

Male Circumcision Policy, Practices and Services in the Eastern Cape Province of South Africa

Case Study

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1. Executive Summary

Circumcision is one aspect of a complex process of male initiation practised among certain groupings within the amaXhosa ethnic group who live predominantly in the Eastern Cape province of South Africa. Male initiation is a secretive and highly sacred practice, the details of which are intricate and are hardly ever discussed with outsiders. Rare first-hand accounts matched with anthropological accounts dating back to earlier decades of the apartheid era indicate that many aspects of male Xhosa initiation have remained unchanged over a long period. The custom has certainly not become any less widespread in contemporary South Africa – if anything, it has become more so.

Traditional male initiation has become the focus of government and media attention as a result of unacceptably large numbers of initiates being severely injured or dying as a result of practices related to initiation. Some of the most important causes of these problems are the loss of skills on the part of traditional surgeons, the erosion of communal authority over the selection of traditional surgeons and nurses and the rise of circumcision lodge overseers who appear to be motivated by financial gain rather than the preservation and responsible execution of custom. Deaths and penile amputations are a feature of every circumcision season as a result of sepsis, gangrene and dehydration.

In an attempt to regulate traditional circumcision government has put in place a number of legal instruments aimed specifically at the practice. The Children's Act of 2005 for instance directly addresses traditional male circumcision in Chapter 2, Section 12 (8) which prohibits the circumcision of male children under the age of 16 unless performed for religious or medical reasons. In the Eastern Cape the Application of Health Standards in Traditional Circumcision Act of 2001 makes it mandatory for circumcision schools to be registered and for traditional surgeons and traditional nurses operating at registered schools also to be registered with the province's Health Department. As a result of the new legislation over 60 traditional surgeons were arrested between 2001 and 2004 with 20 of these successfully convicted and sentenced. In the same period some 150 initiates were rescued from illegal schools by the Department and taken to hospitals in the region. The Department estimates that there has been a 70 per cent decline in unlawful initiations in the province.

The study notes that the Makana district of the Eastern Cape routinely records no circumcision-related deaths or fatalities. This example is instructive in two respects: firstly, traditional circumcision has been very effectively regulated in the district by way of a partnership between government and traditional leadership in the form of an initiative called *Isiko loluntu* (rite of passage) which was founded by members of the local department of health along with traditional nurses and surgeons operating in the district. Secondly, the traditional educative function of circumcision schools which has been lost in so many parts of the province, has been retained in Makana and the Department of Health, working closely with traditional surgeons and nurses in the district, has been able to insert into this traditional educative function, an HIV-awareness component. Education regarding sexuality was always, traditionally, a significant feature of the educative part of traditional initiation. Initiation schools therefore offer a real opportunity for effective sex education among a captive audience of male youth.

Isiko loluntu members take it upon themselves to inform the authorities of traditional nurses or traditional surgeons operating in the area who are not registered or who are not part of the association. They also have in place a range of sanctions for members who do not conform to the rules of the association for instance with regard to alcohol consumption, pricing structures or procedures for the performance of circumcision itself. Anyone who wishes to practice as a circumcision lodge overseer, traditional surgeon or nurse in the area must therefore be vetted by the association. In this way the number and expertise of those involved in traditional circumcision in the district is carefully controlled. Because of the excellent record of safe circumcision in the district, which is well known among community members, there is wide respect for the association and community members. This along with the fact that fees are set at a reasonable rate means that the community therefore has no incentive to agree to send their sons to circumcision schools run by people who are not members of the association. By happy historical coincidence, Mr Mene, of the local Department of Health who has been responsible for liaising with traditional surgeons and nurses on *Isiko loluntu* is himself a trained and respected traditional nurse. This means that he has the respect and acknowledgement of *Isiko loluntu* members and can legitimately make suggestions about regulation of the practice which are in line with new legislation. For this reason compliance with the new legislation has highly effective in Makana. Finally, traditional nurses and surgeons in the Makana district describe themselves as 'less conservative' with regard to tradition by which they mean that in cases where an initiate in their care is found to be ill they have a policy of immediately seeking formal medical intervention. This prioritisation of saving lives is a widespread principle among association members¹.

2. Introduction

This case study commissioned by the World Health Organisation Reproductive Health and Research Department deals with the practice of, and policies governing, male circumcision in the Eastern Cape province of South Africa. The study of circumcision is one of the most disputed issues in contemporary anthropology, raising as it does, questions of human rights, gender equality, cultural integrity, modernisation and moral relativism. Male circumcision rites are symbolically saturated: the enhancement of masculine virility, the performative enactment of the separation between men and women, preparation for marriage and adult sexuality, the hardening of boys for warfare (see for example, Crosse-Upcott 1959; Gluckman 1949; La Fontaine 1985; Spencer 1965; Tucker 1949; Turner 1962).

Typically the traditional male rite takes place before marriage and entails: 'physical brutality, seclusion, testing, esoteric knowledge, death and rebirth imagery, name changes, dance, masked costumes, and dietary and sexual taboos' (Silverman, 2004: 421). These rites play a social role, mediating inter-group relations, renewing unity and integrating the socio-cultural system. For instance, by entrusting a son to a kinsman for circumcision a father is demonstrating his trust in, and commitment to, the group. Senior males are usually responsible for the cutting and it is expected that the pain involved will be endured stoically. Symbolically, circumcision is both a death (of the boy) and a rebirth (of the man). It is a dramatic enactment of the separation of the son from the mother and the integration of the man into the community. As such, it is a central public endorsement of a culture's accepted norms of heterosexual manhood.

¹ Interview field notes, Mr Jackson Vena – *Isiko loluntu* member and traditional nurse (17 April 2007).

While traditional circumcision rites take place among several ethnic groups in South Africa, the present study is limited to an assessment of the practice among the amaXhosa who live predominantly in the Eastern Cape Province. The latter is one of nine South African provinces and is one of the poorest and most rural of these. Spanning an area of some 169 580 square kilometres (13.9 per cent of the total area of South Africa), before 1994, the Eastern Cape consisted of three legally independent countries, the Transkei, the Ciskei and parts of the Republic of South Africa. The capital of the province is Bisho, the former Ciskei capital. The population is estimated at approximately eight million people. Of these the majority are African Xhosa-speakers (87.8 per cent) with the remainder being made of 6.4 per cent 'coloured', 5.6 per cent 'white' and 0.2 per cent Indian. Women constitute 54 per cent of the province's population.

Several sub-groups make up the Xhosa ethnic group including the Mpondo, Thembu and several other smaller groups. Xhosa language speakers also include the Tembu, the eastern neighbours of the Xhosa during much of their history, the Mpondo, the eastern neighbours of the Thembu and the Mfengu, consisting of descendants of small remnants of clans and chiefdoms that were displaced during the early nineteenth-century upheaval of the *mfecane* (crushing) and which attached themselves to the relative stability of Xhosa society (see Peires, 1981).

Ritual male circumcision is among the most secretive and sacred of rites in Xhosa society. Women and uncircumcised males are forbidden knowledge of the rite and it is frowned upon to talk of it. As a result, detailed accounts of the practice itself are rare. In recent years though, the alarming rate of death and injury among would-be initiates has led to the spotlight of media attention and government regulation being aimed at traditional or 'bush' circumcision. Despite the evident dangers of the practice it is by no means a dying relic. Young Xhosa men are today no less eager to be circumcised than their forebears. A battery of social sanctions and violent retribution facing the uncircumcised Xhosa male has ensured that the practice has remained intact despite the onslaught of, first colonisation and missionary aversion to the tradition, then apartheid and its attendant social upheavals and more latterly, the transition to a modern constitutional democracy based on individual human rights.

In the context of the South Africa's high rate of HIV/AIDS infection (between four and five million South Africans are estimated to be HIV-positive), the risk of HIV has featured prominently in calls for the regulation of traditional circumcision. Traditional male circumcision has given rise to concerns about HIV infection as a result of the common practice of a single instrument being used without intervening sterilisation to circumcise several initiates at a time – often in groups of ten or more. This concern arises in the context of the already existing exceptionally high rate of HIV infection among South Africa's children. 'At the end of 1987, 80 000 children below the age of fifteen years were estimated to be infected. Between 1994 and 1997 the number of children infected tripled. Current estimates show that at least one quarter of all children in hospital in South Africa are HIV positive. In some hospitals 70 to 80 per cent of paediatric beds are occupied by HIV-positive infants' (Davel, 2002: 282). Government has thus frequently referred to the threat of AIDS in order to explain and justify its legislative incursions into this most sacred of Xhosa practices. In an ironic twist new research has revealed that circumcising cultures inadvertently provide their male participants with a certain protection against HIV infection.

Government, for its part, has been much more proactive in its regulation of traditional circumcision than in its approach to the country's AIDS crisis. A comprehensive legislative framework has been matched by a massive public outreach campaign and considerable financial and physical resources devoted to the implementation and monitoring of its circumcision regulations. To the extent that its regulatory regime has been met with resistance this has come from traditional authorities who have fought to maintain a toehold on power and influence in the face of criticisms that they are an anachronism in a democratic constitutional state. In this regard, the question of traditional circumcision in South Africa serves as a window into a much wider debate concerning the relationship between culture and rights, between traditional and democratic authority and between customary and formal law.

Many aspects of current tensions and conflicts surrounding traditional male circumcision in the province can only be understood in the context of the province's political, social and physical geography. Important features include: poor conventional health provision in the province, the overwhelming reliance of people in the province on the traditional healing sector and a legacy of bitter struggle between traditional and formal legal authority. Traditional circumcision is a practice which customarily clearly lies within the province of traditional authority. Attempts by the central state to regulate circumcision practices can thus easily be read as intrusions into traditional authority which echo the dismissive approach to custom seen during colonialism and apartheid. The sensitivities of chiefs to such incursions, differing approaches to state regulation on the part of various traditional authorities and the central state's sometimes difficult relationship with traditional leaders are all factors which play into the circumcision debate and which therefore need to be painted in order for the nuance of that debate to be appreciated.

Regulation of traditional circumcision is rendered all the more complex by the intricate, secretive and sacred nature of the rite itself. It is important, therefore, to describe as fully as possible what the ritual involves and what its significance is for those who practice it. Attempted 'compromise' solutions aimed at modernising traditional circumcision often fail because of a failure to fully engage with the meaning of each of the various dimensions of ritual Xhosa initiation. At the same time, a knowledge of what initiation was traditionally aimed at achieving is instructive in the sense that it takes the focus away from being exclusively on the operation itself, which is but one part of initiation, and opens up broader possibilities for what might be achieved by way of cooperation with traditional authorities and the traditional healing sector.

The practice of traditional circumcision is governed, in South Africa, by a battery of different policies and legal requirements. Some of these are part of the general legal framework of the country while others are aimed at specifically coping with some of the concerns that have arisen in recent years with the number of deaths and injuries at initiation schools. The study therefore outlines some of the most prominent difficulties that have arisen in relation to traditional circumcision in the Eastern Cape and then goes on to delineate as fully as possible the legislation that is available to government in its attempt to deal with those problems. These range international agreements through to the Constitution and finally to provincial-level legislation. For the purpose of this study the Eastern Cape Application of Health Standards in Traditional Circumcision Act of 2001 is most directly relevant.

Finally, the study offers a brief overview of the extent to which conventional hospitals are available for the purpose of adult male circumcision in the Eastern Cape. While several hospitals in the province do perform such operations, hospital circumcision is frowned upon in Xhosa culture and the person who is circumcised in hospital risks ostracism or worse. Some hospitals flatly refuse to perform adult male circumcisions unless the operation is required by a medical emergency. Ironically such emergencies arise most often precisely in the course of traditional or 'bush' circumcision.

The study is based on documentary sources, news reports and interviews with key stakeholders. The latter include hospital personnel, doctors, members of the traditional healing sector, government spokespeople and traditional leaders. It is taboo for uncircumcised males to discuss openly the practice of traditional circumcision. In the case of initiates themselves, therefore, the study relies on original transcripts of interviews conducted by Stembele Tenge in the East London area of the Eastern Cape in the course of research conducted for his Masters in Public Health dissertation (Unisa, 2006). The interviews have been reinterpreted and re-coded for the purpose of the present study. Interview material is augmented by a rare anonymous first-hand account detailing a recent experience of traditional Xhosa circumcision. Extensive direct citation of the interviews and the first-hand account is employed to provide, as far as possible, an 'insider view' of beliefs and practices surrounding Xhosa male initiation. A review of the small number of medical and anthropological secondary sources dealing specifically with traditional circumcision in the Eastern Cape have also formed an important part of the study as has a wider secondary literature drawn from disparate disciplines including history, anthropology, sociology, theology and political studies.

3. Traditional Male Xhosa Circumcision

Anthropologists delineate three main categories of ritual:

- ❖ those which arise from particular calendar dates,
- ❖ those which are a response to misfortune and
- ❖ those which are rites of passage.

Male initiation rites are a key example of the latter, acting as the instrument for the transition from boyhood (*ubukhwenkwe*) to manhood (*ubudoda*). The South African amaXhosa, the majority of whom live in the country's Eastern Cape province, are one of several ethnic groups in southern Africa that practice the ritual of circumcision as part of a rite admitting boys to manhood. It should be noted that not all Xhosa groups circumcise. The practice is not, for example, seen traditionally among the Bhaca, Mpondo, Xesibe or Ntlangwini but is widely seen among the Tembu, Fingo and Bomvana groups. Some non-circumcising groups have begun circumcising in more recent years including the Pondo. Historically other South African ethnic groups have also ritually circumcised boys including the Zulu (who have now largely abandoned the practice), the Tswana, the Sotho and the Shangaan.

Since the practice is not fully regulated by the state it is difficult to say accurately how many South African men are circumcised but estimates put the figure at around a third of all South African men which includes not only many indigenous

communities but also the country's small Jewish and Muslim communities who circumcise males shortly after birth. Outside of these communities the practice is also quite widespread in the white English- and Afrikaans-speaking communities where it is seen as having hygiene benefits.

Xhosa boys are aware from a young age that initiation is regarded as an inevitable part of male life. Some 10 000 Xhosa males are circumcised annually in the Eastern Cape.

3.1. Sacredness

Circumcision is a practice considered highly sacred by the amaXhosa. Not uncommonly Xhosa author Peter Mtuze uses a religious analogy to demonstrate the importance of initiation for the amaXhosa: '[it] is the gateway to manhood in the same way that baptism is the gateway to Christianity' (2004:41).

3.2 Secrecy

Related to the highly sacred nature of the practice, it is forbidden among the amaXhosa to discuss the ritual itself with outsiders and anyone found to do so would suffer severe sanction by the community. Attempts by outsiders to penetrate the secret and private nature of the ritual are not tolerated. It is particularly taboo for women and uncircumcised boys to attempt to gain information concerning male circumcision rites.

Anything that happens here is a secret: it is not to be discussed with girlfriends, brothers or friends, the uncircumcised, other nations, mothers (anonymous first-hand account).

Secrecy is seen by many as a way of protecting the practice from those who would wish to discredit it. Nevertheless it is possible to describe an amalgam of what is known from anthropological and other accounts. Included in the latter are those who deliberately transgress to reveal their own personal experience of circumcision. This is rare but where it does occur it is often motivated by a sense that the secrecy surrounding the custom serves to perpetuate harmful aspects of it. Informants suggest that the basics of the ritual have remained intact through colonialism and apartheid and can be divided into three phases: pre-circumcision, circumcision (cutting of the prepuce) and post-circumcision.

3.3 Age group

In Xhosa custom the ritual is performed most commonly on males ranging between the ages of 15 and 25. The Eastern Cape's circumcision legislation sets the legal age for circumcision at 18 but boys of 16 and older may be circumcised with the permission of their parents or guardians. This is in line with the new Children's Act (Act No. 38 of 2005) which was signed into law in June 2006. The Children's Act (Chapter 2, Section 12 (8)) prohibits circumcision of male children under the age of 16 except when performed for religious purposes or for medical reasons. The Act also stipulates that male children older than 16 may be circumcised only with their consent and after proper counselling.

The continued circumcision of under-age boys, sometimes as young as 12, in the Eastern Cape remains a core difficulty associated with the practice. According to

Chief Mandla Mandela the age of circumcision is a matter determined by families with males in his family for instance routinely waiting until their early 20s to be ritually circumcised.

3.4 Surgical Instrument

Traditionally the instrument of choice would have been an *umdlanga* (assegai). Sterilisation was not widely known or employed. This is a very sensitive issue with some traditional leaders baulking at the idea of the traditional surgeon having to obtain permission for the instrument that he chooses to use: 'We cannot use any other instrument to circumcise young boys, we just cannot' (Chief Mandlenkosi Dumalisile).

The Eastern Cape Government has attempted to regulate the use of instruments by stipulating what sort of instrument is acceptable, and by providing chemicals for sterilisation and training in the use of instruments as an alternative to those which it regards as unacceptable.

The Health Department monitors the use of instrument to the extent that it can by visiting each circumcision school and making sure that the traditional surgeon present can produce instruments, sterilising chemicals and so on which makes him compliant with the law. However, it is not possible to actually witness every circumcision both for practical reasons and reasons of cultural sensitivity. Thus there is simply no telling, according the Health Department's spokesperson, Sizwe Kupelo, whether or not even registered traditional surgeons are actually compliant in every case.

3.5 Main protagonists

3.5.1 Traditional healer

A traditional healer is often present at the initiation school to protect initiates from the evil spirits that are believed to lurk there. He also has the responsibility of strengthening the traditional surgeon and ridding him of potential evil spirits which he could pass on to initiates if not attended to. 'To do this, the traditional healer makes small scarifications (*iintlanga*) on the major joints of the surgeon and applies traditional medicine to these. He also provides the surgeon with medicated amulets and strings to tie around the arms, ankles and hip' (Mogotlane et al, 2004:60). Both men (traditional surgeon and traditional healer) are expected to abstain from sexual intercourse during the initiation period as it is believed that this would affect the healing process of the initiates resulting in possible sepsis. The breath of both men is purified with the aid of a herb known as *isiqunga* which is chewed to ensure that impurities are not breathed into the wounds.

Traditional Surgeon

3.5.2. Traditional surgeon

The operation is performed by a traditional surgeon (*ingcibi*) who was traditionally be a man of standing and status in the community, trusted for his experience in performing the procedure. The established custom is for the role of traditional surgeon to be handed down within families from generation to generation. Where demand increases and there is a need to introduce new members into this fraternity, the requirements are traditionally stringent: aside from being a circumcised male of

not less than ten years himself, a prospective candidate should not be a drinker, should be a man of discipline and should be generally acceptable to the community in this capacity (interview, Jackson Vena, traditional dresser). Recent years have seen a mushrooming of self-proclaimed traditional nurses and surgeons motivated by financial incentives. These 'mushrooms' as they are sometimes referred to are naturally frowned upon by the established community of traditional nurses and surgeons.

3.5.3. The lodge guardian or traditional nurse (*ikhankatha*)

The *ikhankatha* has the task of looking after initiates following circumcision: attending to their wounds and ensuring that they eat, exercise, rest and abide by the instructions given. The guardian visits daily to ensure good behaviour and discipline. The *ikhankata* who is sometimes also referred to as the 'dresser', dresses the wounds and takes care of the health needs of the initiates in the period (usually of 7-8 days) immediately following the surgery. He also provides feedback to the elders on the progress of the initiate.



The traditional nurse or 'dresser' is responsible for checking the circumcision wound regularly²..

3.5.4 Initiate

While at initiation school (*ibhoma*) participants are known as initiates (*abakhwetha*). The initiate is expected to obey instructions and has few rights and little say in what happens to him while at the circumcision lodge. Referring to the harsh way in which he was treated by the *ikhankatha*, an initiate explains, 'As a man you do not beg an *umkhwetha*, a Xhosa initiate into manhood, for he is a subordinate' (anonymous first-hand account).

3.6 Dietary taboos

Initiates are expected to observe strict dietary taboos during their initiation. These commonly include the instruction not to drink water or eat salty foods including meat in the first seven days after circumcision. It is presumed that the origin of such taboos lies in attempting to limit urination which would be painful. However, it is now illegal to instruct an initiate to avoid drinking water. Dehydration has been a primary cause of death and illness among initiates.

² Picture credits: All photographs supplied with kind permission of the "Crocodick" website in South Africa.

3.7 The three phases of ritual Xhosa male circumcision

Traditionally, the circumcision ritual is a complex one involving a number of different stages each with its own closely policed regulations and requirements.

3.7.1. Preparatory period

The preparatory period begins when the decision to undergo circumcision (the timing of which is flexible), is taken and an overseer for the circumcision lodge (*usosuthu*), lodge guardian (*ikhankatha*) and surgeon (*ingcibi*) are chosen. Initial preparations are followed by the ritual killing of an animal, usually a goat, at each initiate's homestead the day before circumcision. The animal sacrifice is performed in order to seek the protection and guidance of the ancestral spirits over the process that will follow. However, animal sacrifice is not regarded as compulsory in many contemporary families. To some extent it is dependent upon the financial circumstances of the family and the accompanying rituals are seen as more important than the sacrifice itself.

At this point each participant discards his everyday clothing in exchange for blankets which will be worn throughout the months of the ritual. Initiates are assembled at a homestead of one of the participants who will play the role of principal host (*usosuthu*). This is a position of honour so that, for instance, in some communities a child deemed illegitimate may not be *usosuthu*.



Initiates are stripped of their clothing, symbolically marking the break with boyhood and the entry into a transitional phase en route manhood.

3.7.2. The operation itself

The circumcision itself is seldom witnessed by outsiders. It is conducted in private and women and uncircumcised men are not allowed into the area or informed about what happens during the process. Wilson et al (1952: 200) describe what they observed: before dawn the initiates are led by the men, blankets covering their bodies and heads, to a place near the lodge where the operation is performed. The initiates sit on their blankets on the ground in a row, the surgeon emerges, unsheathing his knife, takes the foreskin between thumb and forefinger, pulls it forward and cuts it in two sawing motions. He drops the foreskin onto the blanket in front of the initiate and moves to the next one. Each boy has to shout '*Ndiyindoda*' (I am a man) at the time of being cut.

The *ingcibi* crouching between my thighs severs my foreskin. This is surprisingly painless, except that my penis itches. He hands the foreskin to my father, who suspends it before my face. I swallow, as told (Anon.).

Several sources (see for example, Zenani, 1992: 108) point out that crying or grimacing is regarded as unmanly and a sign of weakness. 'I must not disgrace myself and my family by escaping to a hospital. I must be stoic, like our forefathers who never used anaesthetics. If I do I will be excommunicated from manhood' (anon.). Medicinal herbs are used to bandage the circumcised penis and the initiate is instructed to keep his legs apart to protect the wound against contact with the inner thighs.

And so, crab-style, I pass through the low doorway into the hut. In the centre is a red fire, to be kept alive around the clock until I leave the initiation school. Beside it is a patch covered with a blanket, my bed for the next five weeks. I lie down, thighs apart. The fire plus the branches that make the walls of my hut combine to create a haunting fragrance. *Somagwaza*, a song sung on the procession to my hut, still lingers in my head as I'm drawn to sleep. I am left alone. Four hours later I'm woken. The men have arrived. My wound is being undressed (anon.).

3.7.3. Seclusion, privation and the break from privation

Following the actual circumcision is a ten day period of privation during which there are restrictions on the drinking of liquid and eating of soft foods as these are believed to cause sepsis. The lodge guardian visits regularly during this time to change dressings and instructs initiates on how to assist one another with dressing their circumcision wounds. Traditional herbs are used. For instance, the herb *umbhangabhanga we hlathi* is used to stop bleeding while the healing process is said to be assisted by the use of traditional medicines known collectively as *izichwe*.



Traditional materials are used to bind the circumcision wound. The wound is not stitched in the Xhosa rite. If a man is found to bear 'cats claws' – the scars from stitches that point to a hospital circumcision – he risks assault for avoiding the pain of the traditional rite but dressing like one of its graduates.

The monotony of seclusion is relieved by a variety of social activities including dancing and hunting of wild animals.

I am too eager for them to arrive with the sacrificial goat that will beckon the time I can have, ahh, water and proper food.... The men arrive and for the first time I am free to go outdoors. Like a mole, I squint at the sun. My eye sockets feel like they've

been sprinkled with grit. The sudden fresh air inundates my lungs. I am getting high on the pure oxygen shooting into my brain. I am suffocating in reverse. Out in the open a fire burns beside the goat being slaughtered. First I am offered *amarhewu*, watery pap, to re-hydrate and finally I stick my tongue into the delicious salty goat meat. This fast-breaking ceremony means access to more than just water. I now receive old newspapers every day and I get a portable radio, so I am able to recite the programme line-ups of a number of stations intimately because I'm up 23 hours a day healing my sore, dressing and undressing my wound at regular intervals. I get more varied meals. The next day I'm pressed to defecate for the first time. But this is impossible because the samp has cemented in my gut because of dehydration. By now my big toe and its neighbour have chafed from being rubbed against one another in reaction to the pain of wrapping and unwrapping my wound. My other involuntary action is shivering hands. I often wished for a gun with which I could end my hell (anon.).



As the wounds begin to heal the initiates paint their bodies with clay as a substitute for washing as they are not allowed to go near water.

The break from privation is followed by a period of seclusion which lasted between two to three months traditionally but is today more commonly a period of three to four weeks. As the wounds begin to heal the initiates paint their bodies with clay as a substitute for washing as they are not allowed to go near water. They do not wear clothes at all during this time, dressing instead in their blankets.



Initiates sing traditional songs and perform traditional dances at the circumcision lodge as part of their induction into the culture as well as to relieve the boredom of the period during which their wounds are healing.

By the third week I no longer shiver at the sight of my khankatha, for he can no longer inflict pain. My wound has developed scabs, which end most of the pain. I now adore him for having been strict with my regimen. Without anaesthesia, no pain means no gain. The next goal is to get the scabs to fall by themselves, without help from my hands. To achieve this quickly the wound has to be exposed to the cold wind, found just past midnight and far out of my fiery hut (anon.).



Initiates do not wear clothes at all during this time, dressing instead in their blankets

Once initiates' wounds are satisfactorily healed preparations begin for their reintegration into the community.

Ten days later the crusts had all fallen off. The circular ring that was once raw has turned into the smooth pink skin coveted by every *umkhwetha*. This means that I may leave this Saturday. Back home, they begin preparing for my homecoming ceremony (anon.).



Once the wounds are healed initiates are ready to be chased to the river to have the white clay washed from their bodies.

Each initiate has his head shaved and the group is chased to a nearby river to wash off the white clay which has been smeared on their bodies. Upon their return they are anointed with a special ointment by a senior member of the family (Momoti, 2002: 36). The period of seclusion ends with the 'coming out ritual' (Wilson et al (1952: 214) which involves initiates giving up their old blankets, being given new blankets and the initiation hut together with bandages, sticks and other personal belongings being burnt in a symbolic break with the past. It is forbidden to look back at the burning lodge and initiates will often cover their heads with their new blankets in order to avoid inadvertently doing so which would result in misfortune befalling them. The initiates then rejoin the community and are given new clothes and their faces painted with red ochre as a mark of status as a 'new man'. They are now permitted a wider but still restricted diet. Gifts are presented to initiates and they are instructed to respect their elders, parents and chiefs.



The communal washing of the initiates' bodies symbolically washes away their boyhood and prepares them to re-enter the community. They will be given new clothing to wear and the blankets worn during initiation burnt along with

the grass huts in which they were housed during their seclusion.

3.8 The Circumcision Lodge as 'School'

Initiation traditionally involved not simply the circumcision operation itself but also an accompanying process of instruction. There are three main aspects to this educational feature of traditional initiation. The first aspect is not so much about imparting information as training in the secret code of the bush which will serve as a mechanism of control in later years, delineating the 'authentically' circumcised from the inauthentic:

Next I am taught replies to the frequently asked questions used by *amakrwala*, recent initiation school graduates, who will want to determine if I had a real Xhosa initiation or hospital surgery. These riddles are asked in a poetic and deceptive manner. One who has not gone through the traditional bush rite would not answer correctly, let alone understand the gibberish, unless someone with first-hand experience has tipped him off. But woe to the man who sells bush secrets to the cowardly hospital initiate. A man has two witnesses, his mouth and his circumcised penis. If he fails to answer convincingly a physical inspection will be carried out in public, like it or not. Your chances of successfully resisting are minimal if you are outnumbered (Anon.).

The second instructional feature of circumcision school is aimed at building certain character traits: forbearance, courage, fortitude and strength. These virtues are taught not so much by way of explicit teaching but by exposure to deprivation and a harsh regime of punishments and criticisms which are meant, in the successful initiate, to be borne stoically. Qualities of endurance, manliness, chastity, courage and respect are emphasised in the training that initiates receive and these qualities are taught in part through physical privation. The degree of privation that initiates are expected to endure varies from area to area and school to school. Momoti (2002: 38) reports, for instance, that among Thonga initiates 'it is common for a young man to be seriously beaten for any offence be it trivial or otherwise. Sometimes the boys would be exposed to the cold at night by being forced to lie naked without blankets, using only light grass to cover their bodies.

The third education feature relates primarily to notions of what it means to be a man. 'In brief, circumcision is a period during which the boy is taught the lifestyle of being an adult' (Koyana, 1980: 60). The lodge serves as a kind of school where the initiates learn about 'the dignity of manhood' (Wilson et al, 1952: 203). Sexual instruction and guidance concerning married life commonly forms part of the training, as does instruction in the history, traditions and beliefs of the initiate's people.

In contemporary circumcision schools much of the traditional educational aspect of the initiation rite has fallen away. One traditional nurse estimated that in '95 per cent of schools it is just not happening' (Interview, Jackson Vena). In some areas of the Eastern Cape such as the Makana district where traditional circumcision is very tightly controlled by an established board of traditional nurses and surgeons (the organisation calls itself *Isiko loluntu* or 'rite of passage') there has been a revitalisation of the educational component of the rite. The motivation has been twofold: firstly, traditionalists in the region are deeply concerned with what they view as the youth's lack of knowledge of Xhosa culture which they see as contributing to social problems such as crime, alcoholism and the high school drop-out rate; and

secondly concerns surrounding HIV/AIDS have given rise to the idea that circumcision schools could be used to spread the message of sexual health, safety and responsibility.

However, there are concerns about the manner of instruction at circumcision schools. At many instruction is enforced with violence. Initiated males report that beating with sticks is the usual method for elders to enforce discipline at circumcision school, usually in cases where an initiate fails to remember the previous day's lessons, is caught speaking Xhosa rather than the 'bush' language taught there or was seen to be not working hard enough. 'I will be taught to speak in *isiSomo*, a language used only at the initiation school. I will be caned if I don't master it' (anon.). Despite descriptions of being treated like 'dogs' by cruel elders, the general attitude is one of acceptance of physical punishment as part of the process of transition to manhood (Wood and Jewkes, 1998: 19).

This regime of routine violence would seem to contradict key teachings at circumcision school described as 'words of manhood' or the 'rules of the elders'. Wood and Jewkes (1998: 33) report that a key component of the traditional education received in the bush teaches that a defining characteristic of masculinity is respect for others and non-violence. All the boys in the study emphasised the teachings of circumcision school that beating female partners and using violence against other men was unacceptable: 'if you are a man you must keep on talking, you must not force things, you must not fight, use guns and all that'.

Circumcised men are expected to take on greater social responsibility in their communities, acting as negotiators in family disputes, weighing decisions more carefully and cooperating with elders. The informants in the Wood and Jewkes study also said that initiates were told that having large numbers of partners was 'what boys do' and that as men they were encouraged to have one partner and to think of marrying. Most of the boys in the study claimed to have reduced the number of partners they were sexually involved with since circumcision and to have begun to think seriously about long-term, stable relationships. One informant described how post-initiation he had told his girlfriend that 'the things I had done to her which were wrong, I would not do now because I am human: beating her, smoking dagga, drinking alcohol' (Wood and Jewkes, 1998: 33-4).

However, in reality many who profess respect for initiation teachings seem quickly to lapse into pre-circumcision behaviour. This is sometimes explained away as being a result of boys going for circumcision too early or for the wrong reasons such as competition with peers rather than for the purpose of real change into manhood. 'While young men's education in the bush involves important teachings about respect and non-violence, circumcision school is short-lived and without follow-up many boys clearly disregard what they learn there'. In theory, older men in the community could provide positive role models and reinforcing instruction but violence and sexual coercion of young women is rife among older men too as is seen for instance in the common practice of 'sugar daddies' in which girls exchange sex with older men for money, clothes, food and other presents (Wood and Jewkes, 1998: 34). Male teachers are also widely implicated in sexual coercion of their pupils.

Anthropological accounts of the policing of sexuality in traditional African communities attest to the important role of initiation in sexual instruction and the control of sexuality in the young. Pitje (1950: 122) for instance describes how 'those

who are known to have seduced girls are taken severely to task. When such a one bleeds profusely after the operation, they torment him saying "It is the blood of women". They are called names and in many indirect ways reminded of their bad behaviour'. In their historical study of sexual socialisation in South Africa Peter Delius and Clive Glaser (2002) point out that while Pedi youth, for instance, have considerable sexual experience and knowledge by the time they reach initiation, during initiation 'they are reminded of the sexual behaviour that is expected of adults' (2002: 33). 'It is clear' the authors comment, 'that Pedi youths experienced a comprehensive process of sexual socialisation'. However, 'just how effective it was in terms of preventing either full sexual intercourse or pre-marital pregnancy is open to question'.

Chiefly rule, communal tenure and initiation, Delius and Glaser (2002: 35) point out, were seen as bulwarks against corrosive processes of change. In the contest of conquest and a modernising agenda deeply influenced by Christian morality, chiefly rule and traditional modes of youth socialisation, including initiation, were at best regarded with suspicion. In their detailed work among Xhosa communities in the 1960s Philip and Iona Mayer argued that sexual activity was regulated by peers through the strict observance of a system of seniority such that at every stage a youth was expected to show submission to those slightly senior and dominance over those slightly junior. They argued that Christian morality stigmatised traditional forms of restraint and shrouded sexual matters in shame and secrecy in contrast to the open discussion which they found among traditional communities where the influence of Christian morality was not yet felt. The result was a higher rate of illegitimate children among Christianised communities or what the Mayers called 'school' communities. Delius and Glaser (2002: 37) conclude that:

It seems likely that missionary Christianity undermined pre-existing forms of sexual socialisation. It led to the dismantling of the forms of youth organisation which had played a key role in this process. It contributed to the abandonment of techniques like limited intercourse which had provided a controlled outlet for adolescent sexuality. And the growing influence of Christian values helped shape an inter-generational silence on matters that become especially damaging as other forms of sexual education withered.

As a number of commentators point out (see for example, Longmore 1959: 60; Wilson and Mafeje 1963) with increasing black urbanisation in the middle of the twentieth century the majority of black urban residents continued to practice certain traditional customs such as *lobola* and initiation. The physical practices of traditional initiation have remained largely unchanged but the role of the rite in the sexual socialisation of youth and their induction into a world of communal adult ties and responsibilities has not. While the stigmatisation of non-circumcised Xhosa males has, if anything, sharpened in recent times, the value of the custom in cementing social ties and its inter-generational support mechanisms have not been possible to sustain. While traditionally, the initiation of a young male was a communal responsibility, it is now much more of an individual project in the experience of many.

4. Traditional Circumcision: Social and Cultural Dimensions

4.1. The Cultural and Social Significance of Ritual Male Circumcision in Xhosa Society

There can be little doubt about the significance of the circumcision ritual in Xhosa culture. Peter Mtuzi, for example, in his *Introduction to Xhosa Culture* describes the coming out ceremony as 'the greatest day in every boy's life' (2004:48). Circumcision and ritual initiation is the only possible way of entering manhood and gaining the status, respect, rights and responsibilities that are thought to attend manhood.

4.1.1 A mark of identity

The Kenyan philosopher of religion John Mbiti sees the shedding of part of a person's flesh as symbolic of discarding childhood and readying oneself for adulthood. Through the shedding of blood, Mbiti avers (1986:93), the initiate is effectively entering into an agreement with his people: 'once he has shed his blood, he joins the stream of his people and indeed becomes truly one with them'. Mbiti refers also to the way in which initiation acts as a bridge between an earlier, more passive stage of life and the more active, productive, adult stage of life (1986: 94). It is a bridge also with the ancestors because their sanction of the process is actively sought as part of its performance. The permanent scars of initiation are a way in which the identity of the person is permanently and incontrovertibly written on the physical body.

4.1.2. The gateway to manhood

Initiation allows Xhosa males to share in the full privileges and duties of the community; to acquire knowledge which is otherwise unavailable; to gain respect and to be entitled to marry. Citing their own experience, Xhosa authors Mayatula and Mavundla (1997:17) write that '[m]ale circumcision is the most widely accepted cultural practice among the Xhosa speaking people whether educated or illiterate, Christian or non-Christian. It is considered the only manner in which a boy ... can attain manhood and adulthood'.

4.1.3. The acquisition of rights

In Xhosa culture, a child is often referred to in relation to a parent as an *inja*, or dog, which is intended to suggest the relationship of dependency that exists between parent and child. In the same way as a dog would not be held responsible for its own misdemeanours – this responsibility properly rests with the owner of the dog – the torts of a child are the responsibility of the father. A child lacks the capacity to acquire and maintain rights for itself (Van Tromp, 1947: 1). While it is common, within Western legal systems to regard the age of 21 as the legal age of majority, it is foreign within Xhosa cosmology to regard majority and minority as being dependent on age in years. Rather than coming into the world as fully-fledged rights-bearing subjects then, the view here is then, that full legal status is only gradually acquired.

4.1.4 The conferral of responsibility

The amaXhosa typically divide male development into a number of phases:

- In the first, which is seen to last between six and seven years, a boy is regarded as lacking the capacity to distinguish right from wrong. He is *a yi ka*

tungululi: he has not yet had his eyes opened (Momoti, 2002: 47). Where a boy in this stage of development commits a wrong neither he nor his lawful guardian is regarded as being responsible because the boy is *a yi ka tungululi* – although the latter may choose to make reparations to an injured party in the interests of preserving harmony in relations.

- The second stage in a male's development is one in which he is given more responsibility in the community and is considered more capable of exercising good judgement. Legally he is still regarded as a boy however and is not held responsible for his actions. He cannot enter into contracts; any property is not his alone but belongs to his household; and he cannot marry.

Initiation is the only way in which a male can exit this stage. No matter how many years may pass, the individual will still be regarded as being in this stage of development if he has not been ritually circumcised. This fact is emphasised symbolically in the treatment of would-be initiates in the period of seclusion that forms a central part of the rite. Punishments and privations without the possibility for redress or challenge serve symbolically to call attention to the fact that full human status with the right to a say in what happens to one is not achieved until initiation is successfully completed.

- It is only once initiated that a male can enter into the third stage of his development, acquiring, in the eyes of the community, the status of *indoda*, a man, for the first time. Now he is regarded as legally capable of entering into a valid marriage and to establish his own homestead for the first time. The gifts which he receives after coming out of seclusion are symbolically important in that it is only as a man that he is capable of receiving property and owning it in his personal capacity rather than anything received accruing automatically to his wider household as it did when he was a boy.

4.1.5 Access to privileges

A wide variety of social privileges and positions of status are available only to a circumcised man. These include the right to inherit, the right to take part in family courts, to attend the Chief's court, to act on behalf of his father when needed, to attend and participate in feasts and beer-drinking ceremonies without being pushed aside and branded a *kwedini* or child (Momoti, 2002: 50). It is not uncommon for this to be the experience of uncircumcised middle aged men. The uninitiated male is treated with contempt and there is no possibility of redress.

Ritual circumcision is the gateway to legitimate marriage and marriage in turn makes it possible for a male to achieve the status of a fully-fledged member of the community. Not only may he participate in his family's and the chief's court but his word now carries more weight (Momoti, 2002: 51). From this point onwards a father is no longer considered legally responsible for the actions of his son although there is the social expectation that he will continue to assist and guide his son. The man is now responsible for his own acts and for that of his household.

4.1.6 Social status

The question of the precise status of a person is very important in Xhosa communal relations because what might rightly be expected of a person and how that person is

correctly to be treated is highly dependent on what their status is. In a community everyone who of a particular status can substitute and act for any other person of that same status. In this understanding of human development status is not a permanent characteristic of a person but rather changes according to age, experience and the performance of certain rites. Importantly, in traditional African societies which operated in the absence of official written records (for instance, of birth, age, etc.), the public witnessing of, and attesting to, a change in status for instance at the coming out ceremony of an initiated male, serves as a substitute for written or legal documentation of age and status and their accompanying implications for the legal and social standing of an individual.

4.2 Social Sanctions Reinforcing the Imperative to be Circumcised:

For Xhosa males then, circumcision is a cultural imperative in the absence of which manhood is literally impossible and the individual is condemned to eternal boyhood and the status of outsider and less-than-human. The cultural imperative to be circumcised is sustained and nourished by a variety of social practices which serve to entrench and reinforce its obligatory nature. These range from pull factors such as access to women, sex and material resources to push factors including social isolation, name-calling, the allocation of menial tasks to uncircumcised males, being labelled as irresponsible and blamed for things that go wrong in the community. Violence is not infrequently a feature of the mechanism by which the cultural imperative is enforced.

4.2.1. Denial of Access to material Resources for the Uncircumcised Male

In a context of scarce material resources a person's circumcision status acts as a legitimising tool for restricting the extent to which food, alcohol and other material resources such as new clothing, comfortable sleeping quarters and so on have to be shared among the group. The need for such a legitimising tool must itself be understood against the backdrop of strong social imperatives in Xhosa society to share food in particular. A newcomer to a group of people eating is commonly greeted 'we are eating' implying that they should join in. This social responsibility is, however, limited to adults who are fully human and therefore can expect to enjoy the rights and responsibilities that attach to that status. The uncircumcised is likened to a dog and therefore there is no expectation that social obligations that form part of mutual humanity, extend to him:

I experienced a situation whereby these newly circumcised men were calling me 'dog' and other names. In events like feasts or cultural ceremonies they always enjoy a larger share of entertainment including food and liquor than me. Discrimination happens in terms of placement whereby men will be allocated a more favourable position than boys. For example, boys will be allocated away from the kraal where food and meat is dished from. The only way to get your share was to wait to be called by these men who would give you a piece of meat (Participant 6).

One other aspect that was frustrating was that nobody wanted to buy me clothes because I am a boy. They will give me older clothes that were used by my elder brothers (Participant 8).

While the elevated cultural reasons for circumcision are thus frequently cited by custodians of the tradition then, these more prosaic material motivations feature strongly in initiate's own accounts of the personal pull towards circumcision. The

pull factors are accompanied by push factors which include practices of social exclusion, name-calling, victimisation and on occasion, violence.

4.2.2. Circumcision and Access to Sex

Importantly, in contemporary society, circumcision is seen as a gateway to accessing sex rather than the moment at which sexual restraint is taught. In interviews with recently initiated Xhosa men the lack of access to women that is implied by being uncircumcised was frequently cited as a reason for undergoing the rite:

[Girls] would respond to your proposal for love by using embarrassing statements such as 'I don't fall in love with a barking dog that has a long tail' (Participant 2).

Moreover, it emerges that those who have been circumcised actively use the fact of a person being uncircumcised to the limit access to women:

At one afternoon myself and colleague were enjoying ourselves in the veranda of the community shop. A beautiful girl of my age came passing by and I followed her with the intention of proposing love. I did not notice that there were men following behind us. They stopped us and attempted to take the girl away from me. I retaliated but to no avail. They beat me up causing gross bodily injuries. When I reported this at home, my elder brothers continued where those men left chasing me out of the house. This beating was due to proposing a girl belong to men and for retaliation to those men (Participant 12).

4.2.3. Social exclusion of the uncircumcised

Young boys face enormous social pressure to be circumcised. Peer pressure, avoiding being called cowards, avoiding being ridiculed and harassed, pressure from women and older people to maintain tradition and the desire to gain respect feature strongly in the self-reported motivations of Xhosa males to be circumcised. A variety of studies in the field of public health (see for example, Tenge 2006; Bottoman, 2006) have found that uncircumcised males are psychologically traumatised as a result of the ridicule and harassment they experience at the hands of peers and elders who have already undergone circumcision. The pressure is so intense that many secretly take themselves off to initiation schools without the knowledge of consent of their parents. They are accepted in contravention of the law by unscrupulous operators.

You were not allowed to introduce yourself using your clan name because you are a boy. This made me feel I am not the son of my biological parents but belong elsewhere. This forces you to consider leaving boyhood (Participant 3).

When it comes to responding to the call of nature men will tell me I cannot relieve myself in the same toilet at the same time with them because I am not a man. What was painful is the fact that some of these men are of my age and some younger than me (Participant 11).

The risk of ostracism is experienced not only by the uncircumcised boy himself but also by his family who fear social exclusion if their son has not been to initiation school. Social shunning of uncircumcised males is reinforced by other discriminatory practices which serve as a constant reminder of difference and inferiority and which, in their constant repetition, take on an almost ritualised character.

Stringent age-group hierarchies are observed in Xhosa society. Young boys tend to mix within their age groups and form friendship bonds within that group. Circumcision is disruptive of these bonds when it cuts across age groups since an uncircumcised male will no longer be accepted in a group of circumcised males even though they may be of similar age and were once friends.

When my friends came back from the bush they paid me some visits. The relationship was not the same and tension was there especially if we were joined by other men who were friends of my colleagues when they were in the bush (Participant 7).

4.2.4. The allocation of menial tasks to uncircumcised males

Uncircumcised males are discriminated against in a variety of ways which are experienced as painful, embarrassing and frustrating. These range from being treated as servants at the beck and call of circumcised males who may or may not be older in years, to tasks regarded as unpleasant such as aspects of slaughtering to do with burning of the animal's hair, to tasks regarded as trivial and demeaning, often because of their association with women's work including work that is related to cleaning and cooking .

At home I was made to fetch cows and sheep from the forest. My elder brothers were exempted from this exercise because they were men. They will only be invited when a sick cow is treated for any sickness such as bilharzias. If they are not at home during supper it is my duty to take food to their rooms when they return. At feast-like events where a cow is slaughtered duties like removing hair around the head and lower part of the legs using fire was allocated to us boys. When they are ready to be eaten those who cleaned the head are forgotten because only the elders are allowed to eat. Boys are made to work very hard with no compensation. The fruits of working very hard are enjoyed by men not boys. During the ploughing period I was forced to wake up in the hours of the morning to organise the cows by applying a yoke around the cow's neck so that they can pull the ploughing equipment in the field. Men will join me when the sun rises (Participant 8).

4.2.5. Victimisation of uncircumcised males

Uncircumcised males frequently report that they are the first to be blamed when crimes are committed based on the assumption that to be uncircumcised is to be irresponsible and incapable of moral worth. In reality it would appear that in at least some of these cases uncircumcised males are used as convenient scapegoats when crimes are committed by anonymous males.

At home every time the money is missing everyone accuses me of stealing. At one time in the presence of my visiting cousin a R50 note went missing. All fingers pointed to me because I was a boy and my cousin was already a man (i.e. circumcised). All bad things were associated with me because I was a boy. A circumcised man was always regarded as a person with morals who can distinguish between what is right and wrong. This was annoying me. I noticed that any bad thing at home or in the community was associated with me and other boys. You are always suspect number one if house-breaking or stealing of stock occurred. You are regarded as the mastermind who is teaching those younger than you how to steal from the neighbourhood (Participant 2).

4.2.6. Name-calling and violence

The exclusion of uncircumcised males is reinforced through name-calling that in its constant repetition takes on the mantle of ritual. The most common of these is the likening of the uncircumcised male to a dog. The image evokes the idea that the uncircumcised male is not yet fully human and cannot be regarded as capable of moral behaviour or moral responsibility. Such a person has limited rights because they are not yet a fully functioning member of human society.

I was also angered and frustrated by the authority given to these men allowing them to tease at me or call me names and yet they are younger than me but circumcised. You are not allowed to retaliate and if you do that especially by beating this young man, people in the scene will summon others to come and witness a 'dog' eating a human being (Participant 1).

The observance of hierarchies and rituals of seclusion are strictly enforced with brutal penalties for those who contravene the rules.

I once broke the rules applying to entrance into a tavern. No boys were allowed entrance. On this day I pretended to be a man and was allowed to join the others inside this tavern. After two to three hours I went to the toilet to relieve myself. I did not notice that the tavern owner followed me. He confronted me and instructed me to produce proof that I am a circumcised man. I tried some delaying tactics but to no avail. He called other men who started kicking and punching me all over my body and I was dragged outside the tavern yard (Participant 13).

Would-be initiates must balance the social pressure to be circumcised against the fears which they have of injury or death associated with traditional circumcision, often reporting that they turn to alcohol and drugs in order to quell their fears about the unknown that awaits them in the bush (see for instance, Tenge, 2006). Circumcised males in the community appear actively to feed into these fears with stories concerning the terrors that await initiates at the circumcision lodge:

The worst experience was on the preceding day for circumcision. The new men came to the party that is held throughout the night. They narrated stories of being unexpectedly visited by big snakes and wild animals such as bears and lions that killed their fellow mates in the bush. I almost gave up and planned to run away from the ceremony (Participant 6).

On the one hand, secrecy surrounding the ritual is strictly adhered to, while on the other, widespread media reports suggest the dangers surrounding traditional circumcision. Would-be initiates are plagued by fears and questions about what would happen should a surgeon perform their circumcision incorrectly. The concern for their physical well-being is augmented by the anxiety surrounding possible hospitalisation and its accompanying inevitable loss of respect should their circumcision go wrong.

I think the cause was fears. It was when the traditional surgeon did not honour the time agreed upon. Because I did not know exactly how the procedure was done, I had many questions such as what if the traditional surgeon incorrectly cut my private parts, am I not going to die? This intensified my fears (Participant 7).

Would-be initiates are aware of the risks and their sense of uncertainty is compounded by an awareness of the extent to which the reproduction of the custom has become fragile and uncertain. The role prescribed by tradition for families is not

always followed in a context in which there are many female-headed households and certainty of communal bonds and hierarchies implied by the practice have been fractured and become muddled. There is a sense then in which the social imperative to be initiated is as strong as it ever was, accompanied as it is by an uncompromising set of social and physical punishments for those who fail to abide by it. However, the social networks and foundations upon which that imperative once securely rested, and which served to support it are no longer in place in many communities. This has led to something of a crisis the dimensions of which are multiple including bogus fly-by-night surgeons and lodge operators, widespread reports of alcoholism and drug abuse by initiates along with those practicing as traditional surgeons and nurses, under-age boys being abducted into circumcision lodges or taking it upon themselves to be circumcised without the knowledge of their families. The dimensions of the crisis are discussed in more detail below.

5. Complications and Concerns Relating to Traditional Circumcision

Since the late 1990s the South African government, media and medical community attention has focused increasingly sharply on ritual circumcision as a result of increasing numbers of documented deaths associated with the practice. In the 2005 winter circumcision season the Eastern Cape Health Department closed over 31 illegal circumcision schools in the wake of charges which included:

- circumcision of boys with un-sterilised knives
- fatalities and amputation of penises resulting from incorrectly performed circumcision and the onset of gangrene
- alarm about the risk of HIV infection with a single instrument used repeatedly to circumcise several boys in turn.

As the table below shows, despite the fact that the provincial Health Department dedicated in 2006 more than 60 health officers to monitor the practice of traditional circumcision, deaths, injuries and amputations do not appear to be declining. On the contrary, it is likely that the higher number of hospitalisations is due to health department interventions in that when illegal schools are closed down many initiates found to be suffering from dehydration or other illness or injury are taken to hospital by Department functionaries.

According to Department of Health spokesperson, Sizwe Kupelo (interview, 2007), in 2006 there were an estimated 10 000 adult male circumcisions in the province (although the exact figure is difficult to calculate since it is difficult to know how many illegal circumcisions are still taking place). While in 2005 there were 20 reported initiate deaths this figure was up in 2006 to 26 according to Kupelo (however, this figure includes early January 2007 which marks the end of the December/January circumcision 'season'). In 2006 there were 562 hospitalisations and 63 genital amputations. The latter figure is high (only five were reported in 2005) and may reflect better and more focused record-keeping as a result of Department interventions aimed at monitoring the impact of legislation.

However, while improved record-keeping and reporting accounts for some of the increases in deaths and fatalities, the rise in circumcision-related casualties in recent years is related to a more complex network of social factors.

5.1. Lack of Skill and Knowledge on the Part of the Traditional Surgeon Leading to Incorrect Surgery

While the traditional surgeon is ideally a person trained by his predecessor with skills being handed down from one generation to the next, in a contemporary period characterised by much greater social change, mobility and cultural rupture, the training and competence of *ingcibi* is not always assured. Some injuries occur as a result of incorrect surgery with for example, too much skin being removed. Associated complications include haemorrhage due to laceration or amputation of the glans and/or the penile shaft as well as removal of too much foreskin, denuding the penile shaft (see also William and Kapila, 1993: 1231-1236; and Menahem: 1981: 45-8).

In interviews with older community members about the process, concern is often expressed about the expertise of modern-day traditional surgeons. Often the process whereby the *ingcibi* would be scrutinised by elders of the community has given way to a more *laissez faire* approach whereby virtually anyone can claim to be a qualified traditional surgeon. Medical reports suggest that traditional surgeons are largely ignorant of anatomy as evidence in the common practice of chopping rather than excising the foreskin. Traditional attendants or nurses are ignorant of aseptic technique, the importance of blood circulation and nutrition in wound healing as evidenced by the nature and application of dressings and restrictions on protein-rich foods. Since pain and suffering is regarded by informants (traditional surgeons and attendants) as good for initiates there is no attempt to control or alleviate pain, haemorrhaging, shock or dehydration.

5.2. Alcoholism and Drug-use

A recurring charge in recent years is that of surgeons operating while under the influence of alcohol or narcotics. The use of alcohol by initiates themselves also represents a danger. Used prior to, and after, the procedure (which is conducted without anaesthetic) in a bid to alleviate pain, alcohol has been implicated in excessive bleeding sometimes leading to death (Mayatula and Mavundla, 1997:18).

5.3. Re-use of Instruments without Sterilisation

Related to the problem of the training and competence of traditional surgeons are questions of hygiene, the correct use of appropriate instruments and sterilisation. While not trained in western medical practice, the experienced *ingcibi* would be well versed in appropriate traditional practices including for example the use of herbal medicines to combat infection. Contemporary reports in contrast highlight the re-use of instruments without cleaning or sterilisation, the use of blunt instruments and a lack of appropriate hygiene mechanisms at many circumcision schools. As a result there are concerns about infection and the spread of venereal disease and HIV in particular.

5.4. Sepsis and Gangrene

The period during which complications most frequently occur is not during the surgery itself but in the care of initiates after circumcision. Traditionally an attendant (*ikhankatha*) is assigned to each initiate and is responsible for bandaging and taking care of the wound which is wrapped in a tight thong. Where the dressing is made too tight gangrene results due to constriction of blood circulation with subsequent

loss of penile tissue, sometimes spreading throughout the body. Septicaemia due to poor hygiene practices can lead to death if not treated with appropriate antibiotics.

This is not a new problem. Already in 1990 one of the few published pieces of research on traditional circumcision in the Eastern Cape pointed to problems relating to circumcision during the hot summer months which led to a greater risk of wounds festering (Funani, 1990). The author, a trained nurse, writes of first becoming aware of the problem of sepsis among initiates in 1978 while working at a clinic in Peddie where secret knocks on the door at night indicated an initiate seeking help with a circumcision wound that had turned septic. In a pragmatic, no-fuss accommodation with culture the nurses would quietly dress and clean the wounds and send the initiate back to the bush (Funani 1990:1). Sepsis is one of the most common and debilitating concerns for traditional circumcision with the effects sometimes so severe that it results in loss of the penis.

5.5. Dehydration



Initiates live in seclusion in the bush. Traditionally grass huts are built to live in at the circumcision lodge. These are torched at the conclusion of the process. Grass is cooler than the plastic sheeting which is often used at contemporary circumcision lodges, particularly those closer to urban areas.

A further difficulty in the after-care period is that of the potential for dehydration which is common at initiation schools because initiates are discouraged from drinking fluid. This prevents frequent urination but is also seen as a test of endurance. Two changes in contemporary practice have made dehydration a bigger risk today than it was in the past: firstly, circumcision is frequently performed in the hotter summer months (presumably to accommodate school holidays) whereas in the past it most often occurred in autumn. Secondly, plastic sheeting is now often used to build the initiate's hut instead of the traditional leaves and grass which were much cooler.

5.6. The Rise of Fly-by-Night Circumcisers Motivated by Financial Gain

At the 2006 Hearings on Traditional Circumcision convened by the CRL Commission, the SAHRC and the NHTL held at the Qawukeni Great Place, Lusikisiki, Prince Zukisile Makaula, a senior royal member of the AmaBacha criticised opportunists who were seeking to gain materially from performing circumcisions, Tembu Chief Mandla Mandela has expressed the same concern noting that in some places up to R1200 is charged per initiate and it is not unusual for a single school to circumcise over 100 people. Circumcision is a large source of income in poverty-stricken areas where unemployment is high. The financial incentives are thus very considerable. As a

result, self-proclaimed traditional surgeons and traditional nurses operate without the sanction of their communities or the chief in authority in a particular area, and they do not register with the government-appointed medical officer.

5.7. Abduction of Under-age Boys into Circumcision Lodges

At the 2006 Hearings on Traditional Circumcision convened by the CRL Commission, the SAHRC and the NHTL held at the Qawukeni Great Place, Lusikisiki, parents and elders also expressed alarm at abductions of young boys who are taken out of their home area to a different district to be circumcised. Members of the public spoke of people 'going around in trucks collecting boys for initiation, without getting permission from parents, and without reporting even to the local traditional leader'.

In a country characterised by very high levels of poverty and unemployment (estimated at over 30 per cent), financial factors inevitably intrude to create incentives other than 'purely' cultural for keeping initiates under the control of the traditional school and its leaders. With each initiate being charged a fee by the traditional surgeon, circumcision is big business and there have been reports of boys as young as eight years old being kidnapped from their homes to increase numbers at circumcision schools.

5.8. Absence of Parental Involvement

A study conducted in the Flagstaff health district of the Eastern Cape in 2004 found that most initiates (41.66 per cent) did not inform their parents before enrolling in the initiation school. They simply disappeared from home and made their way to the initiation site (Mogotlane et al, 2004: 60). Since custom prescribes that circumcision is not discussed at all with female relatives, sons in female-headed households are faced with a genuine dilemma. One informant told the authors of the Flagstaff study: 'I have no father or any male relative. When I felt that I was ready to enrol, I told my mother and I noticed that she was against this So I brought myself to initiation school'. There is even a term in the local vernacular describing this: *uku balekela* (literally, to escape into, meaning to run away from home and seek temporary refuge at the initiation school). Moreover, the circumcision of boys younger than 16 appears to continue to be widespread. In the Flagstaff study for instance, informants reported that the age of initiates ranged from 12 to 20. The informants themselves felt that the most appropriate age at which to be initiated would be 18. Widespread unemployment and poverty in the region means that many families are unable to save enough to pay to send a son to initiation school. As a result some boys had left school early to find work in order to pay for their initiation.

6. Key Legislation Governing Regulation of Traditional Circumcision in the Eastern Cape

The legal framework that governs the practice of traditional male circumcision in the Eastern Cape is more complex than might at first be expected. The supremacy of the Constitution of 1996 provides the overarching structure within which contemporary attempts by the state to regulate the custom takes place. But South Africa is also a signatory to various instruments in international law and these too form part of the relevant legal framework within which initiation rites must be regulated. Additionally,

several of South Africa's nine provinces have established their own legal instruments governing traditional circumcision.

6.1. The 1996 South African Constitution

Questions of culture feature prominently in South Africa's Constitution. The Constitution in effect gives the individual the right to choose a cultural identity. The implication is twofold: the individual can protest if the expression of their cultural identity is stifled but can also resist the imposition on her of cultural practices that she does not choose to follow (see Van der Meide, 1999). Moreover, cultural rights must be practiced in such a way that the Bill of Rights is not infringed.

- ❖ Section 15 which is concerned with Freedom of Religion, Belief and Opinion, allows for legislation recognising systems of personal and family law under any tradition, or adhered to by persons professing a particular religion.
- ❖ Section 30 gives everyone the right to 'participate in the cultural life of their choice'.
- ❖ Section 31 provides that people belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community to enjoy and practice their culture.
- ❖ Sections 181 (c) and 185 make provision for the establishment and functions of a commission for the promotion and protection of religious, cultural and language rights.
- ❖ Section 211 (3) of the Constitution enjoins the courts to apply customary law when that law is applicable subject to the Constitution.
- ❖ Section 212 of the Constitution deals with the Role of Traditional Leaders:
 1. National legislation may provide for a role for traditional leadership as an institution at local level on matters affecting local communities.
 2. To deal with matters relating to traditional leadership, the role of traditional leaders, customary law and the customs of communities observing a system of customary law:
 - a) national or provisional legislation may provide for the establishment of house of traditional leaders; and
 - b) national legislation may establish a council of traditional leaders.

The Constitutional clauses relating to culture are not the only ones relevant to male circumcision. Section 28 deals with the rights of children:

- ❖ In terms of 28 (2) a child's best interests are of paramount importance in every matter concerning a child and a child is defined as a person under the age of 18 years.

The Constitution enjoins the country's courts to consider international law when interpreting the Bill of Rights. The two international measures that are particularly significant to the question of traditional circumcision are the UN Convention on the Rights of the Child (South Africa became a signatory on the 16th of June 1995) and the African Charter on the Rights and Welfare of the Child (ratified by South Africa on the 7th of January 2000).
provisions of the Charter.

6.2. The 2005 Children's Act

A new Children's Act (Act No. 38 of 2005) was signed into law in June 2006. With regard to ritual circumcision:

- ❖ Chapter 2, Section 12 (8) prohibits circumcision of male children under the age of 16 except when:
 - a) circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or
 - b) circumcision is performed for medical reasons on the recommendation of a medical practitioner.
- ❖ Section 12 (9) states that circumcision of male children older than 16 may only be performed:
 - a) if the child has given consent to the circumcision in the prescribed manner;
 - b) after proper counselling of the child; and
 - c) in the manner prescribed.
- ❖ Section 12 (10) says that taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision.

After the National Assembly passed the Children's Bill in June 2005, it was sent to the National Council of Provinces (NCOP) for consideration. As a Section 75 Bill (governed by Section 75 of the Constitution, with regard to laws that fall into this category the National Assembly has a veto power over amendments proposed by the NCOP) the NCOP could propose amendments but whether or not to accept them remained the prerogative of the National Assembly. The Bill was met with intense public debate particularly concerning its proposed ban on virginity testing of children as well as its prescriptions regarding ritual male circumcision. The NCOP took the decision to hold a second round of public hearings on the Bill to allow stakeholders who had not been heard in the first round the opportunity to make submissions. On this basis the NCOP proposed a number of changes to the Bill, the majority of which were accepted by the National Assembly. One of the several amendments which the NCOP proposed and which was accepted by the National Assembly in December 2005 was that circumcision of male children for cultural reasons be restricted to children over the age of 16 and that for those over the age of 16 circumcision should only be allowed with the child's consent and with counselling.

6.3. The Application of Health Standards in Traditional Circumcision Act (Eastern Cape) No. 6 of 2001³

From early 1995 the Eastern Cape Department of Health began to engage in a process of consultation with NGOs, civics, traditional rulers and traditional surgeons with a view to establishing provincial guidelines and ultimately a legislative tool for the regulation of traditional male circumcision in the province. Well-attended public hearings were held throughout the province concerning the Application of Health Standards in Traditional Circumcision Bill during which it was emphasised to the public that the intention of the legislation was not to interfere in the traditional practice of initiation but rather to apply health standards necessary for the prevention of injury and loss of life. The outcome of this process was the unanimous acceptance of the Bill on the part of the various political parties in the House. The Application of Health Standards in Traditional Circumcision Act (Act No. 6 of 2001) came into existence in 2001.

6.3.1. Objects of the Act:

- a) To provide for the observation of health standards in traditional circumcision;
- b) To provide for the issuing of permission for the performance of a circumcision operation;
- c) To provide permission for the holding of circumcision schools.

The Act allows for medical officers who are appointed by the provincial Department of Health to issue permission to people who want to perform circumcision operations and treat initiates. The medical officer is responsible for issuing permits, keeping records and statistics pertaining to circumcision and has the right of access to any occasion or instance where circumcision is to be performed or an initiate treated.

6.3.2 Requirements of the Act

❖ Authorisation and registration of traditional surgeons

The number of casualties and deaths at traditional initiation schools in recent years suggest that some of those who are practicing as traditional surgeons in contemporary society lack the extensive experience, knowledge and skill that those who performed the function in the past could be relied upon to hold. The Act therefore provides that a medical officer must authorise or deny authorisation to the traditional surgeon. Where a traditional surgeon does not have the necessary experience to perform a circumcision, he must perform it under the supervision of an experienced traditional surgeon (Annexure A (6)).

❖ Regulation of instrument used and manner of operation

The medical officer may also stipulate the manner in which the procedure is to be performed. For instance, the designated medical officer for the area in which the circumcision is to be performed can disallow the use of a surgical instrument that the

³ Other provinces which have also established provincial legislation governing traditional circumcision include: The Northern Province (Limpopo Province) -- Circumcision Schools Act No. 6 of 1996 and The Free State -- Initiation School Health Act No. 1 of 2004.

traditional surgeon intends to use and instead supply an instrument which is regarded as permissible. The medical officer must then also offer training in the use of the instrument supplied. This stipulation relates to the fact that traditionally an assegai or blunt spear may be employed by a traditional surgeon rather than a more precise surgical instrument.

Annexure B (1) stipulates that a designated medical officer is only entitled to impose a deviation from the use of traditional material used in the treatment of cases where there are early signs of sepsis or other similar health conditions.

- ❖ Regulation of re-use of surgical instrument

Annexure A (7) of the Act stipulates that an instrument used to perform a circumcision on one initiate must not be used again to perform a circumcision on another initiate, and the traditional surgeon must use the instruments supplied by the medical officer where the traditional surgeon has to perform more than one circumcision on more than one initiate but does not have sufficient instruments. Sterilisation of instruments to be used in circumcision is a specific requirement of the Act.

- ❖ Legal age for circumcision and parental consent

The Act attempts to deal with these problems by making parental consent obligatory, providing that the traditional surgeon must be known to the parents of the prospective initiate, and must use instruments approved by the parents unless a medical officer has prescribed another surgical instrument. In terms of the Act the minimum legal age for a person to be traditionally circumcised is set at 18. However, it allows for permission to be granted for traditional circumcision to be performed on someone who is younger than 18 but no younger than 16, upon application by a parent or guardian. Proof must be supplied in the form of a birth certificate or identity document that the prospective initiate is at least 18 years old, or if the parents of the initiate so specifically request, at least 16 year old. Parental consent must be obtained in respect of a prospective initiate who is under 21 'or who has not acquired adulthood' (Annexure A (2)).

- ❖ Pre-medical examination of initiates

Initiates are required to undergo a medical pre-examination to determine whether or not they are fit to undergo traditional circumcision.

- ❖ Regulation governing access to water for initiates

In order to prevent dehydration, traditional nurses are prohibited from denying initiates all access to water which has been a feature of the practice.

- ❖ Provision for inspection and monitoring

The medical officer must be allowed by the traditional nurse to visit the circumcision school at any time and as regularly as the medical sees fit.

- ❖ Stipulations regarding medical care of initiates post-circumcision

The Act (Annexure B (5)) requires the traditional nurse to exercise reasonable care in the holding of a circumcision school and not to expose any initiate to danger or harmful situations. Any sign of illness of an initiate must be reported to the medical officer as soon as possible. During the first eight days after the circumcision is performed the traditional nurse is required to stay with the initiate at the circumcision school 24 hours a day and thereafter must be available at least once a day until the initiation period has come to an end.

The medical officer is entitled to prescribe any measure at any stage of the circumcision process that he or she on reasonable grounds deems necessary in the interest of the good health of the initiate and such a measure may in appropriate circumstances include a departure from traditional measures. The traditional nurse is required at all times to cooperate with the medical officer.

❖ Penalties for contravention

Those who contravene the regulations face penalties of either a fine of up to R10 000 or up to 10 years imprisonment or imprisonment of up to five years without the option of a fine.

6.3.3. Traditional Leadership Responses to the Act

Whereas traditionally, chiefs have played a role in initiation in a variety of forms that have varied across the region – whether in the form of seeking permission for the ceremony to be performed or the offering of part of a slaughtered animal to the chief -- the Act envisages a very limited role for traditional leaders. Annexure A (5) provides that a traditional surgeon who is to perform a circumcision within an area falling under a traditional authority must inform that authority. No provision is made for redress in the event of non-observance of this procedure.

The response on the part of the traditional authorities in the province echoes the historical bifurcation between resistance and accommodation that has always characterised the relationship between the central state and these authorities. Some traditional leaders have offered their public support to government regulation. National House of Traditional Leaders spokesperson Sibusiso Nkosi, for instance supporting the state has argued that the problem is not with the tradition itself but with its practice by 'bogus' initiation schools which 'claim the lives of our innocent children ... making a mockery of our culture' and bringing 'shame and doubt' on traditional practices' (cited in Sapa, 29 June 2005).

On the other hand, opponents of state regulation have themselves used the language of cultural authenticity to resist what are seen as illegitimate incursions into their sphere of influence. Traditional leaders frame their vigorous opposition to the regulation of circumcision by appealing to the arcane intricacies of the practice which are frequently interpreted in their most uncompromising form. The Congress of Traditional Leaders of South Africa (Contralesa) described the law as 'an insult to our tradition' and vowed to stop medical officers having anything to do with ritual circumcision.

The apartheid state chose to shore up the system of chiefs, some of whom were paid government functionaries, as a means of rule by proxy. Democracy with its paraphernalia of elections and universal suffrage has led to concerns on the part of

traditional leaders that they will lose their power in the new dispensation and, not least, their income. Arguing that they alone are the rightful custodians of culture, traditional leaders protest that the new regulatory regime fails to provide for them to be included in such processes as the registration of *iingcibi* and *amakhankatha*. The picture is politically complicated by the fact that opposition to state regulation of tradition comes from within the ruling party as much as it does from without. Eastern Cape House of Traditional Leaders chair and ANC MP Mweliso Nonkonyana called the province's Application of Health Standards in Traditional Circumcision Act 'nonsensical' as it stripped traditional leaders of their power to administer the custom and vested those powers in the provincial Health Minister and 'his doctors' – some whom may themselves not be circumcised. Contralesa has argued that the Act is unconstitutional as it infringes on the traditional rights of communities protected by the Bill of Rights.

While some traditional leaders such as chief of the abaThembu tribe and ANC MPL Zwelinzima Mtirara have taken a more accommodationist stance, others have advocated outright civil disobedience in their response to government regulation. Nonkonyana, for example is on record as saying that 'if an uncircumcised man is found near an initiation school he will be detained and circumcised' while 'traditionally a woman found in the area near a circumcision school would be killed but because of the human rights thing she's detained and dealt with in another way by the people' (*Mail and Guardian*, 8 December 2003). Nonkonyana has declared that he would be prepared to go to jail rather than comply with the act and his own son was illegally circumcised at an unregistered school although the actual circumcision surgery was performed by a doctor with Western medical qualifications – the important point for Nonkonyana was that the doctor was himself a circumcised man (*Cape Argus*, 10 December 2003).

6.4. National Health Act No. 61, 2004

Specific provincial measures aimed at the regulation of traditional circumcision have been augmented by provisions in the National Health Act of 2004 which provides a framework within which measures such as the requirement for consent and monitoring can be enforced. The Act aims to provide a structured and uniform health system for South Africa. In its focus on record keeping, consent, access to health records, complaints procedures, classification of health establishments, human resource planning, control of blood products, etc. the Act is geared almost exclusively to the regulation of the formal health sector. However in Chapter Six which deals with Health Establishments, Section 43 is concerned with 'Health Services at Non-health Establishments and at Public Health Establishments Other Than Hospitals'.

Section 43 (3) provides that:

- a) The Minister may, in the interests of the health and wellbeing of persons attending an initiation school and subject to the provisions of any other law, prescribe conditions under which the circumcision of a person as part of an initiation ceremony may be carried out;
- b) Initiation is taken to mean here any place at which one or more person are circumcised as part of an initiation ceremony and initiation ceremony means a traditional ritual or practice in terms of which a person is inducted into an order or accorded a certain status or recognition within a community.

According to Section 43 (4) the Minister may, subject to the provisions of any other law, prescribe conditions relating to traditional health practices to ensure the health and well-being of persons who are subject to such health practices.

Also relevant is Chapter 8 (Control of Use of Blood, Blood Products, Tissue and Gametes in Humans) Section 55 which requires written consent before tissue, blood, a blood product or games is removed from the body of another living person. Section 56 stipulates that tissue that is not replaceable by natural processes may not be removed from a living person younger than 18 years. While clearly aimed at regulation of such practices as the use of foetal tissue, stem cells, etc. this aspect of the Act is also of relevance to the question of ritual circumcision.

In Chapter 10 which deals with the appointment of health officers to monitor and enforce compliance with the Act, as well as outlining compliance procedures, Section 82 allows a health officer to enter any premises at any reasonable time to conduct an inspection to ensure compliance with the Act, to question any person who is believed to have relevant information, to require the production of relevant documents. A health officer may be accompanied by an interpreter or any other person needed. According to Section 89 any person who obstructs or hinders a health officer who is performing a function under the Act is guilty of an offence. This aspect of the Act creates the legal framework within which monitoring of circumcision schools can take place.

6.5. Traditional Leadership and Governance Framework Amendment Act 41 of 2003

In this Act the State recognises its obligation to respect, protect and promote the institution of traditional leadership in a manner that is in harmony with the Constitution and the Bill of Rights. But the Act also sets out the obligations of traditional leadership to promote dignity, equality and non-sexism.

7. Challenges Facing Regulation of Traditional Circumcision

7.1. Challenges to the Role of Designated Medical Officers

While the requirements of the Act make perfect medical sense and are reasonably straightforward, their application in practice can be more complicated. Traditionalists have raised questions about the status of the medical officer who plays such a central role in certifying traditional surgeons and their instruments along with authorising the operation of circumcision schools. While the state appears to have in mind the medical training of the person qualifying them to make the decision about whether or not to grant permission to a traditional surgeon, many communities wish to insist that such a person should themselves be a traditionally circumcised male.

The Eastern Cape Department of Health, for its part, takes the position that designated medical officers are departmental employees stationed at district level and seconded to monitor traditional circumcision interventions being carried out by the Department. There is no policy in place requiring only circumcised men to be on this programme. Furthermore, initiates who end up in hospital can be attended by a

female nurse or an uncircumcised male nurse. As Health Spokesperson in the Eastern Cape, Sizwe Kupelo puts it, 'they are treated not as initiates but as patients and the main concern is to save their lives'(Interview, 5 April 2007).

7.2. Challenges to the Authority of Traditional Leaders

The strict need, accompanied with penalties, to apply for permission from the Health Department's designated Medical Officer, introduces some confusion into accepted traditional lines of authority. It would customarily be the chief or other traditional leader of an area who would be responsible for granting such permission. The relationship between the traditional leader and the state-designated medical office is thus potentially conflictual and complex.

7.3. Challenges to the Monitoring Regime

Implementation of certain provisions of the Act such as ensuring that proper procedures are being employed with regard to sterilisation of equipment, hydration of initiates and so on, requires the introduction of a stranger into the initiation lodge which is customarily a place of secrecy and privacy where outsiders are not permitted. Government appointees are made without reference to circumcision status or gender and this leads to an impasse with a cultural prescription that no women or uncircumcised men be allowed near a circumcision lodge.

Given the province's poor communication networks and largely rural character monitoring also faces difficulties associated with enforcing and policing observance of the legal requirements with which traditional circumcision schools are meant to comply. Random visits to circumcision lodges are one mechanism for ensuring compliance with the law. But there are difficulties with this measure in practice in that it can easily be seen as intrusive given the privacy and secrecy that traditionally governs circumcision rites.

7.4. Information dissemination challenges

While the legal and institutional framework that has been put in place has been effective in firstly, providing education regarding safer circumcision procedures and secondly, reducing the rate of injury and death among initiates, there are a number of challenges that remain. In the first instance, there are challenges to do with making the new legislative framework known to the public. While government has taken extensive steps to publicise its regulatory requirements, in a largely rural province, poorly served by electronic media or transport networks and beset by high levels of illiteracy, public information is a typical challenge facing government. Clearly the new laws can only be effective if the various stakeholders know not only what their obligations are in terms of the law but feel that their interests and views have been taken into account in the formulation of the laws. As it stands traditional leaders have not always felt incorporated despite the best efforts of the province's Department of Health.

7.5. Resource challenges

Medical officers are a central lynchpin in the new legislation which envisages that these officers will play not only a regulatory role but also an educational role. This can only be possible however, if there are sufficient medical officers to cope with the

volume of work that arises during the circumcision seasons. In remote rural areas with few transport networks it is not always practical for a state medical officer to gain access to those needing training, assistance, or certification.

7.6. Gender challenges

The problem of the gender and circumcision status of medical officers has been raised by some custodians of tradition as an insurmountable problem:

Government involved have to be people who have been to the mountain so that they could know what they are talking about I am concerned about the fact that the government is involved that may risk certain things of our tradition. The only people who have to be involved in circumcision are males who have been to the mountain not any other person, even in situations when a boy has to be sent to the hospital we have to ensure that male doctors take care of the boy. We know that in hospitals female doctors and nurses do look after the boys, we are not happy with that (Chief Mandlenkosi Dumalisile).

The chiefs object vigorously to the involvement of women in any discussion concerning male circumcision. Forceful traditional taboos govern the exclusion of women from such involvement.

It is commonly accepted that apartheid's intrusion in the form and content of traditional law led to the shoring up of its most patriarchal features. The old shibboleth of the inappropriateness of women's involvement in certain cultural matters, male circumcision among the most prominent of these, has been used by the chiefs as a way of resisting the intrusions of the central state into what they perceive to be their proper sphere of influence. For example, opposing the Eastern Cape's regulatory regime, argued that the law was unacceptable because women were on the team that drafted the legislation and according to tradition women must not be involved in any way with the rituals of manhood. Contralesa The injunction against the involvement of women was taken to a bizarre extreme in the case of one mother who was barred from attending the funeral of her son who had died at initiation school after being beaten by the school leader following an attempt to escape from the school.

7.7. Lack of coordination between traditional leaders and government officials

To some extent chiefs have felt sidelined by the legislative process governing traditional circumcision. Not all chiefs feel that they were properly consulted in the process leading up to the new Act. There is a perception that public hearings were often held in urban areas and that they involved the active participation of women, thus rendering them illegitimate.

Cooptation of chiefs to the apartheid cause in some areas during the apartheid era meant that the reputation of chiefs took a beating. Many were labelled government lackeys and feel that the democratic government has not done enough to restore their dignity and communal respect for them. The regulation of traditional practices such as initiation rites by central government and its appointed medical officers is regarded by many chiefs as a further incursion into the dignity of their office.

8. Assessment of the success of attempts to regulate traditional circumcision

Between 2001 and 2004:

- ❖ at least 42 traditional surgeons were arrested in the Eastern Cape
- ❖ 18 of these were convicted of crimes related to circumcision rituals gone wrong.

In the 2005 winter circumcision season, in a huge operation involving:

- ❖ over 425 officials,
- ❖ 80 4x4 vehicles and
- ❖ three helicopters on standby to rescue initiates in trouble,

the Eastern Cape Health Department arrested 15 traditional health practitioners and rescued 535 boys whom, it said, 'had been left to die in the bush'. The operation saw the teams comprising police and department of health officials raiding and breaking up illegal traditional circumcision schools.

The Eastern Cape Health Department has set itself the target of zero circumcision fatalities in 2007 according to its spokesperson, Sizwe Kupelo (SABC News, Tuesday, 2 January 2007). The Department has embarked on a massive awareness campaign and is in the process of reviewing its strategies and working closely with traditional leaders. According to Kupelo, many people in the province heeded the Department's call in 2006 to attend registered schools and he attributed the decline in the death and injury rate to this fact. However, he acknowledged that there were still children being illegally circumcised by men pretending to be traditional surgeons. More than 400 monitors have been employed by the Provincial Health Department as monitors at initiation schools to ensure proper execution of the surgery, proper care of initiates thereafter and hospitalisation where necessary. Traditional surgeons are frequently brought before the courts and tried under the Eastern Cape's circumcision laws with charges ranging from running an illegal circumcision school for which a suspended sentence may be given, to murder.

8.1. Government assessment of the success of its programmes

Government's own assessment of its interventions to date is that these have been highly successful. According to Eastern Cape Department of Health Spokesperson, Sizwe Kupelo, 'the enforcement of the legislation has saved thousands of lives' (interview, 5 April 2007).

More specifically, between 2001 and 2004:

- ❖ more than 60 traditional surgeons have been arrested for contravening the legislation;
- ❖ over 20 have been successfully convicted and sentenced;
- ❖ some 400 traditional surgeons have been trained regarding the required health standards that must be applied during the operation;
- ❖ there has been a 70 per cent decline in incidences of unlawful initiations;
- ❖ 20 Pondoland initiation schools had been closed down;

- ❖ approximately 150 boys have been rescued from illegal schools and referred to hospitals in the region;
- ❖ sound working relations had been forged between the provincial department of health and the Eastern Cape House of Traditional Leaders (Minister for Provincial and Local Government, Minister F S Mufamadi, Traditional Schools Initiation Conference, May 2004, Fourways, Johannesburg).

The Department is now working with traditional leaders to identify experienced and recognised traditional surgeons across the province. Various role players are being actively rallied, including parents, traditional leaders, community members and the South African Police Service, to protect would-be initiates from unscrupulous fly-by-night operators who operate with little knowledge of tradition, charge high fees and disregard the stringent requirements of the Act in relation to parental consent, registration, medical screening and so on.

By the Department's own admission though, sensitivities among traditional surgeons regarding the regulation of the practice run deep particularly with regard to such matters as the issuing of guidelines for what does and does not constitute an acceptable instrument for the surgery. While the Act requires traditional surgeons to produce for inspection the instrument(s) that they will use, the private and secluded nature of circumcision lodges means that it is difficult to enforce regulation in practice. To aid monitoring and enforcement, 40 4x4 vehicles have been allocated by the Department to the purpose of monitoring and awareness raising. An amount of R4,5 million has been set aside in the 2007/8 financial year to provide substance in practice to the province's legislative armoury. Awareness promotion has included visits to schools in the province, community meetings and media campaigns.

8.2. Government assessment of remaining challenges

From government's point of view, the questions that remain, according to Minister Mufamadi for Provincial and Local Government are:

- ❖ Are the provisions of the law sufficient?
- ❖ What should traditional leaders do to support government in the implementation of these laws?
- ❖ What are traditional leaders themselves doing within their communities to promote the application of these laws?
- ❖ Is the training being conducted to assist traditional surgeons and traditional nurses sufficient, and if not, what should be done?
- ❖ Are initiates being trained to become better persons in their adulthood, as was the case in traditional initiation schools in the past?
- ❖ Are traditional surgeons and health workers working closely as a team?
- ❖ What about initiation of women and other race groups which practice circumcision?
- ❖ Is there too much concentration, in the implementation of government policy, on rural areas to the exclusion of urban areas?
- ❖ What role has alcohol played in contributing to the problems associated with traditional circumcision?
- ❖ What should be done by communities to ensure that initiation schools are not taken over by criminals, and that assaults on initiates are brought to a halt?

- ❖ How can the experience of particular regions throughout the country be properly documented so as to ensure a comprehensive and targeted response? Traditional Schools Initiation Conference in May 2004,

The Minister has emphasised the importance of a coordinated response and has argued that parents must be central to the debate about how appropriately to respond. Communities need to be actively involved in the implementation of government programmes and ensuring that unacceptable conduct is brought to the attention of the authorities.

8.3. Assessment of attempted compromise solutions

8.3.1. Successful compromise solutions

It is possible for hospitals to make special arrangements for circumcision by a circumcised male nurse following which the initiate is immediately returned to bush. Traditional healers then take over those non-medical aspects of the rites relating to teachings about custom, education in the expectations of manhood and so on. Acknowledging that initiates are not permitted to leave the bush to obtain medical assistance, a programme in Alice in the Eastern Cape treats cases in the bush where necessary. Treatment is accompanied by an educational and awareness component around issues such as the use of surgical scalpels and the need for the use of a new blade for each operation. Schools are encouraged to operate in the winter months not only to prevent dehydration but also because warmth and humidity aggravates the onset of infection.

8.3.2. Unsuccessful compromise solutions

Other purported 'compromise solutions' such as the Western Cape government's 2004 proposal to establish 'cultural villages' where 'Xhosa people may practice their culture' (afrol news 2 March 2004) have been less successful. Billed as 'part of bringing democracy to the people' by providing 'an appropriate facility for people to practice their initiation culture', the R1.2 million initiative met with little enthusiasm from traditional leaders who pointed out that the burning of initiation huts so central to the symbolism of the rite would not be possible in a designated cultural village consisting of state-owned permanent facilities⁴. Like many rites of transition physical separation is a central part of ritual circumcision. Seclusion in the bush and building and living in a temporary lodge which is subsequently burned along with belongings to mark the end of seclusion and the start of a new phase in the lifecycle and a new status, are central tenets in the practice.

8.4. Partnership solutions

The most promising results have arisen in those circumstances where custodians of tradition have worked closely with government in setting up structures of self-regulation. The Makana district, for instance, routinely reports no traditional circumcision injuries or fatalities in any given circumcision season. In this locality a

⁴ On the other hand, Contralesa's Phathekile Holomisa has argued that hut burning has long not been widely practiced with many contemporary initiates ordinary houses and only the belongings of the initiate burned. 'We must adapt to changing times' Holomisa is quoted as saying (afrol news 2 March 2004).

coordinating body has been set up called *Isiko lolunto* (rite of passage) at the initiative of a member of the local municipality who is both a western-trained nurse and a traditional nurse. Traditional surgeons and traditional nurses operating in the area are members and the organisation not only coordinates workshops and training programmes so that for instance, HIV awareness can be included in the education programme at circumcision schools, but also sets a compulsory rate which is allowed to be charged by members for the performance of circumcision. In Makana this rate was recently increased from R130 to R200 for the traditional surgeon and the same amount for the traditional nurse – a much lower figure than what is seen in other areas in the province. Members are not allowed to charge less and the association has also discussed setting quotas for how many initiates a single nurse for instance may attend to in one season. This not only assures the quality of the care that the traditional nurse is able to provide but also ensures eliminates the possibility of competition for ‘business’ between the various operators. The Association has strict rules regarding alcohol consumption among its members during the circumcision period. Any member found contravening any of these rules faces a fine or expulsion. The latter would mean that the person would never be allowed to operate again. The Association’s stringent rules have not met with universal acclaim in the region despite Makana’s very favourable record with regard to injuries and fatalities. In 2001 when traditional surgeons and nurses from other districts including Graaf Reinet, Port Alfred and Port Elizabeth were invited to join the Association they declined.

9. Hospital Circumcision

In support of state regulation of ritual circumcision, South African doctors have called for ‘safe and proper circumcisions’ to take place in hospitals. For many this would appear as the ideal solution to the problematic rate of death and injury associated with traditional male circumcision in the Eastern Cape. As one doctor put it: an ‘initiate’ is wheeled into a hospital surgery and wheeled out 20 minutes later ‘with a broad smile on his face, announcing “I am a man”’ (cited in Hosken, 2004). But hospital circumcision is not popular and can result in those who attend legal schools being stigmatised and branded ‘*amadoda phepha*’ (paper men). According to the Head of the Congress of Traditional Leaders in the Eastern Cape, Mwelo Nonkonyana ‘if you are not circumcised through custom in the mountain, you are not regarded as a man. You are a social outcast. Such people are called *abadlezana*, a woman who gives birth in a hospital ward. He is not a man, he is the equivalent of a woman’ (Cape Argus, 10 December 2003).

9.1. Cultural Constraints on hospital circumcision

From the point of view of Xhosa tradition, there are many difficulties with hospital circumcision.

9.1.1. Anaesthetic

Firstly, the use of anaesthetic disregards the important part that pain and suffering play in the ritual as part of the process of demonstrating manhood and fitness for the respect and communal privileges that go along with that approbation. The endurance of physical brutality, seclusion, dietary taboos and testing are a typical and central part of the practice in many different cultural settings (see for example, Beidelman 1965; Hambly 1935; Heald 1986; Holdredge and Young 1927) and initiates are

commonly 'expected to endure circumcision stoically' (Silverman, 2004:421). As Wilson et al note (1952: 202), 'it is the undergoing of hardships and bearing of pain (*ukunyamazela*) that are necessary to becoming a man. If a boy undergoes those, then his manhood is not disparaged'.

Hospital circumcision remove the heart of the practice which has always been about hardship, suffering and the sacrificing of comforts. Initiates acknowledge this and expect little mercy at the hands of traditional surgeons and nurses as is suggested in the naming of these schools in the Eastern Cape after war-torn cities and countries: Afghanistan, Kuwait, Beirut, Bosnia, Rwanda, Panama City (IOL 2004:07:28). The initiation into manhood at the hands of a spear or knife-wielding *ingcibi* is meant to be agonising while traditionally the mutilations and deaths that followed inevitable slips of the hand were dismissed as 'a sign that the victim had not been destined to reach manhood' (Russel, 1997:27). The initiation ritual is not merely a psychological journey into manhood but is centrally a bodily one with healing part of the transformation process.

9.1.2. Contact with women

Likewise, it is one of the most basic tenets of traditional circumcision that it is a ritual reserved for males. Married women should be excluded from all contact with the initiate during the entire period of the ritual. This presents a serious problem for those who are forced to be hospitalised as a result of complications following traditional circumcision. It also means that proposals for incorporation of circumcision within western medical practice are problematic since once hospitalised it is very difficult to prevent contact with married females be they nurses, doctors or visitors to the institution.

Acknowledging that initiates are not permitted to leave the bush to obtain medical assistance, a programme in Alice in the Eastern Cape treats cases in the bush where necessary. Treatment is accompanied by an educational and awareness component around issues such as the use of surgical scalpels and the need for the use of a new blade for each operation.

9.1.3. Individualisation

Moreover the private and individualised nature of hospital circumcision removes from the practice its necessarily public dimension in which the community bears witness to the individual's changed social and legal standing. John Mbiti, in his *Introduction to African Religion* (1978: 93) argues that initiation has a religious significance which is dependent upon the (public) shedding of blood. The blood shed binds the person to the land and hence to the ancestors (Momoti, 2002:58). Mbiti argues that once the individual sheds his blood he 'joins the stream of his people and truly becomes one with them' (ibid.). In this sense, the scars of initiation are also the scars of identity (Momoti, 2002: 60). The public ceremonies, feasting and celebration associated with initiation serve to strengthen communal bonds and renew the vitality of a community.

9.2. Hospital Circumcision in the Eastern Cape

Nevertheless, hospitals in the Eastern Cape do play a role in Xhosa circumcision with many families, alarmed at the rate of death and injury to initiates in certain areas,

opting for hospital circumcision. An added attraction of hospital circumcision is that it comes cheap – free of charge to indigents and a nominal fee ranging from R12 to R20 at many hospitals.

There are over 30 public hospitals in the Eastern Cape. Many of these report that they do conduct adult circumcisions but the numbers vary greatly from hospital to hospital. While some report that adult male circumcisions are ‘never’ or ‘seldom’ performed others report that they perform ‘many’ adult male circumcisions⁵. For the most part, adult hospital circumcisions are performed during June and December – the traditional circumcision ‘seasons’. Not all hospitals have the facilities to perform circumcisions. For instance while Bedford Hospital reported occasional requests for adult circumcision the hospital cited the lack of a working theatre in operation at the hospital as the reason why it declined these requests. Clearly this is not a medically sound reason for refusal and it appears from the tenor of comments that refusal reflects an underlying aversion to the performance of male circumcision on the part of some medical practitioners as well as a lack of expertise in the performance of adult circumcision as this does not form part of the routine training of medics. It would require conscious shifts in the policies and practices of hospital administrators to turn this around.

Differences in attitudes on the part of medical staff at hospitals thus affect whether or not adult male circumcision services are provided in practice. Staff interviewed at some hospitals took the view that ‘we don’t do that here; they must go to the *sangoma* for that’. In some cases this attitude is apparently motivated by repugnance for the tradition and a sense that it ‘does not belong in a proper hospital’ while in other cases it appears that staff are themselves opposed to the idea of male circumcision taking place in a hospital setting because it offends tradition. Many hospitals consider circumcision cosmetic surgery and would only offer adult circumcision in cases of medical emergency, for instance, where an injury has been sustained to the penis. Ironically, most such injuries are incurred during bush circumcision.

In contrast some private clinics have embarked on high-profile adult circumcision campaigns which are billed as ‘giving something back to the community’ (see Hosken, 2004).

District Municipality	Hospital Admissions*	Amputations	Deaths
Nelson Mandela Metropole	6	1	0
O R Tambo	64	0	5
Chris Hani	53	1	0
Amatole	51	2	1
Ukhahlamba	24	0	0

Table: Circumcision-related Hospitalisation, Death and Injury in selected municipal districts in the Eastern Cape (November 2006 to December 2006)

⁵ It may be that more precise records are available at each of these hospitals but doctors, nurses and clerks interviewed were not able to supply them (see annex of interviews conducted).

- * Hospital admissions are typically for a range of conditions but dehydration and sepsis are the most common. Other conditions requiring hospitalisation include injuries as a result of beatings sustained at the hands of circumcision overseers and, in the winter months in particular, conditions such as pneumonia and other exposure-related ailments.

9.3. Hospital circumcision and generation change

Many young Xhosa males find themselves under pressure from their families to be circumcised in hospital but the negative social consequences that would follow if it were to become known that they had not 'gone to the mountain' are so severe that they often go against the wishes of their families to be circumcised in the bush. Recently installed Thembu chief and grandson of former President Nelson Mandela describes how he chose to go against the wishes of both his grandfather and father when the responsibility fell on him to arrange for the circumcision of his younger brother:

Ten years into my manhood, the time had come for my brother to undergo the journey. He had listened to the stories told by his brother and ... he aspired to take the same journey I had travelled. In December 2002 he mentioned his intentions to the elders and he was told to go to hospital. He found it hopeless to take them to task A year later he approached me to take up the challenge with him. We approached our grandfather and father about the matter. Once again, they stood firm on their position. He would have to go to hospital. [They] were motivated not only by the increased rate of death at circumcision schools that was being reported in the local press but also by the risk of HIV/AIDS infection. Even though I assured them that I would attend to the matter myself, they remained firm on the surgery being performed in a hospital. But this is unacceptable in our culture and you would never be recognised as a man if it was found that you had been circumcised in a hospital (Interview, Mandla Mandela).

The suggestion of hospital circumcision for Mandla's brother echoed the family's approach to his own circumcision:

I approached my elders in the summer of 1993 for guidance as I felt my time had come to undergo this journey into manhood. From the get go my grandfather as well as my father were uncertain about the safety of this ritual. Their concern was the increase of deaths in these circumcision schools during recent years. They suggested that I go to a hospital for the surgery and then go to a school for the remainder of the initiation process.

What Mandla Mandela's story reflects is the fact that contrary to what one might intuit, it is not the case that the younger generation favours the modernisation of tradition and the ease and simplicity offered by hospital circumcision. In contrast, contemporary youth often blame their elders for the erosion of culture that occurred during the years of the anti-apartheid struggle and, in a time when the certainties of struggle identities have given way, are turning to tradition for the ingredients of their own contemporary identity construction. Nor is the defence of tradition a phenomenon of illiterate people in rural backwaters. Mandla Mandela grew up in urban Soweto, is a university graduate and successful businessman as well as being a Thembu chief. The inter-generational family conflicts that occur around hospital circumcision are thus a window into a much wider social process that is underway.

Mandla Mandela reflects on his feelings about being urged to go to hospital to become a man:

Many thoughts rushed into my head. I wondered if our move to Johannesburg had conquered our traditions. Have we become prejudiced towards our own identity, or traditions, our culture and values. Within three generations apartheid had conquered and eradicated all the traditional values we had in my family.... I rejected their proposal [to go to hospital] because I was never going to become the weak link in my family. Every man that had come before me had travelled this journey so why did it have to be different in my time? Defiance had come alive again but this time not directed at the state or its agents.

As a result of this decision, Mandela's circumcision was to take place in the absence of his closest male relatives.

I found myself lost and lonely as these were the men whose support I needed to gain.... It was in December 1993 that I parted with my boyish ways in the hills surrounding Tsolo. During the seven weeks I spent there I learnt more than what I had been taught about my own identity in school. My ceremony as a young man was held at the Great Place in Bumbane and my host was the Thembu King Zwelibanzi. It was him and Mqoma that came up with my manhood name in the absence of both my father and my grandfather. The greatest thing about being one of the sons of the Great Place is that the occasion was blessed with the presence of Thembu chiefs.

10. Conclusion

Traditional Xhosa circumcision has presented the South African state with large challenges. These relate to the fact that the practice is held as highly sacred as well as being secretive by nature. It is impossible for a Xhosa male to attain manhood without undergoing the rite in the prescribed manner.

However, while the prescriptions of the tradition are clear, it is equally clear that there is room for manoeuvre around the precise content of these. Where traditional authorities have insisted on preservation of the most intricate and arcane form of the practice, for instance with regard to its gender prescriptions, it is apparent that this stance relates more to broader questions of the balance of power between state and traditional authority, than to the incontrovertible requirements of tradition.

The unacceptable rate of death and injury to initiates has meant led the state to act in a concerted way to enforce its regulatory regime governing traditional circumcision. The Eastern Cape authorities have succeeded in putting in place a regime of registration, training and monitoring which has had the effect of bringing to justice illegal operators. However, the financial incentives on offer for traditional surgeons and nurses, in the context of extreme poverty in the rural areas of the province, mean that regulation has not been entirely successful. Illegal operators continue to exist and under-age circumcision without parental involvement continue to take place.

Where government authorities have succeeded in participating in partnerships with traditional health practitioners as is shown in the case of the Makana district of the Eastern Cape, which is discussed in the study, the greatest success in regulating the practice in the interests of the health of initiates has been achieved. Models for intervention which take seriously the dictates of tradition while at the same time not compromising the health rights of initiates are possible and practicable as the Alice

example of western-trained doctors treating initiates at circumcision lodges rather than removing them to hospitals, shows.

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11. Glossary

<i>abakhwetha</i>	initiate
<i>amakhankatha</i>	lodge guardian
<i>ibhoma</i>	circumcision school
<i>ibulawo</i>	bewitchment
<i>ikhankatha</i>	lodge guardian
<i>indoda</i>	a man
<i>indzevu</i>	uncircumcised adult male
<i>ingcibi</i>	traditional surgeon
<i>ingqesho</i>	migrant labour
<i>inja</i>	dog
<i>isidima</i>	dignity
<i>Isiko loluntu</i>	rite of passage
<i>izilimela</i>	manhood age determined not by age in years but by years circumcised
<i>lobola</i>	bride price
<i>sangoma</i>	traditional healer
<i>siqunga</i>	traditional herb chewed by the traditional surgeon and nurse to ensure that impurities are not breathed into the circumcision wound
<i>ubudoda</i>	manhood
<i>ubukhosi</i>	traditional leadership
<i>ubukhwenkwe</i>	boyhood
<i>ifutha</i>	white clay applied to the bodies of initiates
<i>usosuthu</i>	principal host

Annexure A : Interviews

1. Interviews with hospital representatives

Name	Position and Hospital	Location
Dr Vehbi	Doctor, Dora Nginza	Algoa Park, Nelson Mandela Metropole
Ms Ndomomzi	Patient Administration Officer, Andries Vosloo	Somerset East
Ms Herselman	Staff Officer, Kareedouw	Cradock
Mr Danzil	Bedford	Bedford, Amathole
Ms Gildenhuis	Matron, Burgersdorp	Burgersdorp, Ukhahlamba
Sister Sicigi	Nursing Sister, Cathcart	Cathcart, Amathole
Ms Nondabul	Matron, Cloete Joubert	Barkly East
Dr Olivier	Doctor, Cloete Joubert	Barkly East
Mr Panjwa	Administrative Clerk, Elliot	Elliot, Chris Hani
Ms Nolita	Clerk, Empilisweni	Sterkspruit, Ukhahlamba
Ms Lulama	Nursing Services Manager, Hewu	Whittlesea
Mr Pinca	Administrator, Mount Ayliff	Mount Ayliff
Dr T M Nzimande	Doctor, St Margaret's	Umzimkhulu
Ms Jafta	Manager, St Lucy's	Tsolo

2. Interviews with traditional leaders

- 2.1 Chief Mandlenkosi Dumalisile Speaker, Eastern Cape House of Traditional Leaders
- 2.2. King Zwelibanzi Thembu Kingdom
- 2.3. M. Molosi Spokesperson of the Mpondo
- 2.4 Chief Mandla Mandela Thembu Chief
- 2.5 Mr Cecil Nonqane Eastern Cape Traditional Leadership Project, Albany Museum.

3. Interview with government spokesperson

- 3.1 Sizwe Kupelo Eastern Cape Department of Health

4. Interview with traditional nurse

- 4.1 Mr Jackson Vena Member, Makana Traditional Circumcision Association and traditional nurse

5. Interviews with recent initiates

Interview participants here refer to transcripts of interviews conducted by Stembele Tenge with recently initiated Xhosa men in the East London-Mdantsane District, UNISA 2006.