

# ‘JUST A SNIP?’

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Lemba circumcisers’ perspectives on medical male  
circumcision for HIV prevention in Mberengwa district of  
rural Zimbabwe

**KEMIST SHUMBA**

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prevention in Mberengwa district of rural Zimbabwe

By

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Masters in Social Science (Health Promotion) in the Discipline of Psychology  
University of KwaZulu-Natal

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## **DECLARATION**

I declare in good faith that this dissertation is my own original work. All citations, references and borrowed ideas have been duly acknowledged. No part of this work has been submitted anywhere else in application for any qualification.

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## **DEDICATION**

To my newly born son Tinashe whom, due to this academic commitment I have not yet cuddled.

## ABSTRACT

Medical Male Circumcision (MMC) is an HIV ‘prevention technology’ hailed for holding the promise to containing the epidemic. MMC augments the vision of the Joint United Nations Programme on HIV/AIDS (UNAIDS) that pins hope on the possibility of zero new infections through the adoption of a comprehensive prevention approach. This study’s impetus stems from the view that the success of MMC is anchored not only on the premise that its wide-scale implementation subsequently lowers HIV incidence in heterosexual men practicing vaginal penetrative sex, but is also dependent on the readiness of the target population to undergo circumcision. From a culture-centred approach which holds that health promotion programmes should be planned, implemented and evaluated within the context of the relevant socio-cultural beliefs and value systems prevalent in a particular community, the study is a qualitative exploration of perceptions on MMC for HIV prevention among the Lemba people of Mberengwa. The Lemba are a traditionally circumcising cultural group. In light of the culture-centred approach, how they perceive MMC is worth investigation if success has to be achieved in its implementation among this cultural group. The objective of the study is to identify factors influencing collaboration of Lemba traditional circumcisers and medical institutions rolling out voluntary MMC. Purposively selected Lemba surgeons and elders participated in this study. Findings suggest that the Lemba practise male circumcision not as a mere surgical operation but as a symbolic cultural ritual that is value laden. However, they are ready to embrace MMC provided that it is done in a way that does not compromise the cultural values they attach to male circumcision. A deeper insight into Lemba perspectives generated in this study has been used to suggest ways in which the Ministry of Health and Child Care in Zimbabwe can scale-up roll out of voluntary MMC in Mberengwa through creating synergies between cultural and medical perspectives. For example, the majority of participants suggested that making use of Lemba initiates with medical training to conduct circumcisions in *Murundu* camps can help increase uptake of VMMC.

**Keywords:** Medical Male Circumcision for HIV prevention; Lemba of Mberengwa; AIDS epidemic; culture-centred approach; roll-out of voluntary MMC in Mberengwa

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My Lemba participants, I owe you enormously, particularly my gatekeeper, that passionate uncle whose name I am not worth to mention.

## **LIST OF ACRONYMS AND ABBREVIATIONS**

**AIDS** - Acquired Immune-Deficiency Syndrome

**CCA** - Culture-Centred Approach

**HIV**- Human Immune-virus

**INTACT** - International Organisation Against Circumcision Trauma

**LCA** - Lemba Cultural Association

**MMC**- Medical Male Circumcision

**MoHCC** - Ministry of Health and Child Care

**NAC** - National AIDS Council

**NOCIRC** - National Organisation Information Resource Centers

**NOHARMM** - National Organisation to Halt the Abuse and Routine Mutilation of Males

**RCT**- Randomised Controlled Trial

**STD**- Sexually Transmitted Disease

**STI**- Sexual Transmitted Infection

**TMC**- Traditional Male Circumcision

**UNAIDS** - Joint United Nations Programme On HIV and AIDS

**UNESCO** - United Nations Educational, Scientific and Cultural Organisation

**VMMC**- Voluntary Medical Male Circumcision

**WHO** - World Health Organisation

**ZNASP** - Zimbabwe National AIDS and HIV Strategic Plan

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## **CHAPTER ONE**

### **INTRODUCTION**

The Joint United Nations Programme on HIV/AIDS (UNAIDS) describes AIDS as the most serious contemporary health challenge (UNAIDS, 2013). This description is consistent with the United Nations Educational, Scientific and Cultural Organisation (UNESCO) and UNAIDS' characterisation of HIV/AIDS as a significant global public health challenge (UNESCO, 2001; UNAIDS, 2007). The impact of the AIDS epidemic is felt at the global level across all the sectors such as, agriculture, education, health, industry and education among others (UNESCO, 2001; UNAIDS, 2007). Therefore the AIDS epidemic is not only a health problem but a development challenge as well (UNAIDS, 2010).

HIV prevention remains the primary method of controlling the epidemic (van Dam & Anastasi, 2000). Therefore preventing new infections remains critical, and top on the global HIV/AIDS agenda (UNAIDS, 2010). WHO and UNAIDS recommend medical male circumcision (MMC) as a comprehensive approach to reducing the risk of HIV transmission mainly in heterosexual men; and posit that it is effective in areas with high HIV prevalence, coupled with low levels of circumcision (WHO & UNAIDS, 2009). They both recommended that countries characterised by a high prevalence of HIV and low levels of circumcision in particular consider the roll-out of medical male circumcision (MMC) as an additional strategy to prevent further infections (WHO & UNAIDS, 2007). In response, Zimbabwe, as well as other African countries mainly in sub-Saharan Africa, has begun to promote MMC for HIV prevention (NAC, 2011).

The WHO recommends rolling out MMC in regions with high HIV prevalence and low circumcision rates (WHO/UNAIDS, 2007). However, there is no scientific research ascertaining the preventative efficacy of traditional circumcision against HIV transmission to warrant complacency by public health practitioners regarding traditionally circumcising communities (Gwandure, 2011). Dowsett and Couch (2007) argue that WHO/UNAIDS' recommendations are weak and flawed in that globalisation has resulted in increased mobility, which ultimately disrupts the geography of traditional circumcisions. Their argument is that traditionally circumcised males may experience increased susceptibility to

HIV infection due to perceived protection resulting from their circumcision status. Furthermore, literature has it that there is a marked difference between MMC for HIV prevention and traditional male circumcision (WHO, 2007, 2009; Gwandure, 2011). While MMC is the complete removal of the skin covering the glans penis, this degree of completeness is not guaranteed in traditional circumcision (WHO, 2009; Gwandure, 2011). Some traditional circumcisers remove only a part of the foreskin (Doyle, 2005; Dowsett & Couch, 2007). However, literature that clearly indicates that partial circumcision is not as effective as complete removal of the foreskin is sorely lacking. Be that as it may, Gwandure (2011) argues that areas where traditional circumcision is common do not show any differences in terms of HIV prevalence, which suggests that partial circumcision, might not be effective in HIV prevention.

Concerns about the efficacy of traditional male circumcision highlight the need to encourage uptake of MMC for HIV prevention even among traditionally circumcising communities such as the Xhosa of South Africa, the Lemba, and Yao of Zimbabwe. The Lemba of Mberengwa southern Zimbabwe, among other minority tribes such as the Yao and Shangaan have practised male circumcision for its religious and cultural significance (a rite of passage) for a very long time (Shoko, 2009; Daimon, 2013; Nleya & Langa, 2014). The introduction of MMC for HIV prevention among communities such as these has since raised concern where some argue that traditional circumcisers might view MMC as a threat to their cultural autonomy and power base. Such views could negatively impact on MMC uptake (Gwandure, 2011). Furthermore, literature suggests that the majority of traditional circumcisers may be reluctant to adopt a “fully medicalised version of circumcision” (Dowsett & Couch, 2007, p. 40).

Some empirical studies conducted among communities that carry out traditional circumcision suggest that MMC can be acceptable. For example a study by Mshana, Wambura, Mwangi, Mosha, Mosha, and Changalucha, (2011) among a traditionally circumcising community in Northern Tanzania reveals that the majority of participants would accept MMC for their sons. However, in Zimbabwe, there is a paucity of empirical studies that focus on Lemba traditional circumcisers’ perspectives on medical male circumcision for HIV prevention.

In October 2011, the Zimbabwean government implemented the country's national HIV and AIDS strategic plan (ZNASP II) (2011-2015) where the implementation of voluntary medical male circumcision is identified as a critical strategy for HIV prevention (NAC, 2011). MMC services are offered at virtually no cost. ZNASP guidelines recommend the development of collaborative efforts to sensitise traditional circumcisers on the need to sanitise male circumcision. However, there are few published studies that were conducted among traditional circumcisers to solicit their perspectives about MMC for HIV prevention except one by Daimon (2013) conducted among the Yao of northern Zimbabwe. The findings from Daimon's study revealed that the Yao have embraced MMC. Their initiates are circumcised under clinical conditions before they are taken to the bush for the rest of the initiation school. However, no study has focused on the Lemba of Mberengwa district, yet they constitute the majority of traditional circumcisers in Zimbabwe.

The purpose of this study is to explore Lemba views and opinions about medical male circumcision for the prevention of HIV among the Lemba traditional circumcisers of Mberengwa. Doing so is important in identifying ways in which roll-out and uptake of MMC can be increased in Mberengwa. The findings of this study could be useful for policy-makers as well as programme planners in designing, and developing policies aimed at scaling-up MMC among traditionally circumcising communities. This study also hopes to contribute to the body of literature on culture-centred approaches to health care provision.

### **Purpose of the study and key questions**

The main objective of this study is to explore the views and opinions about medical male circumcision for the prevention of HIV among the Lemba traditional circumcisers of Mberengwa in order to identify ways in which roll-out and uptake of MMC can be scaled-up in Mberengwa. The findings of this study can assist policy makers in informing MMC policy and interventions. The key questions that this research attempts to answer are as follows:

- a) What are the views and opinions of Lemba traditional circumcisers regarding MMC for HIV prevention?
- b) What are the socio-cultural factors impeding or facilitating collaboration between traditional circumcisers and medical circumcisers?

## **Structure of the dissertation**

This dissertation consists of six different, but coherent chapters that address the above aspect as follows:

### **Chapter One: Introduction**

The introduction introduces to the study. It briefly provides the relevant background information to the study, outlines the research problem, states the purpose and objectives of the research, and summarises the significance of the study. This introductory chapter is essentially a road map as it directs, and informs the reader about what to expect in this write up.

### **Chapter Two: Review of Literature and conceptual framework**

This chapter reviews literature relevant to the study. The literature is presented under a number of sub-headings which include a description of Lemba identity; circumcision culture; traditional circumcision in the African context; cultural practices condemned for spreading HIV/AIDS; MMC prior to Montreux 2007; and finally a brief outline of MMC roll-out to recent day. The culture-centred approach (CCA) which is a value-centred approach is introduced as the conceptual framework for this study. An alternative lens for understanding health communication, the CCA seeks to locate the study at the intersection of culture, structure, and agency.

### **Chapter Three: Research methodology**

The chapter provides the methodological outline. It begins with the study design, followed by the research paradigm, study setting and context and a short description of the role of the researcher in the study. Other relevant sections include selection of participants, data collection instruments and procedure, and data analysis. The chapter ends with a presentation of ethical considerations.

### **Chapter Four: Lemba perspectives of male circumcision in the context of HIV**

In this chapter, the reader is taken through the findings from in-depth interviews. These are responses from the Lemba traditional circumcisers, and are adequately nuanced in order to give the reader a clear picture of the context within which data was collected. The chapter is not a mere catalogue of utterances from participants but rather the various quotations are



appropriately supported by brief narratives which form a logical conversation between the researcher and the participants.

### **Chapter Five: Maximising VMMC uptake among traditionally circumcising Lemba people**

The objective of this chapter is to discuss ways through which VMMC uptake among the Lemba can be scaled-up through possibilities provided for by the Lemba culture. The insight provided by the CCA as discussed in Chapter Two is utilised as a conceptual framework for the exploration of these possibilities. A brief section on self-reflexivity is also provided.

### **Chapter six: Conclusions and recommendations**

The chapter concludes this study which examined the perspectives of Lemba circumcisers on medical male circumcision for HIV prevention in Mberengwa district, rural Zimbabwe. The study interrogated the socio-cultural factors that either facilitate or impede collaboration between Lemba circumcisers and the Ministry of Health and Child Care (MoHCC), and its MMC implementation partners.

It is pertinent to end this introduction by also foregrounding that as with any other studies, there are important terms and concepts used in this dissertation which also need clarification in order to put the reader into a proper perspective.

#### **Important terminology**

The following critical terms are used in this study. In the context of the study, the terms are defined as follows:

**Culture-centred approach (CCA):** This refers to a bottom up approach to health promotion developed by Collins Airhihenbuwa (1995). The approach is used in this study as further articulated by Mohan Dutta (2008) positing that health promotion programmes should be planned, implemented, and evaluated within the context of the relevant culture. In other words, health programmes must take cognisance of the socio-cultural beliefs and value systems prevalent in a particular community.

**Medical male circumcision (MMC):** While the Lemba practise circumcision for both hygienic and cultural purposes, MMC is used in this study to refer to a circumcision procedure for HIV prevention conducted by medical surgeons in clinical settings.

***Murundu***: Lemba people are a traditionally circumcising community. Their circumcision procedures are done as part of rite of passage in a Lemba initiation school known as *Murundu*.

***Nyamukanga***: This is a title given to a Lemba surgeon who performs traditional circumcision procedures on the Lemba initiates in a *Murundu* camp.

**Traditional male circumcision (TMC)**: The process of circumcising in a non-clinical setting as part of a people's tradition. The Lemba people perform TMC in *Murundu* camps.

**Voluntary medical male circumcision (VMMC)**: Although MMC for HIV prevention is a highly recommended HIV prevention method, the procedure is done voluntarily. VMMC is used in this study referring to the voluntary uptake of MMC among the Lemba people.

## CHAPTER TWO

### REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

The objective of this study is to explore the views the Lemba people of Mberengwa - who practise male circumcision as part of their culture - have about medical male circumcision for the prevention of HIV. The ultimate aim is to find ways in which the roll-out and uptake of VMMC can be increased among Lemba communities. Much has been written both about the Lemba communities and their culture, as well as medical male circumcision. This chapter reviews literature related to these aspects. It addresses key questions on who the Lemba people are as well as why and how they practise male circumcision. The review also focuses on the concept of medical male circumcision, examining available evidence on its protective efficacy in HIV prevention. Lastly, the chapter outlines the culture-centred approach (CCA); a conceptual framework within which this study is formulated.

#### **The Lemba: Black Jews of Africa**

In Zimbabwe, the Lemba are a tribe who use the elephant, *Zhou/Nzou* or *Ndou* (*Shona* and *Venda* respectively) as their totemic symbol (Le Roux, 1999; Shoko, 2009). There are different names that are used to refer to the Lemba, each of which, according to Le Roux (1999) tells a story of its own. These names are VaRemba, VaMwenye, VaShavi, Balemba, Basoni, Basena (Shona), and Vhalungu (Venda). While the question of who the Lemba are would be of interest to anthropologists and historians, giving a religiously accurate reconstruction of Lemba history is beyond the scope of this study. As evidenced by different names above, it is probable that if the question is subjected to scrutiny, various theories of Lemba origins may emerge.

Despite the different names used to refer to this black tribe of southern Africa (Davies, 2004), the word *Lemba* features the most in this study, which is solely my preference. Tudor Parfitt posits that the name *Lemba* means either ‘those who refuse’ (banned food for example) or ‘a non-African, a respected foreigner’ (cited by Doyle, 2005, p. 357). The Lemba are generally selective and observe a strict dietary requirement which largely compares with that of their Ethiopian and Yemenite Jewish counterparts (Doyle, 2005), hence the phrase ‘Judaising Africans’ (Davies, 2004, p. 44). Takavafira Zhou,<sup>1</sup> a contemporary historian of Lemba

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<sup>1</sup> Takavafira Zhou acceded to his real name being used in this dissertation.

origins argues that the word *Lemba* means a doctor, linking the word to *Shona* derivatives such as *chiremba* referring to a medical doctor. The Lemba tribe's incomparable knowledge of traditional medicine, among other specialities earned them the name *VaRemba* signifying their exceptional expertise in herbal medicine (Zhou, Interview; July 31, 2014).

Among the Lemba, some claim that they have Jewish roots (Davis, 2004; also see, Le Roux, 1999; Parfitt, 1997). It is argued that they came from a distant city called Sana, which could probably be present-day Sana in Yemen (Doyle, 2005). They have many similarities with Jews, particularly Ethiopian Jews (Davies, 2004; Doyle, 2005). Doyle (2005) argues that the majority of researchers subscribe to the Falasha of Ethiopia's claims of Semitic origins. It is claimed that the Falasha are recognised by the current Israelites as 'Black Jews'. Le Roux (1999) argues that original Jews acknowledge the existence of black Jews in *diaspora*, a claim that arguably include the Lemba.

Lemba claims of a Jewish ancestry are to a large extent supported by genetic research conducted by researchers such as Jenkins, 1996, and Parfitt and Bradman, 1997 which confirmed the likely Semitic origins (Davies, 2004; Doyle, 2005). Almost half the chromosomes of Lemba men compared with the deoxyribonucleic acid (DNA) from pure Jews matched; thus further confirming previous claims of a Jewish ancestry (Le Roux, 1999; Doyle, 2005). Despite this seemingly convincing evidence, others contest this Jewish association and argue that the Lemba are Muslim, and this theory is consistent with various Lemba names which are of Arabic origin. The names include those of the twelve clans of the Lemba which are; Bakare, Duma, Hadji, Hamisi, Hassani, Madi (Ngavi), Mani, Mange (Nemanga), Sadiki, Sarifu, Seremani, and Tovakare (Seremani Seremani, Interview; July 08, 2014).

Hadji means a holy journey or pilgrimage to Mecca while Duma is believed to be one of Ishmael's sons. The name Sarifu is a derivative of Al Quran Sharif while Hamisi means Thursday. Furthermore, the Lemba's interest in mineral resources (Takavafira Zhou, interview, 2014) is linked to the discovery of local mining town Zvishavane (Shabane) which is allegedly Arabic (Seremani Seremani, Interview; July 08, 2014).

However, both the Yemenite and Muslim origins of the Lemba are disputed by Takavafira Zhou whose views of Lemba origins are purely Afro-centric.

The Yemenite origin theory lacks credible historical evidence other than the mere city in Yemen called Sana and the 1996 genetic study which reflected Lemba to have higher chromosomes than the Yemenite Jews. Arguably, similarity in names does not in any case imply relationship. At any rate there is no dispute that the Lemba place of origin is Sena, but it is the location of Sena that is disputable. An ancient historical map of Africa shows Sena one and Sena two in Africa covering some current parts of Ethiopia, Sudan, Kenya and Tanzania (Takavafira Zhou, Interview; July 31, 2014).

Zhou further argues that these states whose capitals were at Sena one and Sena two were inhabited by the Lemba who traded with Yemen. Sadly no archaeological evidence has been discovered as yet at the two Senas in Africa and Lemba city in Yemen to determine which one pre-date the other. Be that as it may, Lemba oral tradition, Portuguese and Arabic records prior to 1996 located Sena within Africa. It was only after the genetic studies of the mid-1990s that theories of Lemba (Zimbabwe) and Igbos (Nigeria) linking with Yemenite Jews emerged. Yet even the genetic studies do not prove Yemen as the origin but Africa.

Zhou claims that the Lemba are doctors, itinerant traders, makers of copper wire (*varungu nanguvo*), miners and skilled mason makers. According to him the Lemba are neither Jews nor Muslim but have close relations with Jews. There are only two ways by which a person is Lemba, that is, one is born of a Lemba father or married to a Lemba man, yet Muslims and Jews are even by conversion, he argues. Jews circumcise their children on the 8th day after birth (Luke1:59; Doyle, 2005) yet Lemba circumcision is a school of life at the age of puberty in order to transform the youth into responsible adults. The fact that Lemba names are similar to Arabic names does not imply they are Arabs or Muslims.

The Lemba are a secretive group who also assisted the Jewish and Muslim theories in the hope of remaining a mysterious group. The Lemba tell what they term “necessary lies” to a number of people researching about them (Takavafira Zhou, interview, 2014). Although the Lemba are found in northern South Africa (Limpopo and Mpumalanga), and southern Zimbabwe (Le Roux, 1999), this study is focused on the Lemba of Mberengwa. The Lemba are also found in Gutu, Masvingo in Zimbabwe. However, the many of them are concentrated in Mberengwa district, and they constitute the majority of traditional circumcisers in Zimbabwe (NAC, 2011; Daimon, 2013). The above background is insightful in locating the study in its proper context of traditional initiation and circumcision.

### **Lemba cultural practices**

The word ‘culture’ which is constantly used in this study is understood in Tylor’s (1871) definition of culture as “[t]hat complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society” (Tjallinks, 2004, p. 31). This study is particularly interested in the identity, sexuality, and status related cultural practices among the Lemba tribe of the Shona-Karanga speaking inhabitants of Mberengwa in southern Zimbabwe. Particular attention is given to the *Murundu*; a value-laden cultural initiation school where Lemba adolescent boys’ entry into adulthood is initiated. *Murundu* runs parallel to *Komba*, a female initiation rite for Lemba girls; usually during the winter period (Shoko, 2009). Winter is regarded as proper timing for initiation because wounds generally heal faster in low temperatures than during hot seasons; and this period is also conducive due to absence of rains that might disrupt the initiation school (Shoko, 2009; Daimon, 2013).

A focus on *Murundu* is particular as this study is interested in male circumcision. Although, *Komba* initiation includes genital mutilation (Shoko, 2009) the issue has not of late raised public health concerns compared to its male counterpart. The term *Komba* means to ripen, and therefore it is understood as a marker of a girl’s sexual maturation and transition to womanhood (Shoko, 2009). In this study, effort is made to explore meaning and significance of male circumcision.

### **Male circumcision**

The history of circumcision is a field of academic contestation. Several academics have made attempts at providing a historical account of this practice. Perhaps the only aspect they appear to unanimously agree on is that circumcision is the world’s oldest surgical procedure (Gollaher, 2000; Doyle, 2005). According to Gollaher, circumcision is performed as a biomedical, religious, and social practice. Although it might be an interesting idea to engage in this genesis debate, such an exercise is beyond the scope of this study.

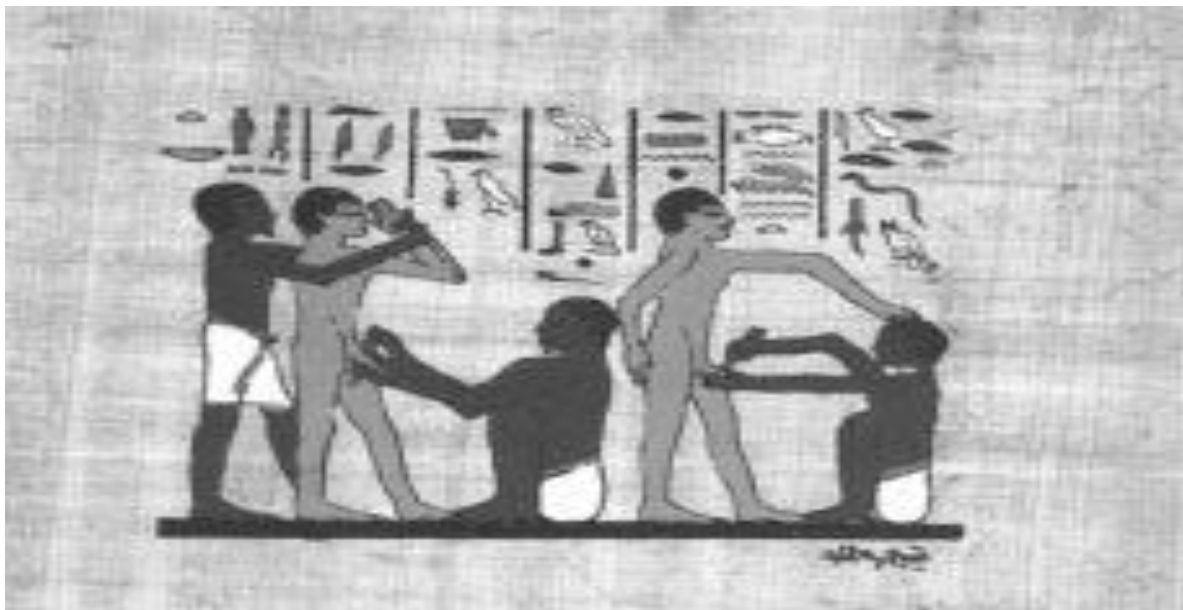
Circumcision was practised from time immemorial among different tribes across the globe for a diversity of reasons (Gollaher, 2000; Doyle, 2005). The practice is found in various literatures including the Holy Bible. For example, it is mentioned in Genesis 17:1-14; Exodus 4:24-26; Leviticus 2:3, and Luke: 1:55; 2:21 among others. Within a religious framework, both Jews, and Muslims practise male circumcision. Although they both relate to Abraham,

the first person documented as circumcised - as the bedrock of their faith - the practice predates the Abrahamic era (Doyle, 2005). According to Doyle, circumcision was in practice long before Abraham was circumcised. However, the fact that he is the first person to be described in literature as circumcised, does not suggest him to be the origin of this practice.

In an attempt to present the history of a practice he describes as the globe's most contentious surgery, David Gollaher (2000) identifies two main strands as leads to the possible origins of circumcision. On the one hand are the tribal communities which include some groups among the Aborigines of Australia, and there is less literature to explore this strand. Similarly, Doyle (2005) posits that there are less reliable details regarding circumcision culture among the Aborigines and Polynesians who practised circumcision as a rite of passage. Circumcision among these societies was interpreted in various ways. For example, Doyle speculates that it was perhaps done as a test of bravery and preparedness to assume adult roles (Doyle, 2005). According to Doyle, another line of argument has it that the dripping of blood was symbolic (signifying sympathising with women's menstruation).

On the other hand is the ancient Egyptian link, which Gollaher (2000) characterises as a tributary that feeds into mainstream Western culture. Evidence supporting the Egyptian theory of origins of circumcision has been found in archaeological artefacts such as the one shown on Figure 2.1 below.

*Figure 2.1: An ancient Egyptian tomb curving depicting circumcision (Gollaher, 2000, p. 2)*



This bas-relief from the Egyptian necropolis at Saqqara Egypt (ca. 2400 B.C.) is arguably the most ancient depiction of a surgical operation.

According to Gollaher (2000), there is no specific reason why the Egyptians practised circumcision. While some believe that they performed circumcision as a result of their unrivalled understanding of the human body, suggesting that circumcision served a therapeutic function; others argue that “Egyptian thought drew no distinction between religion and medicine” (Gollaher, 2000, p. 3). Therefore it is implied that apart from being a rite of passage, circumcision had a strong religious bias. As indicated above, it is not clear when the practice of circumcision started and by whom.

It is perhaps because of this purported Jewish historical origin of circumcision that, as already shown, the Lemba people not only in Zimbabwe but across Africa have come to be known as the Black Jews of Africa. The section below provides a brief overview of circumcision in Africa.

### **Traditional male circumcision (TMC) in the African context**

According to WHO/UNAIDS (2007), the word ‘circumcision’ comes from Latin ‘*circumcidere*’ meaning to cut around. Medically, the term is defined as a surgical process of removing the skin covering the penis glans (Dean, 2000). Traditional male circumcision (TMC) often carried out by a traditional surgeon involves surgical removal of some part of the prepuce or foreskin of the penis. However, the amount removed varies from one ethnic group to the other (Dowsett & Couch, 2007; WHO, 2009). TMC is different from MMC in that the latter is done by a medically trained person under clinical conditions, and most importantly it totally removes the foreskin for health reasons (WHO, 2007). TMC, however, is done as a component of the initiation practice which is a value-laden ritual serving as a rite of passage where the initiate is prepared “mentally, physically, emotionally and morally” for later life (Ntombana, 2011, p. 636).

Across the vast African cultural landscape, male circumcision is practised by certain tribes in almost all countries. For example, TMC is a known practice in such countries as Nigeria, Malawi, Kenya, South Africa and Zimbabwe among others (Gwandure, 2011). In Malawi, male circumcision is practised by the Yao tribe among others, while in South Africa it is the Xhosa, Sotho, Pedi, Venda and Tsonga (Mavundla, Netswera, Bottoman & Toth, 2009, p.



396). In Zimbabwe the Yao, Lemba, Shangaan, and Tonga among other groups constitute a significant percentage of the community of traditional male circumcisers (NAC, 2011; Daimon, 2013).

TMC is thus understood as a social practice at the heart of different African people's traditional belief system and way of living (Ntombana, 2011). For example, among the Xhosas of South Africa, TMC is largely regarded as the most guarded and sacred traditional rite (Gwata, 2009). It is not a hollow exercise of simply removing the foreskin, but instead it has other dimensions too. These include the religious, social, philosophical, and biomedical significance (Niang & Boiro, 2007, p. 23). For the Balante of Guinea-Bissau, male circumcision is linked to *nala*, the supreme God. According to Le Roux (1999, p. 129), the Lemba regard the circumcision ceremony as "the occasion when new comers become part of the covenant of God (Mwari)".

It is beyond the scope of this study to explore circumcision as practised in all the above mentioned cultures, since the focus, as discussed in detail below, is on circumcision as practised by the Lemba people of Mberengwa in rural Zimbabwe. However, it is pertinent to note that traditional circumcision has in the recent past been criticised for causing deaths among initiates. This issue is discussed in a later section.

#### *Lemba traditional male circumcision*

Circumcision as a rite is a long standing practice among the Lemba (Le Roux, 1999; Shoko, 2009). According to Shoko (2009), the Lemba initiation rite is done in a systematic way where initiates are taught some survival skills prior to the actual process of cutting the foreskin. Skills taught include construction of makeshift huts and hunting for game using the most basic traditional weapons. The skills are aimed at enhancing the necessary abilities required in adult life. The initiation process offers initiates what I can describe as a rich traditional curriculum which caters for the individual as a whole as he is moulded into a desired member of the community (also see Ntombana, 2011).

Le Roux (1999, p. 129) identifies circumcision (*ngoma*) as one of the Semitic rites that the Lemba observe and hold in high esteem. Although Le Roux uses the word '*ngoma*', a vernacular *Shona* word for a drum, the meaning of the word within the Lemba initiation context is different. The phrase (*kutema ngoma*) refers to the official opening of the initiation

school while its ordinary meaning is ‘to cut a drum’, which is an awkward phrase. This suggests that the Lemba use a special language unknown to those outside their tradition. The actual process of circumcision is called *kuchecheudza*. The procedure is conducted by a traditional surgeon called *Nyamukanga* (Matanda Makuru, interview; July 25, 2014).

Writing about the Lemba, Le Roux (1997; 1999) notes that they highly regard their role as the custodians of God’s instructions regarding circumcision as articulated in Genesis 17 where all the descendants of Abraham are supposed to be circumcised. He further notes that the Lemba take it upon themselves to safeguard and perpetuate this circumcision practice. Apart from circumcision rite, another important symbol of Lemba allegiance to the demands of the Old Testament is the *ngoma lungundu* which resonates with the biblical ‘Ark of the Covenant’. The Lemba people claim a steadfast regard for the law as enshrined in the books of the Old Testament, and their alleged custody of the *ngoma lungundu* requires them to observe all traditions linked to their identity as a chosen people (Le Roux, 1999).

The above position of commitment taken by the Lemba is indicative to a system or set of values that characterise and inform their perception of the world. From a culture-centred approach (Dutta, 2008; Airhihenbuwa, 1995) one’s world-view directly influences their health behavioural choices. Explaining the concept of world-view, de Villiers and Herselman (2004) concur with Hammond-Tooke (1974) who suggests that there is a link between the physical and the spiritual realm. They argue that there is a relationship between “people’s behaviour and the principles of their world view” (de Villiers & Herselman, 2004, p. 13).

According to Van Dyk (2001), health promoters ought to understand the significance of practices which shape the identity of members of African tribal communities. The implication is that if practices such as traditional circumcision and tribal markings pose a threat to people’s health, an attempt to stop the ritual would be detrimental. Instead, best practice would be suggesting alternative ways to make it safer (Van Dyk, 2001). Van Dyk’s view is consistent with that of de Villiers and Herselman (2004, p. 25) who argue that “an important principle to apply in health-care settings is that of empowerment of the community to participate in their healthcare, which means that they must be able to participate in decision-making on issues affecting their health.”

What the above suggest is that no single approach constitutes a panacea to the problem of HIV as a public health challenge. Neither the top-down medical approach nor the bottom-up approach of the traditional model of health will independently suffice in fighting HIV infection. This analysis implies a CCA which will be discussed in detail under the conceptual framework section.

Circumcision as a rite is a long standing practice among the Lemba (Le Roux, 1999; Shoko, 2009). In light of the foregoing, any attempt to stop the practice may prove problematic. For example, President Yoweri Museveni of Uganda's bid to put a stop to adolescent circumcision of boys so as to decrease the spread of HIV and AIDS was met with scathing criticism from the country's traditionalists (Anonymous, 2003). President Museveni went on record alluding to the fact that the cultural practice of circumcision is a threat to the youths as it makes them susceptible to HIV infection. Uganda's traditionalists viewed the decision to put a ban on TMC as an invasion into people's cultural territories. They publicly declared their commitment to resist such a move in order to safeguard their identity (Anonymous, 2003).

In light of the above, below is a brief discussion of traditional circumcision as a cultural practice often thought to be responsible for helping the spread of HIV and AIDS.

*Traditional circumcision: A cultural practice driving HIV/AIDS*

According to Gausset (2001, p. 509) the African battle against the AIDS epidemic is often framed around fighting "cultural barriers". These are allegedly viewed as enhancing the chances of HIV transmission. Such discourses on "dangerous" African cultural practices have a long standing history. According to Gausset, these discourses come from a past laden with Western prejudices against African sexuality particularly regarding such practices as polygamy, wife inheritance, sexual cleansing and group circumcisions among others (also see Hardy, 1987; Singhal, 2013).

Both cultural practices involving contact with blood as well as those involving the use of shared cutting instruments were condemned in the wake of AIDS for facilitating transmission of the virus. Research conducted in Kenya, Lesotho and Tanzania confirmed the potential of HIV transmission through unsterile circumcisions (Brewer, Potterat, Roberts & Brody, 2007). As such, TMC has come to be known as representative of these 'problem' cultural practices.

According to Gwandure (2011), health educators were until recently, disseminating health messages discouraging communities practising male circumcision from continuing with the practice since it contributed to an increase in HIV transmission. The use of the same cutting instrument for a number of initiates is often criticised for exposing initiates to infection (UNAIDS, 2009). To a large extent, male circumcision carried out in traditional settings is more often than not, associated with a variety of complications (Brewer et al., 2007). It is often shunned particularly by the western paradigm for being unsterile (WHO, 2009; Gwandure, 2011).

According to Brewer and others, possible channels of HIV transmission include “circumcision-related blood exposures in eastern and southern Africa” (Brewer et al., 2007, p. 217). They argue that in traditional settings where a single cutting instrument may be used on a number of initiates, little or no effort may be made to sterilise the cutting instrument resulting in increased chances of passing on the infection among those circumcised in a row. However, Msazizi Karim argues that apart from treating patients with herbs, traditional surgeons also ascertain the sterility of their cutting instruments through the use of herbs (Anonymous, 2003). According to Karim, traditional surgeons have gained knowledge of possible ways of HIV transmission which include use of unsterilised instruments. They strive to avoid such transmissions by sterilising cutting instruments using traditional herbs. Therefore, the argument that traditional surgeons do not have infection control mechanisms may be contested. However, the efficacy of these may be difficult to confirm particularly against HIV transmission.

That traditional circumcision has been blamed for exposing initiates to the HIV risk makes it imperative to closely examine the surgical procedure of the Lemba traditional circumcision process. This is quite important for this study whose objective is to find ways of increasing uptake of VMMC for HIV prevention among traditionally circumcising communities. In the context of HIV prevention, it is only on this surgical procedure that MMC becomes relevant for the already circumcising Lemba. As noted earlier, there is no guarantee of complete removal of the prepuce in traditional circumcisions as the amount removed varies from one ethnic group to the other (Dowsett & Couch, 2007; WHO, 2009). For the protective efficacy of circumcision as an HIV preventative measure to be realised, total removal of the foreskin is required.

As mentioned before, TMC is often accused of fuelling the spread of HIV because of the allegedly unsterile conditions in which it is carried out; coupled with sharing of the same cutting instrument among initiates compared to its more recent and clinically hygienic counterpart (MMC) (WHO, 2009; Gwandure, 2011). The fact that there are different methods, degrees and styles of TMC, resulting in varying levels of completeness of the circumcision procedure is often cited as a weakness in ascertaining traditional circumcision's protective effect (Bailey, Plummer & Moses, 2001; Gruskin, 2007). TMC has thus been accused of being retrogressive, and a hindrance to the achievement of health objectives (Ntombana, 2011; Gwandure, 2011) as compared to the arguably more hygienic MMC which is effective in preventing heterosexual transmission of HIV particularly in sub-Saharan Africa.

For some, MMC in sub-Saharan Africa can be perceived as a replacement of TMC under the pretext of HIV prevention (Crafford, 2009). The Xhosas of Eastern Cape glaringly display denigration of initiates who circumcise the medical way; and this is because they view the cultural significance of Xhosa circumcision as more important than the biomedical reasons for MMC (Mavundla et al., 2009; Peltzer & Kanta, 2009; Mshana et al., 2011). TMC is considered the most guarded and sacred rite in the Xhosa tradition and it awards an initiate recognition, and admiration among community members (Gwata, 2009). It is claimed that there is an intricate connection between an individual's identity and one's cultural background as represented by the CCA (Dutta, 2008). Given the central role of TMC, gaining a deeper understanding of Lemba traditional surgeons' views and opinions of MMC for HIV prevention is important.

While evidence is abundant that TMC is a cultural practice that exposes initiates to HIV, Gausset (2001) argues that elimination of such cultural practices might not guarantee that people are protected from HIV, and that these African practices do not contradict the discourse of safer health and sexual behaviour. Literature suggests that even before medical male circumcision was officially recommended by both the WHO and UNAIDS as a component of the comprehensive strategy to prevent HIV transmission at Montreux, Switzerland, 2007 (WHO/UNAIDS, 2007; Berer, 2007; Gruskin, 2007), circumcision had been widely practiced – both medically and traditionally - for health reasons (Nnko, Washija, Urassa & Boerma, 2001).

While traditional circumcision procedures around the world largely remain clouded in secrecy, with traditional surgeons claiming to be taking precautions to prevent HIV transmission, what is clear in some instances however, are reported deaths of initiates which ostensibly are a result of botched circumcisions. Notable cases have been reported in South Africa where 34 initiates died during the winter initiation school in Eastern Cape alone in 2012 (Feni, 2012), while 23 initiates died within a space of nine days in Mpumalanga (SAPA, 2013).

Comparably, deaths during traditional circumcision are minimal in Zimbabwe, with no deaths recorded in the past two years (Dube, 2014). However, these statistics have resulted in repeated calls in many countries for the transformation of traditional circumcision by including aspects of MMC for the safety of initiates. In South Africa, the government has created policies that mandate training of traditional surgeons, and also inclusion of medical aspects and surgeons in traditional circumcision camps.

However, the ‘medicalisation’ of traditional circumcision in Africa has faced continued resistance by traditional surgeons especially in South Africa, with effects that are reminiscent of the era of AIDS denialism under the Thabo Mbeki administration (see Cullinan & Thom, 2009; Kalichman, 2000). Continued deaths resulting from botched circumcisions demonstrated urgent need to find effective ways through which traditional circumcision can be transformed so as to minimise all forms of risks on initiates. It is also in this context that this study seeks to explore ways in which VMMC uptake can be scaled-up among the Lemba.

#### *The Lemba traditional circumcision procedure*

Details of Lemba initiation rites are highly secretive and are kept among the circle of ritual graduates. Anyone who reveals the fundamentals of TMC to non-Lembas or even other Lembas who have not taken part in the ritual is liable to a punitive fine (Shoko, 2009). As such, there is a paucity of studies that have given details on Lemba male circumcision. Similarly the Xhosa regard the details of their cultural circumcision as highly confidential (Mavundla et al., 2009).

However, it is alleged that the circumcision procedure is done on a rock called *tlaba*, a word whose meaning is not common within the local *Shona* language (Foto, 1992, cited in Shoko, 2009). The significance of the *tlaba* is not known either. Furthermore, Foto attempts to

describe the procedure, for example that a razor blade or knife is used, and that pain is relieved by immersing the freshly circumcised penis in a pool of cold water. It is further alleged that severe pain is also relieved by use of antibiotics (Shoko, 2009). However, the detail available is too scant to portray a clear picture of how the procedure is done.

### **Male circumcision for health reasons**

The year 2007 was a watershed event in the history of public health in that for the first time in history, a surgical procedure was recommended as an intervention strategy (Buve, Delvaux & Criel, 2007). However, before its global recognition in the health landscape, in the United States of America, about 77% of males had been circumcised (Doyle, 2005). This, according to Aggleton (2007), is the highest rate of circumcision among developed countries. Among the developing countries, African countries such as Cameroon and Democratic Republic of Congo also practised MMC for health reasons, and it is believed to be the reason why HIV rates are relatively lower in West Africa (Auvert, Taljaard, Lagarde, Tambekou, Sitta & Puren, 2005). Circumcision was believed to be an effective cure for a variety of diseases (Gollaher, 2000; Doyle, 2005; Aggleton, 2007).

Lewis Sayre, a prominent US orthopaedic surgeon claimed during the 1870s that male circumcision was efficacious in curing paralysis and hip-joint disease among others (Aggleton, 2007). Advocates of MMC for its curative purpose included George Beard, Peter Remondino, Merrill Ricketts, and John Kellogg, founder of the popular cereal manufacturers Kellogg's (Gollaher, 2000; Aggleton, 2007). Doyle (2005) notes that by the twentieth century, it had been claimed that circumcision could cure or prevent more than a 100 health conditions which included rheumatism, epilepsy, asthma, and kidney disease among others.

Circumcision has also been associated with reducing cervical cancer in women, and penile cancers linked to human papillomavirus (HPVS) (Gollaher, 2000). According to Gollaher, prevalence of venereal infections coupled with a lack of effective medical resources may have contributed to physicians' belief in the prophylactic effect of circumcision. As suggested by Auvert Taljaard, Lagarde, Tambekou, Sitta and Puren, (2005), one can argue that practice of circumcision for health reasons spread to other countries including Africa during the diffusion of innovation era, and also courtesy of colonialism.

The idea that circumcision decreases a male's susceptibility to sexually transmitted infections was initially suggested by Hutchinson during the 19<sup>th</sup> century (Bailey, Plummer & Moses, 2001). However, the association between circumcision status and HIV infection was proposed by Fink in 1986 (Bailey et al., 2001; Auvert et al., 2005). Exactly a decade after Fink's proposal, Stephen Moses, a Canadian researcher in 1996 claimed the existence of a substantial body of evidence regarding the efficacy of circumcision against HIV infection which according to Gollaher (2000), has provided a stimulus for various epidemiological studies focusing on the health benefits of medical male circumcision in HIV prevention

Since then, there has been increasing interest in MMC due to its association with reducing HIV transmission. According to Gollaher, four theories emerged among researchers suggesting the protective efficacy of circumcision against HIV transmission (Gollaher, 2000).

- i. That if a strong correlation exists between STD infection and susceptibility to HIV, and that MMC decreases the risk of sexually transmitted infection, it therefore follows that MMC decreases the risk of HIV transmission.
- ii. That an intact foreskin increases the surface area of tissue susceptible to abrasion during sexual intercourse thereby increasing entry points for HIV into the bloodstream.
- iii. That the glans penis of a circumcised male develops a thick layer of keratin that serves as a 'natural condom', reducing abrasions which are entry points for HIV.
- iv. That the anatomy of an uncircumcised penis may harbour HIV for a longer period, thus eventually making transmission a lot easier.

Although arguments for circumcision appeared logical, particularly in promoting the health of individuals and communities, the procedure was resisted. In the USA, there is a vibrant movement dedicated to resisting MMC on moral grounds, that it is unnecessarily painful yet medically unconfirmed (Gollaher, 2000). Marilyn Milos, a nurse who was sacked from work for her advocacy work in resisting MMC, formed the first organisation to formally oppose the procedure in the USA, NOCIRC in 1985 (Gollaher, 2000). Other groups such as NOHARMM, and INTACT were subsequently formed (Gollaher, 2000; Doyle, 2005).



Resistance to circumcision is not a new phenomenon. The Holy Bible, for example, captures the Galatian controversy which documents resistance to male circumcision. This was after circumcision proved to be an impediment to mass conversion to Christianity (Aggleton, 2007). In Africa, the Zulu King and military strategist (Tshaka) banned the practice of circumcision in the 19<sup>th</sup> century accusing it of weakening his warriors (Nnko et al., 2001). In Brazil, after the WHO/UNAIDS recommendations for MMC as an HIV prevention strategy, the government decided not to adopt it as one of its HIV prevention strategies. Similarly, Ugandan President also opposed the strategy (Aggleton, 2007). In Kenya, a Council of Elders for the Luo of Western Kenya publicly resisted the procedure (Buve et al., 2007).

Be that as it may, the turn of the millennium saw an increase in interest regarding MMC as a preventative strategy against HIV transmission (Aggleton, 2007). Clinical trials and epidemiological studies were conducted to determine the prophylactic effect of MMC, and the two global health giants have been on the forefront, WHO and UNAIDS (Auvert et al., 2005; Bailey et al., 2007, Gray et al., 2007). The efforts of these global health governing bodies were supported by other international agencies that include the Bill and Melinda Gates Foundation, PEPFAR, and USAID (Aggleton, 2007; Dowsett & Couch, 2007).

At an AIDS international conference held in Toronto, Canada in 2006, the discourse on HIV prevention pinned hope on MMC which was described in military jargon as the latest ‘weapon in the arsenal’ (Dowsett & Couch, 2007, p.33). Ten months after this Toronto conference, the much awaited moment arrived and the WHO and UNAIDS released the report ‘Conclusions and Recommendations’ formally endorsing MMC as a comprehensive prevention strategy at a conference (6-8 March 2007) in Montreux, Switzerland (WHO/UNAIDS, 2007; Gruskin, 2007). The core messages on MMC were:

- i. MMC is a voluntary procedure, and is not forced
- ii. MMC protects against heterosexual transmission of HIV by approximately 60%
- iii. MMC offers partial protection, and therefore does not replace other HIV prevention measures
- iv. Recommended healing period is six weeks and abstinence from sexual activity is emphasized

- v. MMC must be conducted by a professionally trained, and accredited service providers

MMC as a biomedical HIV prevention intervention focuses on reducing HIV transmission among men who practise heterosexual, vaginal penetrative intercourse (Gruskin, 2007). Available evidence has shown that a medically circumcised male enjoys an estimated 60% protective effect as proved by various clinical trials such as the Orange Farm randomised controlled trials (RCTs) (Grund & Hennik, 2012; Auvert et al., 2005; Bailey et al., 2007). Other clinical trials have also shown statistically significant results of MMC's protective efficacy against HIV incidence in heterosexual men. For example, the Uganda and Kenya RCTs proved that circumcised men had between 51% and 53% lower levels of HIV infection respectively, than did uncircumcised men (Auvert et al., 2005).

As mentioned above, both WHO and UNAIDS recognise MMC as a component of the combination prevention strategy against HIV transmission (WHO, 2007; Horton & Das, 2008; Mshana, et al., 2011). A combination prevention strategy combines biomedical, behavioural, and structural interventions (Horton & Das, 2008). The biomedical approach mobilises medical resources to combat the HIV epidemic, and strategies include use of antiretroviral treatment, condoms, microbicides as well as MMC. The behavioural approach uses communication interventions to influence behaviour or practices related to that behaviour, which indirectly or directly promote health, prevent illness or protect individuals from harm (Lubombo, 2014), while structural approaches seek to address broader social, economic, political, and environmental factors that affect HIV risk and vulnerability.

While MMC falls under the bio-medical approach, the CCA adopted for this study, recognises the broader social, cultural and environmental factors that shape or constrain individual behaviour. This will become clear later in this chapter. Here, it is important to note that while it is a cultural practice, circumcision is viewed as a medical technology with proven protective efficacy against the transmission of HIV. Wide-scale implementation of MMC is believed to lower HIV incidence in men who have sex with HIV positive women (Berer, 2007). However, MMC does not offer full protection, which means that it is only effective if it is combined with other means of protection such as condom use.

Numerous epidemiological studies have reported a significant correlation between absence of male circumcision and HIV infection, leading to recommendations for MMC to be added to

the armamentarium of effective HIV prevention strategies (Bailey et al., 2007). For example, a study in Pune, India, showed that MMC was strongly protective against HIV-1 with uncircumcised men being 6.7 times more likely to contract infection by comparison to their circumcised counterparts (Carael & Glynn, 2007).

### **Roll-out of medical male circumcision in Zimbabwe**

The evidence from RCTs is overwhelming, and supports previous claims about the efficacy of MMC in HIV prevention such as that by Stephen Moses in 1996. Furthermore, the fact that global health custodians (WHO & UNAIDS) have endorsed this procedure as a scientifically proven strategy, defies logic to doubt its efficacy, provided that it is not used to replace other barrier methods. However, MMC has been viewed with scepticism especially by some traditionally circumcising African communities who often perceive it as an “expression of powerful cultural and religious ideas” (Gollaher, 2000, p. 151). Such perceptions can present challenges to the roll-out of MMC. It is in this context that this study explores the perceptions among Lemba people of Mberengwa in Zimbabwe to find ways through which MMC roll-out among these communities can be increased.

Zimbabwe first adopted voluntary medical male circumcision (VMMC) within its National HIV and AIDS Strategic Plan of 2006-2010 which saw about 11, 102 men being circumcised at the end of September 2010 (NAC, 2011). This was however; regarded as a slow uptake despite the fact that MMC is a free service to the public. At least 80% of people between 15-29 years by we set to be circumcised by 2015 and this is projected to reduce HIV incidence by a range between 25% and 35% (NAC, 2011). Despite anecdotal media reports that VMMC uptake is improving, the country’s current circumcision rate of slightly below 10% vis-à-vis the 80% target by 2015 casts a dark cloud on the prospect of meeting the set targets (IRIN, 2013). Indeed this is a challenge which, as this study attempts to do, calls for alternative ways to increase circumcision uptake throughout the country.

Low uptake of VMMC is not peculiar to Zimbabwe alone. The problem has also been reported in other countries where in most communities it has been attributed to scepticism which people have towards MMC (Gwandure, 2011). Research work conducted on issues of MMC acceptability has, however, focused on non-circumcising populations. For example, an acceptability study was carried out among a rural Zulu population around Hlabisa and Mtubatuba in KwaZulu-Natal prior to MMC roll-out (Scott, Weiss & Viljoen, 2005).

Findings indicate participants' preparedness to embrace MMC either for themselves, their partners or their children. Other studies have examined the possible impacts of MMC on men's post-circumcision behaviour, which is "risk compensation or behaviour disinhibition" (Agot, Kiarie, Nguyen, Odhiambo, Onyango & Weiss, 2007). Risk compensation refers to "increases in risky behaviour sparked by decreases in perceived risk" (Cassell et al, 2006, p. 605). A study conducted in Siaya and Bondo districts of Kenya showed no significant levels of risk compensation (Agot et al., 2007) while a demographic health survey (DHS) conducted in Zimbabwe between 2010 and 2011, documented evidence of risk compensation (ZIMSTAT, 2012, Mutede, 2012).

There is still a paucity of studies that take into consideration the perspectives of traditional surgeons regarding MMC. Although acceptability studies mainly among traditionally non-circumcising populations have revealed a reasonable degree of MMC acceptance as a biological intervention (Scott et al., 2005), there seems to be limited studies on the perspectives of traditional surgeons who attach substantial meaning and significance to male circumcision. Although Zimbabwe embraced VMMC a few years ago, little is known about the views and opinions of traditionally circumcising communities regarding this biomedical approach.

Findings of a study among the Yao, a migrant community of people of Malawian origin mostly found in mining towns in Zimbabwe, by Daimon (2013) revealed that these people are prepared to collaborate with the state in the roll-out of MMC. Although the Yao initially resisted collaboration, citing issues to do with compromising the secrecy of their culture, further engagement with the relevant stakeholders resulted in a change of attitudes towards privacy among the Yao (Daimon, 2013). These findings also show the conflict between Yao elders and the younger generation who view collaboration as progressive while their older counterparts view such collaborative work as "external interference" (Daimon, 2013, p. 302). The Yao have shown that culture is transformative since they got to a point of allowing medical personnel to circumcise their initiates in the hospital, before they take them to the bush for the rest of the initiation rite (Daimon, 2013).

It is in light of the foregoing that this study explores opinions of the Lemba of Mberengwa regarding MMC. Insight gained from this study would be useful in the scale-up of VMMC services in such communities. The study is based on a proposition that culture is important to

the way people conceptualise their health and wellbeing. In fact, it has become common practice in the field of public health, and in the social and behavioural sciences to recognise the centrality of culture in the study and understanding of health behaviours (Airhihenbuwa, 1995). As such, the central argument in this study is that for VMMC to be accepted among the traditionally circumcising communities such as the Lemba, it has to be implemented in ways that do not negate the cultural values that these communities attach to circumcision. Centrality of culture in the public health praxis finds expression in the CCA to health discussed below.

### **The culture-centred approach (CCA) to health promotion**

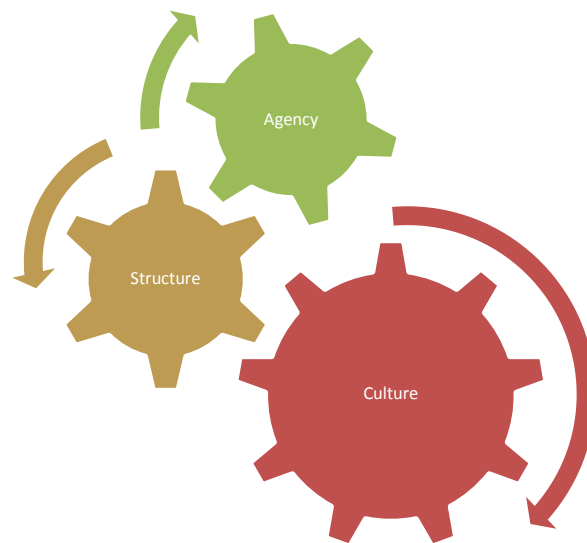
This study draws on the CCA developed by Mohan Dutta (2008) as its main conceptual framework. The CCA has its origins in critical theory, cultural studies, postcolonial theory, and subaltern studies; and therefore its theoretical, methodological and application-based focus draws from these disciplinary roots (Dutta, 2008). It is important to highlight that Dutta, who wrote widely about this approach acknowledges that the CCA is not a theory per se, but rather it is one of the approaches which might develop into a health communication theory.

The CCA is anchored on the work of Collins Airhihenbuwa (1995). Airhihenbuwa criticises the Western medical paradigm for its failure in tapping into the rich culture of the marginalised communities, arguing that health communication theorising should be motivated by culture (Dutta & Basnyat, 2008). As with this study, Airhihenbuwa (1995) argues that health promotion programmes should be planned, implemented and evaluated within the context of the relevant culture. In other words, health programmes must take cognisance of the socio-cultural beliefs and value systems prevalent in a particular community.

It is important to note here that there are two separate strands of scholarship in health communication literature that centralise the concept of culture. These are the culture sensitive approach (Campinha-Bacote, 1994), and the CCA (Dutta, 2008; Airhihenbuwa, 1995). The distinction between these two is on how the concept of culture is conceived in each case. In the culture sensitive approach, culture is viewed as “a static set of values, beliefs, and practices” while in the CCA, it is “a dynamic entity which is contextually constituted, continuously contested, and communicatively negotiated” (Dutta, 2008, p. 40-41). It would

suffice to say that in the former, culture is portrayed as being rigid and intolerant while in the latter; it can be flexible and capable of offering a whole array of possibilities. It is because of this reason that the present study is framed within the CCA. It offers no prescriptions, but seeks to listen to the voices of the Lemba people to find ways through which MMC - a medically approved strategy to prevent HIV among men – can be effectively implemented among these communities. By so doing, the Lemba will be enacting their agency to negotiate established policies (or structures) that may be responsible for low acceptance levels of MMC among Lemba communities.

*Fig 2.2: The culture-centred approach to health communication, (Dutta, 2008, p. 5).*



The CCA, as illustrated in Figure 2.3, thus espouses an interdependent relationship between a people’s *culture*, *structures* that enhance or limit their possibilities, and enactment of their *agency* to negotiate these structures.

### *Culture*

Different definitions of culture permeate the discourse on CCA. Among these is one by Mazrui (1986, p. 239) who defines culture as “a system of interrelated values active enough to influence and condition perception, judgement, communication, and behaviour in a given society.” Culture is “the communicative process by which shared meanings, beliefs, and practices get produced” (Geertz, 1994 cited in Dutta, 2011, p. 11). It is important to acknowledge that culture is at the core of the CCA because “it is the strongest framework for

providing the context of life that shapes knowledge creation, perceptions, sharing of meanings, and behavior changes” (Dutta, 2011, p.11).

Conceptually, culture as represented in the CCA, is framed with reference to the local contexts within whose confines health meanings are shaped and understood. The CCA places emphasis on the significance of designing and implementing health programs that are compatible with key stakeholders’ cultural framework (Airhihenbuwa, 1995). More often, the existing structures discussed below, disregard these cultural frameworks resulting in the failure of public health programs.

### *Structure*

In the context of a CCA, structure relates to the various facets of a social establishment that can either limit or enhance the capacity of cultural members to pursue health choices and adopt health-related behaviours. By definition, “structures are the institutional frameworks, ways of organising, rules and roles in mainstream society that constrain and enable access to resources” (Dutta, 2011, p. 9). Structure encompasses a wide spectrum of services critical to the healthcare of cultural participants such as medical and transport services, diet and shelter among others. Structures that impact on the lives of subaltern communities operate at several levels; these are micro-, meso-, and macro levels (Dutta, 2011). Subalternity refers to the condition of being marginalised and missing from the mainstream discursive platforms (Dutta, 2008).

Furthermore, structure has the ability to constrain or enhance the possibility of cultural members in marginalised communities to take control of their own health. On the other hand; it can hamper them from fulfilling their health needs by determining the quality of health choices that are made accessible. This is compounded by the fact that “marginalised communities have minimal access to basic health care resources and to the mainstream communication platforms on which they could articulate their questions and concerns” (Dutta (2008, p.13).

Marginalised communities thus neither have a voice in the dominant health communication structures, nor a say in the formulation of health policies. It is from this perspective that the CCA places value on listening to the voices of the marginalised as a way of enabling them to enact agency in addressing their health concerns.

### *Agency*

Agency refers to the capacity of people to interact with structures in order to create meanings (Dutta, 2008, p. 61). Such meanings provide scripts for the marginalised, not only to interact with the structures, but also to sustain and transform them. The concept of agency reveals the dynamic processes individuals, groups, and communities engage in as they interact with the structures whose impact is either to constrain or enhance the lives and health of cultural members. Through agency, these cultural members are able to demonstrate their potential to actively participate in influencing health agendas and provide relevant solutions to different health problems they might be confronted with. They engage in a dialogue which is based on the premise that cultural participants are engines of change, and can meaningfully engage with the structures.

According to Dutta (2008), the process of dialogic engagement with cultural members in order to gain a deeper understanding of their interpretation of health, constitutes the core of the CCA. Therefore through agency, platforms are created for those whom Frantz Fanon (1972) terms “the wretched of the earth” to engage “in the co-construction of meanings and in actions based on these meanings” (Dutta, 2008, p. 87).

As evidenced from the foregoing, the relationship between culture, structure and agency is interwoven. In other words the CCA seeks to enhance people’s capacity to engage, from their own perspective, with structures that encompass their lives in order to create discursive spaces to transform these structures. This engagement thus takes place within a cultural context, where culture is conceived as “the local contexts within which health meanings are constituted and negotiated” (Dutta, 2008, p. 7).

In light of the foregoing, it can be argued that there may be no better framework within which this study can be meaningfully understood. It is thus important to end the chapter by explaining the applicability and relevance of this approach in the context of this study whose objective is to explore perceptions the Lemba people of Mberengwa hold about MMC. For this study, the three key concepts of the CCA (structure, culture, and agency) outlined above are arguably useful in providing an understanding of how the Zimbabwean policies on MMC roll-out interact with the Lemba culture in ways that affect uptake of VMMC among the Lemba.



## **Why the CCA?**

The Lemba traditionally practise circumcision for its socio-cultural significance, and incorporate it in their initiation process. Circumcising in a traditional context constitute a cultural practice. This qualifies the Lemba as cultural actors in that what they do is set apart from the rest of other social members. This study explores Lemba readiness to undergo VMMC, given that they already practise male circumcision as part of their culture. It also explores appropriate ways of promoting uptake of VMMC services in a manner that does not undermine the cultural significance of Lemba initiation culture. The CCA thus becomes relevant as it can enhance the Lemba's capacity to engage, from their own perspective, with government policies on MMC in order to increase its acceptance among their communities.

In the context of this study, structure refers to the state as represented by the Ministry of Health and Child Care (MoHCC), and its MMC implementation partners, as well as the legal parameters within which these operate. In other words, structure refers to the health care infrastructure within which VMMC takes place. Top on the government MMC agenda is to increase the number of medically circumcised men in order to reach a population level impact on HIV prevalence (Yikoniko, 2012). Structure here manifests itself through MMC campaigns, and public communication platforms used to disseminate MMC information. From a CCA perspective, structure can promote or constrain the health choices of Lemba cultural members. The study examines the responses of the Lemba to the state's public health message that; sexually active males should be medically circumcised in order to prevent HIV transmission.

In this study, agency is framed around the way in which the Lemba exercise control against structural constraints imposed by the state and its MMC implementation partners noted above. Participation of the Lemba in negotiating these structures is viewed from the CCA as enactment of their agency. In matters of public health concern, agency is not limited to the Lemba's liberty to make decisions independent of the influence of the medical system. Instead, agency should be analysed in terms of what the Lemba are prepared to do in order to promote working with the structure which would ultimately result in increased uptake of VMMC services. Questions relating to agency in this study primarily focus on how best the Lemba intend to harness the benefits of a circumcision status which are located within the recommendations of the health care system.

One can argue that, it is through mutual cooperation between all relevant stakeholders, in this case the relationship between government (structure) and the Lemba people (agency) that successful implementation of community (cultural) programmes can be scaled-up (see Lubombo, 2012). It is this mutual cooperation in order to increase uptake of VMMC services among the Lemba that the study examines.

## CHAPTER THREE

### RESEARCH METHODOLOGY

Methodology specifies how the researcher may go about practically studying whatever he or she believes can be known, Terre Blanche & Durrheim (1999). This relates to the description of the research design as well as methods that were used in selecting participants, in the collection and analysis of data. This chapter thus, describes the nature of this study as well as data collection procedures used to elicit views on medical male circumcision by the Lemba traditional surgeons selected to participate in the study. The chapter also describes how the data is presented, and analysed.

#### **The study design**

A qualitative approach was adopted in this study for its ability to allow for a deeper understanding of the lived experiences of the Lemba with the ultimate goal of gaining an understanding of their perspectives regarding the biomedical approach of MMC for HIV prevention. The term qualitative carries overtones of “an emphasis on the qualities of entities, and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity or frequency” (Denzin & Lincoln, 2008, p. 14). Qualitative research emphasizes depth more than breadth (Ulin, Robinson & Tolley, 2004).

The aim is to produce both explanatory and descriptive data which seek to understand

- a) Views and opinions of Lemba traditional circumcisers regarding MMC for HIV prevention
- b) Factors that can be viewed as impeding or enhancing Lemba uptake of VMMC.

It is unarguable that explanatory and rich descriptive data to arrive at the above understanding can best be obtained through qualitative research (see Hesse-Biber & Leavy, 2006). The qualitative approach was thus preferred to a quantitative approach for its ability to allow posing of questions that solicit for responses in participants’ own words (Guest, MacQueen & Emily, 2012). This particular aspect is important in answering questions which seek to

explore factors influencing human behaviour such as cultural practice vis-à-vis MMC for HIV prevention.

Furthermore, a qualitative research paradigm “sees the world as constructed, interpreted, and experienced by people in their interactions with each other and with wider social systems” (Ulin et al., 2004, p. 18). As such, the study is located within an interpretivist approach which, as discussed below, allows for not only co-construction of knowledge through dialogue between the researcher and the participants, but also interpretation and observation in knowing the social world.

*Research paradigm: An interpretivist approach*

A paradigm is a worldview that presents a definition of the social world linked to the related sources of information (data) and appropriate ways (methods) to tap these sources (Ulin, Robinson & Tolley, 2004, p.12). This study is informed by interpretivism which holds that exploring and understanding the social world should be done through the researcher, and the participant’s perspectives (Snape & Spencer, 2003). Interpretivism is a school of thought that places emphasis on the significance of both interpretation, and observation in knowing the social world (Snape & Spencer, 2003). The underlying assumptions of an interpretivist paradigm are that “the social world is constructed of symbolic meaning observable in human acts, interactions, and language. Reality is subjective and multiple as seen from different perspectives” (Ulin, Robinson & Tolley, 2004, p. 16). Ulin and others also posit that meanings are drawn from perceptions, experiences as well as actions within a social context.

Interpretivism as an epistemological position, located within the qualitative research paradigm asserts that a social researcher has to explore and understand phenomena through interacting with the participants (Snape & Spencer, 2003). In this case, Lemba traditional surgeons are the research participants. Through an interpretive approach, methods such as interviews that allow elicitation of views of traditional surgeons regarding VMMC were used. The purpose was to identify ways in which roll-out and uptake of MMC can be scaled-up in traditional circumcising communities such as Mberengwa.

The interpretive approach places emphasis on experiential data; the focus being to provide an enriched understanding, description and explanation of human experience (Polkinghorne, 2005). The methodological implication for this theory of knowledge is that in order to gather

such data, the researcher should interact with people “who have directly experienced the phenomenon of interest” (Patton, 2002, p. 104). An interpretive approach presented the opportunity to get more information about Lemba traditional surgeons’ perspectives of MMC, since little is currently known regarding this topic. The Lemba have vast experience of circumcision, as they practise it as part of their culture. How they view MMC, which understandably has no cultural significance has strong implications for VMMC acceptance and uptake in such communities.

#### *Study setting and context*

This research was conducted in Mberengwa district of rural Zimbabwe, and data collection was done from mid-June to end of July 2014. Mberengwa district is located in the southern periphery of the Midlands province, in the southern part of Zimbabwe. The population is growing more culturally, and ethnically diverse as a result of in-migrations during the late 1980s as well as the recently ended land reform programme. There is a heterogeneous population observing a diversity of cultural practices (Shoko, 2009).

The Lemba, dubbed “the Black Jews of southern Africa” due to their alleged Jewish ancestry (Doyle, 2005), constitute the majority of the inhabitants of Mberengwa district. Most Lembas are concentrated in the Mposi area, which is Lemba chiefdom, with some sprawling into neighbouring chiefdoms such as Chingoma, Mahlebadza, Mapiravana and Mudavanhu among others. The study participants, described later in this chapter, were mainly drawn from Mposi, and Chingoma areas. Although Ndebele, one of Zimbabwe’s main languages is spoken in some parts of Mberengwa due to the district’s proximity to Matabeleland South which is a predominantly Ndebele stronghold, the dominant language spoken among the Lemba is Karanga, a Shona dialect.

#### *The researcher as the key instrument*

“Everybody has the skills to do interpretive research, but to do it well one needs to turn these [basic skills] into specialised research skills” (Terre Blanche & Kelly, 1999, p. 126). In qualitative interpretive research, the researcher assumes the role of a primary instrument for executing the dual task of data collection and analysis (Terre Blanche & Kelly, 1999). Before entering the field, efforts were made to develop important skills necessary for a successful data collection exercise. These included the ability to listen, to look, to pose questions, and to interpret issues. Careful and active listening motivates the interviewee to

open up (Undheim, 2006). This was particularly rewarding since the Lemba would mostly open up following the interviewee's use of specialised skills to lead them further, even when they felt they had exhausted what they had.

To elaborate on the significance of questioning skills, Rubin and Rubin (2005) identify three types of questions that produce depth, detail and richness. These are; main questions, follow-ups, and probes. Consistent with this principle, questions in this study were formulated in a way that enhanced a thorough examination of the research problem. For example, the question; "As a Lemba, how would you feel about collaboration with practitioners of medical male circumcision?" generated in-depth responses from participants.

### *Entry into the field*

Initial access to the research site was negotiated through Jaku Zhou (Interviews; June 20/23, 2014) who was the gatekeeper into the Mposi area. A gatekeeper is a person, group of persons or an institution with either formal or informal authority to regulate access to a site or research subjects (Neuman, 2006). In other words, gatekeepers are people who have the mandate to determine who is allowed or denied access, usually parties concerned with the subject under investigation or the welfare of prospective participants (Terre Blanche & Kelly, 1999).

During my days as a teacher at the local mission school, I had learnt that Zhou was a man of integrity as he would almost always make noble contributions during important meetings. A passionate informal Lemba historian, a retired head teacher, and member of the Lemba Cultural Association (LCA) in the area, he spends most of his time reading Catholic literature. His first question was: *Sei uchida kuziva zvinhu zvavaMwenye usingadi kuenda kugomo?* (Why do you want to learn about Lemba secrets when you are reluctant to be initiated?). Access to participants was negotiated against the rigidity of cultural bureaucracy (see Undheim, 2006). The interviews ensued after liaisons with other stakeholders in the Lemba culture. It was these gatekeepers who helped clear the cloud of suspicion by explaining to potential participants that the study was acceptable, and important to the tribe too.

### *Selection of study participants*

As mentioned earlier in this chapter, the methodology was influenced by an interpretivist approach. To collect qualitative data, the qualitative researcher should engage with people “who have directly experienced the phenomenon of interest” (Patton, 2002, p. 104). In this study, possible participants belonged to two distinct categories. They were either original members of the Zhou totem who graduated from initiation school or members of the *zindji* (non-Lemba) who were accepted in the circumcising culture by virtue of having participated in Lemba initiation. The former were purposively selected to participate in this study. This was because these have more influence and control of the initiation practice than their non-Lemba counterparts who are almost voiceless. All the Lemba who participated in the study were elders, and experienced surgeons locally known as the *Nyamukangas*.

Unlike in quantitative research, participants for a qualitative study are not selected on the basis of being statistically representative, but because they can provide substance that fulfil an investigative purpose (Polkinghorne, 2005). The list of participants was thus left open in order to enhance the dependability of findings by way of sampling to redundancy (Durrheim, 1999). This technique is important in that, it is exhaustive, since interviewing continues until views are repeated. While the findings of this study cannot be generalised, this technique allows for making inferences about the Lemba.

A large pool of possible participants was established prior to the interviews to increase opportunity for selecting few information-rich cases, since in qualitative research, detail and depth take precedence over numerical accuracy (Durrheim, 1999). Information-rich participants are, “those from which one can learn a great deal about issues of central importance to the purpose of the research” (Polkinghorne, 2005, p. 140). In order to get these participants, experienced Lemba elders who are knowledgeable about the circumcision culture were purposively selected. Vast years of practice were believed to have enriched their experiences, thereby increasing their likelihood of fulfilling the requirements of the research outlined earlier. As such, most of the participants had vast experience of more than two decades of active involvement in the practice of, and decision making in matters related to Lemba circumcision. Rubin and Rubin (2005, p. 66) refer to such participants as “encultured informants”, who are characterised by an intimate knowledge of the culture, and take it upon themselves to explain its meaning.

Although participants were spread over a large geographical area, they were located and interviewed. Some potential participants were, however, not interviewed due to time and resource constraints. The impact of this on the credibility of the study was compensated by reaching saturation on the data obtained from available participants. All the participants were identified using the snow-ball, or chain referral technique which is used to locate participants by asking others to identify persons or groups with special understanding of a given topic (Ulin, Robinson, Tolley & McNeill, 2002). Prior to that, a priori sampling had been used to identify participants. This technique entails the definition of characteristics, and structure of selection criteria in advance (Ulin et al., 2005).

### **Data collection and analysis procedures**

Data collection refers to the “how” part or the manner in which material for the research was generated (Flick, 1998). According to Ulin, Robinson, and Tolley (2005), there are three primary methods which form the bedrock of qualitative data collection namely; observation, in-depth interview, and focus group discussion. In this study, data was collected using one-to-one or dyadic in-depth interviews (Polkinghorne, 2005). Individual interviews were the most suitable method as circumcision is sensitive, and secretive within Lemba spheres. Confidentiality is an important principle that guides the life of Lemba cultural members. As such, engaging participants in a focus group discussion with a non-Lemba (zindji) researcher like me would have been inappropriate.

#### *In-depth interviews with Lemba traditional surgeons*

The interview in qualitative research is seen as being nearer to a dialogue, “than to a question-and-answer session” (Baker 1999, p. 247). Scholars have called this kind of intensive, one-on-one interviewing “a conversational partnership” (Rubin & Rubin 1995, p. 10), “conversation with a purpose” (Burgess, 1984, p. 102), and “social encounter” (Holstein and Gubrium 1999, p. 106, quoted in Ulin et al., 2005). All the interviews were conducted in Shona, which is my preferred language, and my mother tongue. An interview guide was used (see Appendix A1/2). Use of an interview guide made interviewing a lot easier because we all speak the same language. However, most participants had a formal education, and were conversant in English. Therefore, some were code-switching between English and Shona.

Rubin and Rubin (2005) refer to depth interviewing research as responsive interviewing while Hesse-Biber and Leavy (2006) refer to the same as qualitative interviews. The



responsive interviewing model is anchored on the interpretive constructivist philosophy whose goal, as with this study, is to create depth of understanding, and not breadth (Rubin & Rubin, 2005). Apart from having a flexible and adaptive design (Rubin & Rubin, 2005), responsive interviewing proved suitable because the study aimed at eliciting Lemba interpretations of their own experiences, as well as their understanding of the position they occupy in the fight against the AIDS epidemic. A flexible and adaptive design allows, if need arises, for necessary adjustments to be made on both the interview schedule and pool of participants (Durrheim, 1999).

A qualitative interview unfolds as more of a discourse between two parties and is not solely driven by the interviewer's questions but is rather mutually developed during the interview session (Baker, 1999). The interviews were done at a place (setting), and time that the participant felt secure and comfortable. The setting is very important because in some cases, participants may be victimised by their peers for having participated in a study on the basis of the setting where the interview was conducted. Lemba circumcision culture is secretive, and this was taken into account when scheduling the interviews.

Usually the Lemba wouldn't take pleasure in the idea of their area, and culture being turned into a research site. Privacy and confidentiality was therefore ensured, to avoid possible punishments against participants for divulging tribal secrets. Privacy was also important in establishing trust between the researcher and study participants. According to King (1998), the interviewer should strive to earn trust from the interviewee, and the degree of trust is likely to increase with the depth of the interview. The researcher revisited information-rich participants, which proved beneficial in building trust as well as increasing access to more information than previously articulated in the first interview. The chain referral system also worked well, due to the level of trust established and for the purposes of confidentiality.

After sharing a simple and brief introductory statement, participants were allowed to ask questions. This allowed for elaboration, and is important for enhancing understanding (King, 1998). In most cases, this helped ease the interview atmosphere and allowed for a natural conversation. Mistrust was also cleared by making participants aware that they were not compelled to answer all the questions, in the event that they felt uneasy to respond to some, and that they could stop the interview if they so wished. However, as the interviewer, I maintained my prerogative to introduce topics, define and control the interview situation.

Since I am non-Lemba, participants would in some isolated cases indicate that they initially thought that I wanted to open a window into the hidden secrets of the Lemba tribe. Therefore, the need to clear suspicion became a critical challenge that had to be addressed, both at recruitment and during the early stages of each interview.

Open-ended interviews with Lemba traditional surgeons were appropriate in this study, because they offered the participants an opportunity to provide their views and opinions regarding MMC for HIV prevention in a limitless way.

### *Method of analysis*

Data analysis in qualitative research is considered not as an event that occurs when all the data is gathered, but rather as an on-going process that informally occurs even prior to the formal stage of data analysis. Ulin and others (2004) state that, qualitative analysis begins with data immersion which is a process of perusal of transcripts until one is “soaked” in the data. This immersion results in an intimate familiarity with content (see Terre Blanche et al., 2006). The analysis in this study began with listening, and transcribing of the interview recordings.

The recordings were not transcribed verbatim as it excluded sociolinguistic aspects such as intonation, repetitions, pauses, and other conversational aspects. While verbatim transcriptions are considered most loyal and objective (Kvale, 1996), some statements by participants were rephrased and condensed in order to present participant views, not only in a correct written and more readable form, but also in a way that captures only those aspects which are of interest to the study (see Lubombo, 2014). The interest of this study was to understand how the traditionally circumcising participants perceive MMC in the context of HIV prevention. While only the material deemed important and reflective of the above were transcribed, the produced transcripts are as close as possible to audio recordings. Several pages of transcripts were generated from the recordings.

To manage this data, thematic analysis described by Braun and Clarke (2006) was used to arrange it into meaningful themes. Braun and Clarke define thematic analysis as a qualitative analytic method where patterns or themes embedded in the data are identified, analysed, and reported on (2006). They posit that, thematic analysis is inspiring because emerging themes as well as concepts permeating the interview are discovered (2006; also see Rubin & Rubin,

1995). The transcripts were studied several times taking note of emerging patterns within the data which were then organised into meaningful analysable themes.

In the tradition of interpretive research, in order to make sense of the data, the transcripts were interpreted within a CCA framework. As already noted, interpretivism as an approach privileges shared meanings that emanate from a common background that participants share in matters of common experience (Rubin & Rubin, 2005). The Lemba perspectives on MMC are therefore viewed, from a CCA, in light of their circumcising culture. Findings are also related to the reviewed literature, and other relevant theories. To ensure study trustworthiness, direct quotes from the interviews are presented in this dissertation to support conclusions derived from the analysis. To ensure confidentiality, pseudonyms, except where indicated, are used.

Findings of this study could be of some benefit, either to the immediate participants, other researchers in the field, or to the broader society (Durrheim & Wassenaar, 1999). Participants were told that their contributions were important, since the findings of this research could assist policy makers in the design of public health intervention programs that either aim to enhance the protective effect of male circumcision in HIV prevention or create synergy between traditional surgeons and medical surgeons. Another benefit that was explained to participants is that research findings could also help public health practitioners in designing culture-congruent programs, which are programs that respect cultural autonomy.

### **Ethical considerations**

The aim of the study was explained prior to each interview session, and declaration of confidentiality was signed. All the interviews were audio-recorded after permission to use an audio recorder during each session was secured. The fact that high standards of privacy would apply with regards to the handling and storage of the recordings was emphasised. Further explanation assisted participants to understand their rights, and other ethical issues that guided the research as expressed in the informed consent form (see Appendix B1/2), copies of which were distributed to each participant for their signatures prior to the formal interview.

### **Trustworthiness of the study**

According to Babbie and Mouton (2005), trustworthiness is concerned with how the researcher can be convinced, as well as convinces others that research findings are worthwhile. In this particular study of Lemba perspectives on MMC for HIV prevention, trustworthiness was ensured through use of credible methods and sources of information which makes the study dependable, confirmable and transferable as explained below.

#### *Credibility*

A credible research is one whose findings are both convincing and believable (Durrheim & Wassenaar, 1999). In pursuit of this principle, I made efforts to ensure that participants' views, including divergent ones were respected and reflected in both the presentation of findings, and in the analysis. In this study, credibility was achieved through triangulation with data from participants with different levels of formal education drawn from a wide spatial area in order to establish if this could produce discrepant findings.

#### *Dependability*

According to Durrheim and Wassenaar, "dependability refers to the degree to which the reader can be convinced that findings did indeed occur as the researcher says they did" (1999, p. 64). In this particular study, I ensured attainment of reliability by providing thick descriptions of the various steps taken and giving justifications for decisions taken during the execution of the study in the field. For example, it is my estimation that key research questions in this study were simple, and fit well into the research design and study objectives.

#### *Confirmability*

Confirmability refers to the degree to which study findings are a direct result of the study focus as compared to the biases of the researcher (Babbie & Mouton, 2004). Despite that the researcher acknowledges his/her position in the research, the distinction between personal values and those of study participants is maintained; and this is self-reflexivity (Rubin & Rubin, 2005). In this study, confirmability was achieved through maintaining and reviewing field notes, field diary and reference to proposal notes to enable realigning with the original focus of the study.

### *Transferability*

According to Babbie and Mouton, transferability “refers to the extent to which the findings can be applied in [to] other contexts or with other respondents” (2004, p. 277). Since transferability in qualitative research is influenced by the degree of similarity between sending and receiving contexts, I collected adequately detailed data and reported on it with the necessary accuracy. This was done to allow the reader to make judgements about transferability, also known as extensibility (Ulin et al., 2004). I purposively selected participants from across Mberengwa district, thereby increasing the likelihood of the findings to represent the current Lemba perspectives regarding MMC for HIV prevention. However, attention should be given to contextual factors in the event that findings from this study are to be transferred to other contexts.

It is pertinent to end this chapter by declaring that all ethical considerations to conduct the study as articulated in the research proposal, and as approved by the by the Research Ethics Committee of the University of KwaZulu-Natal (see Appendix C), was observed. All the names used in this dissertation are pseudonyms, except for Takavafira Zhou who, as indicated earlier on, acceded that his real name may be used in this final write up.

## CHAPTER FOUR

### FINDINGS

#### LEMBA PERSPECTIVES OF MALE CIRCUMCISION IN THE CONTEXT OF HIV

The findings are discussed using the culture centred-approach (CCA) as the overarching conceptual framework whose three main concepts: structure, culture and agency are intricately interwoven into a complex web. Structure is represented by the state (MoHCC) and its MMC implementation partners while agency refers to the capacity of the Lemba people to interact with the health care system in order to create meanings. The CCA gives credence to listening to the stories of cultural members in order to understand how they define their health, seek to maintain or restore it (Dutta, 2008). This study elicited views about medical male circumcision (MMC) among the Lemba people of Mberengwa. As already indicated in previous chapters, the Lemba communities practise male circumcision as part of their culture. Understanding Lemba views about MMC is critical to finding ways of increasing the uptake of voluntary medical male circumcision (VMMC) in traditionally circumcising communities, which is a recently acknowledged measure for preventing sexual transmission of HIV. This chapter presents findings of the study which are presented in the following pages under three main themes summarised in Table 4.1 below.

*Table 4.1: Themes emerging from the findings*

Aspect	Themes
<b>The Lemba, MMC and HIV prevention</b>	<ul style="list-style-type: none"><li>a) Medical male circumcision (MMC) is useful for HIV prevention</li><li>b) MMC is a welcome development in efforts to contain the HIV epidemic</li><li>c) Poor marketing of MMC among the Lemba</li></ul>
<b>Challenges to medicalising TMC</b>	<ul style="list-style-type: none"><li>a) Resistance and cultural autonomy</li><li>b) Lemba circumcision and social status</li><li>c) Possible discrimination/ alienation from group</li><li>d) The Lemba, secrecy and “necessary lies”</li></ul>

**Scaling-up VMMC  
uptake among the  
Lemba**

- a) Sanitisation of TMC while maintaining agency of traditional circumcisers
- b) Need for involvement of the Lemba in the roll-out of MMC among the Lemba

### **Circumcision from a Lemba perspective**

Participants were asked about their understanding of circumcision. The question of what circumcision is to a Lemba was seen as a significant one because it helped establish the distinction between traditional male circumcision (TMC) and its modern counterpart, medical male circumcision (MMC). To the majority of participants, MMC is known as “Smart”, owing to the campaign '*Pinda MuSmart, Ngena KuSmart, Get Smart*', which is a nationwide programme aimed at promoting voluntary medical male circumcision (VMMC) services for HIV prevention in Zimbabwe.

Majority of the Lemba explained their understanding of the concept, describing the procedure as well as its cultural and spiritual meaning. Circumcision for the Lemba is not “just a cut”, but a culturally significant ritual. One experienced *Nyamukanga* (traditional surgeon) said that, “circumcision is a religious tradition turned into a cultural practice. It is a commandment, and therefore for us as a people, it signifies submission to the total will of Allah” (Seremani Seremani, Interview; July 08, 2014). As evident in this statement, Seremani is one of the few Lemba who strongly believe that they belong to the Moslem religion, which essentially contradicts the ‘Black Jews of Southern Africa’ characterisation discussed in the literature review chapter.

When asked about the Lemba identity, Seremani who is also a school teacher cum ‘Imam’ at the local mosque explained the Islamic faith of the Lemba. Having grown up among the Lemba, I had known them to be Christians. However, Seremani explained Arabic names common among the Lemba which I had known since childhood, but had never bothered to discover their meanings. As with the majority of participants, he could hardly hide this emotional attachment to Lemba spirituality. For example, when asked about the alleged ‘abductions of the initiates to go to *Murundu*’ (Lemba male initiation school), he insisted that initiates are not forced but are “taken to their rightful place, and not abducted”.

The spiritual side of this procedure was observed in most participants who explained circumcision from a spiritual perspective indicating that the practice is passed from one generation to the other, with the spiritual realm playing an active role. Chinoda Mupangeri (Interview; July 16, 2014), another traditional surgeon, also noted that issues of Lemba spirituality are associated with the Lemba curriculum. He intimated that the spiritual aspects of circumcision practically manifest in a number of ways where

ancestral spirits play a significant role in the selection of surgeons who then develop their skills under the tutelage of experienced senior surgeons. Secondly, bleeding from the cutting naturally stops immediately upon confession of secrets, such as adultery and witchcraft. For those who are blameless, bleeding generally stops in reasonable time.

Aspects like pain, endurance and confession were reported to be a significant part of the religious aspect of the circumcision process. Despite the fact that Mberengwa district is largely a Christian dominated area with a few Moslem denominations cropping up only recently, the Lemba equally subscribe to, and participate in African traditional religion (ATR), resulting in what may be surmised as mixed spirituality. In most of the discussions, the Lemba would constantly invoke the holy name ‘*Mwari*’ referring to God, yet the appealing to ‘*vadzimu*’ (ancestors) in their circumcision culture was evident. “*Vamwe vanaNyamukanga vanodaidzwa kuhope nevadzimu vakarara*” (some Lemba circumcisers receive their calling by ancestors in their sleep) (Chinoda Mupangeri, Interview; July 16, 2014).

Mixed spirituality mentioned above emerged when Mupangeri referred to a biblical scripture (Joshua 5: 2), where circumcision culture is depicted as a call to the renewal of the covenant. The spiritual dimension of circumcision was also reiterated by Seremani the Imam who revealed that, “with confession, bleeding of the wound stops immediately” (Seremani Seremani, Interview; July 08, 2014). He added that they circumcise in pursuit of cleanliness, “because cleanliness is half faith. Lemba people are highly religious. This shows how spiritually aligned our circumcision is” (Chinoda Mupangeri, Interview; July 16, 2014).

The cleanliness associated with Lemba circumcision is two-fold: spiritually, and also hygienically. Cleanliness is an important aspect among the Lemba so much so that associations with the uncircumcised (as alluded in the bible) is discouraged. For example, my Lemba brother in law is nicknamed MaShumba, which is his wife’s maiden surname because



he married a non-Lemba. It is derogatory in the *Shona* culture to refer to a man using female names as this is synonymous to being sissy. According to Vutsvene Vutsvene (Interview; June 25, 2014), my brother in law earned that name for transgressing Lemba dictates by “marrying a zindji”. Until recently, intermarriages were loathed by the Lemba who regarded the non-Lemba as unclean because of absence of circumcision.

Circumcision for the Lemba is not only religious. Outside religious circles, the procedure has other socio-cultural significance. As with other circumcising cultures, the Lemba consider circumcision as a cultural rite of passage that marks transition from childhood to adulthood. This concept was articulated by all the participants. For Seremani, Lemba circumcision “is a pointer to attained maturity. It is a sign that one is no longer a child; a point in life where one feels important and entirely representative self” (Interview; July 08, 2014). However, this contradicts the fact that boys who can by no means be considered as adults, are seen enrolling into *Murundu*. While these young boys can still benefit from other aspects of this rite such as identity and other Lemba secrets, their age is contrary to Seremani’s view which suggests independence. Even Vutsvene Zamai, another Lemba circumciser conceded that, “Lemba circumcisions are normally done on initiates aged between 8-12 years”, although it is also not uncommon for people to circumcise at ages older than twenty years (Vutsvene Zamai, Interview; June 30, 2014).

In terms of identity, circumcision is considered an important identity symbol that distinguishes the Lemba from other cultural groups. Compared to MMC, Lemba circumcision is much more than cutting off the fore skin, since the manner in which the procedure is done is also important. As such, “one can easily distinguish a medically circumcised penis from a Lemba one” (Vutsvene Vutsvene, Interview; June 25, 2014). This was echoed by one Lemba surgeon employed at the local hospital where MMC services are offered who intimated that, “our circumcision is like a certificate, it authenticates that one has undergone a prescribed course of study. It is an identity symbol equivalent to a notch on cattle ears, it defines who we are. The Lemba are a unique people, and we are very proud of it” (Mafiredzinza, Interview; July 02, 2014).

While the traditional surgeons could not reveal the nature of the cut due to their secrecy, the above revelations may be linked to the dominant view that traditional circumcisions are partial as compared to MMC which completely removes the foreskin. During the five days I

spent with my Lemba nephew Zamai while attending the funeral of a deceased relative, he refused to disclose how the procedure is done. However, when he discovered, while we were bathing in the river that I am medically circumcised, he made no effort - unlike the usual norm when circumcised Lemba men mix with the zindji - to hide his penis during our routine river bath. It is here that I discovered their being partially circumcised. Although they remove some considerable flesh, their circumcision is different from medical circumcision. Be that as it may, he remained adamant regarding description of the procedure saying

Lemba initiation is laden with many tribal secrets. We do not divulge to outsiders. Circumcision is one typical example of a secret that cannot be explained to a non-traditionally circumcised Lemba. We admit that we do practise circumcision in our camps, but it remains a secret until an initiate discovers on his own; and it is then that they discover the rich Lemba cultural heritage. You are welcome to join us in the mountains (Zamai Nebera, Interview; July 11, 2014).

That partial circumcision does not help in preventing HIV infection, has been established and is undisputable. It is in this light that efforts are being made to roll-out MMC in traditional circumcising cultures such as the Lemba.

#### *The traditional circumcision procedure*

In light of the difference between a traditionally and medically circumcised penis alluded to above, majority of the participants were elusive in their description of how a Lemba circumcision is performed. However, they all accepted full knowledge that the procedure takes place in Lemba camps. Farrid, a young traditional surgeon was too careful not to divulge the Lemba secrets, affirming the secrecy and cultural significance of the Lemba circumcision. “Each culture has its own tribal practices, so as the Lemba, we view circumcision as a private topic. It is so private that discussing about is a taboo, especially to the zindji” (Yassin Farrid, Interview; July19, 2014).

However, some participants had a different view about withholding information on Lemba circumcision culture arguing that it is self-defeating because it only succeeds in promoting misrepresentation of facts about the Lemba people and their practices. Most of these participants are perhaps acculturated or more liberal as they have good formal education and a clear understanding of academic research. However, they are very few, probably a third of

the total number of participants. Chinoda Mupangeri gave a fair description of how a traditional Lemba circumcision is carried out. He explained that

the penis has got what might appear as two foreskins, that is the outer, and the inner foreskin. During the circumcision process, it is from the inner foreskin where we take out much of the flesh because it is the one that harbours both odours and other forms of dirt that can cause infection especially when they mix with the vaginal fluids from a woman during sexual activity (Chinoda Mupangeri, Interview; July 16, 2014).

From the above it can be deduced that while it is not clearly stated, Lemba circumcision also encompasses health aspects such as hygiene. This was also echoed by Takavafira Zhou who lamented the myths associated with the secret Lemba culture, stating that MMC is the same as Lemba circumcision especially in terms of procedure. He argued that it is more rewarding to compromise secrecy through correctly writing one's story than to rejoice in having your truth falsified in the name of maintaining secrecy. Describing the procedure, Zhou elaborated that

the manner in which a patient lies on his back facing the sky on a stretcher bed during a modern circumcision procedure is not different from the posture adopted during TMC. The traditional surgeon, with the help of a Nyamusasa (a graduate in charge of all camp logistics) then performs the sacred operation. The traditional surgeon's knife is used on the first initiate. It is then sterilised and put aside. The rest of the initiates are circumcised using razor blades. The Nyamukanga's knife might be used on the last initiate to mark the end of the ceremony. The wound is left to heal naturally. However, herbs are used in certain instances, for example, the roots or leaves of the rare *munyiinyana* tree which is a very effective herb in wound treatment (Takavafira Zhou, Interview; July 31, 2014).

If what Zhou intimates above is true, then it may be argued that the Lemba circumcision procedure is conducted in what can be described as a safe manner that is aimed at preventing infections such as HIV, which can be transmitted through sharp objects such as knives and razor blades.

#### *Infection control during the traditional circumcision process*

As indicated in the previous chapters, during the early days of the HIV epidemic, male circumcision is one of the cultural practices that were blamed for being a vehicle for the spread of HIV, through practices such as using one knife or razor blade on several initiates

(see Gausset, 2001). Conceding that indeed this used to be the practice, Matanda Makuru indicated, however, that because

nowadays even some of our children are born infected with HIV; we have got to make sure that precautions are taken to prevent the spread of HIV among the initiates. When they buy the razor blades, they have to buy in large quantities. Unlike in the previous days where they could use one knife, razors are now common (Matanda Makuru, Interview; July 25, 2014).

As indicated by Matanda Makuru above, measures to control infection during the circumcision process became essential, and have been recognised in the Lemba camps. Most participants explained that traditional surgeons take adequate precautions to ensure that the health of initiates is not compromised in the name of cultural commitment. Participants revealed that measures to curb the spread of diseases among initiates, particularly HIV/AIDS, have long been adopted before MMC was promoted in Zimbabwe, beginning in the early 90s.

It is almost two decades since Lemba circumcisers began to exercise strict infection control during circumcisions, particularly that of initiate to initiate transmission of HIV infection, as well as infection between the circumcised and the surgeon; and the other way round” (Mashura Masiya, Interview; July 26, 2014).

Majority of participants concurred with Mashura’s claim. “I remember it was in the early 1990s when I visited a camp at Rusaza. They were not using the same cutting instrument” (Takavafira Zhou, Interview; July 31, 2014).

It also emerged that practices meant to promote health among the initiates in a Lemba camp are a priority, as the health of initiates is a major concern. For the participants, prior to the circumcision process, health problems of initiates are identified and addressed accordingly. For example, asthma patients are given preferential treatment and warm conditions so as not to compromise their health (Seremani Seremani, Interview; July 08, 2014).

Another health concern which is related to the above pertains to handling of surgical waste which in public hospitals, is regulated by the Human Tissues Act of 1982 (Makwati, 2014). In the Lemba camps, this concern relates to the disposal of the cut foreskins, the process of which if not done properly, may be a source of diseases (Phorano, Nthomang, & Ngwenya, 2005). Asked how (if ever) this process occurs in the camps, Seremani Mani indicated that the traditional surgeons are equally concerned with human tissue. He confided that the skins

that are removed during the circumcision operation, “are handled with due care because culturally, human flesh is dangerous. It is a source of danger in that it can be used to harm the initiate in a number of ways” (Seremani Mani, Interview; June 28, 2014).

However, the foreskins are not disposed of immediately after the operation as some cultural rituals relating to the tissue have to be observed throughout the duration of the camp. Takavafira described the processes that are involved to preserve the foreskins for the duration of the camp before they are eventually disposed of. He stated that, “traditional medicine is poured over the foreskins in order to allow them to dry. It is kept in an animal skin until the last day when the *college bedrooms* and *lecture rooms* are pulled down” (Takavafira Zhou, Interview; July 31, 2014). He revealed that the tissue is then burnt on the day the initiates return home.

The processes indicated above not only suggest that the Lemba are concerned about the cultural significance of the foreskin, but also with the health of the initiates. The ways through which the human tissue is preserved, as indicated by participants, is also a public health matter as it is done in ways that are aimed at preventing diseases.

Because of the reluctance of the Lemba to share the secrets of their culture, much of this information is unknown. This, as Zhou indicated, results in misinformation about the Lemba culture. Similarly, secrecy by traditional circumcisers deprives public health practitioners of important information (Mavundla et al., 2009). As already noted in the preceding chapters, divulging secrets is a punishable offence. Anyone who is found guilty of disclosure, is liable to a fine, usually the equivalence of a beast, or a thorough lashing using the ‘*tubha*’ (a special Lemba whip) would suffice particularly for the young people who do not own cattle (Mashura Masiya, Interview; July 26, 2014).

This secrecy, as argued earlier, sometimes has negative consequences. For example, Mashura who is an elder in his local Lemba traditional council kept a stash of MMC promotional material he reported to have been distributed by medical surgeons for sharing with other traditional surgeons in his council. However, he did not distribute ostensibly because he did not like the fact that among the medical surgeons were women, who are not allowed to discuss Lemba men issues. While there may be similarities between TMC and MMC in many respects, there are other marked differences which are irreconcilable such as the involvement

of women as surgeons. As such, the traditional surgeons have divided opinion over MMC as discussed below

### **Perspectives on medical male circumcision**

Majority of participants could recall the degree of protective efficacy as 50-60%. More than 75% of participants described the protective mechanism of MMC and others without formal education only indicated its protective benefit. They made it clear that the two circumcision practices are completely different, serving different purposes. “*Murundu* is not for HIV prevention. However we are aware of medical male circumcision for HIV prevention, it is professional knowledge which we do not have a basis to dispute” (Seremani Warehwa, Interview; July14, 2014).

Claiming that even if they have been circumcising for generations, Yassin Farrid indicated that they had no prior knowledge that circumcision would, apart from enhancing hygiene, help reduce sexually transmitted diseases. While participants had fair knowledge about the protective efficacy of medical male circumcision for HIV prevention, that the Lemba embrace a circumcising culture does not suggest that MMC acceptability among them is automatic. Dismissing MMC as a hollow procedure that cannot supplant traditional circumcision, Mwana WeUmambo reiterated the religious character of Lemba circumcision discussed earlier noting that “it is a bond with God. We circumcise with a meaning while Smart [MMC] is an empty process, and that is why we don’t feel threatened by it (MMC). In a way, its popularisation strengthened our tradition” (Mwana WeUmambo: Interview, July 10, 2014).

As can be drawn from Mwana WeUmambo’s statement above, there are fears that MMC might have an agenda to challenge Lemba circumcision. This perception common among the Lemba, was held by other participants who appeared to detest MMC for many other reasons including that of “normalizing the abnormal”. Here the blame against MMC is that it allows discussion of the unsaid (circumcision) in spaces which used to be regarded as wrong platforms for such discussions (Seremani). It was thus felt that MMC indirectly affected the Lemba culture in a negative way in that it made their culture a subject of discussion not only by ordinary people, but also by experts and specialists across the field of health and social sciences.

However, given the fact that in the recent past even some *zindji* could go to *Murundu*, most participants view MMC as a blessing in disguise particularly to the secretive Lemba culture which had slowly become perverted by this development (Zimie Mupangeri, Interview, July 04, 2014). Conservative traditionalist, mainly the older Lemba circumcisers were happy that with MMC, “non-Lemba people that would have wanted to join us in our Lemba initiation, can now be kept at bay because we have an alternative route to suggest to them” it (Zimie Mupangeri, Interview, July 04, 2014). As with other participants, Zimie disapproved the idea of accepting non - Lemba initiates into the circumcision culture, a tradition that is meant for the Jews of Africa. The Lemba were hurting that the *zindji* initiation graduates had previously “disappointed us by divulging our tribal secrets. Unfortunate stories such as these made us feel that MMC is a positive development which protects our interests as the Lemba” (Zimie Mupangeri, Interview; July 04, 2014). They maintained that secrecy is an important socio-cultural aspect of their tradition which, however, was being compromised by non-Lemba initiation graduates.

While acknowledging the above issues, other participants however acknowledged MMC’s positive contribution to public health. Chihora Chihora shared that “while we feel that our culture has been invaded, that it is now treated like a common culture and has therefore lost its past dignity, we feel morally compelled to embrace MMC because the life we are living is full of diseases” (Chihora Chihora, Interview; July 21, 2014). While this view appears to inspire confidence in MMC especially with regards to its supposed HIV preventative efficacy, MMC is largely viewed suspiciously by the Lemba particularly by those who think that it is there to “pervert” their culture. The feeling that MMC brings some challenges to the integrity of the Lemba culture featured strongly among other participants, so much so, that it is perceived as a threat to the Lemba culture.

### **Medical male circumcision as a threat to Lemba culture**

There are many ways in which MMC has conceivably threatened the Lemba culture. The central bone of contention is that Lemba circumcision is not just a nick but a very important practice that defines the Lemba identity and their culture. This is especially true considering the fact that there are important rituals that are performed as part of the circumcision process, over and above the surgical operation; there are specific people allowed to be surgeons, it is a secret process done in the mountains, among other things.

Firstly, participants expressed displeasure about the fact that graduates of “MMC” limp in the public domain after the procedure as they are released to heal at home. This is contrary to Lemba tradition where initiates heal in seclusion before being released. They feared that limping in public brings shame and uneasiness to traditional surgeons who feel exposed. Most were “not comfortable with MMC graduates who walk with difficulty due to medical circumcisions. It exposes us as fellow surgeons. It is lacking in terms of the dignity that is carried by our own circumcision” (Seremani Seremani, Interview; July 10, 2014).

The use of woman in MMC not only as surgeons, but also to disseminate MMC messages is loathed by the exclusively male traditional surgeons. Most participants registered their discontentment with the involvement of women in MMC campaign teams because it is against their cultural values for women to talk about circumcision. This was revealed by one Lemba circumciser Mashura Masiya who said that “we have a problem with MMC because they involve women. We find it humiliating that women talk openly about circumcision. Men are the only ones with the right to discuss about circumcision”, (Interview; July 26, 2014). Participants revealed that traditionally in male circumcision, women play peripheral roles, such as cooking for the initiates in the camp.

An overall concern was the blame against MMC that it posed a threat to the continued existence of Lemba circumcision, as the Lemba men are now expected to undergo MMC. Participants decried that MMC does allow fellow tribesman an opportunity to observe and get enriched by the cultural rituals that take place in *Murundu* camps, as described in the previous sections. The hollowness associated with MMC was reported to be undermining the Lemba culture. Not only does the secretive nature of circumcision ceases to be meaningful under MMC, but things like getting new names after circumcision as well as crucial moments like confession of ills by defiled initiates, are all absent in MMC.

Conceivably, the above has serious implications for the uptake of MMC among the Lemba who perceive it as bent to undermine their culture. All participants reiterated that the Lemba are very secretive and want to continue with tradition as such. Takavafira Zhou clearly stated that “secrecy is an effective strategy. It is believed to be the only source of strength, and once you tell other people about what you do, you are bound to lose the value of it. Lemba secrecy is a patent” (Takavafira Zhou, Interview; July 31, 2014). Indeed this and other factors result in MMC being shunned among the Lemba as evidenced by the refusal of the Lemba to accept



services of medical surgeons who, through the Zimbabwe Association of Christian Hospitals (ZACH), had offered to assist circumcising Lemba initiates in *Murundu* camps (Mwana WeUmambo: Interview, July 10, 2014). “Medical surgeons wanted to get closer to us, but we wouldn’t allow them because we have secret lessons we conduct. These include men’s health and matters of handling of marriage.” (Chinoda Mupangeri, Interview; July 16, 2014).

As can be deduced from the above, the repugnance against medical surgeons is linked to its threat to the secrecy clouding Lemba circumcision. Due to the shunning of MMC, negative myths have been propagated, leading to the suspicious perceptions being held against MMC.

True Lembas are suspicious of the whole MMC project. By true Lembas I mean those who are not ready to sacrifice our tradition for money (Mwana WeUmambo, Interview; July 10, 2014). The people from ZACH are corrupt, and we have evidence to support this. MMC people offered to assist with food and medical kits, they eventually reneged (Takavafira Zhou, Interview; July 31, 2014).

Indeed suspicion against MMC is rife. Mashura and Chakosha believed that MMC removes excessive skin, and that it is unnecessarily painful to the initiate. Citing examples of some people who developed complications in the area after undergoing MMC, they believed that this was a result of the removal of excess skin. They claimed that such people end up seeking treatment from the Lemba herbalists: “MMC is a painful procedure. Some of the MMC clients end up seeking help from us; even your cousin, the one in school, came here smelling, and I helped him (Mashura, Interview; July 26, 2014). It is important, however, to note here that even though the Lemba expressed the above fears, it is ironic that not only pain but many deaths resulting from botched circumcisions have been reported in traditional circumcision camps especially in South Africa. As already shown in Chapter Two, while reported deaths of initiates are rampant in South Africa, the problem - though not uncommon - has not been reported in Zimbabwe in the past two years (Chakanyuka, 2014; Dube, 2014).

It is evident from the foregoing that the participants showed some negative perceptions about MMC, viewing medical surgeons with suspicion and propagating false myths against MMC aimed at discrediting in order to repel the perceived threat against the Lemba culture. This undoubtedly presents challenges to the calls for transformation of traditional circumcision by incorporating elements of medical circumcision to ensure safety of the initiates.

Regardless of the suspicions, participants, however, expressed interest in incorporating medical elements for the safety of initiates. Be that as it may, issues of cultural autonomy and a desire to maintain the Lemba culture were emphasised. As Chakosha Zhou put it, any collaboration must be aligned with the Lemba's cultural norms, and only the Lemba circumcisers must perform the operations in the *Murundu* camps.

One of the main challenges is that medical surgeons want to patronize us, looking at our culture as backward, yet we are the foundation when it comes to circumcision culture. They disregard cultural boundaries by making attempts at supervising our circumcisions in the initiation camps, which is a hopeless case because only those who are circumcised the Lemba prescribed way, can do that (Chakosha Zhou, Interview; July 26, 2014).

The above statement conjures the same resistance against what may be viewed as cultural attack, discussed in the foregoing. The same sentiments were echoed by Omari Omari who intimated that as the Lemba “we are the foundation. The government must come to us because we have been doing these circumcisions for generations, it is our culture” (Omari Omari, Interview; July 10, 2014).

It can be concluded from the foregoing that, participants were ready to accept not MMC per se, but incorporation of the elements of MMC into TMC in order to ensure the safety of the initiates. What emerges from these findings is that MMC, from the Lemba cultural lens, is essentially not “culturally congruent”, meaning that there are certain aspects which are at cross-roads with Lemba culture. That the Lemba circumcision's cultural bias presents challenges to the uptake of MMC among the Lemba appears to be true; especially considering the foregoing. However, the CCA framework employed for this study sees culture as an opportunity that can be utilised to promote health in society (Airhihenbuwa, 1995; Dutta, 2008). Ways through which MMC uptake among the Lemba can be scaled-up through possibilities provided for by culture are discussed in the next chapter.

## CHAPTER FIVE

### DISCUSSION OF FINDINGS

#### MAXIMISING VOLUNTARY MEDICAL MALE CIRCUMCISION UPTAKE AMONG THE TRADITIONALLY CIRCUMCISING LEMBA PEOPLE

The objective of this chapter is to discuss ways through which VMMC uptake among the Lemba can be increased through possibilities provided for by the Lemba culture. The culture-centred approach (CCA) is used to shade light on findings. However, each views the other with suspicion, especially traditional circumcision which has been blamed for causing deaths, and also as a vehicle for HIV transmission. Such views have in turn prompted the Lemba to consider medical male circumcision (MMC) as bent on undermining their culture, a concern which has been shown to hinder acceptance and uptake of MMC among the Lemba. Below is a discussion of socio-cultural factors that emerged as hindrances to the uptake of VMMC among the Lemba. These factors can also be considered as the resources that can be used for the scale-up of VMMC roll-out among the Lemba communities.

#### **Culture**

A discourse of resistance permeated some of the Lemba perspectives on MMC for HIV prevention. Resistance refers to a “process of enacting agency in opposition to the structures that constrain the access to basic resources of life, including the fundamental resources of healthcare” (Dutta, 2008, p. 220). Most of such responses located Lemba resistance within the wider context of power and control. Resistance to MMC existed despite widespread acknowledgement of the benefits it offers. Lemba responses can be interpreted as “informed by an explicit emancipatory ideology designed to challenge the status quo [with regards to] power relations” (Friesen, 1999, p. 291). The findings showed that Lemba cultural autonomy is threatened by MMC. The impact of skewed power relations between the Ministry of Health and Child Care (MoHCC) being the gate keepers and custodians of the health of citizens on the one hand; and the generality of Lemba circumcisers on the other hand is quite clear. It is a fact that the MoHCC has hegemonic power, which seems consistent with Laverack’s characterization of the medical model. Laverack argues that “the medical model serves to protect the legitimate and expert power of the professional” (2004, p.40). In Foucauldian

terms, “hegemonic power is that form of power-over that is invisible and internalized such that it is structured into our everyday lives and [is often] taken for granted” (Laverack, 2004, p. 38; also see Dutta, 2008). Laverack posits that where power differentials exist, it is necessary for the dominant stakeholder to foster the collective empowerment of the less powerful.

Gwandure (2011) argues that the medical model has, in the interest of achieving public health objectives, a long history of looking at TMC as a backward practice, worth abandoning (also see Ntombana, 2011). Furthermore, Dutta (2008) argues that the biomedical model is often viewed as the only appropriate model due to its scientific basis and hence is perhaps the only legitimate resource for tackling health challenges within the modernist paradigm (also see Good, 1994). However, it is important to recognise that the exercise of power-over should not be constantly viewed as negative (Laverack, 2004). For example, promoting MMC for HIV prevention could be said to constitute ‘healthy’ power-over, since the Lemba agree that reducing HIV infection has never been the aim of their circumcision.

The findings suggest that there may perhaps be compatibility issues between these two models as each one of them strives for survival and recognition, despite that they apparently serve different purposes. The above argument by Gwandure finds resonance in Murove’s view that, “the western-oriented health care system has presumed that satisfactory health care would prevail in Africa only once traditional health care had been converted into western” (2009, p. 158). On the other hand, Lemba circumcisers also claimed the therapeutic bias of their circumcision culture which however didn’t include HIV prevention. Perhaps it is within this context that the Lemba felt the need to resist the “self-proclaimed supremacy of the western health care system” manifested in MMC (Murove, 2009, p. 158).

However, the idea of incompatibility between the two models mentioned above; the western oriented medical approach and the African traditional medical practice is rejected by Mutwa. According to him, part of what African medicinal expertise had was only accepted later by the Western oriented medical system after it had been condemned globally (Mutwa, 1996, cited in Murove, 2009). Therefore, one can argue that the Lemba viewed legitimising the discourse of circumcision for HIV prevention as a way of endorsing the biomedical hegemony through a practice they have known for almost an eternity.

The CCA generally questions the dominant ideology of health care systems, particularly how it favours the interest of those who wield power within a social system (Dutta, 2008). By resisting advances by the MoHCC to promote MMC, Lemba circumcisers are exercising their agency as they strive to protect their cultural interests. Scott argues that “the covert non-violent forms of resistance entail a cultural struggle or artful form of resistance against power structures” (1990, p. 96). These findings draw attention to cultural members’ struggles to maintain or reclaim their identity. The findings are similar to those of other studies conducted elsewhere. Both the Luo of Uganda and Kenya, resist MMC on cultural grounds, citing undesirable consequences such as discrimination (Kitara, Ocerro, Lanyero & Ocom, 2013). Similarly, elders among the Yao of northern Zimbabwe initially raised concern over, “contamination of their [the Yao] cultural rite and identity” (Daimon, 2013, p. 302). However, the elders finally changed attitude and embraced MMC among Yao initiates.

#### *Lemba circumcision and social status*

Lemba cultural identity is related to other socio-cultural aspects such as social status. Social status has from time immemorial played a significant role in the African cultural ethos as represented in Chinua Achebe’s classic novel *Things Fall Apart*. The ability to feed ones’ family with yam, regarded as a man’s crop was highly regarded (seen as a status symbol). Similarly, social status is a major concern among traditionally circumcising tribes. Lemba circumcisers accord a high social status to TMC initiates. Studies on the Xhosa show that those medically circumcised males are ostracised and treated with contempt and disrespect (Mavundla et al., 2009). They are described as having cats’ claws, referring to suture marks (Mshana et al., 2011). Therefore, culture has the capacity to limit adoption of innovations such as MMC. The implication on policy is that MMC should be innovative and incentivised.

To regain their social status, Lemba men who undergo MMC (labelled *Ruvangu*, a derogatory name), are made to go to *Murundu* where incisions are made below the glans penis due to absence of the foreskin. This process can be viewed from an anthropological perspective as an act of reintegration. The deliberate cutting of a totally circumcised penis is both a public health concern and a moral issue. This is a novel finding, and thus it provides new knowledge.

Policy makers should perhaps rectify this problem by aligning TMC with MMC. For example, the marketing of MMC standards among the Lemba circumcisers through cultural leadership has the potential to reduce stigma, and increase acceptability. Similarly, Westercamp and Bailey (2007) argue for the engagement of religious leaders prior to promoting MMC as a rewarding approach.

#### *Possible discrimination or alienation from the group*

Lemba circumcisers indicated that their own circumcisions may not meet the standard recommended by the WHO (2007; Gwandure, 2011). Despite their perceived vulnerability to HIV infection; fear of possible discrimination by those who traditionally circumcised forced them to shun MMC. The desire to pursue social identity proved more attractive than the perceived benefits of MMC. This finding is not unique. According to a study by Mavundla and others (2009), Xhosa initiates normally delay seeking medical attention when they experience complication due to fear of possible discrimination. The general implication on health interventions is that each cultural community should be treated as a unique set whose perspectives of a given health problem should be independently investigated without prejudice. Murove (2009) argues that, “no particular health care practice should be postulated as engendering eternal truths applicable regardless of cultural context” (p. 166). This argument is echoed by Airhihenbuwa when he says that “each culture creates its own responses to health and disease” (1995, p. 6).

#### *The Lemba, secrecy and ‘necessary lies’*

As the finding shows, maintaining secrecy was seen as being extremely important among the Lemba. A majority of participants explained that secrecy is important for the survival of the Lemba culture. The need to maintain secrecy was conceptualised at two levels, the individual and the collective. At the individual level, secrecy served to keep prospective initiates ignorant so they become enthusiastic to join the community of the circumcised, and make own discoveries of the rich Lemba cultural heritage.

The collective level is much deeper; and it is that of social cohesion. The concept of social cohesion, closely related to social capital is linked to the theories of French sociologist Emile Durkheim (1858-1917), who conceptualised social cohesion as the glue that binds society. Durkheim linked social cohesion to positive health outcomes (Kawachi, Kennedy & Lochner, 1997). According to the CCA social capital is the degree of “community cohesiveness and

interpersonal trust within the social system”, and is a social determinant of health (Dutta, 2008, p. 163; also see Kawachi et al. 1999). These findings are similar to most studies among traditionally circumcising communities (Mavundla, et al., 2009; Mshana et al., 2011; Shoko, 2009; Daimon, 2013). This common thread is explained by Peter Kasenene’s position that; “[d]espite variety, there is a common Africanness about the culture and world-view of Africans” (2000, p. 348).

Lemba explanation about their secretive culture was that there are certain matters of a high sensitivity such as confessions which accompany the TMC procedure. Initiates or their parents, divulge certain social secrets they are privy to such as *runyoka* and *chikwinho*. Runyoka is a traditional medicine, usually with an adhesive effect on sex offenders and it is used to safeguard against adultery by married women while chikwinho is a lethal medicinal weapon for fighting legitimate warfare among community members. As such, these confessions are important because they serve as an exercise for purging the Lemba community of its social ills. It provides a set of checks and balances necessary to sustain life within a Lemba community.

This study established that important cultural intricacies such as confession and confidentiality constitute an integral part of the whole Lemba initiation process. By contrast to other circumcising communities such as the Yao, it is essentially different because the Yao allow their initiates to be circumcised in clinical settings before they are taken to initiation school where they gain mastery of the Yao curriculum (Daimon, 2013). The implications for designing health promotion interventions within such communities as the Lemba is to actively engage them in dialogue so that they suggest viable ways of achieving the desired health outcomes while they maintain their cultural practices. This is typical enactment of agency.

However, the Lemba gave an elixir of hope that collaboration is possible. Principles identified as critical are respect for cultural taboos, honesty; transparency, and accountability. Collaboration is conceivable if the above guiding principles are foregrounded. This has larger implications on policy formulation that cultural groups should be engaged in utmost good faith, if public health interventions are to stand a good chance of success. Clearly, this is a display of Lemba agency since opportunities for creation of synergy are quite evident.

However, there were indications of willingness among the Lemba circumcisers to cautiously cooperate with medical surgeons so as to transform Lemba circumcision procedure in a culturally appropriate way. This transformation would allow Lemba circumcision to achieve the HIV preventative efficacy that the medical procedure strives for. The Lemba view possible synergies with the biomedical approach as critical in averting cross-infections during traditional surgery thereby ultimately reducing morbidity. Since the Lemba have shown commitment to promoting health among the cultural members, MMC uptake can be scaled-up among this community. Indeed the culture-centred approach (CCA) framework employed for this study sees culture as an opportunity that can be seized to promote health in society (Airhihenbuwa, 1995; Dutta, 2008).

*A culture-centred approach to rolling out VMMC among the Lemba: Question of agency*

The finding that the participants in this study acknowledge MMC as a welcome development in strengthening efforts to contain the HIV epidemic is important. This is critical to the objective of this study, particularly the interest of this chapter to explore effective ways of VMMC roll-out in such a community that has had circumcision as part of their tradition. That this is so is especially true in light of the suspicion that MMC is bent on destroying the Lemba culture. In the following pages, culturally conformant ways through conceivable application of MMC elements to Lemba traditional male circumcision (TMC) while maintaining its cultural and religious significance are explored.

*Giving agency to Lemba circumcisers to conduct MMC procedure in Murundu camps*

The finding regarding sanitising certain practices in the context of HIV prevention is not new. A typical example of a public health intervention program known in the history of HIV and AIDS is the Syringe Exchange Programs (SEPs) among injection drug users (IDUs) meant to sanitise the process of drug injection (Lurie & Drucker, 1997). In the same way, this study shows that Lemba circumcision practices can, through synergies with the MoHCC or practitioners of MMC (Dutta, 2008), be sanitised. This can be achieved in two significant ways namely giving the Lemba professional surgical training on how to circumcise for HIV prevention, and/or utilising former *Murundu* graduates who are already practicing as medical surgeons to circumcise initiates in *Murundu* camps.



The fact that participants described how their circumcision practice attempts to ensure safety of initiates from infections such as HIV is critical in cementing this cooperation between medical and Lemba circumcisers to increase uptake of MMC among the Lemba. The flexibility and readiness of the traditionalists to adapt by receiving professional surgical training is supported by previous research among the Tonga of Zambia (see Gausset, 2001). This capacity to change or adapt in order to remain relevant is known in the CCA as cultural capital (Airhihenbuwa, 1995). Here indigenous knowledge is considered as dynamic as it changes through indigenous creativity and innovativeness as well as through contact with other knowledge systems (White, 1999).

Opportunities for collaboration between Lemba circumcisers and medical surgeons can thus be increased not only on the basis of the readiness of the Lemba to receive training, but also on the fact that, as shown in the previous chapter, they seem to be concerned about possible disease transmission through their practice. The Lemba awareness of the threat of infection during traditional circumcision prompted them to suggest the use of medical practitioners who graduated from *Murundu* to monitor Lemba circumcisions (Seremani Seremani, Interview; July 08, 2014). Their commitment to stem the spread of HIV infection within their cultural context has implications for public health. For example, it shows that collaborative efforts between the Lemba and medical surgeons can lead to successful health promotion interventions.

However, the use of fellow Lemba with medical expertise was resisted by other Lemba circumcisers who feared that their power and control would be usurped. For the Lemba, being a *Nyamukanga* is an achievement normally gained through upward mobility within the hierarchy of Lemba traditional structures. The old generation of surgeons who are often conservative, coupled with a lower level of formal education tend to resist such innovativeness. To the contrary, a study among the Yao of Northern Zimbabwe found that Yao traditional surgeons ceded power to the medical practitioners to circumcise initiates on their behalf (Daimon, 2013). Dialogue between the Yao leadership and the MMC implementation partners led to a development where medical practitioners conduct the circumcision procedure on Yao initiates. Similarly, dialogue with the Lemba may yield the same results leading to increased uptake of VMMC.

Be that as it may, capacitating traditional Lemba circumcisers with surgical skills to conduct circumcisions in *Murundu* camps may in a way help sanitise Lemba circumcisions. This is an exercise of agency. As articulated in the CCA, agency among cultural members conjures elements of self-efficacy articulated in Bandura's social learning theory (Bandura, 1986) as a situation whereby people feel content in their abilities of self-determination. According to the CCA; "agency refers to the capacity of human beings to interact with structures in order to create meanings; such meanings provide scripts for interacting with structures, for sustaining these structures, and for transforming them" (Dutta 2008, p. 61). As shown in the previous chapter, the Lemba have an abundance of political will which may translate into creation of synergy between Lemba circumcisers and medical surgeons' perspectives when developing VMMC programmes for HIV prevention in Mberengwa. From a CCA, possession of political will shows agency. However it is critical to recognise that in as much as political will is important; it is not an end in itself.

#### *Involvement of the Lemba in the promotion of VMMC in Lemba communities*

Participation of cultural members is very critical in community interventions (Laverack, 2004). Similarly, de Villiers and Herselman (2004, p. 25) suggest that an important principle to apply in health-care settings is that of empowerment of the community "to participate in their healthcare, which means that they must be able to participate in decision-making in issues affecting their health". The previous chapter indicated a heightened desire among participants to cooperate in the roll-out of MMC. Another way through which this can be achieved is through involvement of the community in the process of planning VMMC promotion interventions among the Lemba. From a CCA perspective, participation of local communities in the planning and development of health promotion interventions is important in that the programmes become culturally appropriate.

For example, the issues of female facilitators in the dissemination of MMC information, and use of female surgeons have been noted as being culturally inappropriate in the Lemba communities. Lemba men regard involvement of the opposite sex in circumcision as taboo. Involvement of the Lemba, even at consultation level, might ensure that such contentious issues are avoided. Through synergies with medical surgeons, the government and its donor agencies can develop policies that are aligned with the Lemba cultural practices in ways that can increase uptake of VMMC among the Lemba.

A culture-centred approach views the above as recognition of the need for cultural members to negotiate with authorities in order for them to participate in changing or formulating policies that impact on their health. This, as discussed in Chapter Two, represents the interplay between three elements of the CCA namely culture, structure and agency (Dutta, 2008). Such engagement between communities and authorities transforms the subject – object relationships to a subject-subject relationship (Singhal, 2013). At the heart of such relationships is the concept of empowerment (White, 1999), which entails not only the sharing of power and scarce resources, but also deliberate efforts by social groups to control their own destinies and improve their living conditions (White, 1999).

Instead of the MoHCC holding workshops to disseminate MMC information to the Lemba, the subject - subject relationships will entail the Lemba circumcisers suggesting to the authorities how MMC can be rolled out in meaningful and acceptable ways. This as outlined above may include the use of Lemba initiation graduates who obtained medical training to conduct MMC in *Murundu* camps. Lemba circumcisers made it clear that their active involvement in MMC interventions can aid collaboration particularly through building trust in one another. According to Dutta (2008), active participation by cultural members is important because it creates an opportunity for knowledge to be co-constructed, which gives room for health meanings to be shared.

Responses from participants showed that information on MMC was readily available due to the use of various forms of communication media to disseminate information on MMC. The dominant forms of communication cited as the main sources of MMC information are; the print and electronic media. The newspaper, pamphlets, and posters were identified as the main channels of MMC messages, followed by the television.

However, one salient feature of the CCA to health communication is dialogue. Freire (1970) views constant dialogue as a means of conscientisation. The Lemba raised concern over the absence of meaningful dialogue between the Lemba cultural members, and the MoHCC. This is contrary to what Mavundla and others recommend that, “public health education should be a two-way process that is culturally sensitive and respects tradition” (Mavundla et al., 2009, p. 403). This study is similar to previous studies that highlight the need for interactive and participatory communication in public health interventions. This is important because dialogic communication can enhance programme survival as stakeholders (cultural members)

develop a sense of programme ownership. This helps reduce both micro, and macro-practices of resistance (Dutta, 2008). The ability of Lemba cultural members to critique the status quo and also identify the shortfalls within the healthcare system, “represents proof of [their] agency” (Bungay, Halpin, Atchison & Johnston, 2011, p. 16).

Through dialogue, health care system communication creates platforms to enable marginalised communities to access meaningful health care information (Dutta, 2008). The Lemba negotiate their health through interaction with authorities through negotiating for supplies of razor blades, gloves and other equipment from local clinics. Allowing Lemba participation is an enactment of agency, otherwise due to their being a minority group in Zimbabwe’s health care system, the Lemba occupy a position of subalternity. Their voices run the risk of being permanently erased from the discursive spaces. Be that as it may, the MoHCC deserve commendation for passing on information on MMC even though research has shown the failure of an emphasis on knowledge alone in bringing about behaviour change (Van Empelen, Kok, Schaalma & Bartholomew, 2003; Servaes, 2008).

## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

This study examined the perspectives of Lemba circumcisers on medical male circumcision for HIV prevention in Mberengwa district, rural Zimbabwe. The study interrogated the socio-cultural factors that influence collaboration between Lemba circumcisers and the Ministry of Health and Child Care (MoHCC), and its MMC implementation partners. The culture centred approach (CCA) was used as a conceptual framework to help contextualise Lemba responses to the call by the MoHCC for citizens to consider adopting MMC for HIV prevention. The CCA was an appropriate conceptual framework for this study in that gaining an understanding of the scope of the study required one to question the role of both the health care system in popularising MMC on the one hand, and that of the Lemba cultural members on the other hand where greater involvement of the Lemba can increase uptake of VMMC.

A number of conclusions were made. For example, it emerged that both circumcision types are lauded for offering multiple benefits that include partial protection from STIs and increased hygiene. These common benefits nurture the hope for collaboration. It was evident that Lemba culture is dynamic and transformative. These are important elements that can enhance collaboration with medical circumcisers. Although the fact that MMC is offered in public health facilities across Zimbabwe at no cost could be viewed as an incentive, this study has shown that increasing MMC uptake among the Lemba requires unfailing commitment from both parties (Lemba circumcisers and medical circumcisers) to create meaningful synergies through dialogic engagement. The findings are clearly reflective of the fact that there was, and continues to be, a paucity of dialogue between the two circumcision cultures.

The lessons learnt can be applied in the other context and these indicate that, in terms of collaboration between TMC and MMC, there are a number of challenges that require commitment and mutual co-operation to overcome. It emerged that despite the Lemba's knowledge of MMC's protective efficacy against HIV transmission, they are reluctant to abandon their *modus operandi* in favour of MMC due to some deep rooted cultural dictates that guide Lemba circumcisions. Confession and secrecy distinctly emerged as critical to the survival of Lemba culture, and they are closely linked to the procedure, circumcision.

Confession is important and it must be done prior to the procedure, since it heavily relies on secrecy. The issue of confession makes the use of non- Lemba circumcisers difficult since the initiate must confess to the traditional circumciser himself.

The results of this study show that the Lemba are aware of the factors that limit collaboration from reaching a level beyond the MoHCC's supply of medical kits required for carrying out circumcisions at *Murundu* camps. Since the Lemba acknowledge the efficacy of MMC in reducing HIV transmission, they identified possible ways of forging a relationship with the health care system that could result in MMC standards being adopted in Lemba initiation. They suggested that offering refresher courses to Lemba circumcisers on how to sanitise traditional circumcisions to meet quality medical health standards in traditional settings is one way of ensuring that MMC standards benefit the Lemba.

While this study is not a policy document, some recommendations can be made based on the findings presented in the foregoing.

### **Recommendations**

The following are recommendations to the challenges that emerged as impeding collaboration between Lemba TMCs and MMCs in Mberengwa district of rural Zimbabwe.

#### **The Lemba cultural community**

As a cultural community the Lemba should establish a cultural and medical board specialising in matters of health and hygiene. The board should be formally registered with the relevant central government ministry. It is envisaged that this board will facilitate liaison with the MoHCC, and articulate issues related to the health and safety of initiates during traditional initiation rituals, and to safeguard the interests of the Lemba in general. Furthermore, having a formal structure responsible for a particular cultural aspect helps establish proper, functional and legitimate channels through which Lemba affairs can be articulated both from a bottom-up approach, and vice-versa. By so doing, the voices of the Lemba circumcisers will enter the dominant discursive spaces, and bring about the necessary change as need be.

Forming a recognised portfolio such as a cultural and medical board could increase Lemba cultural members' potential to lobby for policy formulation or implementation, and also

mobilise resources required for their rituals. Both accountability and transparency in handling external resources extended to the Lemba by government, NGOs and other stakeholders would be enhanced. Critical processes such as monitoring and evaluation of health interventions are made feasible if such a portfolio is established within the Lemba cultural community. There is also the need for the formation of a council of traditional circumcisers, which would coordinate the affairs of all traditionally circumcising communities in Zimbabwe.

### **The state and its MMC implementation partners**

The state, NGOs, donor agents and other stakeholders should aim to increase dialogue with, and participation of traditional circumcisers in the planning, implementation, monitoring and evaluation of health promotion interventions among the Lemba. Effort must be made to design practical approaches that can result in maximum participation by cultural members. One may not deny the fact that greater involvement of Lemba cultural members in particular, and other traditional circumcisers in general might lead them to an enhanced sense of 'being empowered'.

Regardless of how plausible the above mentioned recommendations may be, it is important to note that they are limited to this study and may not be applicable in every context as explained below.

### **Limitation of the study**

Due to the fact that this study reflects views of a particular group in a particular context; that is the Lemba people of Mberengwa, the findings, conclusions and recommendations emanating from the study cannot be generalised. Neither are they applicable in different contexts. It is also possible that different findings could have been arrived at if among other things, the methodology employed for the study was different or sample expanded. While this limitation affects transferability of the study to different contexts, the fact that the study was conducted in a systematic manner and framed within extent theories and methodologies explained in Chapter Three, its transferability cannot be dismissed. Researchers who feel that the context within which the study was conducted is reflective of their own, can therefore refer to the described methodology and transfer the study to their context. According to

Bassey (1981), it is the responsibility of the researcher who seeks to transfer the study to make sure that they conform to the described methodologies.

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Seremani Mani, Interview; June 28, 2014

Vutsvene Zamai, Interview; June 30, 2014

Mafiredzinza, Interview; July 02, 2014

Zimie Mupangeri, Interview; July 04, 2014

Seremani Seremani, Interview; July 08, 2014

Mwana WeUmambo: Interview, July 10, 2014

Omari Omari, Interview; July 10, 2014.

Zamai Nebera, Interview; July 11, 2014

Seremani Warehwa, Interview; July14, 2014

Chinoda Mupangeri, Interview; July 16, 2014

Yassin Farrid, Interview; July19, 2014.

Chihora Chihora, Interview; July 21, 2014

Matanda Makuru, Interview; July 25, 2014

Mashura Masiya, Interview; July 26, 2014

Chakosha Zhou, Interview; July 26, 2014

Takavafira Zhou\*, Interview; July 31, 2014

Notes: \* real name.

## APPENDIX A1: INTERVIEW GUIDE

This interview guide is not rigid but rather fluid as new aspects worth pursuing may emerge during the interview session with some participants. However the following questions serve as a general guide of the area around which the discussion revolves. The questions are not necessarily going to follow the sequence below and not all of them may be asked, or neither all of them will be pursued with each participant.

1. Views and opinions on circumcision
  - i. What is circumcision?
  - ii. What is the rationale behind circumcision?
  - iii. How is it done?
  - iv. What is the significance of circumcision?
  - v. Do you associate circumcision with any health benefits for the Lemba man?
  
2. Knowledge and attitude about medical male circumcision
  - i. Have you heard about medical male circumcision?
  - ii. What is your understanding of it?
  - iii. In your understanding, does MMC differ from circumcision?
  - iv. Tell me what you think about MMC.
  
3. What are the socio-cultural factors impeding or facilitating collaboration with MMC?
  - i. As Lembas, are you collaborating with MMCs?
  - ii. Have you embraced MMC? Explain.
  - iii. What are the challenges in embracing MMC? (If any).
  - iv. How can these be dealt with?
  - v. Tell me what you think about Lemba members who circumcise the medical route.
  
4. Medical male circumcision and health from a Lemba perspective
  - i. It is said that MMC prevents HIV transmission. Can you tell me what you think about this?

## APPENDIX A2: INTERVIEW GUIDE (SHONA VERSION)

Gwaro rino remibvunzo rakasununguka kurishandisa uchitangira paunoda, nokuti imwe mibvunzo inogona kungonyuka munhaurirano. Zvisinei mibvunzo iyi inoshanda segwara rekuitisa nhaurwa maererano nenyaya iri mudariro. Mibvinzo haibvunzwi ichitevera gwara uye hazvirevi kuti mibvunzo yose ichabvunzwa kumupinduri wese semarongerwo ayakaitwa.

1. Maonero nemafungiro maererano nekudzingiswa kana kuchecheudzwa
  - i. Chii chinonzi kuchecheudza?
  - ii. Ko kuchecheudza kune chizato chei?
  - iii. Ko iko kuchecheudzwa kunoitwa sei?
  - iv. Tinoziva mumwenye anonzi akatamba. Ko kutamba kwakakosherei?
  - v. Ko kutamba kune chekuita here nebonde kana neutano hwemurume wechimwenye?
2. Ruzivo nematorero amunoita kudzingisa nenzira yekuchipatara
  - i. Ko iko kuchecheudzwa kunoitwa sei?.
  - ii. Nzwisiso yenyu yakamira sei maererano naiko kuchecheudza kwemhando iyi?
  - iii. Mukunzwisisa kwenyu ko kuchecheudza muchpatara kwakasiyana pai nekwe chiMwenye?
  - iv. Tell me what you think about Lemba members who circumcise the medical route.
  - v. Ko mafungiro enyu akamira sei?
3. Ndezvipi zvizato zvechivanhu zvingakanganisa kudyidzana pakati pemhando mbiri dzekudzingisa idzi?
  - i. SevaMwenye munekudyidzana here nevachecheudzi vechipatara?
  - ii. Kuchecheudza muchipatara kwava nekanguva kuchiitwa. Imwi sevaMwenye makatambira tsika yekuchecheudza iyi here? Tsanangurai zvizere.
  - iii. Ndezvipi zvimhingaidzo zvinosanganwa nazvo mukudyidzana kana kutambira tsika iyi? Tsanangurai kana zvingadai zviripo?

- iv. Mungandiudzawo here matorero amungaita kana muMwenye achecheudza nemhando yechibatara?
4. Kudzingiswa, utano nemaonero evaMwenye
- i. Zvinonzi kudzingiswa kuchipatara kunodzivirira kutapurirana utachiona hunokonzeresa chirwere cheshuramatongo.  
Mungatsanangurawo here zvamunofunga panhau iyi?

## APPENDIX B1: INFORMED CONSENT DOCUMENT

Dear Participant

Thank you for agreeing to participate in my study. It is part of the requirements for a Master's degree in the Department of Psychology of the University of KwaZulu-Natal, Durban, South Africa. My topic is: *'Just a Snip?' Lemba traditional circumcisers' perspectives on medical male circumcision for HIV prevention in Mberengwa district of rural Zimbabwe.*

All you are requested to do is to participate in an audio recorded 45 minutes – 1 hour interview on issues around medical male circumcision for HIV prevention. All information gathered will remain strictly confidential. To ensure this confidentiality, you will be assigned pseudonym when discussing findings in the research report.

Your participation will take place at a time and place that is convenient to you and in the language you are comfortable and best expressive in.

Participation in this study is not mandatory as you are free to choose not to participate or even withdraw from participation at any time without giving reasons for withdrawal. If you choose to refuse to participate, you will not be at any disadvantage. Similarly, choosing to withdraw at any point during the research will not leave you disadvantaged in any way. However, the information you would have provided before withdrawal will be used for the purposes of the study.

You will be favoured with transcripts of the recorded information you would have provided to verify accuracy of contents. After the study, you will also be favoured with summarised versions of the analysed findings. There is no maximum duration when both these transcripts and recorded interviews will be kept but after completion of the study as the information may be used for further publications. However, it is kept for a minimum period of five years after which the materials can be disposed of.

### **Declaration of consent**

If you have read and understood the contents of this form and are **consenting** to participate in this study, please declare your consent by signing in the spaces below.



I..... (Full names) on .....  
(Date) hereby confirm that I understand the contents of this document and the nature of  
the research project, and I consent to participating in the research project.

Select by ticking the applicable

1. I also hereby consent to have this interview audio recorded [  ].

Or

Do not consent to have this interview audio recorded [  ].

2. Assign me a pseudonym in the research report [  ].

Or

Acknowledge my name in the research report [  ].

*Signed:* ..... *Date:* .....

If you have any questions please feel free to contact me:

**KEMIST SHUMBA**      **E-mail:** [213565322@stu.ukzn.ac.za](mailto:213565322@stu.ukzn.ac.za) or [kemishumba@yahoo.co.za](mailto:kemishumba@yahoo.co.za)

+263 774715258, +27 604 680 490. Alternatively, contact my supervisor

Dr. Olagoke Akintola

Department: School of Psychology

Howard College, MTB

UKZN

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Or

HSSREC Research Office

Ms P Ximba, Tel: 031 260 3587

Email: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)

## APPENDIX B2: INFORMED CONSENT DOCUMENT

Wadiwa mupinduri

Ndinotenda nekubvuma kwenyu kupinda mutsvagurudzo iyi. Tsvagurudzo iyindeye zvidzidzo zvangu zvegwaro repamusoro re Masters zvandiri kuita nebazi re Psychology re Univhesiti yeKwaZulu-Natal, ku South Africa. Musoro wetsvagurudzo unoti:

**Pfungwa nemaonero evachecheudzi vechivanahu vevaRemba maererano nekuchecheudza muchipatara senzira yekudzivirira utachiona hunokonzera chirwere cheShuramatongo.**

Munhaurirano iyi yamava kupinda, munotarisirwa kupindura mibvunzo mishomana pamusoro pekuchecheudza sedonzvo rekudzvivirira utachiona hunokonzera chirwere cheShuramatongo. Ini semutsvagurudzi ndinokuvimbisai nemwoyo wose kuti zvichataurwa zvicharamba zviri pakati pedu chete zvakavanzika uye ifanero yangu kukuremekedzai kubudikidza nekuchengeta zvatataura pakati pedu. Ikodzero yenyu pane ino nguva kuti muzive kuti kupinda kana kubuda mutsvagurudzo iyi isarudzo yenyu uye hapana chakashata chingakuwirai nekuda kwesarudzo yenyu iyi. Kana mapinda, hamutarisirwi kuti mutsanagure chikonzero chekuti mazofungirei kubuda mutsvagurudzo iyi nokuti ikodzero yenyu kuita zvamada panguva iyoyo pasina kutya kana kuvhunduka.

Nzvimbo nenguva yekuita nhaurirano yenyaya iyi ngaive yamakasunungukira imwi uye nguva inogona kuva maminiti makumi mana anorudzira.

Mabvuma kupinda mutsvagurudzo iyi isai runyoro rwenyu apa kuratidza kuti maverenga gwaro rino mukanzwisisa uye mukagutsikana.

Ini.....(zita ruzere) musi  
wa..... ndinobvuma kuti ndanzwisisa donzvo retsvagurudzo  
uye ndazvipira kupinda mutsvagurudzo iyi. Ndzanzwisisa kuti ndine kodzero yokubuda  
munhaurirano uye kubuda uku kunenge kusina manikidzo yekupa tsanangudzo yedanho iri.

Ratidzai neku tika pakakukodzerai

1. Ndinobvuma kuri nhairirano iyi irhikodwe [ ].

Handibvumi kuti nhairirano iyi irhikodwe [ ].

2. Vanziridzai zita rangu mugwaro retsvagurudzo [ ].

Buritsai zita rangu mugwaro retsvagurudzo [ ].

Mune mibvunzo ndibatei pa (+263) 0715 647 512 Kemist Shumba kana kuti mutungamiri wetsvagurudzo yangu kuchikoro kwangu:

Dr. Olagoke Akintola  
Department of Psychology  
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Kana kuti:  
HSSREC Research Office  
Ms P Ximba, Tel: (+27) 031 260 3587  
Email: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)

## APPENDIX C: ETHICAL CLEARANCE CERTIFICATE



04 June 2014

Mr Kemist Shumba (233565321)  
School of Applied Human Sciences - Psychology  
Howard College Campus

Protocol reference number: HSS/0474/014M  
Project title: 'Just a Snip?': Lemba traditional circumcisers' perspectives of medical male circumcision for HIV prevention in Mberengwa district of rural Zimbabwe

Dear Mr Shumba,

### Full Approval – Expedited Application

In response to your application dated 03 April 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Take this opportunity of wishing you everything of the best with your study.

Yours faithfully,

Dr Sheryka Singh (Chair)

/s/

Cc Supervisor: Dr. Drogoko Akintola  
Cc Academic Leader (Research): Professor D McCracken  
Cc School Administrator: Ms Auné Luthuli

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Robyn Clarke    Edgwood    Howard College    Middelburg    Pietermaritzburg    Westville

