exclusion of other villages in the Eastern Cape. This is closely linked to the duration for the Masters degree, which is limited in time, making it costly, both financially and socially, for a researcher to cover a wider study area. Thirdly, the fact that the study focuses only on a Xhosa speaking group, to the exclusion of other ethnic groups, shows a gap. Having identified these limitations, the researcher ensured that the data collection focused on details so that the outcomes are a scientific reflection of what is happening in many

villages in the Eastern Cape Province as a whole. In addition, the researcher is a Xhosa male, who has undergone the circumcision ritual himself, thus making it easier for the respondents to open-up to the discussion, freely and without any reservations.

1.5. RESEARCH DESIGN

The fieldwork for this study was conducted over a three-year period, in Qaukeni Municipality, Eastern Cape Province, in 2003, and in Mthatha, East London and Cape Town in 2005 to 2006[6]. While intensive participant observation was primarily in (Sphaqeni) as part of a broader study on HIV/ADIS issues conducted by the HSRC, the researcher, through mainly opportunistic encounters, as well as convenience sampling (See Denscombe, 2007), conducted more field work in the urban areas mentioned above. In-depth interviews were made to focus on the practice of circumcision rites, cultural meanings, and experiences on circumcision rituals. According to Rubin and Rubin (1995, cited in Van Wyk, 2001), in this type of interview, the participant is given freedom to share information around his/her experience of the phenomenon under study. Participant observations were also useful in gathering some information and recorded soon afterwards. The researcher is an integral part of any ethnographic study. Data collection in ethnographic studies involves hands on approach, where the researcher immerses him/herself in the setting (Ackroyd and Hughes, 1992, cited in Van Wyk, 2001).

In the current study, the researcher was the interviewer, observer, and analyst of the data. Rubin and Rubin (1995, cited in Van Wyk, 2001), considers this personal involvement of the researcher to be a great strength of qualitative research methodology. In addition, the personal conversation with local people within the village was also useful. The selection of the key informants was done to ensure that people who occupy a specialized position in the community were targeted. This was done purposely to make sure that people who influence decision-making in the community were covered as much as possible. The research was conducted through different means, for example, participant observations, the use of structured

[6] Some more interviews were done in Cape Town because Xhosa people still prefer their sons to be circumcised in the Eastern Cape and therefore are affected by this law.

questionnaires, and interviews, were written and tape-recorded. Details of some of the interviews are presented in Appendix 1 below.

Secondary literature in anthropology and health studies was reviewed. The researcher also reviewed the media debates regarding the issue of circumcision in the Eastern Cape; the access to these media cuttings was through Internet. The Daily Dispatch, an Eastern Cape daily newspaper was the most useful source. Government policy documents on traditional circumcision within the Department of Health were reviewed and analyzed. The researcher attended community meetings and national and provincial conferences where these issues were discussed. Focus group guides and key informant schedules were designed to gain an understanding of the meanings people attribute to circumcision injuries and death in Eastern Cape. In addition, the interviews and group discussions were conducted in various localities, such as hospitals, people's homes, at the bush as well as tribal authorities. Categories of people interviewed included traditional authorities in Bisho, uncircumcised youth or boys, present initiates (*abakhwetha*), recent initiates (1-5 years as a man), mature men (10 years and more), parents of recent, present and future initiates (including mothers), community leaders (urban and rural), as well as traditional surgeons and traditional nurses. Collecting some information from friends and colleagues via emails and telephonic interviews was also useful.

1.6. ETHICAL CONSIDERATIONS

Participants were informed that their participation is voluntary and that they had the right to refuse to participate and to withdraw their participation from the study at anytime. According to Ackroyd and Hughes, (1992, cited in Van Wyk, 2001), great caution has to be taken by the researcher that he/she does not violate the law or place the participants or the researcher in danger. Therefore, all the in-depth interviews with participants were conducted confidentially with their approval. According to Van Wyk (2001), confidentiality would afford the participant greater freedom to express him/herself during the interview. The presence of a researcher in community meetings was announced to avoid any confusion caused by such presence. Verbal consent was sought from participants before any interviews took place. The next section lays out the structure of the thesis, including outlines for each chapter.

1.7. OUTLINE OF THE THESIS

This thesis is divided into five chapters.

Chapter One – provides an outline of the problem statement, the aims and objectives, the research design and the significance and limitations of the study.

Chapter Two – presents the broad conceptual framework guiding the study. At the same time, the chapter describes the context for the study by giving a brief background on South Africa's policy dilemmas, with regard to group rights versus individual rights, within the South African cultural context.

Chapter Three - provides an outline of the position and strategies of the Eastern Cape Provincial Government in response to circumcision challenges. More specifically, this chapter reviews several attempts by government, over the last decade or so, to make traditional male circumcision safer, through different regulations, including the Application of Health Standards in Traditional Circumcision Act of 2001. Particular attention is given to different processes before, during, and after the passing of the Act.

Chapter Four - discusses the divergent responses to the Application of Health Standards in Traditional CircumcisionAct, No 6 of 2001, in the Eastern Cape Province of South Africa.

Chapter Five – consolidates several key issues that emerged from the study. It briefly revisits the theoretical debates on group rights and individual rights within traditional circumcision. It then draws the main conclusion emanating from the study.

1.8. CONCLUSION

This chapter started by outlining the problem statement and clarifying the aims and objectives of the study. It further provided an outline of the research design and the significance as well as the limitations of the study. The next chapter (Chapter Two) presents the conceptual framework guiding the study.

CHAPTER TWO: CULTURE, RIGHTS AND PUBLIC HEALTH: A REVIEW OF THE LITERATURE

2.1. INTRODUCTION

In the previous chapter, the research problem, as well as the aims and objectives of this study, were presented (See Chapter One). That chapter highlighted some of the issues that constitute current challenges facing male circumcision in the Eastern Cape. This chapter presents the conceptual framework guiding the study. At the same time, the chapter describes the context for the study by giving a brief background on South Africa's policy dilemmas, with regard to group rights versus individual rights, within the South African cultural context. As this study is about a cultural process, there is a need to understand three key concepts in the traditional male circumcision debate in South Africa. These are culture, rights, and public health (the science and practice of protecting and improving the health of a community, by preventive medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards). In this sense, these concepts are reviewed within the context of a cultural activity, which in this case is circumcision.

The notion of culture is essential for understanding the scope of cultural rights. It is, however, important to find among different meanings used, one, which is universally accepted. Different meanings of this term are proposed in different contexts. In this case, culture is understood as the accumulated material heritage of humankind or as the process of artistic and scientific creation, or the sum total of the material and spiritual activities and products of a given social group, which distinguishes it from other similar groups (Stavenhagen, 1998 cited in Airhihenbuwa, 1995). Rights in the South African context are defined based on Chapter Two of the Constitution of the Republic of South Africa (Act 108 of 1996), which contains the Bill of Rights that applies to all laws, as well as binding to all the branches of government. This reinforces section 7 (1), the introductory clause to the Bill of Rights, which states that, “the Bill of Rights is the cornerstone of democracy in South Africa”. Section 7 (2) of the Constitution also imposes the positive obligation on the state to “respect, protect, promote, and fulfill the rights in the Bill of Rights”.

This chapter has three main sections. Firstly, it presents an overview of the legal system in South Africa, focusing on both individual rights and communal rights to cultural rights/recognition. Secondly, it reviews a theoretical debate on group rights versus individual rights, with examples from the Xhosa male circumcision ritual in the Eastern Cape. The last section presents conclusion.

2.2. OVERVIEW OF LEGAL SYSTEM: DEMOCRACY AND HUMAN RIGHTS

This section outlines the post-apartheid constitutional dispensation in South Africa, which recognizes both individual and communal rights, and seeks to explain how these may generate certain conflicts about rights. Examples are drawn from the situation on the cultural practices of traditional male circumcision in the Eastern Cape of South Africa. It is worthwhile to reflect briefly on the specific sections in the constitution, pertaining to the equal status of individual, as well as the recognition of communal cultural rights. Section 39 (1) of the Constitution of South Africa, cited in Bentley (2003), creates the obligation to take into account specific international laws in the interpretation of human rights. In addition, South Africa has some specific obligations under international law relating to the rights of cultural, religious and linguistic communities. The same author argues further that South Africa is undoubtedly a leading democracy in terms of its recognition of these rights in the constitution and in South African law.

South Africa is a multiparty parliamentary democracy. The Constitution is the supreme law of the republic (section 2 of the Constitution). Some examples of the rights contained in Section 2 are the right to life, access to freedom and security of the person, equal protection and benefit of the law and others. The much-lauded one in the case of South Africa is that the Constitution recognizes both individual rights and communal rights to cultural rights/recognition. However, this very right is the one, which brings ambiguity in the context of challenges facing traditional male circumcision. These are considered in light of the dynamics they are likely to have on individual rights and implications for traditional circumcision in the Eastern Cape Province of South Africa. Here, the debate focuses on how these rights create a conflict between the rights of individuals and the cultural claims of the groups. The state has to negotiate between these two frequently incompatible claims, and formulate policy and legislation in such a

way that is both sensitive to the claims of groups, while still protecting the rights of vulnerable persons (for instance, the initiates who face injuries or death during traditional male circumcision).

2.3. CONSIDERING GROUP RIGHTS AND CULTURE: A THEORETICAL DEBATE

The majority of commentators on the subject agree that people's choices, decisions and practices matter. Therefore, people have cultural rights of one sort or another within given communities (Bentley, 2003). However, the content of those rights, and indeed whose choices they actually are, is highly contested. The first option is to insist upon the equal treatment of all people, even when this is in conflict with the norms and values of a given cultural community. This is the approach of liberal egalitarians such as Barry (2001) and liberal feminists such as Okin (1999), who argue that the demand of equal recognition for one's culture cannot conceptually entail using that recognition to treat others unfairly. According to Bentley (2003), this approach to rights, therefore, yields a "no" answer to questions about entrenched cultural rights that give some power over others. According to Thipanyane (2004), inequalities in South Africa still exist, with many people unable to practice their cultural rights, which are integral to their dignity as human beings. He argues further that a balance between cultural and human rights has to be achieved.

There are those theorists who favour non-interference by the state. This is the approach of some multiculturalists such as Chandran Kukathas (1995), who hold that the equal recognition of all cultures demands that the state refrain from intervening in their ways, even when the norms upon which they are based are non-egalitarian and potentially a threat to the individual rights of their members. Howard (1990, cited in Bentley, 2003) argues that Africans are community or group-oriented rather than individualistic, and hence, the rights of individuals to choose are not relevant to them. This is also evident in traditional male circumcision amongst Xhosas, where a male who has gone past the required age for circumcision could be overpowered by a group of men and be circumcised against his will (Funani, 1990). Therefore, in reality, the human rights claims and practices of the group can and do supersede the rights and choice of individual.

Bentley (2003) argues that what is problematic about the above argument is the claim, framed as cultural rights, to coerce, abuse and disenfranchise members of a given collective, and it is precisely these sorts of claims that deserve to be most critically scrutinized, rather than ignored. This is because, she argues, the abuse of culture in this way is no less detractive than the abuse of culture through its suppression. This raises some uncertainties as to what the Constitution says regarding rights and culture. This, according to Ndashe (2005), raises a lot of questions as to what extent is the right to practice one's culture protected in the Constitution, which respectively deals with the right to belief, religion, opinion, language and culture.

According to Manthata (2004), constitutional norms and values are written under democratic principles, but these face legal and political challenges. The uneasy relationship, between cultural protection for traditional cultural groups and constitutional protection of the equal rights of citizens, is much in evidence in the South African Constitution of 1996. Constitutional norms and values are based on human rights, democracy and good governance. Therefore, hamonizing constitutional and traditional norms and values with the principles of human rights, within the traditional practice of male circumcision in the Eastern Cape, is a great challenge.

Thipanyane (2005) has argued that initiation schools are manifestation of a cultural right, but these institutions should not undermine fundamental human rights and values common to all including initiates during the initiation process. He argues further that the state has to determine whether current practices have remained loyal to the original motivations of our ancestors. Hence, the country's Constitution protects the culture and customs of the various communities, but those who practice initiation have to ensure that the methods applied are not at odds with the provisions of ordinary criminal law. For example, the negative impact of botched circumcision is not only material. The psychological impact of such is far reaching and can have dire consequences. Firstly, the victims of botched circumcisions, if they survive, are not able to enjoy a normal life, as they have been robbed of their manhood. In the event that the child concerned is the only son and he is no longer able to have children of his own, the family name may cease to exist (Goqwana, 2004), thus affecting yet more people than the individual concerned. In this sense, one action (botched circumcision) violates both the initiate

and many more people, and those who have committed the offence often go unpunished by the law of the country.

It is, therefore, implicit that the manifestation of cultural right to initiation schools is subject to the limitations of Section 3(2) of the Constitution, which provides that all citizens are entitled to the rights, privileges and benefits as citizens, and are equally subject to the duties and responsibilities of citizenship, including marrige as well as strength and continuity of the family. This is also confirmed by Bentley (2003), who argues that the claims of culture which conflict with human rights, whether they be hierarchical, property-based or simply a denial of wrongdoing to another, fall back on the claim that they are in opposition to another, equally viable culture which they reject. She argues further that they have to be held to the same standard of equality in assesing the right treatment of others. In many cases, this is in conflict with some cultural norms and traditions, such as in the case of traditional male circumcision, in that young males do not have a right or option to choose whether they would like to undergo circumcision or not.

The constitution does not say that individual rights should prevail over group rights when they are in conflict. The constitution lays down principles that are open to interpretations. The principle of equal respect for all people means that we respect their choices as individuals, which may include non-liberal choices about their traditional ways of life (Mail & Guardian, 2004). What is more problematic are internally directed claims of culture. Members of a group claim a right to decide for other members, lower than them in status, that the practices they advocate are cultural. Such claims are sometimes harmful and are often to the advantage of existing holders of power. For example, in the case of traditional circumcision, traditional leaders claim that they should be the ones coordinating any circumcision reforms, as custodians of culture and ritual. Currently, this is the role of government. Reported violations of human rights in initiation schools occur in contradiction to what the Bill of Rights stands for. This is contained in Section 10, which establishes the right to be treated with equal dignity, and Section 11, which is the right to life. Section 12 deals with the freedom and security of the person, and in particular, section 12(1) (c) establishes the right "to be free from all forms of violence from either public or private sources." Chief Holomisa (2005) was also quoted as saying that the culture of individual human rights will not, on its own,

promote rights and justice. According to him, it needs to be complemented by the promotion of the humane and communal values inherent in African cultures and customs.

The challenge here is how to maintain the balance between cultural and broader human rights. Another option is deliberation and negotiation of a compromise. Ayelet Shachar's (2001) model of transformative accommodation is briefly considered, which seeks to uphold both the rights of members of groups, as well as the equal recognition of the group itself. This argument considers the argument of Andrea Baumeister (2003) and Monique Deveaux's (2003) "strategic interests" approach to deliberation as possible solutions. This approach, according to Bentley (2003), means that all parties must be regarded as having an equal say. So "traditional communities" could quite feasibly agree on many different arrangements that accommodate and recognise the rights of individual members in those communities to choose their own legitimate way of life. This position hinges on whether one adopts a pluralist value or a relativist approach to human rights, and yielding either an argument from the perspective of toleration or an alternative autonomy. At the same time, the state ought to consider the claims of groups, for the continuation of their way of life. Such claims usually reflect an imbalance of power.

According to Mathews (2006), coercive measures are commonly adopted by government in addresing public health problems, particularly in times of health emergency. He argues further that this response is based on the notion of public good, which takes precedence over the rights of individuals in times of crisis. It is, therefore, not suprising that the Eastern Cape Provincial government, in 2001, imposed criminal sanctions against any person who performs illegal circumcision, given the enormous challenge botched circumcisions are posing to the public sector. Human rights aim to promote and protect the well-being of the individual, while, in contrast, public health policies and programmes can either promote or restrict human rights, resulting in a potential conflict.

South Africa is a constitutional state, making the constitutional court its highest deciding judiciary body. This section points out that the state is charged with the responsibility of upholding the rights of the weak. The public policy ought to be shaped

to reflect this. The government, as the guarantor of basic rights, as enshrined in the Constitution, has to curb the deaths of young men at the initiation schools. The South African Department of Health is legally responsible for the control of circumcision causalities, as a public health concern. The department is required to operate within the context of the Bill of Rights, as enshrined in the Constitution of the Republic of South Africa, which affords individual rights to every person to be promoted, respected, and protected. The Bill of Rights also balances competing rights and communal interests. The Eastern Cape Province has its own Application of Health Standards in Traditional Circumcision Act, No 6 of 2001, as amended, which was promulgated in order to try to harmonise traditional practices with Constitutional norms and values. According to Gantsho (2004), it is ironic that the constitutional court lacks the mechanism to enforce its decisions beyond ruling on whether state actions or omissions fail to meet certain standards. Sadly, there are no set constitutionally protected minimum standards for socio-economic rights, which would ensure that everyone lived a dignified existence.

It is necessary that the judiciary, when trying to address a traditional system, as opposed to the constitutional system, understand the traditional concepts, norms and values of the system. It should not swiftly weigh it against the constitutional system. In this section, literature is systematically reviewed to contrast cultural practices with public health policies and legislation. Examples are drawn from communities in the Eastern Cape, in particular, amongst Xhosas who maintain their right to practice culture. Their right to this cultural practice, however, can violate the individual's right to choose. As a result, some are injured, some die, because they are unable to resist the pressure from others (for example, elders). According to the ANC National Health Plan (1994), every person has a right to optimal health; it is the responsibility of the state to provide the conditions to achieve this. Our constitution ensures that new policies cannot infringe on basic human rights.

Airhihenbuwa (1995) argues that to invoke the centrality of culture in public health and health promotion activities is to challenge health promotion and promotion of disease prevention approaches. The centrality of culture in health initiatives is the discourse that resonates with the politics of representation, which are affirmed through voices of various cultural expressions and meanings. This creates tension or unresolvable problems in discourse with the representatives of others, who are defined as inferior,

silent, and in need of being spoken for (Mariani & Crary, 1990). According to Airhihenbuwa (1995), cultures are not static. They change overtime, in accordance with the interpretive values, beliefs, norms, and practices of the group, whose members define and live by the ideals of those practices and values. Very often culture is blamed for certain misunderstood health practices; when in fact, the culprit is the poor interpretation of culture. He argues further that this has been particularly true when westernized professionals have addressed issues of health beliefs and practices in African societies (Airhihenbuwa, 1995). This process of regulating traditional male circumcision should be centered on the mission of public health promotion. It is only through such dialogue that varied cultural expressions and meanings are affirmed and centralized. Then, the production of cultural identity can be legimatizing and empowering, relative to promoting individual, family, community and societal health. According to Illich (1976), each culture creates its own response to health and disease.

2.4. CONCLUSION

This chapter discussed the issues of culture, rights, and public policy. It attempted to explain the difficult relationship between rights to culture of certain groups and human rights of individuals, as espoused in the country's constitution. The chapter emphasized that human rights aim to promote and protect the well-being of the individual, while, in contrast, public health policies and programmes can either promote or restrict human rights resulting in potential conflict. The chapter has presented this discussion using the views of various scholars and other social commentators, who present slightly different perspectives on the issue, depending on their beliefs or philosophies. The next chapter reviews several attempts by government, over the last decade, to make traditional male circumcision safer, through different regulations, including an Application of Health Standards in Traditional Circumcision Act, No 6 of 2001.

CHAPTER THREE: GOVERNMENT'S INTERVENTION IN TRADITIONAL MALE CIRCUMCISION: HEALTH MEASURES AND LEGISLATION

3.1. INTRODUCTION

It was shown in Chapter One that traditional male circumcision amongst the Xhosa people of the Eastern Cape has undergone many changes, some of which put the lives of initiates at risk. In line with the main goal of this thesis, which is to understand how different stakeholders respond to the health-related challenges facing Xhosa male circumcision, this chapter seeks to outline the position and strategies of the Eastern Cape provincial government in this regard. More specifically, this present chapter reviews several attempts by government, over the last decade or so, to make traditional male circumcision safer, through different regulations, including the 2001 Traditional Circumcision Act (No 6). Particular attention is given to different processes before, during, and after the passing of the Act. To accomplish the objectives of this chapter, it is divided into five main sections. Following the introduction, there is a brief discussion of different factors prompting government to intervene. Thereafter, discussion continues on several non-legislative measures to make traditional male circumcision safer, eventually building up to the formulation of the Act. These include the different attempts by the Department of Health to find safer ways of performing the circumcision operation. The section dealing with the process of formulating the Act follows this. The section dealing with the implementation of the Act since 2001 is the fifth section, and a brief conclusion follows it.

3.2. FACTORS LEADING TO GOVERNMENT'S CONCERN ABOUT TRADITIONAL MALE CIRCUMCISION

Over the past two decades traditional male circumcision in South Africa, particularly the Eastern Cape Province, has been faced with many challenges. Some of these challenges are already highlighted in Chapter One. Meintjies (1998b) confirms that since the 1990s, traditional male circumcision has become increasingly topical and controversial, with the number of injuries and deaths of the initiates in the Eastern Cape Province on the rise. The figures below give a broader picture of circumcision complications in the Eastern Cape Province over the years.

Table 2: Statistics of circumcision complications in the Eastern Cape

YEAR	HOSPITAL ADMISSIONS	MUTILATIONS & AMPUTATIONS	DEATHS
1995	1,042	42	55
1996	801	22	16
1997	555	34	17
1998	357	8	17
1999	612	33	26
2000	384	23	22
2001	324	31	36
2002	447	33	50
2003	311	29	41
2004	118	3	14
TOTAL	**4,951**	**258**	**294**

Source: Adapted from Eastern Cape Department of Health: Circumcision annual statistics

The numbers of deaths from 1995 to 2004, in this table above, are still regrettably high, amounting to fifty-five in 1995 in the whole province. There were 1,042 hospital admissions and 42 mutilations. According to the table above, there is a sharp decline in terms of hospital admissions, from over one thousand in 1995 to just over one hundred in 2004. For the period between 1999 and 2003, there was a noticeable increase in terms of deaths compared to the previous three years. Ironically, this period corresponds with the heightened awareness of the health risks of circumcision, as well as numerous measurers by government to make the ritual healthier and safer.

The situation is further complicated by the inadequate information about the causes of these deaths (Meintjies, 1998b). A combination of factors contributes to the problems that are facing the practice of traditional male circumcision. As mentioned earlier, this section seeks to revisit these problems. It seeks to highlight issues within the Xhosa male circumcision ritual that have prompted the health sector and government to take action. To direct this issue, several authors have made contributions in analyzing these problems. Medical practitioners, social scientists, as well as politicians, all give their

own, sometimes different, perspectives. In most cases, however, these commentators agree on some of the root causes of the problem. I start with discussing these problems from a medical perspective.

Meintjies (1998b), a medical doctor, believes that most of the morbidity and mortality amongst initiates is associated with gangrenous and septic complications at the circumcision wound, as well as the practice of fluid restriction. Firstly, with regard to fluid restriction, it needs to be understood that there is a cultural belief amongst the Xhosa that an initiate should abstain from drinking water for at least eight days after circumcision. This is not only to prevent frequent urination, but is set out as a test of endurance. Goqwana (2004) argues that, in fact, most of the common circumcision complications that have been witnessed, and are still being experienced in communities, have to do with fluid-deprivation, which leads to dehydration and could be fatal. In cases of initiates with septicemia (blood bacterial infections), dehydration worsens their prognosis considerably (Meintjies, 1998a). This is also confirmed by Kanta (2004), who examined the plight of initiates in the Qaukeni Local Municipality of the Eastern Cape. He suggests that shock, dehydration, and poor wound management combined, are debilitating, and puts the health and lives of the initiates at risk.

Secondly, Meintjies (1998a) and Kanta (2004) concur that physical complications affecting the private parts of the initiates have been recurring problems. In this regard, these authors argue that sepsis of the circumcision wound, disfigurement of the penis, partial or complete gangrene, deep vein thrombosis, swelling and gangrene of the leg, eventual amputation of the penis, activation of latent infections and diseases such as Tuberculosis (TB), Human Immuno-Deficiency Virus (HIV) and rheumatic heart disease are physical and deadly legacies of tradition gone wrong. Exacerbating these is the fact that exposure to cold, especially during winter months, could lead to pneumonia and other clinical complications, which in turn could cause injuries or deaths.[7] Related to this point is the fact that initiates are not allowed to wear clothes during this period. They have to practically remain naked, with only some white clay on their bodies as a shield.

[7] Report on initiation schools conference, September 27-29, 2004, East London, Eastern Cape.

Thirdly, from a bio-medical perspective, the dressing method on the wound is said to be another contributing factor to the circumcision problems. Traditionally, the wound is dressed with leaves and wrapped by a tightly applied bandage, made from a variety of products, including cloth, canvas, animal skin, and so forth. The tightness of this bandage often leads to a condition known as ischemia (starvation of blood supply) and bacterial infection, with all these eventually leading to gangrene of the penis (Meintjies, 1998a). Mayatula and Mavundla (1997) argue that gangrene is a common problem within this traditional rite, and that attendants of the initiates, who often have no basic training, actually believe that tightening the dressings facilitates early wound-healing. Fourthly, this practice has been implicated in the spread of blood-borne infections, such as tetanus. Tetanus is a dangerous complication related to unclean instruments and the environment in which traditional practices takes place. It occurs when a wound becomes infected with the bacterial spores of *Clostridium tetani*. If the initiate was not previously vaccinated against tetanus, which is usually the case, he is likely to die if affected by this complication.

Fifthly, another risk factor associated with traditional circumcision is sexually transmitted diseases (STDs), which are common amongst initiates. According to Funani (1990, cited in Stinson, 2005), traditionally, sex was forbidden before marriage. However, youth are becoming sexually active at an increasingly younger age. There is, therefore, a higher prevalence of STDs amongst initiates. In addition to this, the high prevalence of STDs is spread amongst initiates through equipment that is not sterilized between each use. Sixthly, some boys have medical histories that are not always taken into consideration before the ritual is performed (Kretzmann, 2001). For example, there are boys who go to the bush and are diabetic, epileptic, or asthmatic. With all the other health risks and unhygienic conditions often associated with traditional male circumcision, initiates, who had an ongoing illness before initiation, had fewer chances of improving or remaining healthy. Additionally, circumcision must be carried out away from modern health facilities, complicating all health-related challenges faced by the initiates. Doctors, with westernized training, or women are not to come near the initiates. Hence, many seriously ill initiates are usually admitted to hospitals too late (Meintjies, 1998b).

In addition to medical analysis of the problem, social commentators, such as academics and politicians, have also contributed to understanding the problems relating to circumcision. Firstly, some politicians perceive the lack of discipline amongst youth to be the root cause of injuries and deaths during male circumcision (Holomisa, 2004). Holomisa pointed to traditional leaders who have abdicated their responsibilities of being custodians of the ritual, as well as parents who have abandoned their duties of bringing up responsible children, resulting in youth having no regard for authority. Secondly, Sizwe Kupelo, the spokesperson for the Eastern Cape Department of Health (ECDOH) has highlighted negligence, ignorance, and lack of knowledge among parents, as well as ill-discipline on the part of initiates, as contributing factors to the high death rate (Feni, 2005). Due to a generation gap, with regard to male circumcision in areas such as Pondoland region, some parents did not have experience and knowledge about circumcision. One of the key informants during fieldwork stated,

> The problem in Pondoland is that our parents see this ritual as *intoyethu* (our thing). The reason for this is that our parents did not go through this themselves; therefore, there is no coordination from elders. Some people end up doing whatever they like.8

Sizwe Kupelo, of the Eastern Cape Department of Health (ECDOH), confirmed that boys as young as eight went to the bush in the Pondoland region. This shows that the practice is in the hands of boys in this region, because most of the adult males did not go through this ritual.

Thirdly, other social commentators believe that opportunists, who are motivated by greed, and are looking to make quick money, pose as traditional surgeons or nurses, but do not really care for the safety of the initiates (Goqwana, 2004). There is growing evidence that initiation rites are now commercialized, with parents paying high fees for their boys to be circumcised (Mabote, 1995). As a result, several boys have been hospitalized following assaults for refusing to attend or attempting to escape from initiation schools. This greed has even resulted in the circumcision of underage boys, without the knowledge and permission of their parents or guardians. Dr Kanta, of the Impilo ya Bantu Health and Development Project, confirmed that there were initiation

[8] Interview with Mzuphelele, traditional nurse, Flagstaff, June 2003.

schools, which admitted initiates without parental permission and without permits to operate (SABC News, May 24, 2004).

Fourthly, some traditional authorities, for example, Prince Langa Mavuso of the Eastern Cape House of Traditional Leaders, argue that some sectors of the populations are relatively new to this practice and, therefore, are not as knowledgeable. He cites the many deaths and injuries in places like Flagstaff and Lusikisiki in Eastern Pondoland, where the legendary King Faku banned male circumcision in the mid 1820s (Stapleton, 1998). This ritual has now returned, since the 1990s, because of great enthusiasm from youth in Pondoland to undergo the ritual, mainly brought on by peer pressure.[9] As a result, various newspapers report that initiates are dying in large numbers in this region.

Fifthly, Prince Ndamase has pointed to the degeneration of the moral fiber within South African society. He argues that consequences of this have exposed themselves in some of the most gruesome acts that South Africa has witnessed since the advent of democracy, including male circumcision.[10] Sixthly, climatic factors also contribute to these problems. For example, initiation schools currently occur more often in the hot summer months, as opposed to autumn, as in the past. Summer months are warm, with a temperature that promotes the growth and multiplication of bacteria. The use of plastic building materials, in lieu of traditional grass and leaves, contribute to a harsh environment that is not conducive to the healing of the wound (Stinson, 2005).

3.3. GOVERNMENT'S NON-LEGISLATIVE INTERVENTIONS TO CIRCUMCISION PROBLEMS

The Eastern Cape government has implemented different strategies to try to curb the challenges facing traditional male circumcision. This section looks at how government has dealt with the problem of injuries and deaths of initiates over the past two decades. Writers, such as Meintjies (1998a), argued that the complications of ritual circumcision are not pathological, but man-induced and, therefore, are preventable. Meintjies has argued that the mortality rate, documented by hospitals, in every circumcision season, in the past years, is unacceptable by society. It necessitates health education and training

[9] Report on initiation schools conference, September 27-29, 2004, Eastern Cape.
[10] Paper presented by Prince Ndamase in initiation schools conference, September 27-29, 2004, East London, Eastern Cape.

of those involved in the circumcision process, such as the traditional surgeons, traditional attendants, initiates themselves, as well as members of community in general.

In an effort to fight against morbidity and mortality associated with ritual male circumcision, several programmes were initiated by various stakeholders, to blend old ways with new methods (Mail & Guardian, January 13, 2000a). As a result, the practice of circumcision has incorporated modern technology, which makes use of specialized and safe equipment or knowledge on transmission of diseases. Some hospitals, for example, have trained male nurses to perform medically directed circumcision, with excellent results. There is a general feeling in the community, however, that this method is foreign and does not meet cultural needs. Nevertheless, the traditional method has been a source of some tragic results (Makupula, 1995). Hence, it is important to observe the chronology of actions, particularly by government, to making make the traditional male circumcision ritual gradually safer.

Since the 1990s, the Eastern Cape Department of Health has been involved in charting out remedial strategies with the stakeholders of this custom, involving NGOs, traditional leaders, civic organizations, *amakhankatha* (traditional circumcision nurses), and *iingcibi* (traditional surgeons) (ECDOH Executive Report, 2002). It is through this background that a programme was begun in Alice to change the practices of traditional surgeons, more specifically by encouraging the use of surgical scalpels and new blades for each initiate (Stinson, 2005). According to Dweba (2000), during these initiatives, great care was taken to exercise minimal interference with the customary aspect, whilst imparting safe and hygienic standards on the other hand. This programme was initiated by the Eastern Cape Department of Health and Welfare in December 1996 (Meintjies, 1998b). People, who were instrumental in establishing this intervention, included medical doctors and a few government officials. According to Meintjies (1998b), around the same time, the Eastern Cape Department of Family Practice in Cecilia Makiwane Hospital set up the Circumcision Task Team, under the direction of Charge Nurse Henderson Dweba. Members of this technical task team included several people, from both the medical field and local government (for example, Dr S.S. Stamper, Dr L.M. Msauli, Mr. M.W. Balley of Port Elizabeth Municipality, and Dr E.N. Nxiweni[11]). The objectives of this task team included, amongst other things, the preservation of the

[11] Personal communication, Mr. Dweba, Eastern Cape Department of Health, Bisho, July 2005.

custom of traditional circumcision in the Eastern Cape; protection of the rights of circumcision initiates, and ensuring safe circumcision practices by *iingcibi* (traditional surgeons) and *amakhankatha* (traditional nurses). The task team was sensitive to the fact that, for many initiates, it is impossible to leave the initiation school to get medical assistance. Consequently, the team treated cases in the bush whenever the need arose.

Apart from this, Mr. Dweba operated an educational programme that attempted to address the behavioral changes needed to lessen the risks of ritual circumcision, whilst upholding cultural values (Stinson, 2005). Subsequently, in 1996, the Department of Family Practice /Primary Care within the Eastern Cape Health Department, through the Provincial task team, developed a discussion document wherein a number of issues and challenges pertaining to traditional circumcision were raised for public comments. The proposals, suggested in this document, formed the basis of a green paper that was to be circulated for a province-wide debate (Meintjies, 1998b). The same author continues to argue that the document was circulated for discussion, comments, and amendments amongst community-based organizations, health-related NGOs, youth organizations, political organizations, health professional bodies, religious formations, and the public. Newspaper advertisements requesting submissions from all stakeholders and role players were due on December 31, 1996. Meintjies (1998b) argues that input received on the discussion document and during subsequent consultations led to the achievement of the following:

- establishment of measures and guidelines to ensure that deaths and injuries, as a consequence of traditional circumcision, are prevented;

- establishment of channels, by which the provincial health authorities can cooperate with traditional surgeons and attendants;

- stipulation of acceptable and safe methods of circumcising and managing thereof;

- establishment of means by which the practice can be monitored and regulated to ensure its safety;

- establishment of means by which those found responsible for injuries and deaths are punished within the framework of the legal system;

- ensuring that there is concern with establishing safe practices only and not dictating on matters unrelated to this;

- accommodation of the fact that the practice of traditional circumcision may have local differences across the province, and will continue to take place; and

- accommodation, under the same provisions, of the regulation of female traditional circumcision where this rite is being practiced.

The King of the Xhosas, Xolilizwe Sigcawu, as part of the new drive to end the bloodbath in the bush, set up a royal circumcision school in 1998 (Mail & Guardian, January 7, 2000b). This school, according to Xhosa Royal Council chief executive officer, Zolani Mkiva, was to accommodate between 3000 and 4000 initiates (Mail & Guardian, January 7, 2000b). This circumcision school project was inspired by Prince Xhanti Sigcawu, the heir to the throne, and is headed by a highly respected traditional surgeon, Melibhunga Nobinjana[12].

The high number of deaths of initiates, in 1999, led the Western District Council in Port Elizabeth to call for a summit to find solutions to save the nation. King Maxhobayakhawuleza Sandile of the Rharabe tribe, chiefs, traditional surgeons, traditional nurses, and some visitors from Eastern Cape villages and townships attended this summit. At this summit, a task team was elected to look into the matter (Daily Dispatch, November 4, 1999). According to Pretoria News (2001), the breakthrough eventually came with the establishment of an intervention committee on the advice of the former deputy chairman of Senate, Mr. Goven Mbeki. It included Dr Chabula and other local councilors. Dr Chabula was appointed as the director of the Western District Council, serving a large section of the Port Elizabeth community. This gave her the official platform to drive the campaign for controlled circumcision across several residential areas. It resulted in about 200 practitioners being registered. As part of this campaign, there was also an aggressive radio drive to make people aware of the dangers

[12] This circumcision school is apparently still in operation. Telephonic interview with Idutywa male resident.

they were facing (Pretoria News, February 28, 2001). Medical intervention by health officials and providers was said to be compulsory, when and if health implications arise, during the duration of the school. Male nurses were preferred as health providers, when such instances emerge.

There were other initiatives by government officials to deal with the problem of deaths and injuries in traditional male circumcision. As part of this intervention committee, health facilities made special wards/rooms available for such purposes. The Health and Welfare Primary Health Care facilities provided the following medication and instruments to traditional practitioners:

- Sterile latex gloves
- Bactrigrass 100 mm x 400mm
- Wooden spatulas
- Furacin-antibiotic ointment
- Milton-sterilizing solution/Jik
- Betadine ointment
- Gauze (dressing)
- Bandages

Plans were put in place to identify early signs of sepsis, so that it can be reported to the parents, and intervention be arranged immediately. An emergency call number at Cecilia Makiwane Hospital was also arranged outside of the direct line, for 24 hours a day coverage (Meintjies, 1998b).

In 1999, health officials, traditional leaders, and some traditional surgeons in the Eastern Cape turned to the Far East in search of help. The trip resulted in a proposal for the use of the Tara Clamp, a Malaysian instrument used for male circumcision, which does the job with less bloodshed (Mail & Guardian, 2000). It was hoped that the Tara Clamp, imported from Malaysia, would put an end to botched circumcision in the Eastern Cape. As reported above, traditional leaders, who were part of the delegation to Malaysia, were supportive of the Tara Clamp and felt it was the way out of the mess. Some sectors of society, including the Eastern Cape Traditional Healers Association, welcomed this new, inexpensive device that would reduce the risk of injuries, diseases,

and deaths during circumcision and abolish the need for bandages (The Star, 2000). To support these initiatives, the Eastern Cape Minister of Health, Dr B. Goqwana, was even quoted as saying that the Tara Clamp would first have to fit in with local customs if it was to achieve widespread acceptance (Mail & Guardian, 2000). All the initiatives mentioned above were a prelude to a more formal legislative framework by government. On November 3, 2000, the Department of Health then took the initiative and made a call for all role players and stakeholders to come together and get involved in an effort to curb the mortality rate and the number of botched circumcisions (Goqwana, 2004).

3.4. DESIGNING THE LEGISLATION: CONSULTATION, THE BILL AND PASSING OF THE ACT

According to Meintjies (1998b), the views of traditional leaders, statutory bodies, government departments, the public, and other relevant stakeholders were obtained on identified legislation issues, through an extensive and coordinated consultation process. It was believed that provincial regulations would eventually emerge from the legislative process in both the Provincial legislature and the House of Traditional Leaders (Meintjies, 1998b). In 2001, these initiatives had been characterized by great progress towards the realization of a legal framework to oversee the conducting of traditional circumcision practices in the Eastern Cape Province (ECDOH executive report, 2002). Through the many workshops held, provincial guidelines on the subject were born, and it was the general wish of most of the participants in these workshops that a legislative tool be promulgated to regulate the custom (ECDOH, 2000).

Eventually, after intense legal discussions and arguments between the Eastern Cape Province and National Government, a legal framework document was produced. This framework was circulated for discussion, comments, and amendments to a number of stakeholders, including community-based organizations (CBOs), health-related NGOs, youth organizations, political organizations, health professional bodies, religious formations, and the public in general. It is important to note that traditional authorities and other stakeholders were fully consulted before the formulation of this Act. For example, in 2000, a number of workshops were organized through a joint standing committee on traditional affairs and health, where each group had a representative from

the House of Traditional Leaders (ECDOH Executive report, 2000). Representatives from Eastern Cape House of Traditional Leaders included Chief M. Ndamase, Chief Z.N. Mtirara, Hon. M.S. Letlaka, Hon. Chief Kakudi, as well as Hon. T.S. Mhlahlo (ECDOH Executive report, 2000).

However, objections were raised by some traditional leaders to the Bill, in terms of the implications that this may have on this custom. Additionally, serious concerns about the use of English terminology and the participation of women in decision-making process were also raised in public hearings (Herald, 2001). This Bill raised different opinions from members of the community, with some men arguing that they do not want women to participate in the custom, while women were saying that they had a parental right to be involved (Eastern Province Herald, September 5, 2001). This Bill called for the appointment by the MEC, of a medical officer to oversee circumcisions. Although this idea was not well received by the communities, some argued that they would only accept the presence of a medical officer if he was an African and circumcised traditionally. Others suggested that a prospective initiate should bring his own *umdlanga* (circumcision knife). According to the Eastern Cape Herald (2001), parents agreed that before a boy go for circumcision, a parent or guardian had to give consent and that a traditional authority should be informed prior to the rite.

According to Kretzmann (2001), the proposals, which included initiates undergoing a medical examination before circumcision and having a medical practitioner (*ugqirha*) present to oversee the process, angered many traditional leaders and men who had already undergone the rite. The lack of vocal support by some traditional leaders undermined the good position thus far accomplished, and this raised some concerns by public. According to ECDOH executive report (2000), this criticism to the circumcision Bill even triggered global interests through media. These objections are discussed in more detail in Chapter Four. However, the provincial parliament passed the Bill into law on November 15, 2001. It was called an Application of Health Standards in Traditional Circumcision Act (No 6 OF 2001). The premier of the Eastern Cape province endorsed the Act, to be administered by the Department of Health, in particular. According to the Traditional Circumcision Act of 2001, cited in Sokhela (2005), the Act contained several key sections pertaining to the age of initiates, parents/guardians, people who perform the surgery, and western medical requirements.

Section 4 (1) of the Act, for example, requires that a person who performs circumcision must obtain written permission from a medical officer designated for the area. Section 4 (2) of the Act requires that an applicant not be allowed to circumcise unless he meets the requirements set out in Annexure A of the Act. As stated in Section 7, there must be a proof of the age of the initiate, and this must be 18 years and above. If the initiate is between 16 and 17 years, there must be a special parental request in the format set out in Annexure C.

Other key elements of this legislation are that:

- Each child must get parental/guardian consent before he undergoes traditional circumcision.

- Each prospective initiate must be examined by a medical doctor to ensure that he is "fit and healthy" to undergo circumcision and initiation into manhood.

- Each traditional surgeon must get permission from a designated health officer to do a circumcision on each child, and the instrument and procedure used to perform the circumcision must be approved.

- Each traditional nurse must get permission to nurse each initiate in the circumcision school.

- Permission to hold a circumcision school must be obtained from a health officer and from the traditional leader, for example, the chief and/or ward councillor.

According to the Act, designated health officers have a right to inspect every circumcision school, and to institute whatever remedial action is necessary if the health of the initiates is at risk. Annexure B of the Act stipulates conditions to be met in order to obtain permission to hold a circumcision school. The following must all be met:

- The medical officer is entitled to deviate from the use of traditional instruments in cases of signs of sepsis or other health conditions. The medical officer must be allowed to visit the circumcision school at any time deemed necessary in order to inspect the health and condition of the initiates.

- The initiates must, at least within eight days of circumcision, be allowed to take reasonable amounts of water to avoid dehydration.

- The traditional nurse must not expose initiates to danger or harmful situations, and he must report any signs of illness of the initiates to a medical officer as soon as possible.

- A traditional nurse must stay with the initiates 24 hours in the first eight days. After the eight days have passed, he must be available once a day until the end.

- The medical officer designated shall be entitled to prescribe any measures he deems necessary at any stage of the circumcision.

In 2003, certain amendments and deletions were made to the Act of 2001. The new title for the Act is Application of Health Standards in Traditional Circumcision Amendment Bill of 2003. Areas that have been included were the provision of protective material by the medical officer. Additionally, traditional surgeons must perform circumcisions in sober minds, and must refrain from indulging in any intoxicating substances at any time before the circumcision on the day of performing the circumcision. It states that traditional surgeons must appoint a traditional nurse to treat the initiates. The traditional nurse must also have permission to treat initiates on the same day the traditional surgeon obtains permission to perform the circumcision. This Act only prescribes the fine for unregistered traditional surgeons, traditional nurses, and the owner of the school, but not the initiates who break the law. Penalties for transgression of any of the above, are stipulated in Section 9 of the Act.

3.5. IMPLEMENTATION OF THE APPLICATION OF HEALTH STANDARDS IN TRADITIONAL CIRCUMCISION ACT (NO 6 OF 2001)

As can be observed from the discussion above, the implementation of the Act was rather late to address the immediate problems for the November/December, 2001, circumcision season of the same year. However, the Department of Health managed to put immediate implementation plans in place where logistic mechanisms were implemented by designating 43 medical officers as defined by the Act (ECDOH Executive Report, 2002). According to ECDOH executive report (2002), these medical

officers gave an even distribution of this service throughout the province. This report shows that this first step has obtained a good baseline/starting point for the long-term objective of this service. Although there were some reported cases of hospital admissions, mutilations, and deaths in 2001, the figures were relatively low compared to the previous (ECDOH Executive Report, 2002). Apart from the Act, for government to ensure maximum effectiveness of these efforts, the Department of Health has taken a more structured, developed, and coordinated programme to complement, enhance, and inform the public about the dangers of irresponsible circumcisions. According to Goqwana (2004), these efforts are implemented in different forms, including the following measures:

- Education Awareness campaigns

- Discussions on 12 Down radio programme of the national broadcaster Umhlobo Wenene

- The hiring of vehicles during circumcision season, which are evenly distributed across the province to some chiefs to help monitor and promote vigilance

- The purchase, by the provincial government, of a fleet of 30 four-wheel drive vehicles to monitor the ritual and to be used by ECDOH officials and traditional leaders

- Active involvement in conducting raids at random, to identify and shut down illegal circumcision schools.

As part of this Act, in 2004 over 300 medical officers drawn from various health practitioners, were designated, firstly, to oversee the practice of this custom; secondly, to issue permits and assess applications; thirdly, to provide surgical training and equipment; and fourthly, to monitor the practice on the ground and intervene where necessary [13]. In addition to the ongoing programmes, there are mobile clinics on

[13] Presentation by Dr Bevan Goqwana, MEC for Health, Eastern Cape. Initiation schools conference, held in East London 27-29 September 2004.

standby to treat youths needing medical care either at initiation school or at their homes, rather than sending them to hospital (Sowetan, 08-06-2004).

Predictably, this Act has attracted different official responses. Within government circles, these measures have been hailed as a success. This positive outlook is largely based on the enthusiasm that is shared with the public through the media, public gatherings, and other promotional activities. The Provincial Department of Health has embarked on a proactive approach, spearheaded by the MEC, Dr Bevan Goqwana, aimed at curbing the violation of the Act.

As results of this approach, by the Eastern Cape Health Department, 42 traditional surgeons and nurses have been arrested since the Traditional Circumcision Act was introduced (Goqwana, 2004). The same author argued that of these, 18 were convicted for not complying with the Law. The same author argued that since the implementation of this Act, there has been a 70 percent decline in incidences of unlawful initiations from 2001 to May 24, 2004. The drive by the MEC saw 802 illegal initiation schools closed down in 2005, and approximately 150 boys rescued from these schools and referred to hospitals in the region. The Department has forged sound working relations with the traditional institutions, especially the Eastern Cape House of Traditional Leaders. The Department has also rallied and urged all role players (parents, traditional leaders, community members, and the South African Police Service) to work together in protecting young men from unscrupulous persons, who rob them of their youth, future, and life itself (Goqwana, 2004).

The Department of Health has outsourced some of the tasks to service providers, such as Impilo ya Bantu Health Development Project. This organization trained more than 300 traditional operators and traditional nurses (Kanta, 2004). According to Kanta (2004), this organization is more involved in public health education and awareness, performs pre-circumcision health assessment on intended candidates, treats circumcision complications, and performs postmortems on victims of ritual circumcision. The same author continues to argue that other interventions, which are provided by this organisation include cleaning and dressing of the wounds, supply of the necessary pharmaceutical and surgical material for the care of the initiates, as well as psychosocial support (Kanta, 2004).

Other measures being taken by the Department of Health to address the problem include building traditional initiation huts on hospital premises (Feni, 2004). It is said that the first pilot project was established at All Saints Hospital in Ngcobo, Eastern Cape. According to Feni (2004), to ensure the sacredness of the ritual to accommodate the wishes of traditional leaders, the Department of Health is implementing a process whereby only medical practitioners, who have themselves been circumcised, would attend to initiates in hospital.

3.6. CONCLUSION

This chapter has given detailed analysis of the traditional male circumcision interventions by the government of the Eastern Cape. Specific references were made to factors that led to government interventions. More specifically, this chapter traced these initiatives by government from the early 1990s until the 2004/05-circumcision season. The challenges for this intervention are that it raises both positive and negative reactions from the public. The negative reactions are arising from some of the traditional leaders. However, the year 2001 can be symbolized as a milestone in the developments around traditional circumcision and its related problems, due to the passing of the traditional circumcision Act No 6 of 2001. In the following chapter, a wide range of community responses to circumcision injuries and deaths is analyzed in detail.

CHAPTER FOUR: DIVERGENT RESPONSES TO GOVERNMENT'S LEGISLATIVE INTERVENTION IN XHOSA MALE CIRCUMCISION IN THE EASTERN CAPE

4.1. INTRODUCTION

The previous chapter of this thesis gave an in-depth background to both non-legislative and legislative measures taken by the Eastern Cape government to curb circumcision injuries and deaths. This present chapter discusses the divergent responses to the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001 in the Eastern Cape province of South Africa. The chapter is divided into three main sections. The section following this introduction presents the responses of traditional authorities to government's intervention in Xhosa male circumcision. The next section presents the responses of different social actors, which includes uncircumcised youth/boys, present initiates (*abakhwetha*), recent initiates (one to five years as man), mature men (10 years and more), parents of recent, present and future initiates, including mothers, community leaders (urban and rural), and traditional surgeons and nurses. The last section is the brief conclusion of the chapter.

4.2. RESPONSE OF TRADITIONAL AUTHORITIES TO GOVERNMENT'S INTERVENTION IN XHOSA MALE CIRCUMCISION

With their roles and powers being controversial, but with the constitution, and indeed, elements within government providing some legitimacy for their existence, traditional authorities are determined to latch on to those areas where they can still exert control or where their opinion is still considered. Traditional male circumcision just happened to be one of those issues that allowed them to have a say. It is worthwhile to provide a background on traditional authorities in the Eastern Cape before discussing what they have to say about the Act.

4.2.1. Understanding Traditional Authorities in the Eastern Cape

Traditional leaders in rural areas of South Africa use to be the only institutions preserving the people's culture and traditions. Even in the face of the onslaught of modern democracy and new policies of transparency, traditional institutions are

beginning to claim their pride of place, such as at traditional weddings and traditional circumcision. Ntsebeza (2002) argues that at the time of colonial conquest in the nineteenth century, African communities were comprised of groups that were under the authority of the independent chiefs.

Prior to the first democratic elections in 1994, local government and development activities were centered on the traditional authorities, including recommendations for the allocation of land, which happened at the local village level (Ntsebeza, 2003). Under apartheid, traditional authorities officially derived their legitimacy from tradition, but, in practice, these bodies were incorporated into and became an extended arm of the apartheid government. According to Ntsebeza (2000), traditional authorities used to have more power, in terms of traditional rule, in the rural areas of the former Bantustans, but subsequently, their powers were boosted under the Bantu authority's Act of 1951, in order to prepare the homeland areas for self-government.

In the post-apartheid South Africa, it is interesting that traditional authorities, despite their divisions, seem to be drawing closer and closer to one another, and focused on retaining their power base in rural areas. The role of traditional authorities in the post-colonial era in Africa was debated long before it became an issue in South Africa (Ntsebeza, 2003). In the case of South Africa, traditional authorities were excluded from participating in the forums that negotiated South Africa's transition to democracy. This was limited to political parties and the governments of the independent homelands (Southall & Kropiwnicki, 2003). However, the same authors argued that there was an increasing need by the ANC to accommodate traditional leaders for pragmatic and, to some extent, attitudinal reasons. According to Ntsebeza (2003), a compromise had been reached during the constitutional talks of the early 1990s, resulting in the recognition of the institution of traditional leadership in the South African constitution, but without much clarity about that institution's role. The principal strategy adopted by the ANC to win over the chiefs was the establishment of the Congress of Traditional Leaders of South Africa (CONTRALESA). When this structure was established, it aligned itself with the ANC. During 1994 elections, CONTRALESA, and most traditional authorities, were known to be ANC supporters (Ntsebeza, 1999). This author argued further that some; such as Chief Patekile Holomisa, became card-carrying members, and are now ANC members of parliament.

However, since the 1990s there has been an ongoing debate in South Africa regarding the roles, functions, and powers of traditional authorities in South Africa's democracy. Scholars differ in their writings about the role of traditional authorities in constitutional matters. On the one hand, there are those scholars who believe traditional leaders do not have a role to play. Bank and Southall (1996) argue that democracy in post-colonial Africa would be compromised if traditional authorities were accorded an active role in politics; their argument being based on the fact that their capacity in political administration is doubtful. These authors also base their argument on the grounds that a large number of traditional authorities collaborated with the apartheid regime, discrediting themselves in the eyes of many South Africans. They continue to argue that these leaders were unaccountable and corrupt when they administered the Bantustans. Lastly, Bank and Southall (1996), argue that there is a conflict between the patriarchal values of traditional leadership and gender equality in the constitution, which would make their full involvement in democratic structures, such as elected local government, controversial.

In contrast with the above argument, traditional leaders such Prince Ndamase argued that it is an undeniable reality that the indigenous institution of traditional leaders not only pursues an agenda of promoting traditions, customs, norms, and values, which may at times serve as a sense of identity for the country, but also sustainable rural development (Ndamase, 2004). Other scholars, such as Ismail (1999), argue that indigenous governance has democratic elements that can strengthen rather than weaken current efforts to build democratic culture among the African people.

However, traditional authorities at government level strongly articulate their voice for recognition, especially in areas such as the Eastern Cape and Kwazulu Natal where they have jurisdiction over rural constituencies. Consequently, there has been a continuation of the struggle between the provincial governments and the chieftaincy (Southall & Kropiwnicki, 2003). Firstly, the battle over the role of traditional leaders in municipalities has emerged as one of the issues that resulted in political tensions between traditional authorities and government (Zwane, 2000). This dispute emanates from the government's desire to extend municipalities to rural areas. This has seen the government and traditional leaders go head-to-head on the role and powers of chiefs (Zwane, 2000). According to this author, this proposal was based on the Municipal

Structures Amendment Bill, which proposed giving elected councilors power to rule over rural areas. From the traditional leaders' point of view, this was a signal of government's plan to strip the traditional authorities of their right to allocate land and decide what development is allowed on it.

Secondly, traditional authorities want recognition as the primary form of rural local government (Zwane, 2000). Thirdly, with further resentment provoked by government, who were bypassing the chiefs to implement development projects in rural areas, conflicts started over the number of seats that should be allocated to the provincial House of Traditional Leaders (HTL), and over the chiefs' demands for full-time status for better pay (Southall & Kropiwnicki, 2003). The issue of better pay also emerged in a public hearing to the National Council of Provinces (NCOP) at the University of Transkei. In this hearing, Prince Xhanti Sigcawu was quoted, saying, "Traditional leaders should be properly paid because they dealt with Bills and community matters and attended House Committee meetings" (Naki & Kumbaca, 2002).

Most importantly, it is this historical background between traditional authorities and the Eastern Cape legislature, which still has an influence on the tension between traditional leaders and government in the Eastern Cape. Furthermore, the constitution makes provision for the recognition of the role of traditional leaders in Chapter 12, which includes the cultural rights. It is against this constitutional background that traditional authorities of South Africa, especially the ones from the Eastern Cape, view themselves as the custodians of culture, including traditional male circumcision. The Minister of Arts & Culture, Pallo Jordan, in his speech during the initiation schools conference in East London was quoted as saying that the conference is important because the Constitution of South Africa gives power to traditional leaders to be custodians of culture and customs. The next section presents the views of the traditional authorities regarding the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001.

4.2.2. Issues of contention between government and traditional authorities with regard to Xhosa male circumcision

Custodianship

Traditional authorities claim that they are the custodians of African culture and that they should, therefore, be given the resources and authority to oversee the regulation of practices such as male circumcision (Meintjies, 1998b). Chief Mwelo Nonkonyana, the CONTRALESA provincial chairman, has even gone on to argue that the provincial government needed to strengthen traditional structures and support the tribal elders who were custodians of the ritual (Maclennan, 2003). He also proposed that an urgent Indaba (Consultative meeting) be held with the Eastern Cape MEC, aimed at putting the ritual back in the hands of its proper custodians. So passionate are the traditional authorities about this custom that they even use undated, non-referenced literature to argue that according to tradition, all initiates merely accompanied the sons of chiefs. These boys would go for initiation with the chief's son(s), and the chief would be responsible for the process. According to USAID (2005), the boy, who was circumcised after the chief's son, become the headman –the chief's advisor. Chief Holomisa supported this argument in his presentation at the same conference, where he argued that:

> The ritual must be placed firmly in the hands of traditional leaders, such as in places like Limpopo, Mpumalanga, Free State, and North West, where hundreds of boys undergo male initiation and all come home unscathed because there is still discipline and respect for traditional authorities in these provinces. Traditional leaders or their representatives play such an active role in the matter that they spend days in the initiation sites to ensure that the requisite procedures are followed. Most importantly, boys wait for a son of a traditional leader to be of age. They then form the core of the regiment, which safeguards the future growth of the prince.

At an initiation schools conference in Johannesburg in 2004, Dr Motshekga also gives an outline of the structure of African religion when he said:

> The veneration of ancestors and circumcision went hand and hand with the Africans worship of one god. In African culture, the king was the earthly

> representative of his predecessors or God, and in this capacity, the king organized communal prayers and initiation schools on behalf of their communities. The recent abuses reported at initiation schools raise many questions about whether the current traditional leaders could still be said to be divine rulers and custodians of order.

This doubt was also highlighted in an interview with a member of The House of Traditional Leaders in the Eastern Cape. This is what he said:

> I appreciate the role played by the Department of Health, in as far as it relates to initiatives with initiate casualties. However, I equally contend that the custom is not to be administered primarily by department; it is a joint responsibility between Arts, Culture, and Traditional Affairs. The intervention by Department of Health should only appear when there are complications regarding the surgical procedure. Therefore, my own contention is that health has a secondary role not a primary role. That health now plays a primary role is an indication of failure of the institution, which is supposed to be championing the primary responsibility if it had not been for the casualties.[14]

In addition to this, and perhaps fuelling the traditional authorities' discontent, the Eastern Cape MEC of Health made it clear that the Department of Health do not view themselves as the custodians of the custom and have no such ambitions in the future. He went on to say that the custodians of the practice are the traditional leaders (Goqwana, 2004). This was also confirmed by Sizwe Kupelo of the Department of Health, who admitted that the situation had gone from bad to worse, when he argued further that traditional leaders, communities, and the Xhosa nation in general, have failed the custom, as this is not the responsibility of the Department of Health. He argued that they are only trying to help; they are not the custodians of traditions (Daily Dispatch, 2001). However, the minister emphasized that government is the guarantor of the basic right to life, and, therefore, could not sit back as the mortality rate rose on a daily basis (Goqwana, 2004). In addition, the chairperson of the House of Traditional Authorities in the province, Chief Mwelo Nonkonyana was even quoted saying that anybody who defies the lawful orders of a traditional leader could also be charged, because in rural areas it was an offence to defy the lawful orders of a traditional leader

[14] Interview with a spokesperson for The House of Traditional Leaders (CONTRALESA) Zolile Burns –Ncamashe in Bisho, September 2005.

(Daily Dispatch, July 12, 2001). This is similar to Sotho culture, where all the processes of the *lebollo* (circumcision) and initiation schools are kept by the custodians of indigenous knowledge systems or the chiefs, and enforced by the *lekhotla* (traditional court) (Sekonyela, 2004). He argued further that the king and the queen epitomize the height of real traditional values. However, this argument is questionable today, because the tradition has changed, and now the boy himself or his father decides on the date of initiation. This is often determined by whether people can afford to cover the related expenses or not, and whether it is convenient or not in terms of the work or school calendar.

Involvement of medical personnel and females

Some of the traditional leaders are concerned about the danger of losing their cultural identity, with western religion, education, and politics combined, in an attack on the indigenous way of life and its institutions (Holomisa, 2004). Holomisa argues that Xhosa male circumcision is about the only ritual that has managed to survive in its original form. According to Kretzmann (2001), criticism from traditional authorities is based in terms of section 4 (3) of the schedule to Application of Health Standards in Traditional Circumcision Act, 2001, which requires initiates to undergo a medical examination before circumcision, as well as having a medical practitioner present at the ceremony. For years, people who are not part of the culture and African women, in particular, have been curious to know the hidden secrets of the Xhosa male's ritual of manhood (Witbooi, 2005). According to Kretzmann (2004), anything that involves a western doctor or women, in this custom, is certainly regarded as non-African. Another issue, which angered some traditional leaders, was the plans for village circumcision. This issue surfaced after it was learned that Cape Town metro councillors, including women councilors, had approved the building of a R1.2 million cultural village, incorporating a circumcision school (Daily Dispatch, March 11, 2004).

Regarding this issue, Chief Nonkonyane was even quoted as saying, "We have noticed this dangerous trend, of people trying to colonize our initiation custom." This statement was also echoed by a spokesperson of the House of Traditional Leaders, Chief Zolile Burns Ncamashe, who argued that the custom is not a fashion, that it is a ritual, which has to be performed properly. The two chiefs were reacting to reports that a number of traditional leaders in the Eastern Cape, including CONTRALESA president, Phatekile

Holomisa, supported the idea of using cultural villages as initiation schools. They pointed out that the burning of initiates' huts after they had completed their circumcision rituals was an important aspect of the custom, and that one could not burn down the permanent structures in cultural villages. However, the involvement of women in the issue angered them the most. A shocked Burns Ncamashe asked, "What are women doing in the circumcision issue? It is taboo for women to participate in the initiation process" (Daily Dispatch, March 11, 2004).

It may be worth noting the relevant sections of the Circumcision Act, to emphasise this point, which may potentially be in conflict with one another. In particular, as far as culture is concerned, this is worrisome for some traditional leaders. For example, Section 3(a), Annexure B of the Act, outlines the powers and functions of medical officers. This section states that, in addition to any other powers and functions entrusted to him or her by this Act, the medical officer must exercise and perform the following functions:

- issuing of permission to circumcise or treat an initiate;

- keeping of records and statistics pertaining to circumcision and reporting thereon; and

- attending, through right of access, of any occasion or instance where circumcision is performed or an initiate is treated.

Traditional Leaders and some communities have rejected the Circumcision Act precisely because, like all other legislation, it diverts the power to administer the custom from traditional leaders and communities, to medical personnel (whether males or females; circumcised or not) (House of Traditional Leaders, 2001). Chief Magadla, leader of the House of Traditional Leaders, has argued that the tricky thing about medical officers being involved in this ritual is that they may be uncircumcised or even female, a taboo according to Xhosa culture.

This argument by traditional leaders is confusing, because the resulting infections, common after traditional circumcision, frequently necessitate hospitalisation or care in

the clinic. Females predominantly run both these institutions (hospitals and clinics). Once referred to them, it is practically impossible to prevent initiates from contact with females (Mayatula & Mavundla, 1997). According to the spokesperson of the House of Traditional Leaders in the Eastern Cape, Prince Zolile Burns Ncamashe:

> Circumcision is a noble custom, which can never be abandoned, but the problem of fatalities, amputations and mutilations has led to degeneration of the dignity in the custom itself. The challenge we're facing now, as a nation, is how to restore that dignity.

Traditional authorities argue that the involvement of government officials will only be acceptable if such officials are themselves members of the tribe, who have undergone the ritual, and are acceptable to the community concerned (House of Traditional Leaders, 2001).

According to Maclennan (2003), some traditional leaders seem to be more concerned about the involvement of females in forums regarding circumcision debate than they are with other aspects of the Act. In an interview with a spokesperson for the House of Traditional Leaders, Zolile Burns-Ncamashe, he condemned the involvement of women, arguing that even though the Department of Health's intentions may be positive, many unintended consequences may be the result. The one example he cites is that of the MEC of Health, while promoting the safety of the tradition in villages, travels with journalists, amongst who are females. His argument is that these women are not supposed to be part of these discussions, even for the purposes of mere reporting to their audiences. The president of the Congress of Traditional Leaders of South Africa, Chief Phatekile Holomisa, confirmed this. He was quoted as saying:

> It is only in the Eastern Cape that this sacred African ritual has been brought into disrepute. It is in the Eastern Cape that you read in newspapers, you listen to radio shows, and see on national television, discussions being held over this sacred custom by people, some of whom are not suppose to be involved with it.

In the national newspaper, Business Day, the president was even quoted as saying:

> It is in the Eastern Cape, where boys undergoing this ritual, are maimed and even killed because of irresponsible behavior on the part of all those involved—

> the boys themselves, their parents or guardians, the traditional surgeons and nurses, and in some cases, the traditional leaders, who fail to enforce discipline within their communities.

He argues that it is the result of the lukewarm support that government gives to traditional leadership in the country (Business Day, April 25, 2006). Chief Matanzima of The House of Traditional Leaders in the Eastern Cape Province, for example, was quoted as saying,

> Men die during circumcision as women die during childbirth; the custom is the custom and nothing will change. But, I cannot blame parents for being scared because in the olden days, there were no unnecessary deaths.

This statement implies that the deaths should not be seen as an aberration of the ritual, but as a necessary and intrinsic element, functioning to uphold the social purpose of the ritual. The deaths and injuries are social utilities, which ensure this.

Traditional leaders rejected the newly passed Act with contempt, as it allowed for the involvement of women in the traditionally male ritual. The chairman of the Eastern Cape House of Traditional Leaders, Chief Mwelo Nonkonyana, was quoted as saying that he would be the first to defy the Act when his son undergoes the circumcision rite (Herald, October 27, 2001). He argued further that traditional authorities cannot allow women, particularly those who are breastfeeding, to fiddle with boy's genitals. Chief Patekile Holomisa supported this, expressing himself in Xhosa, saying, "*Mabangabhucabhucwa ngoomama nanini na abantu abangena ebudodeni*" (Initiates should not have their penises fiddled by women at any time) (Holomisa, 2004). This is in line with the cultural belief that cleanliness on the part of all those who come into contact with the initiates is considered to be of vital importance. By implication, therefore, it is believed that women are likely to be unclean. According to Chief Magadla, of the Eastern Cape House of Traditional Leaders:

> Women play a very supportive role with regard to *ulwaluko* (circumcision). Hence, any man would inform his wife before he sends his son for circumcision. And the cutting of grass for building the lodge is a full responsibility of women, but there is a limit.

According to Holomisa (2004), in villages, you cannot imagine a situation where a woman is required to participate in a meeting called to discuss problems relating to male circumcision. This view about women, especially coming from leaders such as Chief Holomisa, who also happens to be a member of parliament, is ironic for two reasons. Firstly, Chapter Two, Section 9(3) of the Constitution of the Republic of South Africa, 1996, recognizes the equal human rights of all, including those rights that are cultural and religious in nature. This certainly includes the rights of women be involved in all aspects of life in their communities. Furthermore, the constitution makes provision for the recognition of the role of traditional leaders. The constitution, therefore, recognizes rights and institutions that may potentially be in conflict with one another. As far as cultural rights and powers of traditional leadership are concerned, this is of particular concern for the declared equal rights of women. Secondly, it is ironic that these chiefs have this view about women discussing initiation of males, when traditionally females are allowed to be leaders. If the traditional authorities then insist on being recognized as custodians of the circumcision rite, why must female traditional authorities be left out?

The accommodation of the claims of traditional leadership, and the recognition of traditional communities in South Africa, poses a great challenge to democracy and human rights. In so far as the equal rights of rural communities are concerned, and in particular women within them, the attainment of a workable balance between the powers of traditional authority, and the democratic rights of the people in the communities over which they preside, could constitute either one of the greatest failures, or one of the greatest achievements of the post-apartheid dispensation. It is a matter of critical national concern that this balance be achieved, as it is integral to the achievement of the rights and well being of rural women, as well as the peace and stability of the communities in which they reside (Bentley, 2003).

Registration of Traditional Surgeons and Nurses

One of the requirements of the Circumcision Act is the registration of traditional surgeons (*iingcibi*) (See section 4 of the Application of Health Standards in Traditional Circumcision Act, 2001, TCA). Traditional authorities are not actually opposed to this registration, but are against this being done by government. They want the registration of *iingcibi* to be done under the auspices of the relevant traditional leader (Holomisa, 2004). In the case of communities without traditional leaders, a community leader

should be identified upon consultation with the relevant king. The social scientist, Dr Mathole Motshekga, also confirmed this. According to Motshekga (2004), initiation schools should be modernized without undermining the cultural and religious values that underpin them. He argues further that there was an urgent need for a cultural education programme, which would restore the authority and responsibilities of traditional leaders in the establishment and administration of initiation schools. According to Holomisa (2004), if the current legislation does not place the control of the ritual in the hands of traditional leadership, it is an illegitimate piece of law even if it may have been passed by a democratic legislature.

Consultation process

The other issue that is contested by traditional authorities, with regard to the Act, is the question of proper consultation during the creation of the Act. Having claimed to be the custodians of this ritual, traditional authorities in the Eastern Cape complain that they were never consulted when the proclamation was drafted (Kretzmann, 2001). One traditional leader claimed that the Bill was referred to in the House of Traditional Leaders at a time when there were still some political misunderstandings between the institution of traditional leadership and institutions of government. Therefore, he argues, any consultation on the legislation relating to male circumcision should not be taken seriously.

According to Mati (2003), in 1997, CONTRALESA had submitted a report in which it made recommendations to the provincial government, where they objected to the provision of the Bill on circumcision, and had made suggestions. They objected to the idea that the MEC of Health and his appointees (for example, doctors) administer the circumcision custom, whether they are male or female. Some traditional authorities were even concerned with the fact that public hearings were being held in urban areas, instead of Great Places (homes of traditional authorities), where all can give input (Daily Dispatch, August 1, 2002). This is another strange rationalization by traditional authorities, because there are millions of Xhosa people living in urban areas, who do not have village ties, where the Great Places presumably are. Another irony is the fact that there is documented evidence that some traditional leaders were part of the consultation processes (see Chapter Three, Section 3.4 for more details).

4.2.3 The Position of Traditional Authorities to Circumcision Injuries and Deaths of Initiates during Male Circumcision

Having outlined the issues of contention between government and traditional authorities, it is important to discuss traditional authorities' views on the core issues that the Act is attempting to resolve. Firstly, it needs to be mentioned that traditional leaders are equally concerned about deaths and injuries of initiates in the Eastern Cape. Based on the traditional leaders of South Africa's position paper of 2001, traditional leaders believe that these problems are caused by the following factors:

- incompetent surgeons who lack the requisite skill;
- surgeons who perform the operation whilst under the influence of alcohol and drugs;
- surgeons and attendants who fail to abstain from sexual relations with women during the days preceding the performance of the ritual;
- the lack of government support for the institution of traditional leadership as enforcer of law and order in the rural areas; and
- the use of surgical instruments, which have not been sterilized.

In principle, traditional authorities agree with some aspects of the Act as set out in Annexure A. In addition, traditional leaders argued that as the custodians of culture, they should be allowed to have curriculum to equip initiates to take up their roles in society (House of Traditional Leaders of South Africa, 2001). Finally, given the divergent positions with regard to the circumcision debate among the different stakeholders, it is necessary to analyze community responses to circumcision problems and changes.

4.3. VIEWS OF AFFECTED COMMUNITIES ABOUT PROBLEMS AND CHANGES IN MALE CIRCUMCISION

Having presented the responses of government to the deaths and injuries during Xhosa male circumcision and the responses of traditional authorities to these interventions by

government, this section attempts to explore community responses to both government's intervention, and responses of the traditional authorities to these. The responses were collected from a number of key stakeholders in local communities, including uncircumcised youth, initiates, young and old circumcised males, parents of initiates, community leaders, and traditional surgeons and nurses. The interviews, on which these responses are based, took place over several years in Siphaqeni Village, Border Technikon in East London, and in Cape Town townships.

4.3.1. Uncircumcised youth or boys

Although uncircumcised youth did not know anyone who had experienced problems during circumcision, they argued that they are aware of the scale of the problem and expressed some concerns about it. For example, one respondent stated:

> Circumcision used to be respected in Xhosa culture, as the road to manhood, but now it seems it is the road to a death sentence. What is happening now is no longer part of culture but a process of torture.

This group of stakeholders had a number of concerns. Firstly, the high rate of HIV/AIDS amongst youth in South Africa, which might be transmitted during the initiation process if there are no safety precaution measures applied, concerned uncircumcised youth. One respondent said, "*Baya esuthwini sele bephelile*" (They go to initiation school already finished).[15] The fact that initiates, who go to circumcision school already infected, die during the process is of serious concern to those uncircumcised males who are already sexually active. Secondly, the honor associated with being an initiate is another contributing factor, resulting in boys going to initiation schools at a younger stage. One respondent argued that in the past people were circumcised as old as 25 years and above.[16] Now, in pursuit of this honour, many uncircumcised males rush into circumcision without necessarily ensuring that it is safe to do so. Thirdly, lack of parental care is seen to have resulted in juvenile delinquency, which manifests in the initiation process, whereby a boy would go to initiation school

[15] Telephonic interview with a 19 year old uncircumcised grade 11 student of Esangweni Senior Secondary on 8th of September 2006 in Cape Town

[16] Telephonic interview with a 18-year-old uncircumcised grade 11 student of Esangweni Senior Secondary on September 8, 2006, in Cape Town.

without the approval of his parents. In such cases, there is usually no pre-initiation counseling or safety protocols put in place.

With regard to the provincial circumcision law (Application of Health Standards in Traditional Circumcision Act (No 6 OF 2001), it was the general feeling of all interviewed that the law is a good initiative by government. Part of the suggested solution was that the existing law should instead be strengthened, including the age restriction for undergoing initiation. On the other hand, respondents disapproved of the position of traditional leaders in Bisho, of their criticism of the circumcision law, arguing that for so long this has been in their jurisdiction and these incidents are a sign of failure on their side as traditional authorities. One respondent said, "*Ukuba urhulumente akanongenelela kulento, kuyekelwe kwezonkosi, singaphela"* (If government cannot intervene and rely on traditional leaders, we will all die.). Another respondent declared, "This is a national crisis and we need to be flexible and adapt to current ways of doing things."

4.3.2. Present initiates (*abakhwetha*)

Most of the initiates, who were interviewed, had left their initiation school due to injuries and illness, and were admitted at St Barnabas Hospital in Nyandeni Region. They give their perspective based on their personal experience. One initiate said:

> I ran away, because of bad treatment we got in the initiation school, where people in-charge were drunk and very harsh on us. They told us that *ayilulanga indlela eya-ebudodeni* (the journey to manhood is not easy).[17]

Another initiate argued that government should monitor initiation schools and culprits who circumcise children should be prosecuted, and that people who are trained to do the job should only do circumcisions in hospitals.[18] Another initiate shared his bad experience during his own circumcision. This is what he said:

[17] Interview with an 18-year-old initiate from Emampondomiseni Village in Ngqeleni District, Eastern Cape on July 4, 2003.
[18] Interview with an 15-year-old initiate from Nquba Village in Ngqeleni District, Eastern Cape, on July 4, 2003.

> We were doing well in our initiation school and we visited other initiates in another distant rural village. We came across this one initiate who had such a terribly infected circumcision wound that his organ of manhood appeared like it was going to fall off. On our way back to the initiation school, we were so shocked about what we had seen that there was complete silence all the way as we walked back. No talking; no singing; we still wonder whether that initiate recovered well without any residual consequences.[19]

These unfortunate initiates felt they would be ostracised and made social outcasts by their peers because they presented themselves to a public hospital. Initiates are concerned about peers who are still conservative in their approach, and who still maintain circumcision as a closed ritual that should be dealt with in a one-way approach. Those who become victims had different views and argued that government should supervise the ritual and the law should be strictly implemented.[20] This trauma, and the frustration brought about by severe damage or total loss of the organ, resulted in the suicidal tendencies of the unfortunate ones.[21]

4.3.3. Recent initiates (one to five years as a man)

This category of respondents seemed well aware of scale of the problem. They were able to mention several contributing factors to injuries and deaths. Firstly, they believe there is a lack of adherence to health safety measures by traditional practitioners. Secondly, the credibility, capacity, and skill of the *ingcibi* (traditional surgeon), as well as adherence to an age limit of eighteen and above, are the main culprits of the problem in male circumcision among the Xhosa.

Some recent initiates suggest that health management must be done at the lodges by male health professionals, who themselves have undergone initiation into manhood and accept traditional health practices. In instances where initiates have to be taken to clinics or hospitals, they should be treated in a culturally sensitive and accommodating manner. Others seem to be more concerned about the spread of HIV. Regarding awareness of the circumcision law, respondents give positive responses. They claimed

[19] Initiate interviewed by Dr Kanta during the inspection of initiation schools in Lusikisiki, Eastern Cape, 2003.
[20] Interview with a 23-year-old initiate from Mngamnye Village in Ngqeleni District, Eastern Cape, on July 4, 2003.
[21] Documented in project report executed on behalf of the Department of Environmental Affairs, 1996

that they hear about it particularly around the circumcision seasons of June/July and November/December. However, there was a common belief that more awareness was still needed to get more people to understand and appreciate the law. These recent initiates also believed that traditional authorities could work hand in hand with government on initiation issues.

4.3.4. Mature men (10 years and more)

Almost all the respondents stated that they have heard about the problem, citing television and radio as their source of information. This thought is reflected in the following narrative. This group had much to say. Firstly, they had an issue with the choice of traditional surgeons and nurses. They asked questions such as who chooses these traditional nurses? Why do they seem not to be accountable to the family of the initiate? Secondly, this group argued that the majority of initiation schools are illegal, as opposed to traditional initiation schools, which have the support of the local communities. They believe that it is difficult to monitor and coordinate health compliance in these illegal schools. Thirdly, this group believes that another contributing factor is that traditional health practitioners have acquired their knowledge and skills through indigenous means, and that there is a need to provide them with new skills in other areas in, for example, HIV/AIDS, hygiene, infectious diseases, and ethics.[22] The views highlighted here are similar to the ones highlighted in Chapter One (See section 1.1.3). However, some respondents associate the deadly sepsis of initiates with witchcraft, arguing further that, in the past, circumcision was an exclusively male domain, but now everything is exposed for public scrutiny, with females arguing that their opinions on this issue needed to be considered as well.

Another debated issue concerns the knowledge of traditional circumcision legislation. Most respondents reported that they have heard about traditional circumcision laws and are in support of it. Great concern was also raised with regard to the stigmatization and discrimination within communities for medical circumcision. Such stigmatization and discrimination has led to divisions within communities, and even death of community

[22] Interview with a 34-year-old male educator on September 5, 2006, in Samora Machel Primary School in Cape Town.

members. Some respondents, however, argued that people have a right to choose.[23] In addition to this, respondents criticized the position of traditional leaders in Bisho, on the basis that their role is vague. They argue that these traditional authorities also failed to take responsibility for the situation in rural areas, where these problems seem to prevail. This argument raised many questions in some respondents, especially with regard to what traditional authorities themselves do within their communities to promote the application of the law. Respondents argued that traditional authorities are not realistic by trying to adhere to old practices when times have changed. They need to be flexible for the sake of a dying nation. The conclusion here is that there is need for co-operation between traditional health practitioners and western health practitioners.

4.3.5. Parents of recent, present and future initiates (including mothers)

Parents expressed concern about the deaths of initiates. Almost all respondents argued that there are problems associated with traditional male circumcision and initiation into manhood in almost all areas where the ritual is practiced. They argued that traditional male circumcision and initiation into manhood poses a serious public health problem, not only for initiates, but also for traditional surgeons and nurses and the community as a whole.[24] In an interview with a 69-year-old man from the Eastern Cape, who has lived in Cape Town for more than nine years, he pointed to today's surgeons and nurses, claiming, "*Bayaraqaza"* (they sleep around), while they are responsible for aftercare of the initiates, something which is traditionally not allowed in the Xhosa culture. This is also confirmed by Meintjies (1998), who argued that the surgeries on, and nursing of, initiates have always been in the hands of mostly the experienced elderly and unemployed. Meintjies states further that experienced men, usually traditional healers with an interest to pass on the nation's traditions and customs, would be engaged in this task. The views of this group also concur with the argument that was made earlier (see Chapter One, Section 1.1.3).

Beside the above concerns, there was generally widespread support for a pre-medical examination of all potential candidates because of the fear of the possible spread of sexually transmitted infection via the use of the same instrument. One female

[23] Interview with a 34-year-old male educator on September 5, 2006, in Samora Machel Primary School in Cape Town.
[24] Personal conversation with Dr Kanta, who is a medical practitioner in the Eastern Cape, in 2005.

respondent said, “I will make sure that my two boys consult a medical doctor before going to the bush, for health reasons.”

Another female parent commented, “Every time, when I hear about an initiate admitted to the hospital, I get worried.”

Still another respondent pointed out, “I like this new law because the boy, parent, traditional surgeons and traditional nurse are all registered and known by the community. At least if something happens, there is some form of law involved.”

According to Cecilia, a single parent who lost her 20-year-old son during circumcision, “It puzzles me when you lose a child through something that you cannot intervene in. My son is no more, just for going through the circumcision school,” (Daily Dispatch, July 4, 2002). Some villagers have welcomed the circumcision legislation and the campaigns focusing on the importance of adhering to circumcision laws. Mutile Loli of Dyam-Dyam Village was quoted as saying:

> It is time to accept change for the best. We have been criticizing government for its intervention in circumcision, but now that everything is clarified, we are in full support of the initiation law, as long as it will save lives (Daily Dispatch, November 11, 2004).

Respondents argued that initiation schools had, in the past, been one of the right institutions to maintain discipline and respect, but with the high moral decay in African communities, the ritual has lost the value it used to have. One respondent noted that the practices in the Eastern Cape had changed, and pointed to a number of areas where modern influences and inexperience could potentially cause wound complications.[25] There was also a suggestion that some initiates might be allergic to herbs that are used in the mountain.

Parents raised some doubts about the position taken by traditional authorities in Bisho. They are concerned about ambiguity in rural communities around the location of responsibility and accountability in post-apartheid South Africa. The issue of injuries

[25] Interview with Umdlana on September 7, 2006, in Khayelitsha, Cape Town, from the Eastern Cape Cofimvaba District.

and deaths of initiates has made these doubts even worse. One of the respondents argued that traditional authorities at both local and provincial levels have failed the Xhosa nation on the issue of removing the lawlessness that seems to prevail in this ritual.[26] Female parents are even questioning the ritual, given the crisis within it. One said, "*Lisiko ebelitheni lona eli lizokude lisibulalele abantwana*?" (What kind of ritual is this that it now kills our children?). Parents, cited in Meintjies (1998), have argued that this problem used to be a problem of city people, mainly because of their ways and their ignorance of traditional practices. This argument now is challenged, with some respondents making reference to the situation in Cape Town where initiation schools are held, without traditional leaders, but comply with structural standards and values as enshrined within that particular traditional community.[27]

4.3.6. Community leaders (urban and rural)

The circumcision intervention by government was well received by community leaders, although some were not as so clear as to what it entailed. With regard to the responses of traditional authorities in Bisho, some community leaders are questioning the legitimacy of this institution in post-apartheid South Africa.[28] Contrary to popular belief, that traditional authorities are the sole custodians of this ritual, community leaders in urban areas view this as a challenge to their own roles and responsibilities. Other community leaders, such as the South African National Civic Organization (SANCO) argue that they are involved in issues relating to the ritual. The SANCO provincial chairperson, Fudukile Mbovane, said that the provincial executive committee talks in Port Elizabeth resolved to take up the campaign against the problem of botched circumcisions. In other words, urban community leaders do not accept that traditional authorities in rural areas are the sole custodians of the ritual.

Community leaders in rural areas are equally concerned about deaths in the initiation schools. Some of the contributing factors highlighted were alcohol and drug abuse by people involved. Most of these rural community leaders were interviewed in Eastern Pondoland. In this region, there is a generation gap regarding circumcision practice (see

[26] Interview with Nomaduna from Centane, in Khayelitsha, Cape Town, on September 13, 2006.
[27] [27] Personal conversation with educator from Samora Machel Primary School in Cape Town, on September 5, 2006.
[28] Interview with ward councilllor in Harare, Khayelitsha, on September 5, 2006.

Chapter One, Section 1.1.1. for more details). This means male parents could not supervise the circumcision wounds of their children in the lodge because they themselves did not go through this ritual. It is, therefore, not surprising that these leaders were not specific as to what should be done by communities to ensure that there is safety in the initiation schools.

Some respondents agreed that circumcision is a cultural issue, which has to be administered by traditional leaders without outside interference. High profile traditional leaders, such as Chief Phathekile Holomisa, support this thought. He was quoted as saying that educated and Christianized sections of the society tended to look down on those who stuck to worshiping God in the ways of their forefathers, and in following their cultural practices when they held wedding ceremonies, baptized their babies, and initiated their girls and boys into womanhood and manhood, respectively.[29] In a meeting with traditional local leaders held at a tribal authority, there was a general feeling that no formal government intervention strategy should exist without the traditional authorities being in the forefront, as rural people are loyal to them. For example, one respondent argued, *"Abantu abamazi urhulumente, abantu bazi iinkosi zemveli"* (People do not know government, they know traditional authorities).

4.3.7. Traditional surgeons and traditional nurses

Most traditional surgeons and nurses interviewed are in support of the legislative regulations of the ritual. Almost all respondents have welcomed the support of government, particularly the provincial Department of Health, in helping to resolve the problem of injuries to and death of initiates. However, traditional surgeons and nurses argued that there is a need to initiate local programmes aimed at education on safer practices on the part of the surgeons and nurses. The issue of HIV/AIDS was always mentioned when people were responding on the need for change. Traditional surgeons and traditional nurses have a relatively clear vision and motivation for engaging in safe circumcision. However, there are no written policy guidelines on legislative regulations for traditional circumcision. In general, views of both traditional surgeons and traditional nurses are in line with government legislation.

[29] Paper presented at the Human Sciences Research Council on *Human rights, customary law and women: Throwing the baby out with the bath water*: Date September 13, 2006

4.4. CONCLUSION

This chapter has given a historical background of traditional authorities in South Africa, with specific reference to the Eastern Cape Province. A closer examination was made of their views regarding the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001. A numbers of issues and contentions, of some aspects of the circumcision law by traditional authorities have been outlined. This chapter further analyzed community responses to both government's intervention and the responses of traditional authorities to these. The next chapter presents the conclusion based on some of the key issues that emerge from this thesis.

CHAPTER FIVE: CONCLUSION

5.1. INTRODUCTION

The aim of this thesis was to conduct an ethnographic analysis of the Xhosa traditional male circumcision intervention by government, through the Application of Health Standards in Traditional Circumcision Act, No 6 of 2001. More specifically, the thesis sought to understand how different stakeholders respond to this intervention and what steps they take to indicate their responses. Some of the issues that constitute current challenges facing male circumcision were explored. These were education, urbanization, commercialization of culture, as well as sexually transmitted diseases (STDs) (See Chapter One, section 1.1.3 for more details). In order to achieve the objectives set out for this study (see Chapter One, section 1.5), a combination of methods was used. In particular, the combination included observation, in-depth interviews, a review of anthropology and health studies literature, and media debates regarding the issue of circumcision in the Eastern Cape. The researcher also drew from personal experiences and observation over a period of close to four years in Qaukeni Municipality, Eastern Cape Province, in 2003; and again in Umtata, East London, and Cape Town in 2005 to 2006.[30]

To provide a foundation for arguments made in this thesis, a brief background was given on South Africa's policy dilemmas with regard to group rights versus individual rights within the South African cultural context. However, the content of those rights, and indeed whose choices they actually are, is highly contested (See Chapter Two, section 2.3.). The aim of this concluding chapter is to consolidate several key issues, which have emerged from the literature review, legislation analysis, and the case study. This chapter reminds the reader of what has been presented, highlighting some important observations made. The chapter is presented in four main sections. Firstly, there is a section, which revisits the scale of the problem in Xhosa male circumcision ritual, as well as concerns associated with this problem. Secondly, there is a brief analysis of South Africa's policy dilemmas with regard to group rights versus government responsibility to save the powerless, which is in this case are the initiates.

[30] Some more interviews were done in Cape Town, because the majority of Xhosa people still migrate between the Eastern Cape and Western Cape in search of employment. Therefore, they are affected by this law; hence, they will always take their sons back to the Eastern Cape for circumcision.

Even though there is a suggestion that initiates are powerless in the context of circumcision ritual, they clearly do exercise their agency when it is absolutely necessary. For example initiates are known to eat food that they are forbidden from (e.g. eggs), but which they might know is good for their health and healing of the wound. In many cases in urban areas they have even taken themselves to hospitals. However, due to hierarchical nature of the ritual, whereby elders have the right to punish initiates if there is a perceived transgression, initiates can be said to be powerless, as they it is taboo to fight back.

Thirdly, the roles and functions of traditional authorities according to the South African Constitution are discussed within the context of traditional circumcision. Lastly, what emanates from the study makes up the concluding section.

5.2. THE SCALE OF THE PROBLEM IN XHOSA MALE CIRCUMCISION RITUAL: PUBLIC HEALTH CONCERNS

As discussed earlier in Chapter One (Section 1.1.3.) and Chapter Three (Section 3.2.) of this thesis, there is overwhelming evidence that thousands of initiates die or suffer severe ill health because of botched circumcisions, and that this has become a recurring nightmare. The Eastern Cape Department of Health (ECDOH) systemically records the rate of complications. The statistics seem to be going up and down, even after different intervention strategies by the ECDOH. These complications relate to the surgical technique employed. There is a real risk of the transmission of blood-borne infections when the same blade is used to circumcise more than one initiate, without safety precaution measures or protocol being followed. This is a common practice in traditional settings. It requires a need for the policy-makers to consider co-operation between traditional health practitioners and western health practitioners, in this regard, to ensure that health standards are met during circumcision. In the traditional setting, initiates, with pre-existing health conditions, experience a deterioration in their condition while in the bush, due to the traditional requirement that western medication should not be used. Given that some western intervention, in the form of a pre-initiation medical exam, has now been fairly accepted by different stakeholders of the custom, there should be an argument for allowing more western treatment, including medication, in traditional circumcision.

Dealing with the after-effects of botched circumcisions, including serious injuries and deaths, has proven to be costly for both families of initiates and the government. The costs to the state of treating one initiate for one day, in 2004, was estimated at R700, with those injured spending an average of 30 days in hospital. Therefore, it is argued here that appropriate circumcision interventions could save the lives and health of initiates, as well as the costs associated with these for both the families and the government. As this thesis has indicated, the negative impact of a botched circumcision is not only material; the psychological impact of such a misfortune is far-reaching. For example, the victims of botched circumcisions, if they survive, can no longer enjoy a normal life as they have been robbed of their manhood. This is especially more serious in an event that an initiate affected is the only son; the family name may cease to exist (Goqwana, 2004). Most important, however, is the fact that botched circumcisions present a threat to the way of life of the cultures that practice circumcision. The other problem is that due to the sensitive issue of cultural rights versus the state's responsibility to ensure public health, the more there are problems in this ritual, the more there will be conflict in the human rights-state responsibility issue. This issue is dealt with next.

5.3. CULTURAL RIGHTS AND RIGHT TO HEALTH: CHALLENGES TO THE CONSTITUTION

As mentioned in Chapter Two (section 2.2) of this thesis, authors believe that the figures for deaths and injuries during circumcision are indicators of the violation of the provisions of the right to human dignity and the right to life (Thipanyane, 2004; Ntuli, 2004; Makhafola, 2004).[31] The South African government has certain international obligations, with regard to the right to life. This is based on recommendations of the World Conference on Human Rights of 1993, which resulted in the Vienna Declaration and Programme of Action. Article 71 of part 2 of the Vienna Declaration recommends a national action plan, in order to identify the steps the state ought to take to promote and protect human rights. In particular, the Department of Health has a primary objective to save lives. This is especially the case where traditional circumcision is concerned. As discussed in Chapter Three (Section 3.4.), in 2001, the Eastern Cape

[31] Papers presented in traditional initiation schools conference hosted by the National House of Traditional Leaders 24-25 May in Johannesburg, 2004.

provincial government decided enough is enough, through legislation called the Application of Health Standards in Traditional Circumcision Act (No 6 OF 2001). Although society is divided around the introduction of this law, the evidence in the study shows that views on this vary widely. There is general acceptance of government's intervention in the ritual (See Chapter Two, Section 2.1.). Evidence from other studies also supports this view, which emphasises that government has to ensure that the rights of initiates are protected from possible abuse or infringement (Momoti, 2002). A general moral decay in our communities, insufficient experience of the practitioners, and commercialisation of the ritual, compounds this problem. Recommendations are that the health issues of the initiates be considered before and during the circumcision period. Families need to take caution by choosing experienced circumcision practitioners to perform the ritual on the initiates. Males are taking the leading role in decision-making. What is the role of women, especially mothers, in this process? With the increase in single parenthood in South Africa, it is imperative that mothers be involved in the decision-making process. Thus, bearing in mind that there are deeply entrenched norms and beliefs that only males should play a role in decision-making during the circumcision process, this would require a radical change in the thinking in families and communities. Circumcision is a highly guarded ritual within African culture with males assuming dominant roles.

Traditional leaders object to state intervention as far as circumcision is concerned, because they believe that Africans are the custodians of this ritual. The medical approach (or intrusion), in the performance of this ritual, is not acceptable. However, as this thesis has shown (See Chapter Four, Section 4.3.), there seems to be contradictions in the views of traditional leaders and the broader communities on this matter. The broader community seems to be more receptive of state interventions. There is, therefore, a need to balance the traditional ways and the constitutional requirements in performing circumcision. This would require much consultation and education among various stakeholders, as the role of the traditional authority in traditional male circumcision cannot simply be dismissed. This is particularly so because of the constitutional guarantees to upholding tradition, including traditional authorities, as a legitimate way of life for some cultures in South Africa. The next section deals with this issue.

5.4. ROLES AND FUNCTIONS OF TRADITIONAL AUTHORITIES: CLAIMS AND DISPUTE IN THE CONTEXT OF TRADITIONAL CIRCUMCISION PRACTICE

According to Ntsebeza (2004), traditional authorities controlled rural governance in the former Bantustans prior the 1994. One of the compromises agreed to in the negotiation process, leading up to the drafting of the Constitution, was the recognition of traditional leaders (Bentley, 2004). While the Constitution allows for a public role for traditional leaders, the provision states that traditional authorities may continue to function subject to any legislation applicable thereto (Dladla, 2000). Chapter 12 of the Constitution states that the institution, status, and role of traditional leadership according to customary law, are recognized, subject to the Constitution. Ntsebeza (2004) argues that, in post-1994 policies on rural governance, a prominent role for traditional authorities has not been provided for. For example, local government municipalities are made up of elected councilors, and are the leading actors. According to Dladla (2000), the position of chiefs may become redundant as elected officials begin performing similar functions to theirs. According to the Municipal Structures Act, chiefs are prohibited from exercising public power. This Act takes all public powers, functions conferred to chiefs, and gives them to municipal councilors as part of a process of giving democratic power back to the people. Therefore, their position is only advisory and is subordinate to the elected councilors. Other public commentators arguing that traditional leadership is notoriously undemocratic as chiefs follow a line of succession, which is patriarchal in nature. Therefore, the institution would not be able to co-exist with a democratic authority.

It is significant, therefore, to note that, while traditional leaders claim their constitutional right in circumcision practice, and state their position and main causes of concern for circumcision interventions by the state, their position on the human rights aspect regarding initiates who die during this period is not clear. The recognition and tacit blessing of violence during circumcision by traditional authorities could contribute to the formulation of policies and curriculum aimed at challenging violent practices, and improving the lives of the initiates during this process. Both Eastern Cape Legislature and the House of Traditional Leaders need to formulate policies and programmes to address these violent practices.

With some social scientists criticizing the position taken by traditional authorities as far as customary law is concerned (such as Bentley, 2004), there is an argument that the bias of traditional authorities on traditional practices and norms seems to be strongly in favour of the retention of traditional power on the bases of cultural norms and traditions. This is the case in traditional circumcision interventions. The traditional leader's role as the representatives of local people in this regard is also not without controversy. For example, people at community level disapproved of the Congress of Traditional Leaders of South Africa's (CONTRALESA) demand that the government should leave circumcision matters to the chiefs and traditional leaders (See Chapter Four, Section 4.3). Whilst the legislation is a good idea and accepted by communities, it has also become clear that the Department of Health, on its own, will not be able to address the multi-factorial causes of the problems of traditional circumcision and initiation. However, there is an emerging need for consensus to incorporate traditional leaders more adequately in circumcision initiatives. It is recommended that such co-operation obtain essential endorsement and support from traditional leaders both inside and outside the House of Traditional Leaders.

According to Airhihenbuwa (2004), the centrality of culture in health promotion initiatives is a discourse that resonates with the politics of representation, which are affirmed through the voices of various cultural expressions and meanings. When this occurs, the outcome is misrepresentation of cultural meaning. The situation is the same in traditional circumcision. Traditional authorities claim to be representatives of the broader community, and this appears to misrepresent the true feelings of the community. Van Vuuren and De Jongh (1999) confirm the argument, that the control by the royal house entrenched the traditionalist agenda and royalism. According to Rankhotha (2004), an alternative way of looking at circumcision could help the traditional authorities, who pursue the practice in the name of culture, to realize that our constitution carries values of inclusiveness and gender equality, which could help reform this ancient custom. Traditional leaders should also understand that the present form of circumcision is in violation of the same ancient practices they claim to protect. I argue, therefore, that if traditional leaders are honest in their endeavors to restore, what they see as an honorable cultural practice, in the face of what is seen as moral erosion, they need to demythologize the practice, and understand culture as dynamic and needing to be considered in the contemporary realities in which it exists.

5.5. CONCLUSION

This concluding chapter has captured the significant findings of this study and its recommendations. Firstly, on the issue of the escalation of injuries and deaths within Xhosa male circumcision, this study has concluded that all involved stakeholders do wish to see improvements in the situation. Secondly, on the issue of cultural rights, within which Xhosa male circumcision falls, versus the state's responsibility to ensure the health of all people, the study concludes that a balance between cultural and human rights has to be achieved. Hence, group rights should not be allowed to override individual rights. Thirdly, on the role of traditional authorities and their clinging to exclusive traditional tendencies, such as barring women from being involved in the discussions about the ritual, or the banning of Western medicine during the initiation schooling, the study concludes that such use of medicinal treatment be accepted, so as not to compromise the health of the initiates. In addition, the study concludes that women have the parental right to decide who should be responsible for the aftercare of their children during initiation. Lastly, on the issue of intervention by health officials, it is recommended that when such health implications arise during the duration of the school, such health management be done by male health professionals who themselves have undergone traditional initiation process.

By way of a final word, if there is anything significant that this study has attempted to do, it was to present an in-depth look at how different stakeholders (government, traditional authorities, and affected communities) respond to this crisis. The thesis shows that government has made all reasonable attempts to improve the health situation of initiates, while traditional authorities, in their attempts to cling to power and show that they are in charge of traditional issues, have negatively reacted to the government's proposals. Largely left on the sidelines are the affected communities. The findings reveal that little communication is taking place between the communities and government, as well as communities and traditional authorities, on the circumcision issues. Besides traditional leaders, the people with some knowledge of the legislation and how it is being implemented are the traditional surgeons and nurses. This would definitely have to change.

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APPENDICES

Appendix 1: Interviews

- Hand-recorded interview with Mzuphelele, traditional nurse in Qaukeni Local Service Area, Flagstaff (03/06/2003).
- Telephonic interview with Idutywa male resident (07/09/2005).
- Tape-recorded interview with a spokesperson for the House of Traditional Leaders (CONTRALESA) Zolile Burns –Ncamashe in Bisho (06/09/ 2005).
- Hand-recorded telephonic interview with a 19-year-old uncircumcised grade 11 student of Esangweni Senior Secondary in Cape Town (08/09/ 2006).
- Hand-recorded telephonic interview with an 18-year-old uncircumcised grade 11 student of Esangweni Senior Secondary in Cape Town (08/09/ 2006).
- Tape-recorded interview with an 18-year-old initiate from Emampondomiseni Village in Ngqeleni District, Eastern Cape (04/07 2003).
- Tape-recorded interview with a 15-year-old initiate from Nquba Village in Ngqeleni District, Eastern Cape, (04/07, 2003).
- Tape-recorded interview with a 23-year-old initiate from Mngamnye Village in Ngqeleni District, Eastern Cape, (07/04/ 2003).
- Tape-recorded interview with a 34-year-old male educator, in Samora Machel Primary School in Cape Town (05/09/2006).
- Tape-recorded interview with a 34-year-old male educator, in Samora Machel Primary School in Cape Town (05/09/2006).
- Tape-recorded interview with Umdlana, in Khayelitsha, Cape Town, from the Eastern Cape Cofimvaba District (07/09/2006).
- Tape-recorded interview with Nomaduna from Centane, in Khayelitsha, Cape Town, (13/09/2006).
- Tape-recorded interview with ward councillor of Harare, Khayelitsha, (05/09/2006).
- Tape-recorded interview with a medical officer in Eastern Cape Department of Health (10/09/2005).
- Tape-recorded interview with Thembela Mdunyelwa a lecturer at the University of Walter Sisulu University previously known as University of Transkei (11/09/2005).

- Tape-recorded interview with Mkhuseli Mdlekezi a traditional nurse in his home at Payne village in Mthatha (11/09/2005).
- Group discussion with group of uncircumcised male students ranging in age from 18to 21 in youth-Boys of Esangweni Senior Secondary Khayelitsha in Cape Town (2006).
- Group discussion with group of initiates (*abakhwetha*) ranging in age from 18 to 21 of Sipaqeni village in Flagstaff, Qaukeni Local Service area (11 /06/2004).
- Tape-recoded group discussion with group of recent initiates 1-5 years as a man /tertiary students of Border Technikon in East London (17/05/2005).
- Hand-recoded group discussion with group of 10 mature men (10-and more as men) in Nyanga Township, Cape Town (04/05/2006).
- Hand-recorded group discussion with group of 7 parents of recent, present and future initiates in in Sipaqeni village in Qaukeni Local Service Area Eastern Cape (3/05/2004).
- Hand- recorded group discussion with group of 5 Traditional nurses in Gugulethu Township, Cape Town (11/05/2006).
- Personal communication, Dr Thembela Kepe, Cape Town, 19/05/2005.
- Hand- recorded interview with an *ikhankatha* (traditional nurse) in Flagstaff, /15/06/2003.
- Hand- recorded interview with an *ingcibi* in Port Elizabeth, 23/06/2004.
- Personal communication, Mr. Dweba, Eastern Cape Department of Health, Bisho, 18/06/2005.
- Personal conversation with Dr Kanta, who is a medical practitioner in the Eastern Cape, 14/07/2005.
- Hand-recorded interview with Chief D. Ndabankulu of Sphaqeni in Qaukeni Local Service Area, Flagstaff (03/06/2003).
- Hand-recorded interview with local traditional leaders in Sphaqeni great place in Qaukeni Local Service Area, Flagstaff (03/06/2003).

Appendix 2: Acronyms

AIDS	Acquired Immune deficiency Syndrome
HIV	Human immunodeficiency Virus
ECDOH	Eastern Cape Department of Health
ECHTL	Eastern Cape House of Traditional Leaders
HSRC	Human Sciences Research Council
CBOs	Community Based Organizations
NGOs	Non Governmental Organizations
MEC	Member of Executive the Council
ANC	African National Congress
CONTRALESA	Congress of Traditional Leaders of South Africa
HTL	House of Traditional Leaders
NCOP	National Council of Provinces
USAID	United States Agency for International Development
TCA	Traditional Circumcision Act
SANCO	South African National Civic Organization
STDs	sexually transmitted diseases
TB	Tuberculosis

Appendix 3: Glossary of Local terms

Umgidi	coming-out ceremony
Ugqirha	medical practitioner
Tara Clamp	Malaysian instrument for circumcision
Ikrwala -plural amakwarla	new man
Ibhoma- plural amabhoma	temporal dwelling built to house initiates during their seclusion
Umkhwetha-plural -abakhwetha	initiate
Isicwe or isigqutsu	Helichrysum pedunculare
Ndiyindoda.	I am a man.
Umdlanga.	Traditional circumcision surgical instrument
Umngcamo	Tasting of meat before the circumcision ritual
Inja –plural izinja	Dog
Inqambi	an unclean thing
Usosuthu	Initiation host
Ithonto	lodge
Ingcibi-plural iingcibi	traditional surgeon
Umguyo	celebration
Lebollo	Circumcision in SeSotho
Lekhotla	Traditional court
Bayaraqaza	they sleep around