

Traditional male circumcision: How to prevent deaths and complications

Overview

This policy brief emanates from an intervention study that was conducted to develop a male circumcision health-promotion programme in the Libode rural communities of the Eastern Cape province in the period 2009–2013. The study established that there is a need to include traditional leaders as custodians of the circumcision custom in the planning and development of intervention programmes to reduce both the high mortality rates and the incidence of injury associated with the practice. The deaths of circumcision initiates are preventable provided there is mutual respect, understanding, cooperation and common purpose between the healthcare systems, the initiates themselves, traditional leaders and the local communities. Prevention of deaths and injury also requires evidence-based policy formulation and commitment to implementation from policy-makers. The aim of this policy brief is to advise policy-makers on ways to prevent deaths and injuries related to the complex environment in which traditional circumcision takes place in South Africa.

Introduction

In South Africa, male circumcision is performed as a rite of passage from childhood to manhood among boys and young men by various cultural groups. Male circumcision and the initiation schools which oversee it are an important component of the cultural landscape of the country and are protected by the South African Constitution (Gudani 2011). Initiation schools are key educational institutions for the teaching of societal norms, customs and values.

In the Eastern Cape, for the period June 2006 to December 2013, a total of 453 circumcision initiates died and 214 initiates had penile amputations (EC DoH 2013). Most commonly, deaths are due to complications such as dehydration, sepsis and gangrene. A danger facing young initiates is that wound management may be in the hands of young, inexperienced traditional attendants with no basic health training (Anike et al. 2013). The Eastern Cape, especially the OR Tambo region, has experienced a mushrooming of illegal circumcision schools alongside a high number of initiate deaths every year (Kepe 2010). The challenge confronting the province is that the illegal schools disregard provincial legislation governing male traditional circumcision. Their continued operation has produced a direct conflict between government authorities

and the traditional leaders who consider themselves custodians of the circumcision custom.

Why the current policy needs to be revised

In 2001, the Eastern Cape provincial government passed the Application of Health Standards in Traditional Circumcision Act (Act No. 6 of 2001). The Act was aimed at regulating the traditional circumcision practice by setting health standards to be followed by the traditional attendants. This policy was met with resistance from traditional leaders, who claimed that they were the custodians of the practice. They viewed the legislation as interference with the local custom.

The resistance of the traditional leaders emanates partly from the fact that research findings and associated interventions have not been well presented and clearly communicated to them. Examples of these research findings and interventions include:

- The promotion and recognition of male circumcision as an efficacious intervention for the prevention of heterosexually acquired HIV infection in men, as documented by the World Health Organization and the Joint United Nations Programme on HIV and AIDS (Castro et al. 2010).
- The HIV-prevention strategy embarked on by the Soul City Institute of Health and Development



Communication in 2009 under the banner of the One Love campaign. In 2011, Soul City included medical male circumcision (MMC) as part of the strategy.

- The launch of MMC in South Africa by the national Department of Health as an effort to curb the spread of heterosexual transmission of HIV and AIDS.

The traditional custodians complained that they were not properly consulted on or involved in these interventions and campaigns, and they viewed MMC as yet another threat (Kepe 2010; MMC in South Africa 2015). There is a need for proper consultation and engagement with traditional leaders around research findings and interventions in a way that recognises the role they play.

Study aims and methods

An intervention study was conducted in the Libode district in the Eastern Cape in the period 2009–2013. The objectives of the study were: (i) to explore the views of the Libode rural communities regarding male circumcision and related complications; and (ii) to plan and develop a health-promotion programme that would encourage safe and healthy circumcision practices.

The study used a mixed-method approach. The quantitative component utilised a cross-sectional survey with a sample of 1 036 boys, while the qualitative component involved focus group discussions and key informant interviews. The study population included boys aged 12–18 years attending schools and living in the rural communities of Libode. Participants came from 22 schools randomly selected out of 102 schools. Ten key informants from 10 rural villages were also identified. These informants held special positions in their communities and were willing to share information about male circumcision with the researcher. The

key informants included three chiefs, a church pastor (who is also a retired psychologist), a church elder, one of the Nyandeni AmaMpondo king's liaison officers, three life orientation teachers, and one senior education specialist. A total of seven focus groups were assembled, with 12 participants per group.

Key findings

Key informants and focus group participants expressed their views on how to minimise harm associated with traditional circumcision. For example, the key informants suggested that community groups and committees concerned with preventing injuries and death should be established in the form of traditional circumcision forums (TCFs). Elderly men should be part of these forums, trained and given responsibility to take care of circumcision initiates in the initiation schools. The boys in the focus groups indicated that lessons about circumcision and HIV and AIDS prevention should be given at school. They also recommended that such programmes should be incorporated into the life orientation subjects that are already part of the Department of Basic Education school syllabus.

Moreover, study participants were of the view that male medical doctors and other male health professionals should train traditional surgeons (*iingibi*) and nurses (*amakhankatha*) in how to incise the foreskin and manage the wound afterwards.

The information and feedback supplied by the Libode study led to the development of a circumcision health-promotion intervention programme under primary healthcare practitioners within the framework of the TCF model. Implementation of the programme in Libode led to a reduction in the number of initiate deaths and amputations in that district to zero per cent in the December

2010 season. Prior to programme implementation, in the June 2010 season, nine deaths and eight amputations were recorded in Libode (EC DoH 2013). This health-promotion programme is available for implementation elsewhere (Douglas 2013).

Characteristics of effective preventive health-promotion programmes

The success of the Libode health-promotion programme is due largely to the comprehensive involvement of all relevant stakeholders, including the traditional leaders and traditional practitioners. In this context, *health promotion* means 'the process of enabling people to have control over and improve their health'. The central tenet of this approach is the concept of empowerment. Empowerment, knowledge and application of health-promotion principles, approaches, methods, strategies and activities were by design incorporated in the intervention research (Egger et al. 2005). The intervention study also made use of knowledge generated from within the communities to identify key stakeholders. The TCF model, which bridged the gap between government initiatives and traditional circumcision practices and was used as a theoretical framework of the study, was adapted from Beattie's health-promotion model (Naidoo & Wills 2009). Four paradigms were generated from the model using a combination of top-down and bottom-up approaches:

1. *Health persuasion.* Health professionals – nurses, doctors, psychologists and others – give health advice and education to individuals while being mindful of social, cultural and environmental realities.
2. *Legislative action.* The House of Traditional Leaders is affirmed as the custodian of the circumcision custom. This body works collectively with other sectors in policy-making and regulation. The House

of Traditional Leaders works collaboratively with government departments such as health, education, traditional affairs, police, justice, agriculture and forestry, sanitation and water affairs, and with local municipalities.

3. *Personal counselling.* Personal counselling is about empowering young males by training youth workers to become peer educators/ helpers in a user-friendly fashion. The strategies used in this paradigm include counselling, one-on-one education and group work.
4. *Community development.* Community development embarks on empowering and building capacity among groups such as parents, residents associations, sport clubs, churches, organisations, local political parties, traditional surgeons and nurses. Activities used in this paradigm include group work, action research and lobbying (Naidoo & Wills 2009).

Recommendations

The TCF is an evidence-based, socially relevant, preventive tool to address the persistent high death and injury rates of male circumcision initiates. Policy intervention recommendations based on this model include:

1. Policy-makers should adopt and implement public policies that are effective at a community level based on relevant intervention research evidence as reflected in this policy brief.
2. Health-promotion programmes should strengthen community involvement by acknowledging and supporting socially accepted, trained and experienced traditional practitioners who take responsibility and custody of youths in the initiation school.
3. Health-promoting school programmes need to link circumcision health to HIV and AIDS programmes already existing in the

life orientation subjects offered by the Department of Basic Education.

4. The revitalisation of primary care in the healthcare system should consider health promotion as central. Adequate funding should be allocated for approved circumcision health-promotion programmes. Traditional leaders, the main custodians of the culture, should be educated about and sensitised to epidemiological trends resulting from some traditional male circumcision practices.
5. Stakeholders in the legal sectors need to be more actively involved in protecting children, and the police should enhance patrols to guard against violation of the law by anyone responsible for assaults, restraints and any form of abuse targeted at circumcision initiates.

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